Birmingham and Solihull Mental Health NHS Foundation Trust

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Board of Directors Public Meeting

09.00, Wednesday 3 December 2025, Uffculme Centre

AGENDA

Ref	Item	Purpose	Report type	Time
	Service User 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 1 October 2025**	Approval	Enc	09.35
5	**Matters arising from meeting held on 1 October 2025**	Assurance	Enc	
6	**Chair's Report** *Phil Gayle, Chair*	Assurance	Enc	09.40
7	**Chief Executive and Director of Operations Report** *Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Executive Director of Operations*	Assurance	Enc	09.45
8	**Board Assurance Framework** *David Tita, Associate Director of Corporate Governance*	Assurance	Enc	10.00
9	**Corporate Risk Register** *(for information)*	Assurance	Enc	
10	**Integrated Performance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	10.10
	Quality and Clinical Services			
11	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	10.20
12	**Quality and Safety Report** *Lisa Stalley-Green, Chief Nurse*	Assurance	Enc	10.30
13	**Safer Staffing Report** *Lisa Stalley-Green, Chief Nurse*	Assurance	Enc	10.40
14	**Assertive and Intensive Action Plan Highlight Report** *Lisa Stalley-Green, Chief Nurse*	Assurance	Enc	10.50
15	**Resident Doctor Peer Representative Report** *Fabida Aria, Executive Medical Director and Ella McGowan, Resident Doctor Peer Representative*	Assurance	Verbal	11.00
	People			
16	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	11.10
17	**Guardian of Safe Working Hours Quarterly Report** *Hari Shanmugaratnam, Guardian of Safe Working Hours*	Assurance	Enc	11.20
	Sustainability			
18	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.30
19	**Finance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	11.40
20	**Audit Committee Report** *Winston Weir, Non-Executive Director*	Assurance	Enc	11.45
21	**Caring Minds Committee Report** *Monica Shafaq, Non-Executive Director*	Assurance	Verbal	11.55
22	**Trust Strategy Report** *Patrick Nyarumbu, Deputy CEO*	Assurance	Enc	12.05
23	**Committee Terms of Reference** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	12.10
	Reflections			
24	**Living the Trust Values** *Peter Axon, Non-Executive Director*		Verbal	12.15
25	**Board Assurance Framework reflections**		Verbal	12.20
26	**Any other business**		Verbal	12.25
27	**Questions from Governors and members of the public**			
	Close by 12.30			

Date and Time of Next Meeting: Wednesday 4 February 2026, 09.00-12.30

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST Minutes of the Public Board of Directors Meeting Wednesday 1 October 2025, 09.00, Uffculme Centre			
Members	Philip Gayle	PG	Chair
	Fabida Aria	FA	Executive Medical Director
	Peter Axon	PA	Non-Executive Director
	Sue Bedward	SB	Non-Executive Director
	Bal Claire	BC	Deputy Chair/Non-Executive Director
	Linda Cullen	LC	Non-Executive Director
	Vanessa Devlin	VD	Executive Director of Operations
	Roisin Fallon-Williams	RFW	Chief Executive Officer
	Nick Moor	NM	Associate Non-Executive Director
	Patrick Nyarumbu	PN	Deputy CEO/Executive Director of Strategy, People and Partnerships
	Monica Shafaq	MS	Non-Executive Director
	Lisa Stalley-Green	LSG	Executive Director of Quality and Safety/Chief Nurse
	Dave Tomlinson	DT	Executive Director of Finance
	Winston Weir	WW	Non-Executive Director
Attending	Kat Cleverley	KC	Company Secretary (minutes)
	David Tita	DTi	Associate Director of Corporate Governance
Observers	Two governors and one member of staff/the public observed the meeting in person.		

Ref	Item
0	**Staff Talk** CYP colleagues attended to talk about the transfer of staff and the service into BSMHFT. Key themes highlighted included the helpful integration support, with good support from HR and IT colleagues and how inclusive and engaging everybody had been. The team commented on the compassion received throughout the process. There were some concerns in relation to IT, including making sure laptops and phones worked and that CYP staff could not yet access room bookings. The team noted that many of these issues would be worked out during Phase 2. The team had received feedback from staff who had felt no discernible change during the transfer. Patients had also not been affected. The team highlighted staff shortages and repeating mandatory training. Pharmacy issues relating to timeliness and responsiveness were raised. The team commented on the bus tour and noted that staff felt very welcomed. Staff had fed back that they found the Trust induction helpful and the felt well cared for. RFW commented that it was positive that there had been minimal disruption to young people and families, which was down to how everyone worked together as a team. RFW apologised for the pharmacy experience which would be reviewed. The Culture of Care programme could potentially be looked into for CYP. LC noted that she was heartened to hear an overall positive experience of the service transfer, and noted that time needed to be given to the team to ensure training was completed. BC commented that it was clear that the CYP team was patient focused and wanted to achieve the best outcomes. BC asked what the team would like to see in a year's time that made a real difference. Team fed back about estate, in particular car parking at Oaklands. PN noted that the CYP team would be involved in the Trust's strategy refresh, and reminded the team that the Trust valued feedback through the staff survey.

	PG commented on the Board's anticipation of the all-age model and welcomed the CYP team to the Trust. The Board thanked the team for attending to share their experiences of the transfer.
1	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting, and PA was formally welcomed to the Board.
2	**Apologies for absence** None.
3	**Declarations of interest** No new interests were declared.
4	**Minutes of meeting held on 6 August 2025** The minutes were approved as a true and accurate record.
5	**Matters arising from meeting held on 6 August 2025** All actions were updated.
6	**Chair's Report** The Board received the report and PG highlighted the following key points: • The Trust's AGM had been held on 23 September. PG commented on the different format, with a more engaging style and stalls from various areas of the Trust and a workshop delivered by Women in Theatre. Governors had a stall and several young people had expressed an interest in working more closely with the organisation. • PG had visited several sites, including Orsborne House where staff had noted increased referrals but were clearly proud of the services they delivered.
7	**Chief Executive Officer and Director of Operations Report** The Board received the report and noted the following key points: • There was steady improvement reported in many key performance indicators, however the CYP transfer had impacted on bank and agency use. • The Trust was reviewing short-term sickness absence rates, and the Board noted the 24/7 access available through Optima Health for specialist services such as counselling. • The Trust had ratified the Sexual Safety Policy. • There was ongoing balloting for industrial action. • The Mental Health Provider Collaborative continued to develop, and RFW highlighted the recent Lifecourse specification and inks to the CYP service. • The team continued to enhance the mental health support teams in schools offer. • The Trust met with NHSE each month to discuss the financial recovery plan. • The rollout and phasing of the Culture of Care programme continued across the organisation. • The Recovery College celebrated its ten-year anniversary. • Cluster arrangements for ICBs had been confirmed; BSMHFT would be part of the Black Country, Birmingham and Solihull ICB. The Chair and CEO had been confirmed. • Finance, Performance and Productivity Committee had visited Omnia Practice and the 24/7 Neighbourhood Centre. • The digital offer the deaf service was highlighted. • The Winter Plan had been discussed and approved by the Board in September and would be signed and submitted.

	LC commented on medical workforce and issue of agency use in urgent care pathways, querying whether alternative models for job planning could be considered. FA noted that the Trust was discussing with CYP about the challenges they experienced and how the pathway could be improved. VD noted that the Lifecourse specification would look to provide one offer around urgent care and how the team could work more closely together. The Board discussed how the 24/7 team supported sustainable care for service users, with continuity and delivery of services from the centre being placed in the heart of the community. PG asked about system integration and how the Trust was working with partner agencies over the winter period to divert pressure. VD advised that partners were very engaged and invested in Recovery House for Birmingham Mind, focused on step down and alternative to admission. There were many other pathways and routes to reduce winter pressures, including Talking Spaces, Call Before Convey, the Psychiatric Decisions Unit, and locality coordination centre. VD commented that Finance, Performance and Productivity Committee would receive showcases from these areas on the work that was being undertaken. RFW noted that the Committee could monitor how many patients were in each site, as data was nationally collected, and monitor the intention and focus and the impact that joint working was having.
8	**Board Assurance Framework** DTi presented the current version of the BAF, advising on updates to SR3, SR4 and SR7. DTi confirmed that the new risk appetite framework would be aligned to the BAF once approved. WW commented that there had been a full review of the BAF at September's Audit Committee, noting that the key challenge was around the pace of developing the Trust's refreshed strategy, whilst acknowledging the amount of consultation work underway to ensure all staff have been engaged with. PN noted that the goals were set for 2025/26 with flexibility included to ensure the Trust could adapt to challenges. PN reinforced the importance of listening to staff to ensure the strategy was coproduced. BC noted that the approach to the strategy was right, but noted the conversation related to how quickly the Trust could make changes and whether there was enough focus on the future. RFW commented that the Board had discussed the strategy in two sessions so far, and could continue to hold these conversations as a Board in future discussions. BC commented that he had recently attended Risk Management Group meetings and was assured by the conversations, noting that the continued alignment of the Corporate Risk Register to the BAF needed to be proactive rather than reactive. PG asked Committee Chairs how well the BAF was integrated and scrutinised at meetings. There was positive feedback about how well the BAF was embedded and was central in driving the agendas, reflected in reports and was reviewed and highlighted throughout meetings. WW noted that Audit Committee had also discussed external risks that impacted on the BAF and Corporate Risk Register, and assurance had been provided on how these were managed.
9	**Integrated Performance Report** The Board received the report and discussed the following key points: • A deep dive into CYP services had taken place, with very impressive feedback. The team was fully aware of issues and was performing well across a range of measures. • NM commented on Clinically Ready for Discharge and beds that were being used by people who were ready to leave. VD described the focused work around older adults and partnerships with agencies to coordinate discharge. RFW commented on the need to consider more productivity and the impact of working relationships with agencies to address clinically ready for discharge. • The Trust was reviewing a new set of metrics around bank and how shifts were being filled. • SB noted some inconsistency in data reporting. SB and PN had discussed data cut off points during the month and the need to consider whether this could be coordinated and streamlined once for all reports.

	• PA raised the need to utilise Statistical Process Control (SPC) tools to present the key important data. PA also highlighted the importance of data quality, particularly in relation to the five-year strategy planning.
10	**Quality, Patient Experience and Safety Committee Report** The Board received the report for information. LC highlighted the key points from September and August meetings: • The Committee continued its site visits, having recently visited Reaside, Zinnia and Juniper. The Committee was hoping to visit a CYP site next. • Safeguarding training compliance within CYP had been highlighted as an area of focus. • The Committee received information on the ongoing investigation into the Larimar incident. • Well-led preparations were ongoing. • The intensive and assertive action plan had been received and endorsed. PG asked about the assigned responsible clinician issue raised under the Mental Health Act Legislation Committee report. FA provided assurance on the process and that time had had been given to ensure the legislation was adhered to. BC commented on the complaints process and how well complaints were being managed. LSG advised that a deep dive was undertaken into complaints, and there were a significant number still found to be allocated. A lead complaints manager was now in post and was implementing greater rigour of processes and monitoring. Initial family contact was also being implemented and was resulting in earlier resolution. LSG noted the focus on closing down complaints that had been open for a long period of time, and the next step to look into the culture of complaints.
11	**Quality and Safety Report** LSG presented the report, highlighting the following key points: • Three deaths across the Trust were related to physical health issues. • Family liaison was in place in relation to the Larimar incidents, with terms of reference now agreed for the investigation. An audit was taking place into multi-disciplinary team standards, care and safety plans and how this fed into the Safe Care dashboard. LSG also noted that there was a review of Dialogue Plus and how this was used in practice. • The Safe Care dashboard was presented to the Board for information; this would be rolled out across the organisation. • There were new risks identified at the mother and baby unit and would be discussed fully at Risk Management Group. • The Culture of Care programme was now live across all acute wards. • The team was also reviewing culture of night working and levels of risk, and a Staff Safety Strategy had been developed. • The flu campaign had been launched on 1 October. BC queried the alignment of activities to well-led review preparations, and LSG described the general approach including setting out the strategy and how it was demonstrated through clinical services and delivery, showcasing and showing pride in the work delivered by the Trust.
12	**Assertive and Intensive Action Plan** The Board received the action plan and approved the submission.
13	**People Committee Report** The Board received the report for information. SB highlighted the key points from September's meeting: • The Committee was alerted to the impact of the CYP transfer in relation to increased workforce pressures, and increase in agency use.

	• Subcommittee quoracy concerns had been raised, with a lack of representation from various professions. • The Committee received assurance from the Medical Directorate Report, which highlighted doctor appraisal compliance of 97%. • Assurance had been received on staff survey planning, particularly how the Trust planned to engage with hot spots from last year. • The Committee noted reduced sickness absence, noting that the Trust had the lowest sickness absence rate across the system. • SB reiterated the data consistency needed across all reports. PN noted that the team would consider data cut off points and review. • The Committee noted that the apprenticeship levy was underutilised, particularly in leadership and management development courses.
14	**Finance, Performance and Productivity Committee Report** The Board received the report for information. BC highlighted the key points from September and August meetings: • The Committee continued to track and monitor progress against delivery of the 2025/26 plan, which was a significant challenge and came with associated risks. • The Committee had discussed the planning for 2026/27, including digital opportunities and how the quality improvement team would support efficiencies. The delivery of recurrent savings was highlighted as a significant concern. • An extraordinary session had been held in August, focusing on the National Oversight Framework. • The Committee had discussed whether a specific digital subgroup was required. RFW queried whether the current structures enabled delivery of the digital strategy or whether this should be considered on a wider scale through the new ICB cluster. PG asked how the Board could be assured that the savings delivery was recurrent. BC advised that the Committee was not assured on this, as the majority of the £36m savings for 2025/26 would be made through non-recurrent means. PA commented on the need to link to the provider capability assessment, and utilise benchmarking data to consider whether the Trust could be more ambitious. ***Delegation of Approval of Green Plan*** The Board formally noted delegation to Finance, Performance and Productivity Committee for approval of the Green Plan, which would be published by the end of October to meet NHSE requirements.
15	**Finance Report** The Board received the report for information, noting the position around bank spend within CYP services and the plans required to reduce this.
16	**Audit Committee Report** The Board received the report. WW highlighted the focus on risk management and the discussions that had taken place regarding the impact of external risks on the Corporate Risk Register and Board Assurance Framework.
17	**NHS Provider Capability Assessment Update Report** The Board received the progress report for assurance.
18	**Risk Appetite Framework** The Board received the framework and agreed the following: • Reputational risk: 'Open' approach agreed • Digital risk: 'Eager' approach agreed

19	**Risk Management Policy** The Board approved the policy, subject to amendments to Finance, Performance and Productivity Committee subcommittees and language change from 'shop floor' to 'teams and services'.
20	**Audit Committee Terms of Reference** Approved.
21	**Board Effectiveness Annual Self-Assessment** The approach was approved.
22	**Living the Trust Values** PN reflected on judging September's Team of the Month. He had visited Shenley Fields and saw the compassionate nature of staff. PN noted that the Central Assertive Outreach team had won Team of the Month for the work that was being done in such a compassionate way, particularly for one service user who was supported to reconnect with family and stay in current accommodation following a physical health diagnosis.
23	**Board Assurance Framework reflections** The Board noted that consideration of external risks would be given for the next iteration of the corporate risk register, and how these were reflected in the BAF.
24	**Any other business** None.
25	**Questions from Governors and members of the public** No questions were submitted.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
Risk Appetite Framework	The Board agreed on the approach to Reputational and Digital risks, and approved the risk appetite framework.		
Risk Management Policy	Approved, subject to minor amendments.		
Audit Committee Terms of Reference	Approved.		

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	6					
Date	3 December 2025					
Title	Chair's Report					
Author/Presenter	Phil Gayle, Trust Chair					
Executive Director	Phil Gayle, Trust Chair	**Approved**	**Y**	✓	**N**	

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

Summary of Report

Alert		**Advise**		**Assure**	

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

Recommendation

The Board is asked to receive the report for information.

Enclosures

N/A

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 cultural change and embedding the *Culture of Care* across our inpatient wards. This work is already delivering positive outcomes for staff morale and wellbeing, though we recognise there is still more to do. Our Executive Team, operational managers, and dedicated staff remain committed to providing high-quality care across both community services and inpatient settings.

These achievements come against the backdrop of a challenging national context, where NHS organisations are being asked to exercise greater financial discipline. We are acutely aware of the pressures this places on our workforce, and we remain steadfast in our commitment to supporting staff while maintaining the highest standards of care. Our approach is aligned with the ambitions of the NHS Long-Term Plan and the NHS Oversight Framework, ensuring that our strategic direction promotes sustainability, quality improvement, and better outcomes for service users. I am proud of the resilience and professionalism demonstrated across the Trust as we navigate these demands together.

Since our last meeting, I attended the Midlands NHS Leadership Meeting in Leicester, alongside NHS Chief Executives and Chairs, where discussions focused on regional priorities and collaborative approaches. I also participated in the NHS Providers Annual Conference in Manchester, which offered valuable insights into national policy developments, leadership challenges, and opportunities for innovation across the sector.

As we close the months of October and November, it is clear that our Trust continues to demonstrate resilience and commitment in the face of significant national challenges. The NHS is operating under sustained pressure, with financial constraints, workforce shortages, and rising demand shaping the environment in which we work. Despite these realities, I am proud of the progress we have made in strengthening our culture, improving quality, and maintaining a clear focus on patient care and staff wellbeing.

Looking ahead, we must remain agile and collaborative, ensuring that our strategic priorities align with the NHS Long-Term Plan and the expectations of the Oversight Framework. By continuing to engage openly with our Governors, partners, and communities, we can navigate these challenges together and build a sustainable future for the Trust. I am confident that, with the dedication and professionalism of our teams, we will continue to deliver high-quality care and make a positive difference for those we serve.

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.

We held our first BSMHFT Board Well-Led facilitated session, which focused on strengthening governance, leadership effectiveness, and alignment with the Care Quality Commission's Well-Led framework. This session provided an opportunity for constructive discussion and reflection on how we can continue to improve Board dynamics and strategic oversight.

I had the privilege of chairing the recent Council of Governors meeting, which proved to be highly constructive and collaborative. Governors offered valuable insights and posed thoughtful questions, contributing to a robust discussion on the Trust's strategic priorities. The session reflected a strong commitment to transparency and partnership, with open dialogue helping to shape a shared understanding of how we can continue improving service delivery and patient experience. It was encouraging to witness such engagement and dedication to our collective responsibility for the Trust's vision and accountability.

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.

Roisin and I visited 24/7 Neighbourhood Centres with Danielle Oum BSOL and Black Country Chair which was a really positive visit.

David Slatter and I also visited HMP (Her Majesty's Winson Green Prison) Birmingham to look at the work we are doing in with regards to prison care. We were really impressed with the work we are doing in a challenging environment.

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, in my role as Chair, I've remained 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.

Additionally, I attended the BHP Annual Meeting, which brought together key partners to discuss research, education, and innovation priorities across the region. This was an excellent opportunity to reinforce our commitment to collaborative working and to explore how academic partnerships can support service improvement and workforce development.

4. Stakeholder Engagement

I continue to Chair the Council of Governors meetings, where we dedicate time to receiving assurance from our Non-Executive Director colleagues on key areas of focus for the Trust, while fostering meaningful discussions and supporting ongoing development.

In addition, I maintain regular monthly meetings with NHS Midlands, 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.

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, Patrick Nyarumbu, Deputy Chief Executive, and both Executive and Non-Executive Directors to maintain strong leadership cohesion.

My 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

PHIL GAYLE

CHAIR

Report to Board of Directors							
Agenda item:	**7**						
Date	3 December 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 Officer and Director of Operations Report

PEOPLE

People Goals

- Targeted equality actions: There is ongoing work to address the disproportionate involvement of staff from global majority backgrounds and men in formal cases, with divisional Workforce Inequality Plans and strengthened collaboration with Inclusion Advisors.
- Manager capability and support: Masterclasses and coaching for managers on investigations, discipline, and just culture principles are being delivered, with positive feedback and increased confidence in handling complex cases.
- Knowledge and resource accessibility: The CONNECT Knowledge Base and Resource Hub has improved access to HR guidance and operational tools, supporting self-sufficiency and reducing delays.
- Temporary staffing reductions: Agency usage increased slightly within the Children and Young People (CYP) TUPE however we have had a 38% decrease in non-medical agencies since July. Bank reduction remains an area of focus.
- Improving Working Lives of Resident Doctors: Following publication of the 10-Point Plan by NHSE, we have established a working group to include Resident Doctor representation to progress the Trust Action Plan.

Strategic Interventions

- Divisional hotspot interventions: Acute and Urgent Care and Secure and Offender Health division's remain priority areas due to higher levels of disciplinary and dignity at work cases, with recurring themes of violence/aggression, sexual misconduct, and fraud. Interventions include sexual safety training, restorative practices, and targeted equality actions. These divisions are being supported to address fraud matters appropriately. There is also additional support being provided to CYP services to increase their Fundamental training compliance.
- Sustainability of support: Temporary support for the Children and Young People division is not sustainable beyond March 2026, with a review of People Operations team structures is underway to ensure ongoing support across all areas.
- Medium Term Planning: An integrated planning group has been set up to develop and support our planning. We are still waiting for the associated templates and technical guidance but have an ICB deadline of 9 December for the first submission.

Additional Information

- Positive trends despite challenges: Despite recent spikes, there has been a 32% reduction in active cases from the previous peak, indicating overall improvement in case management and resolution.

- Job Evaluation: A detailed review of the Trust's Job Evaluation processes and infrastructure is underway, ensuring that this process best supports our people and is resilient.
- Temporary staffing solutions quality improvement: Work continues to ensure we have a more sustainable and manageable bank workforce with higher levels of training compliance and supervision.
- Resident Doctor Industrial Action: Resident Doctors industrial action took place again from 7am Friday 14th November 2025 to 7am Wednesday 19th November 2025. Clinical work that had to be cancelled was rearranged, and a backup Rota was established to cover all on call shifts over the period, ensuring provision of patient care out of hours.
- Learning and Development Strategy: This will be available in December 2025 and will map out Trust offers in line with local, regional, and national drivers.
- Study leave policy: This policy is being revised and will include an equitable and transparent study process that will enable data collation and provide clarity for staff and managers.
- Coaching and mentoring framework: This is being developed, and the offer will be available by March 2026.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

Progress continues across the Integrated Community Care and Recovery division, with a focus on reviewing the complexity of caseloads and collaborating with the wider Trust and system partners. Efforts are underway to refine a new cross-pathway data dashboard, supporting all divisions in monitoring Key Performance Indicators. The rollout of the Patient Initiated Follow-Up pilot is advancing, with processes and documentation being reviewed at key governance forums to support implementation. This initiative aims to improve patient flow through Community Mental Health Teams and empower service users to initiate their follow-up care. Oversight through the Financial Performance Panel remains focused on diagnostic data capture, including Next of Kin, outcome appointments, Did Not Attend (DNA) rates, and diagnosis. Quality Improvement projects are in place to address these areas.

Neighbourhood and Community Mental Health Teams (NMHTs and CMHTs):

Clinics are being piloted in Voluntary, Community, Faith and Social Enterprise (VCFSE) community spaces, enhancing partnership working and supporting people to be seen within their communities. Integrated Neighbourhood Teams (INTs) continue to be established, with staff onboarding led by Birmingham Community Health Care. Two new INTs have launched in the East locality.

Community Mental Health Teams (CMHTs):

Demand continues to rise, with increasing numbers of new and complex referrals. Staff capacity and sickness levels are being closely monitored, with plans in place to ensure clinical rigor. The 24/7 service will soon move to its permanent base, enabling the full handover of service users on depot and clozapine treatments from Small Heath to the new location. Matrons are reviewing Multi-Disciplinary Team standards to promote effective discussions and leaner working practices. Individual Community Mental Health Team Key Performance Indicator meetings have commenced, chaired by the Associate Director and supported by the Head of Service and Clinical Service Managers, to address current pressures and identify solutions. A Multi-Disciplinary Team working group has been

established to address gaps in provision for individuals with Learning Disabilities, with strong links to the Birmingham and Solihull Steering Group for Learning Disabilities and Autism. Recommendations from a recent service evaluation are being reviewed to ensure reasonable adjustments are embedded.

Assertive Outreach Teams (AOTs):

Joint working with acute care and bed management has improved patient flow. Assertive Outreach Team managers support twice-daily bed management conference calls, coordinating admissions and escalating delays as needed. Progress continues with the Community Mental Health Team interface, reducing waiting lists. The Intensive Community Rehabilitation Team (ICRT) has increased caseload capacity and diverted high-cost care packages as planned.

Solar:

Solar is working with partners, including Barnardo's, to provide assurance around service provision, particularly for Mental Health in Schools Teams. Secondary care waiting times remain a focus, with updated job plans being a focus to ensure effective working, and a Capacity and Demand model has been developed to support service planning and reduce waits. The Integrated Community Care and Recovery Quality Improvement project on addressing culture-based health inequalities was presented at the Asian Professional National Alliance 2025 Conference, receiving first prize for research and innovation.

Acute and Urgent Care (A&UC)

Workforce Updates:

Appraisal completion rates have improved, now at 79.6% across the Directorate. Clinical Supervision metrics show significant progress, and Regular Management Supervision figures are steadily rising. Fundamental training compliance remains strong at 94.4%. A business case is being developed to enhance the Home Treatment workforce, aiming to strengthen community support, reduce admissions, and facilitate earlier discharge from inpatient settings.

Quality and Safety:

Support and funding has been agreed to proceed with a proposal to pilot a de-escalation room on George Ward in the North of Birmingham. The scope of this room will align with existing Trust policies and procedures, with an expected outcome of further reducing restricted practices.

Learning Improvement Network (LIN) and National Oversight Framework (NOF):

Length of Stay: Colleagues participated in a Learning Improvement Network event focused on strategies to reduce length of stay and improve performance in this area. Linking with the NOF requirements an action plan has been finalized, which builds on the Patient Flow Improvement programme and reflects a system-wide approach, this will be monitored through established governance channels, aligning closely with the Culture of Care programme.

Framework Contract Beds:

The division has begun using new framework for contracted beds following a competitive procurement exercise. Collaborative work includes daily bed management calls, formulating a new In-reach Standard Operating Procedure, and strengthened arrangements for extra observations. A 'Get to Green' model has been developed to guide bed utilisation, categorised as green, amber, or

red, each with specific actions to restore optimal status. A practice standard for bed escalation has been approved and outlines escalation levels when internal beds are unavailable.

Good News:

Strong engagement with the Staff Survey: ten teams have achieved response rates above 70%, including four Home Treatment teams at 100%. Twelve teams have met the minimum requirement for team-level results, supported by regular communications.

Children and Young People's Division (CYP)

Children & Young People's Access performance continues to improve well, with Birmingham & Solihull ICB delivering 108% of the national target and now ranked 11th best system in England. Discussions are currently taking place to recommend a formal step-down of the Recovery Action Plan.

Crisis demand and flow across our 18-25 pathway has stabilised as increased oversight and improvements are now well embedded, reporting shows sustained caseload reductions and reduced adult bed usage contributing directly to flow, quality and financial stability. The caseloads are now consistently below maximum thresholds for the first time in over a year. In parallel, the Division continues to maintain a circa 60% reduction in adult inpatient bed usage, compared with the same period last winter.

Our Early Intervention in Psychosis service sustained performance above the national standard at 73% (Referral to treatment), despite a sharp increase in referrals and caseloads remaining above recommended staffing ratios. Clinical outcome recording completion remains strong.

The Specialist Eating Disorder service continues to provide high-quality care, with 100% of urgent cases seen within 1-week, high assessment utilisation and zero inpatient admissions in month. Access performance has dipped to 60% due to a small number of service users who fall into the volatility and Avoidant/Restrictive Food Intake Disorder cohort which has driven down some delays with accessing the service.

Secure Care and Offender Health (SCOH)

Psychology: Recruitment of registered practitioner psychologists remains challenging, particularly into the men's inpatient services. Plans are in place to provide psychological cover, with some successful recruitment at Band 8a and 8b levels. The service received positive feedback from the Enabling Environment award visit and the first national evaluation report for the Enhanced Reconnect service.

Service User Lead Recovery Pathway: Experts by Experience collaborated with Belgrave Theatre to produce a play based in a Secure Mental Health Hospital. An Art exhibition was held at Reaside, showcasing the excellent service users work. Recovery Suppers continue and are well attended. Patient Reported Experience and Outcome Measures for the last quarter will be presented at the next Patient Care Group meeting.

Reaside and Hillis Lodge: We are pleased to confirm we currently have no Registered Mental Health Nurse vacancies and only have six Healthcare Assistant vacancies. We are also achieving improvement in Occupational Therapy vacancies and psychology vacancies. Culture of Care work continues, with progress being shared in the Royal College of Psychiatrists newsletter. Our Advanced Nurse Practitioner for Physical Health has commenced in post. The division held successful

celebration events for Occupational Therapy Week, Black History Month, and Diwali along with a Freedom to Speak Up Masterclass event. Our Positive Patient Reported Outcome Measures report was completed.

Tamarind: The service is generally well staffed, with new nurses allocated to cover upcoming leavers. Occupational Therapy provision has improved, and teams are being supported and challenged to ensure timely assessments, referrals, admissions, and discharges. Planning and scrutiny continue across the inpatient wards in the division to reduce length of stay, with barriers identified and escalated as needed.

Meetings have taken place with Experts By Experience (EBE'S) to discuss what a good night shift should look like, feedback will be shared with managers with a focus on areas of improvement. Close working with teams & the Head of Nursing is taking place around effective roster management in line with bank gold and safer staffing. Our Black History Month went well with a moving tribute paid to our late Carers Lead Dawn.

HMP Birmingham: Clinical activity remains very busy within healthcare. Ongoing estates remain a concern which includes fire extraction work, which has resulted in cells being out of use in the health care wing and delays in admissions to the mental health wing. Medication hatch work, commenced on 17th November, this work will take at least 8 weeks, we are working closely with the prison to ensure that all prisoners receive their medication safely during this period. Excellent feedback was received following the recent inspection by HMIP and CQC, Healthcare was recognised as being efficient and delivering good quality care. Some areas required action plans which have been completed.

FIRST: Renovations at Main House are on track for a move in March/April 2026, with service user involvement in the planning and recruitment is ongoing. Data collation improvements are underway, with new reporting forms launching soon. An oversight group is developing plans to streamline service delivery. Service user groups, including football, breakfast, and brunch clubs, continue to run, with new groups planned. Experts by Experience involvement remains strong, with training for new participants planned. An inequalities workstream will launch, focusing on supporting those with no recourse to public funds.

Primary Care, Dementia Services & Specialties

Specialties: The Jasmine Suite (Deaf service) has started the Culture of Care programme with NHS England, complementing ongoing development work. Key Performance Indicators are improving, and Deaf Awareness training is now available for all staff. The Cilantro Eating Disorder Service is completing a Care Quality Improvement project and has received positive feedback from former service users.

Dementia and Frailty: In September, leads convened for a strategic away day to develop a 12-month business plan, focusing on health and workforce inequalities and quality improvement. There is a strong commitment to delivering measurable change.

Bipolar Service: Two papers have been accepted and published, highlighting innovative interventions and evaluations in bipolar disorder care.

Birmingham Healthy Minds: The service continues to improve recovery rates. A revised recovery action plan was submitted for approval, and a newly recruited Clinical Psychologist will strengthen the service. Training for new and existing staff is ongoing, and service user feedback remains positive.

Perinatal Mental Health Service: The Community Perinatal Mental Health Service continues to exceed its access targets, with increased referrals reflecting successful awareness initiatives, particularly in culturally diverse areas. A Quality Improvement project has significantly reduced Did Not Attend rates by offering home visits for initial assessments, with plans to expand this practice.

Veterans Service: Funding was secured for an art exhibition celebrating Remembrance Day, including a short film to promote service access.

SUSTAINABILITY

Bsol Mental Health, Learning Disability & Autism Provider Collaborative

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

- The framework for adult inpatient acute and psychiatric intensive care unit (PICU) beds went live in October 2025 following a successful procurement process.
- A tender opportunity for a new counselling offer across BSOL has now closed and the evaluation phase has commenced.
- Following a workshop with the Voluntary, Community, Faith and Social Enterprise (VCFSE) Collective a number of areas for action have been identified for inclusion in the local mental health place delivery plans which will underpin the new Mental Health Strategy which is due to be launched in 2026.
- A tender opportunity for Emergency accommodation and wrap around provision has been issued to the market.

Funding and Finances

The NHS continues to experience significant financial pressures, and this is also true in our local system of Birmingham, Solihull and the Black Country.

We continue to manage our position through our financial recovery plan and remain confident that our plans will deliver.

We are currently working to develop plans as part of the NHS Medium Term Planning Framework for the next three years and the first version of these will need to be submitted to NHS England before Christmas. At the moment it appears unlikely that there will be significant levels of new money for mental health so our focus will be on the transformation opportunities in the 10-year plan and how these can support our productivity plans.

QUALITY

Between October 13th and 16th, there was a joint inspection of HMP Birmingham. The team included a total of 18 inspectors – 10 His Majesty's Inspectorate of Prisons, 5 Ofsted and 3 CQC. The initial high-level feedback for healthcare has generally been a positive one, with recognition of improvement in staffing and practices since the last inspection. The healthcare teams were praised 'as one of the best the CQC inspectors had seen in the country'. However, there was also a

requirement for an action plan from the Birmingham Recovery team to demonstrate how they would improve care planning and risk assessments for prisoners. We now await the draft report.

The final report for the North and Central Acute Wards CQC inspection has shown improvement in three domains since the last inspection as indicated in the table below. Both Effective and Responsive have changed from Requires Improvement to Good and Safe has been changed from Inadequate to Requires Improvement. The CQC noted the responsiveness of the Trust to their concerns and a number of actions were taken in respect of the staff gender balance on the female Psychiatric Intensive Care Unit (PICU), and some concerns raised about the culture and level of capability demonstrated by some operational leaders. There was positive feedback about engagement from staff and the number of patients being involved in activities and stating that they felt safe and cared for. The report is published on 27th November 2025.

Domain	North Wards & Zinnia June 2025 Inspection	Zinnia October 2024 Inspection
Overall Rating	Requires Improvement	Requires Improvement
Safe	Requires Improvement	Inadequate
Effective	Good	Requires Improvement
Caring	Requires Improvement	Requires Improvement
Responsive	Good	Requires Improvement
Well-led	Requires Improvement	Requires Improvement

The CQC's annual State of Care report was published on October 24, 2025. Key findings as summarised by Mind are:

- Community services need significant investment in order to help realise the vision of the 10-year plan.
- There has been an increase of 15% in monthly referrals for mental health services since 2022/23.
- Longer waits are linked to worsening mental health. Although an improvement on the 2023 survey findings, more than two fifths of respondents said they felt their mental health got worse while waiting for care.
- There is a lack of holistic care that properly addresses both physical and mental health due to system pressures. Services often focus on medical treatment rather than addressing social, emotional and physical needs.
- Systemic recruitment and retention issues remain, which are creating significant challenges around staff experience and skills. Staff reported feeling burned out and overworked.
- Over a third of respondents to the community mental health survey said they were not given a choice about how their care and treatment would be delivered, and over 1 in 4 (28%) said they did not feel in control of their care.
- There remain longstanding health inequalities faced by Black people. The CQC commissioned Queen Mary University and University College London to carry out a rapid review of what 'good' looks like in relation to care for Black men. Black people are 3 to 5 times more likely to be diagnosed and admitted to hospital with schizophrenia compared with all other ethnic groups.

- Several mental health inpatient providers have raised concerns that ageing estates are increasingly unfit for purpose and do not meet the needs, or even safety requirements, of patients and staff.

The findings resonate with the Trust approach to key priorities for our service users and communities.

LOCAL TRUST, BIRMINGHAM AND SOLIHULL SYSTEM AND MIDLANDS REGIONAL NEWS

BSMHFT Celebrates Double Win at Prestigious RCP Awards

We are proud to announce that two outstanding colleagues from Birmingham and Solihull Mental Health NHS Foundation Trust have been recognised at the Royal College of Psychiatrists Awards.

Dr Nudrat Rizvi was named *Specialty Doctor/Associate Specialist of the Year* for her exceptional work in CAMHS, championing inclusion, neurodiversity, and transformative care. A passionate advocate for service improvement and medical education, Dr Rizvi leads initiatives such as *Invisible in Plain Sight* and inspires SAS colleagues through CESR and CASC teaching.

Dr Rekha Lodhia received the *Carer Contributor of the Year* award for her impactful leadership in lived experience research and mental health promotion. Her work addressing culture-based health inequalities and promoting holistic wellbeing has driven meaningful change across services and communities.

These achievements reflect the dedication and innovation of our colleagues in advancing inclusive, high-quality mental health care.

BSMHFT Shortlisted for HSJ Award for Race Equality

We're delighted to share that Birmingham and Solihull Mental Health NHS Foundation Trust were shortlisted for the prestigious **HSJ Award for Race Equality 2025.**

This recognition reflects our collective commitment to fostering an inclusive culture and advancing race equality across our organisation.

The awards ceremony took place on 20 November in London, and we were thrilled to go along to celebrate this achievement and milestone.

NATIONAL NEWS

CQC publishes State of Care Report 2024/25

The Care Quality Commission's annual *State of Care* report highlights a health and social care system under severe strain, with rising demand, long waits, and persistent inequalities. While there are examples of innovation and improved quality, the report warns that without significant investment in community services, the shift toward neighbourhood care risks eroding care quality. Access challenges remain across GP, dental, mental health, and social care services, with vulnerable groups most affected.

Some detail from the report has been highlighted in the Quality section of this report above. Colleagues are considering the report in detail and will take through our Quality governance route our learning and actions for us as a Trust.

Read the full report here: State of Care 2024/25

NHS Providers and NHS Confederation Announce Merger Plans

NHS Providers and the NHS Confederation have confirmed plans to merge, creating a single membership body to represent NHS organisations across England, Wales and Northern Ireland from April 2026. Following extensive engagement, 85% of nearly 400 senior leaders supported the move, which aims to provide one clear, influential voice for the NHS and strengthen collaboration across the system. A new membership offer will launch in March 2026, with a transition committee, leadership structure, and external recruitment for a chief executive underway. The merged organisation will focus on improving care, supporting members, and driving value for patients and communities.

State of the Provider Sector 2025: Key Insights
The latest NHS Providers report highlights a sector under sustained pressure but showing resilience and adaptability. Trust leaders report cautious optimism on care quality and financial delivery, yet concerns remain high around winter pressures, workforce burnout, and industrial action. While confidence in current staffing has improved, worries about future skill mix persist. Mental health services face particular challenges, with only 9% of leaders believing investment matches demand. Financial constraints and integration hurdles continue to impact progress on the NHS 10-year plan, though examples of digital transformation and neighbourhood health initiatives signal promising strides toward system reform

Read the full report here: State of the Provider Sector 2025

Technical Guidance for Medium-Term Planning
NHS Providers has published a briefing to help members navigate the technical guidance accompanying the Medium-Term Planning Framework for 2026/27 to 2028/29. The guidance sets out key changes to planning and financial allocations, aiming to move away from single-year cycles toward longer-term planning that supports sustainability and productivity. It also highlights NHS Providers' influence on shaping the framework and what the proposals mean for trusts.

Read the full briefing here: Technical Guidance – Medium-Term Planning Framework

Commitment to National Leadership for Mental Health, Learning Disability and Autism

The Department of Health and NHS England have reaffirmed their commitment to maintaining a **National Programme Director for Mental Health, Learning Disability and Autism**, ensuring strong national leadership for these priority areas. Recruitment for this pivotal role is now underway, with the successful candidate expected to drive strategic goals, performance oversight, and improvement initiatives across the system.

Wes Streeting Highlights Concerns on Over-Diagnosis of Mental Health Conditions
Health Secretary Wes Streeting has raised concerns about the risk of **over-diagnosis of mental health illnesses**, warning that resources must be focused on those with the greatest need while ensuring access to appropriate care. His comments form part of a broader discussion on improving mental health services, reducing waiting times, and shifting towards preventive care models. The report calls for balanced approaches that avoid unnecessary medicalisation while strengthening support for genuine cases.

Read more here: Full Report [theguardian.com]

NHS England Responds to ADHD Taskforce Final Report

The independent ADHD Taskforce has published its final report, highlighting urgent action needed to tackle long waits for diagnosis and treatment and improve support across health, education, employment, and justice. Recommendations include recognising ADHD as a common condition, introducing new diagnosis models, expanding professional training, and using digital tools to streamline services. NHS England has committed to reviewing these recommendations and continuing work with local systems to improve access, experience, and outcomes for people with ADHD.

Read the full report here: ADHD Taskforce Final Report

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

Report to Board of Directors							
Agenda item:	**8**						
Date	3 December 2025						
Title	Board Assurance Framework						
Author/Presenter	David Tita – AD Corporate Governance						
Executive Director	David Tomlinson – Executive Director of Finance	**Approved**	**Y**		**N**	✓	

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

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

Alert		Advise		Assure	✓

1. Purpose:

This report presents the Board Assurance Framework to the Board for strategic oversight, scrutiny and assurance, recognising that feedback received from the People Committee, QPES, the FPP and Audit Committee has been incorporated. The FRC Guidance on Risk Management argues that effective risk management must be supported by robust monitoring and strategic oversight to ensure alignment with the organisation`s strategic objectives.

2.1. Introduction:

A Board Assurance Framework provides a structured and comprehensive tool that enables the Board and its committees to focus on those principal risks that might compromise the achievement of the Trust`s strategic priorities/objectives and to map out the key controls in place to effectively and proportionately mitigate and manage such risks as well as gain assurance. The BAF is also seen as the key source of evidence that links strategic objectives, principal risks and assurance and the main tool that the Board and its committees use in discharging their overall responsibilities of strategic oversight, strategic foresight and assurance.

An effective BAF should provide a comprehensive level of assurance to the Board, inform its agenda, shape its discussions and debates as well as underpin its decision-making.

2.2. Key changes to this iteration of the BAF include:

- All BAF risks have been reviewed, progress on implementing actions noted and some new actions added. The refreshed CRR has been aligned with this iteration of the BAF.

2.3. Summary of feedback from Board Committees:

- Members of the People Committee after reviewing and scrutinsing their BAF were satisfied with the updates and progress that has been made with mitigating and managing the risks on it while noting the updated links of its CRR to the BAF.

- Members of QPES had some discussion on their BAF during which they sought and received assurance on progress with some actions on SR4 which relate to the PEAR Sub-Committee and challenged the current scores of SR3 and SR6 both of which are scored at 20. Members then agreed to monitor progress in mitigating and managing these risks over some months before recommending any reduction in scores.
- Members of the FPP also reviewed and scrutinised their BAF, noting the progress that has been made and after some discussions recommended inclusion of the current scores of CRR risks cited on the BAF as `linked risks` and echoed QPES by advising for sustainable assurance to enable them to be satisfied for the current score of any of their BAF risks to be reduced.
- Members of the Audit Committee had some discussions around the potential impact on the Trust of externally generated risks such as Cyber-attacks, ICS reconfiguration, the difficult financial situation at the BCC, business continuity risks arising from supply chain disruptions, inflation and external organisational failures as well as noted the challenges and risks arising from the CYP transfer. Members then advised against inconsistency in risk scoring and recommended that the above risks be appropriately reflected on our internal risk registers with regular monitoring, management and strategic oversight.

2. **Key issues and risks:**
   The key issue worth noting is the need to regularly update the BAF while ensuring both the BAF and CRR complement and feed-off each other.

Strategic Priorities

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

Recommendation

The Board is *requested to:*

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

Enclosures

Table 1: Summary of the Trust Board Assurance Framework.
Table 2: Heat Map of the Trust 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 Trust Board Assurance Framework (BAF)

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1.	**People: Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users.**						
SR1	Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care.	June 2024	February 2025	DSPP	**3x3 = 9**	N/A	**4x3=12**
SR2	Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.	June 2024	February 2025	DSPP	**3x3= 9**	N/A	**4x3=12**
2.	**Quality: Delivering the highest quality services in a safe inclusive environment where our services users, their families, carers and staff have positive experiences, working together to continually improve.**						
SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.	Sept 2024	April 2025	CN	**4 x 2 = 8**	N/A	**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**

SR7	Failure to deliver optimal outcomes with available resources.	Sept 2024	March 2025	DOF / CN	**3 x 3 = 9**	N/A	**4x 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**

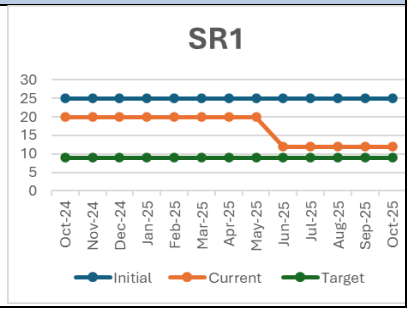
Table 2: Trust QPESC Board Assurance Framework - Heat Map

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 3 = 12	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 consistency of the cultural improvements in place, this is further reinforced through programmes of work like that culture of	**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.	
		DATE OF LAST REVIEW	9th October 2025	

	care and the engagement seen through the authentic leader programme			

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

ACTIONS PLANNED

Action	Lead	Due date	Update

Develop and implement a clear reducing health inequalities programme, moving from programmes approach to BAU.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	30th September 2025	All Divisions now have reducing inequality plans, milestones are currently being reviewed. Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed. HI reporting scheduled reviewed to ensure capacity to showcase 'deep dives' in 3 areas per meeting Completed and would advise moving into BAU, actions will be monitored and reviewed.
Develop and implement infrastructure to identify and address Racism and Discrimination across the Trust.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	31st March 2026	Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed. Policy awaiting final confirmation at TCSE in March 2025. Anti Racist practitioner and leader remaining to be rolled out. Anti Racist Framework Roadshows scheduled from September onwards. Anti Racist Policy Ratified and currently being socialised. Comms shared in relation to current surgency in hate crime and violence against racialised communities.
Take PCREF from pilot to full implementation.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	31st March 2026	Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed. PCREF to be incorporated into HI plans and also key corporate frameworks i.e. PSIRF.
Develop a learning and development strategy which utilises feedback from ER, FTSU, Staff Survey and stakeholders to inform management training and masterclasses.	Associate Director of People, Learning and Development	30th September 2026	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE

• Ability to offer flexible working arrangements. • Values-based recruitment. • Workforce Race Equality Standard. • Workforce Disability Equality Standard. • Model Employer • NHSE High Impact Actions. • Pay Gap • Public Sector Equality Duty Report. • Reducing Health Inequalities Programme • Patient Carer Race Equality Framework. • 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	• Diversity gaps in senior positions. • Gender pay gap. • Cost of living increases with AfC pay-scales not as competitive as some private sector roles. • WRES and WDES indicators.	Internal audit reviews 2024-25: • Race Equality Code • Recruitment and Retention • Complaints • Bank and agency • Disciplinary Process • Sickness Absence Management	• Data quality concerns for all demographics. • Changes not translating into change of experience at the pace and levels of sustainability we would require.

▪ NHSP and Direct Engagement being utilised • Divisional Workforce plans in place • Culture of Care roll out • Race Code Quality Mark			

LINKED TO RISK REGISTERS/CRR RISKS	
CRR042/2119	Risk that persistently high rates of DNA's among both substantive and temporary staff, particularly in face-to-face training sessions, will place additional demands on training teams. (Impact = 4 x Likelihood = 4 = 16)
CRR041/2100	Risk that BSMHFT may be unable to workforce plan effectively. (Impact = 4 x Likelihood = 4 = 16)

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

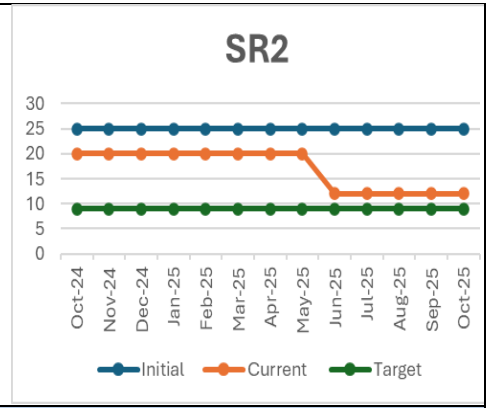
23rd June 2025
- Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.

9th October 2025
- Actions updated
  - Suggested to move HI plans in BAU

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

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 3 = 12	Despite continuing demand and acuity pressures, workforce is in a healthier position with the vacancy factor reduced, turnover improved and pipelines have been strengthened.	**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.	

	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.	**DATE OF LAST REVIEW**	9th October 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 (albeit reducing). ▪ No formalised marketing and attraction strategy / plan for some hard to fill clinical roles ▪ High dependency on temporary staffing. ▪ Not using E-Rostering to full ability. ▪ Not following values and behaviours framework. ▪ People processes not being adhered to. ▪ Not enough vacancies at band 5 nursing levels for the pipeline

▪ 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	31st March 2026	Work is continuing through the Bank Gold group and we are starting to see the impact of bank reduction strategies. Reliance on bank staff is improving as our substantive staffing levels improve and rostering practices. Reductions in time to hire is supporting 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	People promise workshop and staff survey results led to focus on EDI and freedom to speak up. Turnover continues to improve.
Collaborate with comms to create a marketing and candidate attraction plan.	Associate Director of People, Learning and Development	27th February 2026	

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.	• Diversity gaps in senior positions. • Gender pay ga • Cost of living increases with AfC pay-scales	Internal audit reviews 2025-6: • Race Equality Code • Recruitment and Retention. • Complaints • Bank and agency • Disciplinary Process • Sickness Absence Management. • Bank Gold oversight	• Data quality concerns for all demographics. • Changes not translating into change of experience at the pace and levels of sustainability we would require.

• Customer satisfaction survey positively improving. • Values based recruitment • Stay conversation data • Comprehensive health & wellbeing offer. • Increased % of staff recommending BSMHFT as a place to work. • Improved staff engagement scores. • 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.	not as competitive as some private sector roles. • WRES and WDES indicator 2 (likelihood of appointment from shortlisting). • Colleagues not adhering to flexible working initiatives in some areas. • Non-adherence to values-based recruitment principles.		

LINKED TO RISK REGISTERS/CRR RISKS	
CRR040/2099	Efficiency and accuracy risks associated with the administration workforce not utilising new technology and modernising admin practice. (Impact = 4 x Likelihood = 4 = 16)
CRR043/2121	Risk that we may lose out on future workforce because we cannot afford financially to over establish at a band 5 level. (Impact = 4 x Likelihood = 4 = 16)

Update since last review:

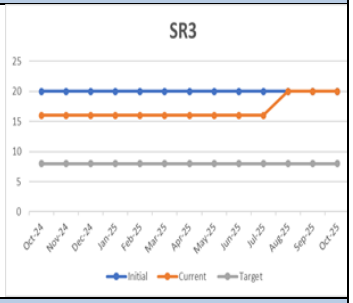
21st October 2024
Risk newly assessed with inputs from the team and presented for Exec sign-off.

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.
9th October 2025 • Updates added to planned actions. Current score reviewed and maintained at 12 as many of the trust-wide metrics such as turnover, bank and agency reduction, vacancy rates etc are improving and have been for a significant period of time.

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	18th 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	14th October 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 • QSIS compliance • Shared Care Platform • Capital prioritisation process • Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation. • Bronze Silver Gold Escalation/Resolution Process. • Agreement on process for sharing information and providing assurance to stakeholders in place with MHPC, ICB, NHSE and CQC. • Gaps in MHA Action Plan oversight arrangements from CQC inspections – now complete, in place and reporting through CGC • Clinical Supervision 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 • Variation in Physical health assessments • Staff feedback on WHAT Tool time consuming for handovers

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**

Roll out of Culture of Care Programme across all in-patient areas during 2025/26	Executive Director Quality & Safety	31st March 2026	Reaside Clinic programme progressing, wards in all divisions now participating in the programme, plan in place for sign up for all areas. Ardenleigh site to go live from May. Reaside CQC regulatory notice now removed. Eight additional wards now signed up to National process. Discussion with NHSE and CQC about aligning CQC I Statements with 12 Culture of Care Standards, to be presented at National CoC steering group. Scaled roll out plan now in place for the Trust. Monthly Executive chaired CoC meeting remains in place at Reaside Clinic, commencing for Acute Wards in July. Culture of care (CofC) inpatients QI programme progressing well. Ardenleigh went live in June. Reaside and Hillis lodge's CofC – Live, Love, Life held first collaborative learning event. Acute care planning phase started, monthly Strategic Divisional group setup, soft launch planned July/August. First draft reviewed of the CofC QI programme measures dashboard based on the 12 CofC standards, supports the CofC Trust Assurance Framework in alignment with CQC 'I' statements. Four more pilot sites join the existing eight wards for National Culture of care (CofC) programme. Four Ward Managers undergoing the FoNS WM development programme. CofC Organisational support virtual sessions schedule finalised, focus on coproduction, Race equity, Trauma and LDA informed care, open to non-clinical and clinical colleagues. The Acute Wards will undertake the new self-assessment framework developed by the Trust for Culture of Care and CQC I and we Statements.

			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	26th 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	27th 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) Update on ACPA work • Data regarding ACPA was collected from Oct 2024 and formed a benchmark report that was presented to SMB in July 2025. The report highlighted that further awareness of this type of abuse is required as well as a better understanding of Think Family and Routine Enquiry, all of which are themes arising from the current DARD work. BSMHFT safeguarding team continue to raise awareness of Think Family and Routine Enquiry by delivering local awareness sessions to targeted teams (those that have been involved with external reviews) • To raise wider awareness of this type of domestic abuse, the trust safeguarding team are completing a business case to secure funding for a new mandatory training resource from Women in Theatre. The intention was to use this training as a starting point, and to further develop bitesize training that could be delivered to local teams where there is a high percentage of cases being identified such as AOT/CMHT's. If business case is not approved, this have to be reviewed as to what resources can be used. Awareness of this type of abuse will be limited without the funding for a bespoke video. The local training may now have to be the starting point. Delivery of this training to CYP (services from 0-18 years) is on hold until there is a legal definition of CPA. • Safeguarding Facilitator and BSWAID continue to rollout DA awareness training that includes awareness of ACPA. The plan for 2026 is to roll this out to Older Adult Community Services and CYP (Services from 18-25 years). A one-off bespoke ACPA session has been delivered to George Ward.

			• There is now 7-minute briefing on ACPA, available to all staff. • PEGS resources –Trust approval is required for BSMHFT to sign up to the Covenant. This is being taken to trust SMB in October 2025. Once signed up to the Covenant, BSMHFT will then be able to use the resources. Work is needed in 2026 to work with People Partners to ensure that staff experiencing this abuse have access to support and a Comms on Connect to share resources for staff to use with service users. We continue to collect data on staff referrals to BSMHFT IDVA- numbers remain low,- step up in Comms is required (more posters and supporting managers to understand what their response should be if they receive a disclosure). Posters are taken to local teams for them to advertise this support in staff only areas and details are on Connect. There was also "Line Managers Guidance on Responding to Colleagues experiencing domestic abuse". This looks like it is no longer on Connect so Named Nurse for Domestic Abuse and Sexual Safety will look at developing a Flash Card with People Partner Team.
Embed suicide prevention and safety planning approaches into routine clinical care across all services.	ED Q&S	31st March 2026	Implement Dialogue+ Training on safety planning Audit to follow 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 QPESC.

Ensure robust audit & assurance policies to ensure they are effective and reflect practice.	ED Q&S	26th March 2026	Policy review completed Audit framework in place aligning to all policies Additional training session for Matrons on use of AMaT and compliance requirements September 29th as part of the new Matron Development Days - completed AMaT system has opened up and implemented CYP areas to the system in September. This means CYP teams can start to participate in AC (nursing) Audits once training has commenced. Training session planned in October to start this process that is ahead of trajectory as a need requirement over NICE portfolio.
Improve Quality data and monitoring from a Trust and Divisional perspective (quality metrics and deep dives).	ED Q&S	27th February 2026	Update on SafeCare Dashboard - An initial dashboard has been developed for ICCR and ACUC which was shared with the ICB on the 21st September 2025 . This version includes key domains of data the organisation currently reports yet held within various systems . Further development of the dashboard is planned over the next 3 months to capture further data /metrics relating to quality , safety and patient experience . Once finalised the incorporation of forensics , older adults , specialties will occur . A Quality Assurance Group has been established to provide oversight of the dashboard with the SLT and division. Culture of Care National Programme progressing well with online sessions available for all staff and the launch of the Culture of Care Dashboard. Inpatient Trust programme well established at Reaside with Tamarind and Ardenleigh launched in last quarter. Acute Inpatient Wards have launched across all areas simultaneously with great engagement noted.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
Learning for improvement: • Structured Judgment Reviews reviewed at local safety panels. • Corporate led learning from deaths meeting. • 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 • System Quality improvement Group in place for in response to CQC inspection and reviews.	• Reaside regulatory notice environment and governance. • Reaside FTSUG Regional escalation. • Reaside CQC Report • External Audit Clinical Governance Review (18 recommendations). • Zinnia Section 29A warning notices – training, sharing learning, supervision, governance, observation. • Zinnia CQC report • PFD on learning identification through internal investigations • CQC Inspection 'North' Acute Wards • Serious incident Larimar Ward	• CQC planned and unannounced inspection reports. • Reaside commissioned support programme and Culture of Care Programme. • Door alarm implementation programme. • Internal and External Audit reports. • Triple A reporting to QPES from CGC. • Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting. • QMS update reporting to QPES • QI reporting to Trust and Local CGC's, STMB and requested for regular QPES/Board- This has been embedded from June 2024 with regular reports built into committee planning structures. • Incident reporting and learning is included in the Patient Safety Report to Trust CGC, QPES, and Board. • Independent annual assessment against the 68 NHS Core Standards for EPRR. • Safety Huddles review staffing on a daily basis • DIPC/IPC/Estates monthly escalation Meeting. • 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	• The availability of real time safety data to triangulate information. • Analysis and triangulation of data across different sources needs is weak and inconsistent. • Lack of an accountability framework in place for how actions from Ligature and Environmental risk assessments are overseen/managed at Divisional level with stratification of associated risk at trust level. • Staff training via e-learning and lack of assurance on competence • Searching policy update, staff training and audit required • Assurance process with data on physical health checks and admission assessments to be added to dashboard • Safety Notice on completion of physical health observations and reviews to MDTs
LINKED TO RISK REGISTERS/CRR RISKS			
CRR005/1929	Individuals presenting at General Hospitals, Place of Safety, and PDU may deteriorate while waiting for a Mental Health Assessment. This is caused by a lack of AMHP availability, resulting in delays to their treatment (Impact = 3 x Likelihood = 5 = 15)		

CRR006/1930	Patient care and safety may be negatively affected by delays to discharge, treatment or admission due high levels of use of Section 136's by the police, increasing the length of stay in A&E and keeping the patient in an unsafe environment not suited to their needs. (Impact = 3 x Likelihood = 5 = 15)
CRR004/1933	Patients may come to harm as they may not be able to be admitted to an Acute inpatient bed within a timely manner, from both A&E and general wards caused by the lack of bed availability. (Impact = 4 x Likelihood = 4 = 16)
CRR017/1803	The Trust may not be able to provide efficient and effective care due to gaps in assurance in the 10 key criteria's from the Health and Social Care Act 2008. (Impact = 3 x Likelihood = 5 = 15)

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

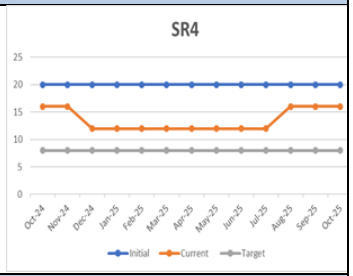
8th April 2025

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.
14th October 2025 BAF reviewed, updates on safeguarding, physical health focus and patient handovers. Physical health management reviews of each division taking place Review of implementation of Dialog+ with plan to come to QPESC for assurance in November System Quality Group in place, Trust Quality Assurance Group in place to review SafeCare Dashboards and AMAT audit compliance.

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	• 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	QPES	Executive Director for Quality & Safety/ Chief Nurse	SR3 SR8 SR9

			facing teams.	• Increased service demand.			
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	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	3rd 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.	• 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

• 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. • 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	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'. • 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	31st 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	27th February 2026	On track – Dialog + 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	31st October 2025	Off track – final refresh ready for launch in September 2025 Original refresh was completed however poor attendance at meetings and adherence to forward planner has initiated a subsequent refresh with a revised due date of October 2025

To review the PEAR agenda and Forward plan to ensure these are robust.	Chief AHP	31st October 2025	Off track - Constructed in PEAR Away day June 2025 Original refresh was completed however poor attendance at meetings and adherence to forward planner has initiated a subsequent refresh with a revised due date of October 2025
Ensure a range of co-production and Co-delivery opportunities with EbEs – Optimise EbE resource pool.	Chief AHP	31st March 2026	On track – Recovery College, QI programme and EbE engagement pyramid in place

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• FFT • Healthwatch • EbE Observer project • Patient councils in Secure Care. Urgent care, CMHT and D&F.	• Community Mental Health survey 2024	• Monthly reports on participation and engagement presented QPES • QI Reports • Participation and Experience team provide quarterly reports to divisional teams. ICCR have requested bi-monthly reporting to support with actions related to negative comments in Community Mental Health survey. • Executive oversight of the engagement activities. • Participation worker visits to clinical areas reported via Participation & Experience Team monthly meetings and escalated through PEAR. • TOR to come to QPESC	• Lack of regular and frequent governance reporting and oversight – divisional teams to provide assurance 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	
CRR035/2058	Risk of harm to service users and the general public due to the lack of AMHP provision in Birmingham. (Impact = 4 x Likelihood = 4 = 16)
CRR039/2072	Complex patients who struggle to engage with mental health services and treatments may cause significant harm to themselves or the public. (Impact = 5 x Likelihood = 3 = 15)

CRR006/1930	Patient care and safety may be negatively affected by delays to discharge, treatment or admission due high levels of use of Section 136's by the police, increasing the length of stay in A&E and keeping the patient in an unsafe environment not suited to their needs. (Impact = 3 x Likelihood = 5 = 15)
Update since last review:	
5th March 2025 Additional actions being taken to align capture of patient experience data with 'I statements' Addition of EBEs to Culture of Care Programmes in services	
8th April 2025 15 step programme pilot commenced. Led by Participation & Experience Manager, monthly updates will be shared at PEAR and advised through Triple A to QPESC. Patient / Service User Council action plans to be shared through PEAR to provide further assurance of the patient Voice. Action have been updated.	
6th June New have been added as those which have been completed will be taken off.	
10th June 2025 BAF risk entries reviewed, and new actions added.	
23rd June 2025 • Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.	
11th July 2025 • Lead for actions changed to Chief AHP to reflect job description. • Terms of Reference for PEAR meeting are being refreshed to reflect chair as Chief AHP and co-chair once EbE has been recruited via expression of interest process. • New reporting process for PEAR meeting to ensure divisional participation is under constriction to be piloted in September 2026 meeting	
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.	
6th October 2025 • Data collections underway for Recovery college and physical health service evaluations • Service evaluation commissioned for Patient Experience Team to ensure alignment with think family principles and 10 year plan. • PREOMs presented at Board development day with further presentation at PEAR for organisational learning and implementing Trustwide	

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. • Ranking in lower segments for financial metrics in Oversight Framework.	FPP	Executive Director of Finance	SR6 SR7

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact: 5 x Likelihood 5= 25	Current score demonstrates the current performance, 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	9th October 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. • Development of new Performance Assurance Panel to provide greater oversight on areas of poor performance. • Continued review and utilisation of balance sheet flexibility. • Savings Policy • Sustainability Board review. • ICS expectations and reporting requirements. • Development of Financial Recovery Plan	• Consequences of poor financial performance do not attract any further review. • Requests for cost pressure often made without following agreed process. • Attendance at Sustainability Board variable. • Trust has not been able to develop a pipeline for delivery of savings. • Recovery Action Plans not having required financial impacts
ACTIONS PLANNED	

Action	Lead	Due date	Update
To roll out of new finance reports – work is ongoing to identify the capability within the ledger system, the training and resource requirement including specialist expertise.	Deputy Director of Finance	30th September 2025 Superseded and wrapped together into a new action around improved reporting and governance.	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		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	1st August 2025	Developed and delivered to NHSE – after presentation to FPPs
Preparation for national Medium term Financial planning exercise	Deputy Director of Finance	1st January 2026	Awaiting planning guidance – initial framework issued allowing preliminary work to commence, including work on underlying position and three year plan
To improve reporting and governance arrangements	Deputy Director of Finance	31st December 2025	Update policies that impact on governance arrangements for financial management, including around pricing, training and savings. Also explore technological opportunities around workflow and real time reporting

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Ability to deliver planned financial position dependent on sufficient controls. • Financial recovery plan focused attention on trajectory and mitigations. • Recovery plans in key areas on beds and bank spend demonstrating run rate reductions.	•	• 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. • Ongoing monthly oversight from NHSE around delivery of financial recovery plan.	• 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. • Multi-year plans will be required as part of new national Medium Term planning framework.
LINKED TO RISK REGISTERS/CRR RISKS			

CRR010/108	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. (Impact = 4 x Likelihood = 4 = 16)
CRR022/2004	There is a risk that the Trust is unable to deliver its financial plan. This may be caused by a lack of control and delivery of plans in relation to the key drivers of financial spend in the Trust. (Impact = 4 x Likelihood = 4 = 16)
CRR023/2003	Risk of significant overspend on Out of Area beds for 2024/25 caused by the number of patients requiring inpatients beds (for which the Trust has financial responsibility) continuing to exceed the number of contracted beds and productivity plans to reduce demand. (Impact = 5 x Likelihood = 5 = 25)
CRR032/1989	There may be an impact/effect on pre-committed expenditure for works or dilapidated buildings that are no longer fit for purpose due to lack of capital availability to fund major capital works at Reaside. (Impact = 5 x Likelihood = 5 = 25)

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

9th October

- Presentation to October Risk Management Group recommending changes to finance scoring in risk matrix – will require all finance risks to be reassessed once confirmed
- Financial recovery plan presented to NHSE (after FPP) in August with further submission with detailed trajectory in September
- Key mitigations identified to ensure financial plan delivered

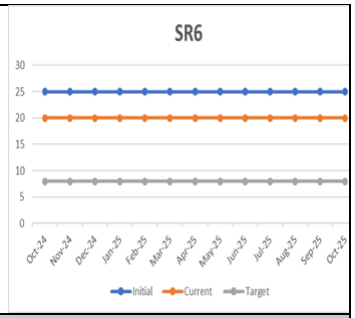
Appendix 4: Details of QPES & FPP Shared BAF Risks.

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
					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.	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 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		**Cautious** - 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. ***Target risk score range 6-8.***		**INHERENT RISK SCORE**	Impact	Likelihood	Risk score
					5	5	25
				DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 5 x Likelihood 4 = 20	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 3 = 12**	Aligns with the Trust`s risk appetite and reflects the threshold at which	

			risk could be tolerated as it can`t be eliminated and due to controls being embedded.	
		DATE OF LAST REVIEW	14th October 2025	

CONTROLS/MITIGATIONS	**GAPS IN CONTROL**
• Shareholder, Liaison, Contractor and Operational Management Team Meetings and Committees are all in place to ensure communication, Service delivery, and physical aspects and priorities are delivered to meet all quality requirements. • Trust Sustainability and Net Zero Group established. • Heat De-carbonisation reviews across sites. • Trust prioritisation of Risk Assessments, Statutory Standards and Backlog Maintenance Programme. • Delivery of the Trust Green Plan and the built in Action Plan. • Regular audits on compliance. • Staff training and awareness sessions to tackle poor behaviour around compliance. • Strengthen the internal control systems and processes. • Regular horizon scanning for cases of non-compliance. • Inappropriate Out of Area numbers/ 3 day Follow up reported via Trust FPPC and local Service FPPCs and included in IPD • Daily 3 day follow up notifications in place for clinical teams • Community waiting times reported via FPPC against trajectory and granular reports available to clinical teams to manage and progress at patient level. • Patient Flow Steering Group in place to oversee reduction is use if out of area placements with workstreams looking at demand management/ Locality Model/CRFD and Length of Stay. • Service level Deep dive meetings cover national indicators, waiting times and benchmarking.	• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Named Non-Executive Lead for Sustainability, Net Zero Carbon and Green Plan. • Condition Surveys, review of premises statutory standards and compliance assessments / independent AE audits ensure standards are met and maintained. • Operational pressures negatively impacting on staff capacity to fully implement these controls. • Self-assessments, accreditation and self- certification processes aren`t strong. • Governance around compliance is weak.

ACTIONS PLANNED

Action	Lead	Due date	Update

Trustwide Sustainability/ Green Group. With representation Corporate and Clinically.	Trust/ SSL	31st March 2027	Helps to mitigate impact on carbon and environment. The Sustainability / Green Group does not impact on major factors in for example 'Failure to maintain acceptable operational governance and environmental standards I.e. death / serious injury'. The Green Plan is in direct response to the NHS E mandate and Carbon Net Zero with targets at 2030/32, 2040 and UK wide legislation at 2050.
Development of Business cases and securing of major capital to address Reaside functional suitability.	Trust/ SSL	31st March 2027	Mitigation of backlog is progressed via SSBM, Capital programmes and Maintenance regimes where Trust finances allow. Replacement of current Reaside facility to address poor functionality, Service user accommodation and environmental system life cycle impacts is a Trust led major project. This is as before a Trust not SSL action. In any event it is logical that the action will remain until either the Trust decides to stop trying to replace Reaside and / or secures the necessary funding for a major project.
Implementation of the Talking Therapies Action Plan to address performance issues.	AD for Specialties	31st Dec 2025	Recovery action plan in place with good oversight from the Divisions leadership team. Regular reporting and scrutiny and the Performance Delivery Group and service deep dives. Meeting with MH provider collaborative took place in September 2025 to further review and explore additional actions to mitigate the risks of underperformance.
Productivity Improvement Plan developed and implemented within Acute & Urgent Care.	AD for Acute & Urgent Care, and AD for Children and Young People	31st March 2026	Plan on track. Weekly patient flow meetings in place to review performance against plan. Other operational divisions called to the meeting to support flow and focus on patient who are clinically ready for discharge (CRFD). Additional weekly Gold escalation meeting stepped up in July 2025 to drive down the increasing spot purchasing bed activity.

			Plan achieved over the planned 6-week period. Meeting has good clinical leadership representation. New bed contract mobilised in September 2025 to further reduce use of non-contract beds and to aid patient flow.
New divisional performance and assurance panel commenced Oct 2025 to strengthen oversight and ensure deliver against standards and national requirements.	AD's for Specialities, AD for secure and offender Health, AD for Integrated Community Care and Recovery, AD for Acute and Urgent Care and AD for Children and Young person Division	31 March 2026	Commenced October 2025. To review March 2026.

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.

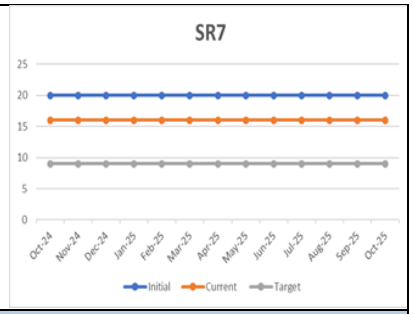
LINKED TO RISK REGISTERS/CRR RISKS	
CRR034/2055	Delayed recognition, poor infection prevention and control (IPC) practices, and heightened exposure HCID risk to staff, patients, and visitors caused by mental health trust not been given access to HCID training. (Impact = 4 x Likelihood = 4 = 16)
CRR033/2049	Risk of the Trust not meeting its Governance requirements on July 1st 2025 with regards to the transfer of the Children & Young People Service (CYP) (Impact = 3 x Likelihood = 5 = 15)
CRR020/950	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. (Impact = 4 x Likelihood = 4 = 16)
CRR015/1905	Risk of missing critical updates in fire safety standards, failing to address emerging risks in a timely fashion, and a lack of compliance with the requirements of the Regulatory Reform (Fire Safety Order). (Impact = 5 x Likelihood = 3 = 15)
CRR012/1622	Potential health and safety risk which could affect the quality of patient care and staff wellbeing at the CSB building which houses FIRST and Pharmacy teams. (Impact = 3 x Likelihood = 5 = 15)
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.	
14 October 2025 Actions reviewed and updated with operational divisions. New CYP division references in the work relating to productive plan in acute and urgent care as applies also to children and young people urgent care pathways. System and wider partnership working to address ADHD waits and review the model.	

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		INHERENT RISK SCORE	Impact	Likelihood	Risk Score
	Open - Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance. ***Target risk score range 9-10.***		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	**14th October 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

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	31st 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	27th February 2026	Executive and Non-Executive visits continue, QPESC visit planned for Reaside Clinic 16th July. Night visits completed across all Acute Wards 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	31st March 2026	E-roster training completed E-roster rules agreed and monitored through the Safer Staffing Group. From September 2025, we are now reporting e – roster compliance through the safer staffing committee, this will include feedback from the roster dashboard that provides our compliance levels. There has been an additional offer of support into the clinical areas to support with the roster compliance and improved annual leave planning. This work is taking place to be able to support with Christmas and New Year Planning. AHP's are planning to starting rostering, initial meetings will be taking place in 2025. As part of the Culture of Care in Acute Care, a key workstream on workforce is underway looking at the safer staffing principles inline with the National Quality Board 2016 standards, this will include roster compliance and ensure high quality. Band Reduction spend project remains in place till April 2026. We are progressing with the work Key workstreams for bank reduction are 'Enhanced therapeutic observations project', Planning of the day, B7 bank spend and TSS quality project.

			Additional support is being offered to CYP to understand the current position and how we can best support with the bank reduction.
Agree a set of metrics aligned to the programme.	EDQ&S/CFO	31st 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 10th to discuss the proposed metrics with the Information Team to agree source of reporting for all identified metrics. The plan is to then share the finalised document firstly at QPESC in August and then at Senior Leaders Forum in September and commence the socialisation process. Implementation of self-assessment process and metrics started
Programme to be scaled up from four wards across the Trust to all wards from April on a rolling programme.	EQD&S	31st August 2025	Programme plan now agreed with prioritisation of areas, Phase 1 - Secure and Offender Health, Phase 2 -Steps 2 Recovery, Phase 3 – Specialities and Older People, Phase 4- Acute Wards. All Divisions have at least one ward now actively engaged with the programme 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	31st 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
Learning for improvement: • Structured Judgment Reviews reviewed at local safety panels • Corporate led learning from deaths meeting.	• 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.	• 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.

• Participation Experience and Recovery (PEAR) Group.		• Co-produced Trauma informed recovery focussed training rolled out (NMHT).	• Non-compliance e-roster • Above plan utilisation of TSS

LINKED TO RISK REGISTERS/CRR RISKS	
CRR030/2010	Risk of compromise of patient safety and quality of care due to a low number of experienced qualified nurses across the organisation, caused by a high vacancy rate of 187 positions at Senior Band 6 nurse. (Impact = 4 x Likelihood = 4 = 16)
CRR024/1922	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. (Impact = 3 x Likelihood = 5 = 15)
CRR005/1929	Individuals presenting at General Hospitals, Place of Safety, and PDU may deteriorate while waiting for a Mental Health Assessment. This is caused by a lack of AMHP availability, resulting in delays to their treatment. (Impact = 3 x Likelihood = 5 = 15)

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

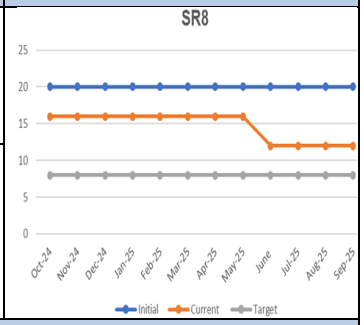
3rd September 2025
- Implementation of training and support in e-roster, clinical supervision and audit now completed and transferred to Divisions with clear expectations of what is business as usual for performance to be monitored through Divisional Performance meetings and assurance taken through Safer 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
14th October 2025 • Culture of care Programme to be implemented Trustwide, including Children and young people, and Community Teams, work to start on adaptation of the model and adding these areas to the delivery plan • e-roster metrics incorporated into Divisional performance reviews • Cap on number of bank shifts that each Division can access per month • Review of temporary Staffing Services Underway

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

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES		CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR8	**Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.**		• **Quality** ❖ Preventing harm ❖ Patient safety culture ❖ Quality improvement and assurance ❖ Improving service user experience. ❖ Using our time more effectively	• Inability to effectively use time resource in driving learning and transforming services. • Inability to develop and embed an organizational learning and safety culture. • Failure to identify, harness, develop and embed learnings from deaths processes. • Lack of support for and involvement of families and careers. • Lack of effective understanding by staff of what the Recovery Model is about and its expectations. • Services that are not tailored to fit the needs of our local communities	• A culture where staff feel unable to speak up safely and with confidence. • Failure to learn from incidents and improve care. • A failure to develop pathways of care within the Integrated Care System. • Lack of equity for service users across our diverse communities. • Ineffective relationships with key partners. • Lack of continuity of care and accountability between services. • Negative impact on service user access, experience and outcomes. • Negative impact on service user recovery and length of stay/time in services. • Some communities being disengaged and mistrustful of the Trust. • Negative impact on service user recovery and	QPES	Executive Medical Director	**SR3** **SR4** **SR9**

			or aligned to local services. • Lack of understanding of our population, communities and health inequalities data. • Not working together to tackle inequalities across the BSOL system.	length of stay. • Increased local and national scrutiny. • Increased risk of incidents due to inappropriate physical environments. • Poor reputation with partners. • Negative impact on service user access, experience and outcomes.			
RISK APPETITE		**Open** - Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance**.** ***Target risk score range 9-10.***		**INHERENT RISK SCORE**	Impact 4	Likelihood 5	Risk Score 20
				DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	**RATIONALE**	**TARGET RISK SCORE**	**RATIONALE**	**RISK HISTORY**
Impact 4 x Likelihood 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.	
		DATE OF LAST REVIEW	23rd June 2025	

CONTROLS/MITIGATIONS	**GAPS IN CONTROL**
• Patient Safety Advisory Group (PSAG).	• Limited assurance from current approach to review of quality and governance metrics at Divisional level.

• Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity. • Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels. • Culture of Care national QI and other pieces of QI projects that address health inequalities. • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Implementation of Learning from Excellence (LFE). • PSIRF Implementation Strategy including PSIRF Implementation Group and PMO support. • Freedom to speak up processes. • Cultural change workstreams including Just Culture. • BSOL Provider Collaborative Development Plan. • Experience of Care campaign. • Health, Opportunity, Participation, Experience (HOPE) strategy. • Family and carer strategy. • Implementation of Family and carer pathway. • BSOL peer support approaches. • Expert by Experience Reward and Recognition Policy. • EbE educator programme. • EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • Divisional inequalities plans. • PCREF framework • Synergy Pledge. • Provider Collaborative inequalities plans. • System approaches to improving and developing services. • Community Transformation Programme – now in year 3 of implementation. • Community caseload review and transition. • Out of Area programme. • Transforming rehabilitation programme, including new of Intensive. Community Rehab	• Limited reporting of Divisional quality reviews to QPES and Board. • No organisational wide reporting of LFE metrics. • Family and carers pathway not consistently applied or suitable for all services. • Performance in these areas is not effectively measured. • Divisional inequalities plans not fully finalised for all areas. • Availability of sufficient capital funding for developments. • Capacity within teams to deliver transformation and service developments alongside day job. • Inability to identify milestones that reduce health inequalities and improve patient experience. • Inability to identify clear data metrics to demonstrate impact (Cause and effect) in reducing health inequalities.

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

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE

• Learning from Peer Review/National Strategies shared through PSAG. • Serious Incident Reports. Increased scrutiny and oversight through SI Oversight Panel. • Executive Chief Nurse's Assurance Reports to CGC, QPES Committee and Board. • New processes have been devised to improve learning from deaths including improved oversight of Structured Judgement Reviews (SJR's) and associated learning/actions. • Participation Experience and Recovery (PEAR) Group. • Community collaboration with system partners. • Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme.	• Highlight and escalation reporting to Strategy and Transformation Board. • Reports to QPES Committee.	• Updates on PSIRF Implementation to QPES and Board. • Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • BSOL MHPC Executive Steering Group. • Health Inequalities Project Board. • Community Transformation governance structures. • Out of Area Steering • Performance Delivery Group "deep dives". • Highlight and escalation reporting into BSOL MHPC Executive Steering Group. • Each division has its own health inequalities action plans that feed to Inequalities board.	• The Trust currently has no baseline to understand the organisations view on safety culture. An options appraisal on how this could be undertaken is being prepared for the Board. • Senior leader session/Board meeting- to discuss how to use QI methodology- driver diagrams, plan, and risk asses, etc. Check knowledge. New First line manager QI training now in place: QI methodology in day-to-day leadership- using process mapping, driver diagrams, read data etc. • The Safety Summits are in their early conception and may not be adopted well by Divisions/services. • Work to be undertaken to embed human factors/just culture. • Inability to engage with all parts of the Trust.

LINKED TO RISK REGISTERS/CRR RISKS	
CRR039/2072	Complex patients who struggle to engage with mental health services and treatments may cause significant harm to themselves or the public. (Impact = 5 x Likelihood = 3 = 15)
CRR035/2058	Risk of harm to service users and the general public due to the lack of AMHP provision in Birmingham. (Impact = 4 x Likelihood = 4 = 16)

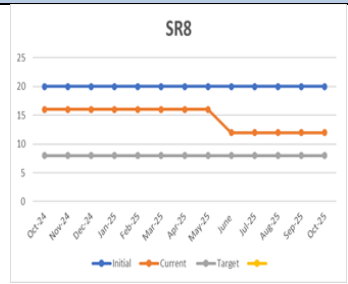
Update since last review:

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

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

24th April 2025 Risk reviewed and new controls and actions have been added.
23rd June 2025 • Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.

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

			• Lack of service user voice in informing service transformation. • Lack of support for and involvement of families and careers. • The difficult financial landscape.	community not available.			
RISK APPETITE		**Open** - Receptive to taking difficult decisions to support the achievement of the Partnership or Provider Collaborative when benefits outweigh risks. Processes, oversight / monitoring and scrutiny arrangements in place to enable considered risk taking**. Target risk score range 9-10.**		**INHERENT RISK SCORE**	Impact 4	Likelihood 5	Total score 20
				DATE RISK WAS ADDED	September 2024		
CURRENT RISK SCORE	**RATIONALE**		**TARGET RISK SCORE**	**RATIONALE**		**RISK HISTORY**	
Impact 4 x Likelihood 3 = 12	Current score demonstrates the controls in place and level of assurance evidenced.		**Impact 3 x Likelihood 3 = 9**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.			
			DATE OF LAST REVIEW	23rd June 2025			
CONTROLS/MITIGATIONS				**GAPS IN CONTROL**			
• Inpatient Bed Strategy and Inpatient quality transformation programme. • Digital transformation programme. • Partnership working with the Voluntary Sector. • Inpatient flow improvement programme. • Patient initiative follow-up work. • Urgent care and Community transformation. • Better prioritisation and triaging of patients of waiting lists. • System approaches to improving and developing services. • Solihull Children and Young People Transformation.				• Not enough beds for population when compared nationally. • Lack of the right model of care that is suitable for our patients. • Capacity within teams to deliver transformation and service developments alongside day job. • Family and carers pathway not consistently applied or suitable for all services. • Partnerships strategy is currently being refreshed – containing gap/opportunity analysis of current pathways. • Needs assessment for BSOL is not up to date, which weakens our			

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Transformation of the Urgent Care Pathway	Associate Director of Operations- Acute and Urgent Care and AD of Children's and Young people	31st March 2028	Urgent Care pathway group TOR currently being reviewed to ensure it has full oversight of urgent care transformation. Recover House procurement completed, with opening due in Oct/Nov 2025, which will bring additional capacity into the system which will improve access and flow through urgent care pathway. Winter plan development along with Baird Assurance Statement and signed by Board. Urgent and Emergency Care Assessment tool - Improvement Event facilitated by NHSE took place in March and April 2025. Action plan under the headings of Strategic Leadership and Governance, Integration of services and pathways and Data and Intelligence has been formulated and implemented, monored via the Urgent Care stakeholder pathway group .

Implementation of the Talking Therapies Action Plan to address performance issues.	AD for Specialties	31st Dec 2025	On track Recovery action plan in place with good oversight from the divisions leadership team. Regular reporting and scrutiny and the Performance Delivery Group and service deep dives. Meeting with MH provider collaborative took place in September 2025 to further review and explore additional actions to mitigate the risks of underperformance.
Implementation of pilot 24/7 service in East Birmingham.	Akilah Duffus 24/7 Programme Lead	30th Nov 2025	On track Regular monthly steering group meetings in place to monitor delivery along with assurance meeting and visits from NHSE. Capital investment secured with new build on track to open in November 2025.
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	31st March 2026	On track. Implementation work in train and recruitment of the team continues as part of phase 1

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.	• 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).	• Having a strong service user/carer voice across all of our governance forums. • Variations in inputs across pathways. • Gaps in the CYP Pathways.

• Evidence that the Community transformation is working as people are getting better access.		• Physical health connectors pilot.	

LINKED TO RISK REGISTERS/CRR RISKS	
CRR Risk IDs	**Risk Descriptions**
CRR024/1922	Admissions to secure care beds from prison may be delayed and it may be difficult to respond to crises in the community due to current lack of capacity in BSMHFT secure beds and the provider collaborative. (Impact = 3 x Likelihood = 5 = 15)
CRR006/1930	Patient care and safety may be negatively affected by delays to discharge, treatment or admission due high levels of use of Section 136's by the police, increasing the length of stay in A&E and keeping the patient in an unsafe environment not suited to their needs. (Impact = 3 x Likelihood = 5 = 15)
CRR038/1875	Risk that emergency services will not be able to access the Oleaster or Barberry sites in case of a fire, medical emergency, or any other emergency. (Impact = 5 x Likelihood = 3 = 16)

Update since last review:

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

4TH Feb 2025

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

12th March 2025

Risk updated and new controls added noting the following progress:

- Multi-disciplinary triage hubs now in place in the South and we have already seen benefits of service users being supported to link with the most appropriate teas, especially joint working with colleagues in Talking Therapies.
- NMHT now managing new referrals coming through via SPOA for PCNs without ARRs roles ensuring timely access to Mental Health support for those that previously would not have been suitable for Secondary Care.
- Arrangements agreed with two of the nine GPs in scope to commence receiving new referrals for the team.
- Discussions with Neighbourhood Mental Health Team (NMHT) to start redirecting new referrals for individuals within pilot catchment area to 24/7 team that would otherwise be allocated to CMHT or NMHT.

11th April 2025

- Both transformations have progressed in their next phases (i.e. Community transformation – 4th phase & Urgent Care transformation – 2nd phase) work continues.
- Recommending reduction of risk score from Impact 4 by Likelihood 4 = 16 to Impact 4 by Likelihood 3 = 12.

6th May 2025

- Significant improvements in mitigating and managing this BAF risk have been noted. New actions have also been added.

23rd June 2025 • Changes approved at the RMG meeting in June and an updated chart showing movements in risks scores have been incorporated in this iteration of the BAF.
14 October 2025 Reviewed by Divisions and actions updated.

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

	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 Informal complaint or inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2)	Non-compliance with national standards with significant risk to patients if not resolved. Multiple complaints /	Incident leading to totally unacceptable level or quality of treatment or service. Gross failure of patient safety if

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		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	independent review Low performance rating Critical report	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 breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved.	Single breech in statutory duty Challenging external recommendations / improvement notice.	Enforcement action Multiple breeches in statutory duty Improvement notices. Low performance rating Critical report.	Multiple breeches in statutory duty Prosecution Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable. public expectation.	National media coverage with >3days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5% over project budget.	<5-10% over project budget	Non-compliance with national 10-25% over budget project.	Incident leading >25% over project budget

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		Schedule slippage.	Schedule slippage	Schedule slippage. Key objectives not met.	Schedule slippage. Key objectives not met.
Finance – including claims	Non delivery/Loss of budget to value of £0-£50K	Non delivery/Loss of budget between £50K and £500K.	Non-delivery/Loss of budget between £500K and £2M.	Non delivery/Loss of budget between £2M and £4M.	Non-delivery/Loss of Budget of more than £4M.
Service / Business interruption **Environmental impact**	Loss / interruption of >1hour Minimal or no impact on environment	Loss / interruption of >8hours Minot impact on environment	Loss / interruption of >1day Moderate impact on environment	Loss / interruption of >1week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

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

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise or graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse side effects Physical attach such as pushing, shoving or pinching causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health 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				

Report to Board of Directors							
Agenda item:	**9**						
Date	3 December 2025						
Title	Corporate Risk Register Report						
Author/Presenter	Kate Smith, Risk Manager						
Executive Director	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

This report reflects the current position of the Corporate Risk Register (CRR) since its review, scrutiny and approval at the Risk Management Group meeting on 16th October 2025; and was updated to reflect any changed made on the Eclipse system up until 20th October 2025. The Trust CRR comprises high-level operational risks scoring 15 and above that have been identified by Directorates, Services, and Departments and have been escalated via their local and Divisional governance arrangements to the RMG for approval and inclusion onto the CRR.

Introduction

The RMG receives the CRR report bi-monthly to provide review, scrutiny and constructive challenge.
QPES, FPP, and People Committee receive their relevant sections of the CRR for review.

Current Status of CRR

QPES Risks- 17 risks
Finance Risks- 6 risks
People Risks- 4 risks

Highest Scoring Risks-

- Risk CRR10/108 (Score 25)- 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. Increased in score from 16 to 25 in June 2025.
- Risk CRR22/2004 (Score 25)- There is a risk that the Trust is unable to deliver its financial plan. This may be caused by a lack of control and delivery of plans in relation to the key drivers of financial spend in the Trust. Increased in score from 16 to 25 in April 2025.
- Risk CRR23/2003 (Score 25)- Risk of significant overspend on Out of Area beds for 2024/25 caused by the number of patients requiring inpatients beds (for which the Trust has financial responsibility) continuing to

exceed the number of contracted beds and productivity plans to reduce demand. Linked to Risk 1932- clinical risk to patients due to being placed in out of area beds.

- Risk CRR32/1989 (Score 25)- There may be an impact/effect on pre-committed expenditure for works or dilapidated buildings that are no longer fit for purpose due to lack of capital availability to fund major capital works at Highcroft and Reaside (complete rebuild).
- Risk CRR29/1225 (Score 20)- Lack of available capital funding and investment requirements could lead to misunderstandings, over commitment and inter-departmental tension.
- Please note that the risk scores for finance risks are currently under review following an update to the impact descriptors on the risk scoring matrix.

Changes and updates in relation to the CRR since last review at Audit Committee

- Impact descriptors which guide the impact risk score have been reviewed for finance related risks, comparing them to those used by other trusts in the Midlands. The current descriptors were devised in 2010, so are no longer relevant to the current context. This may mean a reduction in risk scores. This was discussed at FPP and fed back to RMG who agreed to the changes, so these will be reflected in the next CRR.
- Strategy, People & Partnerships, in particular People and Workforce, have undertaken a full risk register review and completed exercises to identify risks which need to be added to the risk register. Many historical risks have been closed and 14 new risks added, 4 with a score of 15 and above which were accepted onto the CRR at the October RMG meeting. In terms of Workforce there are themes around workforce planning, being able to meet the needs of the future, and lack of experienced nursing staff. Temporary Staffing risks are related to oversight of competencies and provision of training. Risks related to training look at financial costs, compliance, and DNA rates for sessions. In terms of staff morale there are risks around low appraisal rates, lack of follow up following sickness absence, impact of racial and discriminatory behaviours, increase in employee relations cases (including those from CYP).
- The CYP Division presented their risk registers and high scoring risks at the RMG meeting in October for assurance and oversight. Due to using a different RMS system reporting is separate to the rest of the trust. The historical risk management process and scoring system has been different to that of BSMHFT so workshops are in the process of being set up to review risks, starting with high priority/ extreme risks. The decision has been made at this point not to present any risks for full inclusion to the CRR as these risks need to be re-worked to ensure that they are appropriate, however the CYP directorate will highlight their top 3 risks as they stand to the Audit Committee so that there is a level of understanding. Currently there are 14 risks with a score of 15 or above in the directorate, 10 of which relate to staffing and the impact of this on patient care.
- Relevant sections of the CRR will be reviewed at QPES, FPP, and People Committee every 2 months following the updates to the CRR at RMG meetings. This will ensure more oversight and ownership of these risks.
- Risk descriptions, controls, and actions continue to be reviewed to ensure that they contain risks and not issues and appropriate mitigations are in place.

Risks Escalated to CRR since last review-

- CRR040/2099- Workforce: Efficiency and accuracy risks associated with the administration workforce not utilising new technology and modernising admin practices. New risk entered 07/08/2025.
- CRR041/2100- Workforce: Risk that BSMHFT are unable to workforce plan effectively. New risk entered 07/08/2025.
- CRR042/2119- HR Management Team: Risk that persistently high rates of DNA's among both substantive and temporary staff, particularly in face-to-face training sessions, will place additional demands on

training teams. New risk entered 22/09/2025.

- CRR043/2121- Workforce: Risk that we may lose out on future workforce because we cannot afford financially to over establish at a band 5 level. New risk entered 22/09/2025.

Risks De-escalated from CRR since last review-

- CRR002/1924- Acute Care: Potential insufficient capacity across Acute Care pathway meaning we may not be able to manage patient demand in our community teams. Risk score reduced to 12 because a lot of work has taken place to mitigate and new bed contracts are in place.

Risks awaiting acceptance to CRR

Please note that these risks have not yet gone through the formal process at RMG to be accepted onto the Corporate Risk Register, therefore risk information and scores may change.

Risk ID	Title of Risk	Date Entered	Team/ Department	Risk Score
2137	Risk that there will be a lack of capital availability to fund major capital works at Highcroft caused by lack of cash availability or lack of capital availability within the system	29/09/2025	Capital Programme	16
1236	Undue delays in MHA assessments of HTT patients due to the shortage of AMHP provision in Birmingham	01/05/2020 (upgraded risk score)	Acute Care	16
2144	Potential harm caused by inconsistent searches by staff and contraband on wards	17/10/2025	Corporate Nursing	15

Pending risks with a score of 15 or above

Please note that these risks have not yet gone through the governance process to be formally accepted onto the risk register, therefore risk information and scores may change. These are the initial reflections of the person who entered the risk and is for awareness only at this stage.

Risk ID	Title of Risk	Date Entered	Team/ Department	Provisional Risk Score
2154	Potential harm caused by commissioning issues with dementia drugs	12/11/2025	Dementia & Frailty	15

Key Issues and Risks

- Finance risks have been increasing in score- however the criteria for these scores are no longer in line with current context and as such we will be aligning them with risk impact scores from other trusts.
- People risks have been reviewed and identification exercise undertaken, 4 high scoring risks have been added to the CRR.
- CYP risks are difficult to view in line with BSMHFT risks, firstly as they are held on a different system, but also due to the risk management policies and processes at BWC. Every risk needs to be reviewed to ensure that they are scored and articulated in line with the BSMHFT RM Policy. Workshops are being planned in to complete this piece of work, however it will take some time.
- The review and design of the Trust CRR is a dynamic and ongoing piece of work which will be strengthened as the Trust's risk management arrangements mature and embed it into business as usual.

Recommendation

The Board is asked to:

1. Note the content of this report.

2. Review and endorse the content of the CRR as found on appendix 1 below.

3. Gain assurance that high level operational risks to the delivery of the Trust's operational objectives are appropriately mitigated and managed in lined with best practice and the Trust's Risk Management Policy.

Enclosures

Appendix 1- Trust CRR Report- updated 16th October 2025 (to be reviewed 18th December 2025)

Birmingham and Solihull Mental Health NHS Foundation Trust

TRUST CORPORATE RISK REGISTER

OUR VALUES

Compassionate. Inclusive. Committed.

VISION

Improving mental health wellbeing.

REPUTATIONAL RISK APPETITE STATEMENT

As a Board, we are willing to take decisions that are likely to bring scrutiny of the organisation.

We outwardly promote new ideas and innovations where potential benefits outweigh the risks.

NB All risk scores detailed in Appendixes – CRR Risk Scores as of 16th October 2025. Updates to risks correct as of 16th October 2025.

Appendix 1: Details of QPES Corporate Risk Register

Appendix 2: Details of the FPP Corporate Risk Register

Appendix 3: Details of People Committee Corporate Risk Register

Birmingham and Solihull Mental Health NHS Foundation Trust

Table 1a: Updated Trust Corporate Risk Register summary

CRR Risk ID	Title of Risk	Date of Entry	Last Updated	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. QPES CRR						Severity x Likelihood	
CRR004/1933	Patients may come to harm as they may not be able to be admitted to an Acute inpatient bed within a timely manner, from both A&E and general wards caused by the lack of bed availability.	14/05/2024	17/07/2025	Kreshan Nirsimloo, CNM Urgent Care	2x3=6	4x4=16	4x4=16
CRR005/1929	Individuals presenting at General Hospitals, Place of Safety, and PDU may deteriorate while waiting for a Mental Health Assessment. This is caused by a lack of AMHP availability, resulting in delays to their treatment	24/04/2024	10/07/2025	Jessica Asson, LP and Crisis Pathway Manager	2x3=6	3x5=15	3x5=15
CRR006/1930	Patient care and safety may be negatively affected by delays to discharge, treatment or admission due high levels of use of Section 136's by the police, increasing the length of stay in A&E and keeping the patient in an unsafe environment not suited to their needs.	24/04/2024	17/07/2025	Kreshan Nirsimloo, CNM Urgent Care	2x3=6	3x5=15	3x5=15
CRR012/1622	Potential health and safety risk which could affect the quality of patient care and staff wellbeing at the CSB building which houses FIRST and Pharmacy teams.	04/11/2021	04/08/2025	Dianna Dass-Farrell, CSM of FIRST	2x2=4	3x5=15	3x5=15
CRR015/1905	Risk of missing critical updates in fire safety standards, failing to address emerging risks in a timely fashion, and a lack of compliance with the requirements of the Regulatory Reform (Fire Safety Order).	15/01/2024	15/07/2025	Lisa Stalley-Green, Executive Director of Nursing	3x2=6	5x3=15	5x3=15
CRR017/1803	The Trust may not be able to provide efficient and effective care due to gaps in assurance in the 10 key criteria's from the Health and Social Care Act 2008.	14/07/2023	14/07/2025	Zalika Geohaghon, IPC Lead Nurse	2x2=4	3x5=15	3x5=15
CRR018/1901	Risk that unchecked and potentially unsafe medical devices/ equipment is in use within the trust due to medical devices not being managed, resulting in issues with both patient safety and operational efficiency.	29/12/2023	22/07/2025	Lisa Stalley-Green, Executive Director of Nursing	3x2=6	4x4=16	4x4=16

CRR020/950	High risk of clinical incidents and staff burnout as OA CMHT caseloads continue to be above 35	29/10/2018	23/07/2025	Lou Pickering, CNM for Older Adult CMHTs	3x2=6	4x4=16	4x4=16
CRR021/1545	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.	04/06/2021	18/07/2025	Lou Pickering, CNM for Older Adult CMHTs	2x2=4	3x5=15	3x5=15
CRR024/1922	Admissions to secure care beds from prison may be delayed and it may be difficult to respond to crises in the community due to current lack of capacity in BSMHFT secure beds and the provider collaborative.	02/05/2024	28/03/2025	Dinesh Maganty, CD of Secure Care	2x3=6	3x5=15	3x5=15
CRR030/2010	Risk of compromise of patient safety and quality of care due to a low number of experienced qualified nurses across the organisation, caused by a high vacancy rate of 187 positions at Senior Band 6 nurse	08/11/2024	26/06/2025	Lisa Stalley-Green, Executive Director of Nursing	4x2=8	4x4=16	4x4=16
CRR031/2016	M-power, which is SOLAR's enhanced team for hospital avoidance for those CYP that have a confirmed diagnosis of LD&A, may not be able to continue in its current form.	11/12/2024	23/04/2025	Stephen Harrison, CSM Solar CAMHS	3x2=6	4x4=16	4x4=16
CRR033/2049	Risk of the Trust not meeting its Governance requirements on July 1st 2025 with regards to the transfer of the Children & Young People Service (CYP)	10/04/2025	01/08/2025	Sophia Fletcher, Associate Chief Nurse for Policy and Practice	3x2=6	3x5=15	3x5=15
CRR034/2055	Delayed recognition, poor infection prevention and control (IPC) practices, and heightened exposure HCID risk to staff, patients, and visitors caused by mental health trust not been given access to HCID training	12/05/2025	14/07/2025	Zalika Geohaghon, IPC Lead Nurse	3x3=9	4x4=16	4x4=16
CRR035/2058	Risk of harm to service users and the general public due to the lack of AMHP provision in Birmingham.	06/06/2025	None	Lisa Stalley-Green, Executive Director of Nursing	4x2=8	4x4=16	4x4=16
CRR038/1875	Risk that emergency services will not be able to access the Oleaster or Barberry sites in case of a fire, medical emergency, or any other emergency.	07/11/2023	25/09/2025	Danni Juttla, CSM Oleaster & Natassia James, Head of Health &	4x2=8	5x3=15	5x3=15

				Safety and Compliance			
CRR039/2072	Complex patients who struggle to engage with mental health services and treatments may cause significant harm to themselves or the public.	23/07/2025	None	Liz Thurling, Clinical Director of ICCR	5x2=10	5x3=15	5x3=15
2. FPP CRR							
CRR010/108	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	16/04/ 2015	03/10/2025	Richard Sollars, Deputy Director of Finance	4x3=12	4x4=16	5x5=25
CRR022/2004	There is a risk that the Trust is unable to deliver its financial plan. This may be caused by a lack of control and delivery of plans in relation to the key drivers of financial spend in the Trust	22/08/2024	03/10/2025	Richard Sollars, Deputy Director of Finance	3x3=9	4x4=16	5x5=25
CRR023/2003	Risk of significant overspend on Out of Area beds for 2024/25 caused by the number of patients requiring inpatients beds (for which the Trust has financial responsibility) continuing to exceed the number of contracted beds and productivity plans to reduce demand.	22/08/2024	03/10/2025	Richard Sollars, Deputy Director of Finance	3x3=9	5x5=25	5x5=25
CRR029/1225	Lack of available capital funding and investment requirements could lead to misunderstandings, over commitment and inter-departmental tension	05/03/2020	29/09/2025	Richard Sollars, Deputy Director of Finance	3x3=9	4x5=20	4x5=20
CRR032/1989	There may be an impact/effect on pre-committed expenditure for works or dilapidated buildings that are no longer fit for purpose due to lack of capital availability to fund major capital works at Reaside	15/10/2024	29/09/2025	Richard Sollars, Deputy Director of Finance	3x3=9	5x5=25	5x5=25
CRR037/2047	Risk of a cyber security incident caused by Microsoft ending support/ security patches/ updates for PC's running windows 10 operating system beyond October 2025.	08/04/2025	07/10/2025	Carl Beet, Head of ICT & Programmes	3x2=6	5x3=15	5x3=15
3. People Committee CRR							

CRR040/2099	Efficiency and accuracy risks associated with the administration workforce not utilising new technology and modernising admin practices	07/08/2025		Ngozi Anya, Associate Director of People, Learning & Development	4x2=8	4x4=16	4x4=16
CRR041/2100	Risk that BSMHFT may be unable to workforce plan effectively.	07/08/2025		Ngozi Anya, Associate Director of People, Learning & Development	3x3=9	4x4=16	4x4=16
CRR042/2119	Risk that persistently high rates of DNA's among both substantive and temporary staff, particularly in face-to-face training sessions, will place additional demands on training teams.	22/09/2025		Ngozi Anya, Associate Director of People, Learning & Development	3x3=9	4x4=16	4x4=16
CRR043/2121	Risk that we may lose out on future workforce because we cannot afford financially to over establish at a band 5 level.	22/09/2025		Ngozi Anya, Associate Director of People, Learning & Development	3x3=9	4x4=16	4x4=16

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1b. Trust CRR Heat Map

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic			CRR015/1905 CRR033/2049 CRR037/2047 CRR038/1875 CRR039/2072		CRR010/108 CRR023/2003 CRR022/2004 CRR032/1989
4 Major				CRR004/1933 CRR018/1901 CRR020/950 CRR030/2010 CRR031/2016 CRR034/2055 CRR035/2058 CRR040/2099 CRR041/2100 CRR042/2119 CRR043/2121	CRR029/1225
3 Moderate					CRR005/1929 CRR006/1930 CRR012/1622 CRR017/1803 CRR021/1545 CRR024/1922 CRR033/2049
2 Minor					

1 Insignificant					

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Details of QPES Corporate Risk Register (CRR)

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	5 Catastrophic	4 Likely	20	QPES	
Title of risk	Patients may not be able to be admitted to an Acute inpatient bed within a timely manner, from both A&E and general wards caused by the lack of bed availability.	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	01/03/2016
CRR ID	**CRR004/1933**	**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.**			**Last updated on Eclipse**	17/07/2025

Risk description

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

This is caused by the lack of bed availability.

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

Controls in place	Assurances
• National target is being introduced to state that patients are; 'not to wait longer than 4 hours to be in a bed' which will impact on timeframes. • Daily report which details ward round compliance to enhance flow. • CNM's are contacted on a daily basis to see if patient under home treatment still requires an inpatient admission. • Bed Management Policy are reviewed, and a multi-agency capacity meeting is held daily. • Additional wards have been opened with further discussions of increases in future capacity.	• Bed management issues discussed daily with the executive director of operations and weekly at OMT performance management, Urgent Care Forum and Acute Care Forum. • Daily bed management meetings which are multi agency provide robust monitoring of situation

	• Eclipsing of incidents and review/ monitoring at UC CGC.

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

Links to other risks on Ulysses		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1924	Potential insufficient capacity across Acute Care pathway to manage patient demand.	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
		SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.
		SR9	Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**

Actions being implemented to achieve target risk score	CRR004/1933/ 001	Agree admission process	Kreshan Nirsimloo	30/08/24	To ensure all referrals are discussed with an allocated or gatekeeping consultant.	Completed 23/08/24
	CRR004/1933/ 002	Ongoing discussions about increasing HTT/Crisis/Acute capacity and reviewing the model of care.	Emmanuel Agiam	31/03/25	Links to other risks on the Acute Care Risk Register	
	CRR004/1933/ 003	To review the efficacy of the 10am conference call.	Kreshan Nirsimloo	30/06/25		Completed

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
12/02/2024	Risk newly added onto the CRR.
23/08/2024	Risk reviewed by Kreshan Nirsimloo- actions updated on Eclipse
28/11/2024	Risk reviewed by Kreshan Nirsimloo- actions updated on Eclipse
02/04/2025	Risk reviewed by Kreshan Nirsimloo- actions updated on Eclipse
17/07/2025	Risk reviewed by Kreshan Nirsimloo- actions updated on Eclipse, one action closed

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Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	Individuals presenting at General Hospitals, Place of Safety, and PDU may deteriorate while waiting for a Mental Health Assessment. This is caused by a lack of AMHP availability, resulting in delays to their treatment	**Current Risk Rating**	3 Moderate	5 Almost Certain	15		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	24/04/2024
		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.**			**Last updated on Eclipse**	10/07/2025
CRR ID	**CRR005/1929**						

Risk description
There is a risk that individuals presenting at General Hospitals, Place of Safety, and PDU may deterioate while face long waits for a Mental Health Assessment. This is caused by a lack of AMHP availability. This results in delays to their treatment, a risk that their mental health will decline without appropriate treatment, a risk to their safety by not being in an appropriate facility, a risk to the safety of the staff who are caring for them, and a risk of reputational damage. Often no AMHP is available out of hours which means that out of hours requests must be resubmitted and processed again after 9am- this impacts staff due to the time they have to spend chasing and following up on assessments, taking them away from patient care. As AMHPs are provided by Birmingham City Council we are limited in the steps that we can take to overcome the issues.

Controls in place	**Assurances**

• Discussions take place regularly with the Local Authority AMHP help desk to prioritise allocation of AMHP. • Two additional Nurse AMHPs have been employed through the trust to support in the Place of Safety, however this is still not enough resource and is not 24 hour cover. • Incident reporting should be captured after a 4 hour delay. • Bi-monthly meeting with Joanne Lowe- Head of Social Care for BCC to look at AMHP provision. • Shortage of AMHP provision in Birmingham is reflected on the Social Care risk register. • Work actively with the bed management team to ensure that beds available when needed.	• Eclipse reporting and feedback into CGC. • BCC collate reports with the length of time between request and assessment. • Discussed at Bed Management meetings.

Gaps/weaknesses in Controls/mitigations
• The LA has limited resource specially at the transition hours of early evening and again in the early hours of the morning when often there is only one AMHP on duty but the demand is high. • As AMHPs are provided by Birmingham City Council we are limited in the steps that we can take to overcome the issues.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1933	Patients may not be able to be admitted to an Acute inpatient bed within a timely manner from A&E and general wards due to a lack of bed availability.	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
1924	Potential insufficient capacity across Acute Care pathway to manage patient demand.	SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.
		SR9	Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR005/1929/ 001**	A new referral system is being developed collaboratively by both BCC and BSMHFT which will explore the issue of the lack of Emergency Department Team handovers to the AMHP day team. The initial contact form is passed onto the day team or OOH team worklist where an AMHP will contact the referrer, take full details and triage so all requests are considered by an AMHP before accepting.	Jessica Asson	31/10/25	The hope is this will reduce waiting times and by triaging will reduce the need for unnecessary assessments.	
	CRR005/1929/ 002	To explore with Joanne Lowe from BCC the possibility of using our own trained AMHPs to ensure that more AMHPs are available when needed- we will continue to have conversations however BCC are hesitant due to the cost and resource implications.	Jessica Asson	31/10/25	Increase the number of AMHPs available	
	CRR005/1929/ 003	To ask Joanne Lowe if they keep a log of delays which can be shared with BSMHFT for information.	Jessica Asson	31/10/25	So that we can keep a track of data to know how we are performing	Complete
	CRR005/1929/ 004	An audit is currently being done to look at the waiting times, following this an action plan will be create and information fed back to BCC.	Jessica Asson	31/10/25	So that we can keep a track of data to know how we are performing	

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	CRR005/1929/ 005	Ongoing with conversations ongoing with support of the ICB to understand the challenges and resource issues	Tariro Nyarumbu	31/03/26	Gain support and understanding from the ICB	

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
24/04/2024	Risk newly identified
05/09/2024	Risk reviewed by Jessica Asson- actions updated on Eclipse
11/12/2024	Risk reviewed by Jessica Asson- actions updated on Eclipse
25/03/2025	Risk reviewed by Jessica Asson- actions updated on Eclipse
10/07/2025	Risk reviewed by Jessica Asson- actions updated on Eclipse

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Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	Patient care and safety may be negatively affected by delays to discharge, treatment or admission due high levels of use of Section 136's by the police, increasing the length of stay in A&E and keeping the patient in an unsafe environment not suited to their needs.	**Current Risk Rating**	3 Moderate	5 Almost Certain	15		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	24/04/2024
		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.**			**Last updated on Eclipse**	17/07/2025
CRR ID	**CRR006/1930**						

Risk description
There is a risk that patient care and safety may be negatively affected by delays to discharge, treatment or admission due to the increased use of Section 136's by the police. This may increase the length of stay in A&E, putting pressure on A&E and LP staff managing the patient, and prevent admissions from ambulances while the bay is in use, as well as keeping the patient in an unsafe environment not suited to their needs. This also results in increased clinical workload on top of an already busy service and pressure on AMHP and bed availability. We are limited in the steps that we can take to overcome the issues as they are due to interfaces with other agencies.

Controls in place	**Assurances**
• Ongoing regular discussions with Police and other system partners. • A phone number has been provided to give support for mental health queries. • Ongoing work around AMHP availability • Ongoing work around bed availability by Acute Care	• Monitoring of impact on teams. • Data is being collected and reviewed. • Eclipse reporting and feedback into UC CGC.

• New pathway implemented for the police to call before to convey to ensure the Right Care Right Person.	

Gaps/weaknesses in Controls/mitigations
• Reliance on Police and hospital staff- out of our control.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1930	Lack of AMHP availability	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
1933	Patients may not be able to be admitted to an Acute inpatient bed within a timely manner from A&E and general wards due to a lack of bed availability.	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.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR006/1930/ 001**	Monthly liaison meeting with police and senior managers to discuss issues	Kreshan Nirsimloo	31/12/25	To create joined up working between WMP and BSMHFT	
	CRR006/1930/ 002	Meetings will be set up with Chief Inspector in Birmingham to discuss the issues.	Kreshan Nirsimloo	30/06/25	To create joined up working between WMP and BSMHFT	Complete

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	CRR006/1930/ 003	As the number of 136's has been lower in the last few months we will continue to monitor this and will review the situation in June.	Kreshan Nirsimloo	31/12/25	Understanding the current numbers and potential future actions required	

Date	**Risk Reviews and Progress made since last Committee review/scrutiny of risk:**
24/04/2024	Risk newly added onto the CRR.
23/08/2024	Risk reviewed by Kreshan Nirsimloo- actions updated on Eclipse
28/11/2024	Risk reviewed by Kreshan Nirsimloo- actions updated on Eclipse
02/04/2025	Risk reviewed by Kreshan Nirsimloo- actions updated on Eclipse
17/07/2025	Risk reviewed by Kreshan Nirsimloo- actions updated on Eclipse, one action closed

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Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	Potential health and safety risk which could affect the quality of patient care and staff wellbeing at the CSB building which houses FIRST and Pharmacy teams.	**Current Risk Rating**	3 Moderate	5 Almost Certain	15		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	04/11/2021
		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.***			**Last updated on Eclipse**	04/08/2025
CRR ID	**CRR012/1622**						

Risk description
There is a risk to the quality of patient care, staff wellbeing, and a health and safety risk due to the CSB building housing the FIRST and Pharmacy Teams being too small to safely accommodate the staff group. Currently about 20 desks have been put in the area for a staff group of about 90. This has been caused by the increasing size of the team. The team needs to yet further increase in size, however we are unable to recruit as there is nowhere for the staff to be based, meaning that patients will be kept in hospital longer than they need to be as there is not enough staff resource to be able to facilitate their safe discharge. The desks currently in place in the building are put into spaces too small to house them, and there are only 2 toilets on site. As a consequence the building may be over capacity, and there is an infection control risk as staff members are unable to maintain a safe distance. The staff may also face wellbeing issues due to working in unsuitable and stressful conditions. Confidential conversations cannot take place, meetings have to be held in a hybrid capacity which is not ideal, and we are regularly unable to see patients on site as there is no room to do so. The team cannot recruit to expand as it needs to do to facilitate patient safe discharge from hospital, meaning that patients are remaining in hospital for longer taking up beds which could otherwise be utilised, putting pressure on the wards and with a financial implication.

Controls in place	**Assurances**
• Information on management of the building in relation to Covid/ Infection Control is available to all staff.	• Discussed and fed back into Secure Care CGC

• Environmental risk assessment is updated regularly. • Agile working is promoted where possible. • Robust room booking is in place for shared rooms. • Over 80% of staff have had both Covid vaccinations. • Regular RMS/ Supervision for staff taking place. • Staff are considerate of individuals space wherever possible. • Service users requiring rooms are prioritised.	

Gaps/weaknesses in Controls/mitigations
• The delays to discharge are not something we can measure easily. • Clinical need that requires staff to be in the building above and beyond the numbers recommended. • Not all staff are able to work in an agile manner due to personal circumstances.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1742	There is a risk that patients who require forensic community follow up are not able to access the service (new referrals, not existing outpatients). This is caused by lack of capacity in the team.	SR2	Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.
1922	Lack of capacity in BSMHFT Secure beds	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
		SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.

Actions to mitigate risk and attain target score:

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	**CRR012/1622/ 002**	Awaiting approval of capital money and board approval. Head of capital planning and projects has been in liaison with the FIRST service regarding the requirements for the team's long term accommodation needs.	Dianna Dass-Farrell	28/02/26	Funds required to better house the team	
	CRR012/1622/ 001	Additional IPC works completed including new flooring and redecoration	Dianna Dass-Farrell	2023	Completed	

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
02/05/2024	Risk reviewed and escalated.
12/08/2024	Risk reviewed by Diana Dass-Farrell- funding agreed and hoping to complete building work by October 2025
22/08/2024	Risk reviewed at Risk Management Group meeting- it was noted that the score had been reduced from a 15 to a 10. It was agreed that as no changes have taken place other than a future plan being agreed that this risk should remain at a score of 15 until works have taken place and the team have relocated. Confirmed with Diana by email
05/11/2024	Risk reviewed by Diana Dass-Farrell- action updated on Eclipse
15/01/2025	Risk reviewed by Diana Dass-Farrell- action updated on Eclipse. Currently working with architects to understand service needs and building plans. Expected move in date now Dec 2025
23/04/2025	Risk reviewed by Diana Dass-Farrell- action updated on Eclipse. Trust has given just over £1million to renovate Main House however this is still not enough to begin the work (£1.4 million is required for the cheapest quote). This is delaying renovations.
04/08/2025-	Risk reviewed by Diana Dass-Farrell- action updated on Eclipse. Work will begin in middle of August.

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Risk of missing critical updates in fire safety standards, failing to address emerging risks in a timely fashion, and a lack of compliance with the requirements of the Regulatory Reform.	**Inherent Risk Rating**	5 Catastrophic	4 Likely	20	QPES	
		Current Risk Rating	5 Catastrophic	3 Possible	15		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	15/01/2024
		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.**			**Last updated on Eclipse**	15/07/2025
CRR ID	**CRR015/1905**						

Risk description
There is a risk of a lack of compliance with the requirements of the Regulatory Reform (Fire Safety Order). This is caused by a lack of resilience in the team with only one Fire Safety Advisor to cover the whole Trust, over 50 sites. This limited resource significantly hampers the trust's ability to effectively manage and mitigate fire safety risks across all locations. Fire safety in such an extensive organisation requires regular routine inspections and compliance checks but also continuous training, updates to safety protocols, and rapid response planning. The probability of missing critical updates in fire safety standards or failing to address emerging risks timely is high, given the extensive area and the diverse building structures and uses within the trust. This could lead to an impact the Trust's ability to deliver fire safety training, provide fire drills and evacuation exercises, complete fire risk assessments and fire incident investigations and generally ensure an effective fire safety management structure is in place resulting in harm to staff and service users, which could in turn have a negative impact on the reputation of the organisation.

Controls in place	**Assurances**
• There is currently a full time Fire Safety Advisor in post for the Trust. • Training is provided via e-learning. • There is a Fire Safety Management Policy in place. • Drills are undertaken every 6 months for inpatient units and every 12 months for other sites.	• Oversight takes place at the quarterly Trust Health, Safety and Fire committee. • Incidents reported on Eclipse are reviewed by the current Fire Safety Advisor. • The post holder completes risk assessments, training, investigations, committee reports, drills and provides advice and guidance to the Trust. • The training is a statutory requirement, so monitored via traffic light system.

	• The policy is reviewed every 3 years, latest version just gone through that process and awaiting ratification at the next H&S meeting in June.

Gaps/weaknesses in Controls/mitigations
• There is no cover for this specialist role during absence as well the role is too big for a single person to cover the entire Trust. We saw the impact of this in November 2022 to February 2023 when the post holder was off work due to sickness and we had to get an external company in to cover the role for the duration. • Another resource is required to support this fire safety management system.

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
823	There is a risk that the Trust does not meet the requirements of the HTM in relation to Fire Safety and Management	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
		SR4	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.
		SR6	Failure to maintain acceptable governance and environmental standards.

Actions to mitigate risk and attain target score:						
Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	CRR015/1905/ 001	Add a Band 6 Fire Safety Officer to the establishment to build resilience in the team and enable a more proactive approach to fire safety management.	Natassia James	05/12/24	Ensure we have the required resource in place	Recruitment in progress

	CRR015/1905/ 002	Fire Safety Officer to plan a face to face training programme to ensure that sites are compliant	Natassia James	31/12/25		

Date	**Risk Reviews and Progress made since last Committee review/scrutiny of risk:**
24/04/2024	Risk reviewed and escalated.
08/08/2024	Risk reviewed by Lisa Pim- this post is under review with the new CNO.
05/12/2024	Risk reviewed by Lisa Pim- Funding has now been agreed for the additional fire safety role and recruitment processes are underway - the risk remains unchanged whilst the post is vacant.
15/07/2025	Risk reviewed by Natassia James- The new Fire Safety Officer started in post last week. He is in the process of scoping sites so he can commence a training programme and develop a workplan for other aspects of the role.

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	The Trust may not be able to provide efficient and effective care due to gaps in assurance in the 10 key criteria's from the Health and Social Care Act 2008.	**Inherent Risk Rating**	3 Moderate	5 Almost Certain	15	QPES	
		Current Risk Rating	3 Moderate	5 Almost Certain	15		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	14/07/2023
CRR ID	**CRR017/1803**	**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.**			**Last updated on Eclipse**	15/07/2025

Risk description

There is a risk that the Trust may not be able to provide efficient and effective care as the current trust compliance has gaps in assurance in the 10 key criteria's from the Health and Social Care Act 2008:code of practice on the prevention and control of infections and related guidance.

Following a gap analysis against the 10 key criterion it was identified that the Trust is non-compliant across a number of statements within the mandated requirements leading to a risk of regulator interest/concern and a lack of assurance in IPC systems and controls within the Trust.

This has been caused by issues like IPC Team staffing shortages, systemic oversight, and resource constraints. Evidence from audits shows persistent lapses in crucial areas like hand hygiene and equipment use, revealing a pattern of difficulties in maintaining consistent IPC practices. High patient volumes within certain divisions and the pressure of urgent care scenarios further exacerbate these challenges, making breaches in requirements more likely despite known standards.

Such non-compliance can lead to increased rates of healthcare-associated infections (HAIs), which may prolong hospital stays, increase the need for medical intervention, and elevate treatment costs. Although not every noncompliance results in a severe outcome due to existing safeguards, repeated or systemic failures can undermine SU confidence, strain healthcare resources, and lead to regulatory scrutiny. This not only affects patient outcomes but also impacts staff safety and the Trusts ability to provide efficient and effective care.

Controls in place	Assurances
• An assessment against the Health & Social care act compliance criterions was undertaken in April.	• Monthly reports are produced by the clinical areas and reviewed by the IPC team to identify concerns.

• The team produced a self-assessment tool action plan that identifies where our trust shortfalls are, and what actions are to be taken. • IPC team has put in place a tool to monitor monthly clinical setting driven IPC audits and Hand Hygiene audits, also has set a monthly operational IPC committee to discuss IPC issues. • Recruitment has taken place.	• The team implemented a dashboard to monitor monthly clinical inpatient adults to close gaps.

Gaps/weaknesses in Controls/mitigations
• The system requires further work to strengthen processes. • 2 x Band 7 and 1 x Band 8a are new to post and still settling in, so are unable to have much impact at this point. • There is currently no admin support. • Risk of burnout as staff are covering more aspects. • The team is comprised of 4 nurses, and 1 part time admin and another full time agency admin. Currently the work load and the stretched geographical nature of the Trust makes it very difficult for the team to support and monitor all areas of the Trust to the desired standard. The team has also been asked recently to give support to external organizations which even more impacted the team resilience.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1840	IPC capacity to respond to current demands is now insufficient - IPC team due to decrease 75% in the next months	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
		SR4	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.
		SR6	Failure to maintain acceptable governance and environmental standards.

Actions to mitigate risk and attain target score:						
Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	CRR017/1803/ 001	Monthly IPC meetings to be implemented with clinical areas.	Zalika Geohaghon	31/08/23	Greater awareness across the trust	Completed 22/3/24
	CRR017/1803/ 002	Recruitment of staff to the team to be able to work on the action plan created on April 2024.	Zalika Geohaghon	17/01/25	Need the required numbers of staff	Completed Dec 24
	CRR017/1803/ 003	New staff member is now in post, however will need some time to settle in. Once staff member is established a plan will be made to address the annual programme of works and look at the 10 criterion	Zalika Geohaghon	31/10/25	Integration of new staff to the role	

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
24/04/2024	Risk reviewed and escalated.
07/10/2024	Risk reviewed by Zalika Geohaghan- staff member has been recruited to and will start in post at the end of December.
14/01/2025	Risk reviewed with Zalika Geohaghon- risk remains the same until new staff member is established. Linked this risk with risk 1840 as both workstreams will be addressed together.
01/04/2025	Risk reviewed with Zalika Geohaghon- risk remains the same. Plans for the next 12 months are in the process of being drawn up.
14/07/2025	Risk reviewed with Timea Vig (Deputy IPC Lead Nurse)- the annual work plan which will address this has been created, many new team members have settled in, we have a member of the team returning from maternity leave, a new admin started at the end of June to support the team, and a new B4 support worker has been introduced in July 25 to provide IPC support in clinical areas. Whilst there is a lot of work still to be done the team is now in the right place to move forwards.

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	Risk that unchecked and potentially unsafe medical devices/ equipment is in use within the trust due to medical devices not being managed, resulting in issues with both patient safety and operational efficiency.	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	29/12/2023
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. **Target risk score range 6-8.**			**Last updated on Eclipse**	15/08/2025
CRR ID	**CRR018/1901**						

Risk description

There is a risk that unchecked and potentially unsafe medical devices/ equipment may be in use within the trust.

This may be caused by lack of a Medical Devices Lead, and a lack of clear structures and processes regarding maintenance, repair, and accurate recording of which equipment is on site. We have medical devices that haven't had oversight or maintenance, some back to 2014.

This may result in issues with both patient safety and operational efficiency. Proper management and monitoring of medical devices are crucial for ensuring that they function correctly and safely. Without adequate oversight, there is a significant risk of device malfunctions or failures, which can lead to incorrect diagnoses, inappropriate treatments, or delayed care. This can compromise patient outcomes, increase the likelihood of adverse events, and potentially lead to serious harm or fatalities. Additionally, insufficient oversight can result in non-compliance with regulatory standards and failure to meet legal requirements, exposing the Trust to legal liabilities and financial penalties. The inability to effectively manage medical devices can lead to inefficiencies in resource utilisation, increased costs due to equipment downtime, and the need for unexpected expenditures on repairs or replacements.

Controls in place	**Assurances**
• HoN&AHPs are monitoring the issue at directorate level. • Medical Devices group has been set up.	• HoN&AHPs are monitoring the issue at directorate level. • This has been escalated to the exec team to discuss concerns.

Gaps/weaknesses in Controls/mitigations
• Current system is out of date • No oversight • Not able to get parts for equipment

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
		SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
		SR4	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.
		SR6	Failure to maintain acceptable governance and environmental standards.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR018/1901/ 001**	A Medical Devices management group will be established to include HON&AHPs	Lisa Stalley-Green	01/06/24	To complete a full review of the asset register and address concerns	Completed
	CRR018/1901/ 002	Baseline Assessment to be completed and sent to UHB	Natassia James	24/08/24	Baseline assessment completed and shared with Dave Tomlinson, Lisa Pim and Amanda Hill at UHB on August 8th. Response received from	Completed

		for system support and Dave Tomlinson as Exec Support			Amanda stating that she will review the documents and respond accordingly	
	CRR018/1901/ 003	TOR to be devised and completed for the Medical Devices Group	Lisa Stalley-Green	31/01/25		
	CRR018/1901/ 004	Review and agree specific working groups to support improvement to processes and procedures aligned with the baseline assessment finding	Lisa Stalley-Green	31/01/25		

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
10/05/2024	Risk reviewed and escalated.
08/08/2024	Risk reviewed by Lisa Pim- two new actions added re working groups and ToR
05/12/2024	Risk reviewed by Lisa Pim- whilst actions are underway to support improvement in working systems and processes - this has not yet yielded mitigations to improve the current risk score
22/07/2025	Risk reviewed- Medical Devices policy has been updated and circulated for consultation
15/08/2025	Update from Natassia James via email- The current score needs to remain. Nothing has really progressed meaningfully beyond the completion of a benchmarking exercise that highlights a whole range of gaps. There isn't a lead, there are no formal systems for managing devices and no resources identified.

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	High risk of clinical incidents and staff burnout as OA CMHT caseloads continue to be above 35	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	29/10/2018
CRR ID	**CRR020/950**	**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.**			**Last updated on Eclipse**	23/07/2025

Risk description
There is a risk of clinical incidents and staff sickness if CMHT caseloads continue to be above 35, which will breach regulation 18 HSCA (RA) Regulations 2014 Staffing. This may be caused by CMHT having 3 workstreams being: primary care talking therapies, memory drug prescribing & monitoring and core secondary mental health provision. Referrals into the OA CMHTs has been increasing over the last 5 years, and the Neighbourhood Mental Health Teams are unable to support the majority of this caseload due to their illness being organic in nature. It is challenging to step down from the caseload as there is a requirement for this cohort of patients to see a medic yearly, there have been discussions about whether this needs to be the case however there has been no movement on this requirement. This may result in higher risk of clinical incidents because of staff being rushed, 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.

Controls in place	**Assurances**
- Regular caseload supervision for staff with team managers - Work being completed with IT to identify memory pathway patients in each HUB. to consider a business case to make this a separate service or to further explore a shared care protocols with primary care partners as documented in updated NICE guidance June 2018. - The NICE Dementia Medication Management NICE guidance states that memory pathway patients are to be reviewed every 12 months. Currently the Trust reviews this cohort of patients every 6 months. to consider	- Reporting and updates through D&F CGC. - Incident reporting via Eclipse. - Monitoring of number of complaints and SI, fortnightly. Issues/ concerns escalated to AD. - Team managers meeting undertaken monthly with CNM and staffing reports reviewed.

discussions with appropriate senior managers about being reviewing practices so services are in line with NICE standards. - Bank Assistant Psychologists are being utilised to help with waiting lists and caseloads. - Agency and bank nurses have been sourced to be able to help cover. - Caseloads are being capped at 35, however this is resulting in longer waiting lists.	- Regular review of rotas by management.

Gaps/weaknesses in Controls/mitigations
- Although supervision occurs on a regular basis caseloads remain high as there are not always appropriate to discharge. - Bank and agency staff only provide a short term fix and cannot be relied upon. - IAPT services for house bound physically frail people. BHM are unable to see these patients, therefore the onus is on CMHT to support patients who needs could be met in primary care if services were available. - Discussion still to had regarding review of KPI, however this will need to be formally agreed by the Trust to take forward - There are new referrals received to the CMHT's on a daily basis, increasing the pressure on resources and impacting on staff morale. - We are still seeing an increase in referral rates.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1545	High waits across all Older Adult CMHTs- this includes waits for new assessments, follow ups and patients awaiting care coordination.	SR2	Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.
1544	Risk to patient safety, experience and treatment efficacy due to vacancies and sickness amongst consultants.	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
1883	Older adults in the community may not receive psychological assessments and interventions in a timely fashion due to vacancies in the psychology team.	SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.

		SR9	Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR020/950/ 001**	Recruitment to over recruitment posts on-going, still very little interest even though the posts have been widen to other professional staff groups	Hannah Kenny	31/12/2024	Providing more posts to enable the teams to keep up with demand for services.	Complete
	CRR020/950/ 002	The number of referrals for teams is increasing, to have a look at the data behind this to understand better and see what potential staffing needs are	Hannah Kenny	31/12/2024	Understanding the reasons for referral and therefore how we might mitigate further	Complete
	CRR020/950/ 003	To work with neighbourhood teams to see if older adults can be referred to these, which may result in a quicker assessment, a more local assessment and less admin	Lou Pickering	31/07/25	Direct service users to more appropriate services reducing our caseload	Complete

	CRR020/950/004	The figure for a manageable caseload of 35 comes from the CPA policy, this equates to approx 7 patients per day per WTE. To assess if this will change with the rollout of Dialog+	Lou Pickering	31/08/25	Ensure that current workload capacity numbers are realistic	Complete
	CRR020/950/005	A service wide bid is currently in the process of being written to try to ensure that we have the correct staffing levels and resource for the demand	Lou Pickering	31/08/25	Ensure that we have the correct staffing levels and resource for the demand	Complete
	CRR020/950/006	To look at the service design and principles of flow. - Currently there is a requirement to see a medic yearly- this has been highlighted to the medical director for discussion and review. - People tend to stay on the caseload for prescribing longer than they perhaps need to- look at how we can discharge from the service	Lou Pickering	31/08/25	ensure good patient flow and discharges so that patients are not being held on the caseloads for too long, this will free up capacity for new referrals	

	CRR020/950/ 007	A trustwide CPA review is being undertaken which may have an impact on this risk	Lou Pickering	31/03/26		

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
20/06/2024	Risk reviewed and escalated to CRR.
15/10/2024	Risk reviewed by Hannah Kenny, whilst staffing has improved across all teams, Caseload sizes have not decreased and majority of staff have caseload of over 35 service users.
17/03/2025	Risk reviewed with Lou Pickering (CSM), Hannah Kenny- large caseloads remain an issue however a lot of work around patient flow and service design is currently underway. Actions updated
23/07/2025	Risk reviewed by Lou Pickering (CSM)- Risk description amended, actions updated.

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	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.	**Current Risk Rating**	3 Moderate	5 Almost Certain	15		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	04/06/2021
		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.**			**Last updated on Eclipse**	18/07/2025
CRR ID	**CRR021/1545**						

Risk description
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 This may caused by an increase in demand and the complexity of service users requiring more resource. At March 2025 the highest waits are in Solihull (12 weeks) and North (10 weeks)- this should be 4 weeks. This may result in higher risk of clinical incidents- leaving patients untreated may mean that their mental health or cognition may deteriorate; all patients may face poor experience; and the service not meeting internal standards. This may also create a reputational risk.

Controls in place	**Assurances**
- Patients can access support from Duty. - Patients with higher level of need or who present a greater risk will be on CPA and therefore have a care coordinator allocated. - Reviewing waiting lists to identify where there are priorities, specific issues and patients where risk indicated appointment may need to be expedited. - Remote consultations are being offered in the interim period to try to identify those who may need a sooner intervention. - Booking clinics for the earliest opportunity.	- Reporting and updates through D&F CGC. - Incident reporting via Eclipse. - Monitoring of number of complaints and SI, fortnightly. Issues/ concerns escalated to AD. - RMS - Discussion in MDT. - Waiting list - Risk assessments

- Routine reviews will not be prioritised, however the team will be responsive to changes in service user need. - Agency and bank have been sourced to be able to help cover. - Medic who was providing cover to the Juniper Admission Suite has agreed to support North Hub and provide clinical cover. - RC cover in place as an interim measure whilst consultant vacancies are being recruited to, start date arranged for substantive consultant in Solihull Hub.	

Gaps/weaknesses in Controls/mitigations
- CPNs have high caseloads (see risk number 950) and some teams are facing staffing issues (see risk numbers 1212 and 1541) - Bank and agency staff only provide a short term fix and cannot be relied upon. - Lack of Senior Medic presence in MDTs in Solihull Hub (see risk number 1543) and in North Hub (see risk 1544) - There are new referrals received to the CMHT's on a daily basis, increasing the pressure on resources and impacting on staff morale. - We are still seeing an increase in referral rates.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
950	CMHT caseloads continue to be above 35 resulting in higher risk of clinical incidents and staff burnout	SR2	Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.
1544	Risk to patient safety, experience and treatment efficacy due to vacancies and sickness amongst consultants.	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
1883	Older adults in the community may not receive psychological assessments and interventions in a timely fashion due to vacancies in the psychology team.	SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.

Actions to mitigate risk and attain target score:

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	**CRR021/1545/ 001**	Recruiting to vacant medic (including consultant) posts	Susan Adams	31/03/2025	Providing more posts to enable the teams to keep up with demand for services.	Complete
	CRR021/1545/ 002	Ongoing recruitment to vacant posts and recruitment to 12 month fixed term contracts	Hannah Kenny	31/03/2025	Providing more posts to enable the teams to keep up with demand for services.	Complete
	CRR021/1545/ 003	Additional leadership to go into SPOA to ensure that all referrals into the service are appropriate	Lou Pickering	20/03/2025	Ensure appropriate referrals	Complete
	CRR021/1545/ 004	Work on principles of flow and discharges is being undertaken to see how we can reduce caseload numbers	Hannah Kenny	31/10/2025	Reduction in caseload numbers	
	CRR021/1545/ 005	Reviewing impact of transformation work and funding	Lou Pickering	01/11/2025	Direct service users to more appropriate services reducing our caseload	
	CRR021/1545/ 006	A QI project to be done regarding referrals into the service to ensure that all referrals are appropriate	Hannah Kenny	30/09/2025	Ensure appropriate referrals	

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
20/06/2024	Risk reviewed and escalated to CRR.

01/07/2024	Risk reviewed by Sue Adams- we may be able to reduce this score soon as recruitment has taken place, we are just waiting for people to start in post.
26/11/2024	Risk reviewed by Hannah Kenny- currently ongoing issues and complaints. There are plans to review all services.
17/03/2025	Risk reviewed with Lou Pickering (CSM), Hannah Kenny- risk description updated, actions updated
18/07/2025	Risk reviewed with Lou Pickering (CSM)- actions updated

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	Admissions to secure care beds from prison may be delayed and it may be difficult to respond to crises in the community due to current lack of capacity in BSMHFT secure beds and the provider collaborative.	**Current Risk Rating**	3 Moderate	5 Almost Certain	15		
		Target Risk Score	2 Minor	3 Possible	6	**Date opened**	02/05/2024
		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.**			**Last updated on Eclipse**	28/03/2025
CRR ID	**CRR024/1922**						

Risk description
There is a risk that admissions to secure care beds from prison may be delayed, and that it may be difficult to respond to crises in the community. This is caused by a current lack of capacity in BSMHFT secure beds, compounded by a lack of capacity across the provider collaborative and within the national resource. At of May 2024 BSMHFT medium secure beds are at capacity. This could lead to delay in providing effective treatment and care for patients who require secure care, meaning that they may deteriorate or their treatment may take longer, and services users not being held in an appropriate safe facility to contain risk.

Controls in place	**Assurances**
- Manage and ensure awareness through local bed management meetings - Discuss at central bed management to identify wider resources - Regular contact with other members of the provider collaborative	- Eclipsing of incidents for monitoring at PCG - Waiting lists reviewed daily

Gaps/weaknesses in Controls/mitigations

- Shortage of beds also at provider collaborative partners and nationally

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1742	Patients who require forensic community follow up are not able to access the service (new referrals, not existing outpatients) caused by lack of capacity in the team to take on new referrals, assessments, and acceptance onto caseloads. This may result in patients having extended inpatient stays	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
		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.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to	**CRR024/1922/ 001**	Communicate arrangements for sourcing urgent beds at Reach Out partners where possible	Dinesh Maganty	31/12/24		Complete

achieve target risk score	**CRR024/1922/ 002**	To explore creation of Mens Low Secure Beds for young adults and step-down beds for women (Dawn House)	Marimouttou Coumarassamy	28/10/25	Proposal accepted- work commencing on implementation	

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
24/10/2024	Risk newly added onto the CRR.
03/01/2025	Risk reviewed with Dinesh Maganty- new action added
28/03/2025	Risk reviewed by Dinesh Maganty- action updated. Dawen House proposal has been accepted and agreed, work commencing on implementation

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Risk of compromise of patient safety and quality of care due to a low number of experienced qualified nurses across the organisation. This may be caused by a high vacancy rate of 187 positions at Senior Band 6 nurse	**Inherent Risk Rating**	4 Major	4 Likely	16	QPES	
		Current Risk Rating	4 Major	4 Likely	16		
		Target Risk Score	4 Major	2 Unlikely	8	**Date opened**	08/11/2024
		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.**			**Last updated on Eclipse**	26/06/2025
CRR ID	**CRR030/2010**						

Risk description
There is a risk of compromise of patient safety and quality of care due to a low number of experienced qualified nurses across the organisation. This may be caused by a high vacancy rate of 187 positions at Senior Band 6 nurse level, resulting in a low number of experienced qualified nurses across the trust. While recruitment efforts have successfully attracted newly qualified nurses alongside international nursing cohorts, this has led to high ratios of inexperienced to experienced staff in some areas. This situation is further challenged by national shortages of experienced mental health nurses and regional competition with other mental health organisations, including private providers, which makes it difficult to recruit and retain experienced staff in the necessary numbers. This may result in the compromise of patient safety and quality of care, as less experienced staff may lack the clinical expertise to manage complex cases independently. Additionally, the increased demands placed on existing experienced staff to provide oversight may lead to burnout, reduced morale, and increased turnover.

Controls in place	**Assurances**
- Comprehensive Preceptorship and Mentorship Programs: Newly qualified and international nurses participate in structured preceptorship and mentorship programs designed to accelerate skill development, support integration into clinical teams, and ensure safe, high-quality patient care. - Clinical Education Programs: Ongoing clinical education programs provide training and development for nursing staff at all levels, focusing on enhancing clinical competencies, leadership skills, and adherence to best practices in mental health care.	- Scrutiny and Oversight at the Safer Staffing Committee: The Safer Staffing Committee provides regular oversight, monitoring staffing levels, skill mix, and patient dependency ratios, and ensuring that any risks related to staffing are promptly identified and managed.

- Individual Competency Support Programs: Tailored programs within each division focus on building specific competencies, with targeted support to develop staff expertise in key clinical areas, ensuring the right skills are in place to manage complex cases effectively. - Active Recruitment Strategy: The trust maintains a proactive approach to recruiting experienced Band 6 nurses, with efforts to attract qualified candidates. - Use of Health roster to Support Safe Staffing: The system supports skill mix and patient acuity needs, supporting optimal staffing levels and allocation of experienced staff where they are needed. Health Roster also provides real-time insights into staffing gaps, allowing timely adjustments to maintain safe care standards	- Training programmes across the trust - Roster clinics - confirm and challenge

Gaps/weaknesses in Controls/mitigations
- Individual Competency Support Programs are new and remain untested for effectiveness. - This is a relatively new reporting arrangement into Safer Staffing Committee and so will need embedding - Despite significant training of ward leads with responsibilities for roster management - the appropriate use and understanding of health roster varies across the trust reducing its effectiveness.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1019	Insufficient capacity in HTT teams due to a shortage of RMNs	SR2	Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.
1058	Potential shrinking supply of mental health nurses nationally coupled with difficulties in recruiting to and retaining B5 RMNs and shortage of experienced B6 RMNs.	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
1813	Clinical demand in excess of the workforce capacity across multiple professional groups (ICCR)	SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.

Birmingham and Solihull Mental Health NHS Foundation Trust

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR030/2010/ 001**	Development Opportunities: Offer advanced practice training, or financial support for further education in mental health nursing, helping to build a more highly skilled workforce and provide additional career progression options for current staff.	Lisa Stalley-Green	31/05/25		
	CRR030/2010/ 002	Expanded Recruitment Campaign: Broaden recruitment efforts by launching regional and national campaigns that highlight the benefits of working within the trust, focusing on attracting experienced Band 6 nurses, particularly in different mental health specialties. This could include partnerships with universities and professional bodies.	Hayley Brown	28/02/25		

	CRR030/2010/ 003	Enhanced Retention and Engagement Strategy: Develop targeted retention initiatives, such as stay interviews, well-being programs, flexible working options, and leadership development pathways, to encourage experienced nurses to remain with the organisation.	Hayley Brown	28/02/25		
	CRR030/2010/ 004	Enhanced Support for International Nurses: Provide extended orientation and cultural competency training for international nurses to help with faster integration and adaptation, along with mentorship programs that continue past the initial transition period to ensure ongoing support.	Katie Atcherley	28/02/25		
	CRR030/2010/ 005	Enhanced Leadership Visibility: Increase the presence of senior leadership, including the Chief Nursing Officer and Deputy Chief Nursing Officer, in high-demand areas to provide real-	Lisa Stalley-Green	28/02/25		

		time guidance, reassurance, and oversight for both experienced and less experienced staff.				
	CRR030/2010/ 006	Dedicated Workforce Planning Strategy: Establish a taskforce focused on workforce planning to analyse future staffing needs, identify anticipated skill gaps, and create a sustainable long-term recruitment and retention strategy.	Lisa Stalley-Green	28/02/25		
	CRR030/2010/ 007	Targeted Professional Development Programs: Develop tailored training programs focusing on key skills identified as areas for improvement helping to quickly build the competencies of newer staff.	Raksana Begum	31/01/25		

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
09/12/2024	Risk newly added onto the CRR.
26/06/2025	Risk reviewed at at CNO DMT- risk description amended to remove figures as unsure if this number is correct. Original number in Nov 2024 was 187, in June 2025 this looks like 151, however we are unsure of the accuracy of this data. Katie Atcherley will look to dive into these numbers and understand the true figure.

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	4 Likely	16	QPES	
Title of risk	M-power, which is SOLAR's enhanced team for hospital avoidance for those CYP that have a confirmed diagnosis of LD&A, may not be able to continue.	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	11/12/2024
		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.**			**Last updated on Eclipse**	23/04/2025
CRR ID	**CRR031/2016**						

Risk description
There is a risk that M-power, which is SOLAR's enhanced team for hospital avoidance for those CYP that have a confirmed diagnosis of LD&A, may not be able to continue in its current form. This may be caused by the team being commissioned for 3 years. The funding for this aspect of the service has not currently been agreed past 1st April 2025. The M-power team works intensively with the CYP, their families and consults with external agencies to ensure there is advice around any care packages etc that may be required along with aiming to avoid a hospital admission. The service consists of 0.2 consultant, 0.8 LD nurse, 1.0 support worker, 0.4 SLT, 0.5 OT and works in conjunction with the crisis home treatment team. This may result in the team not being able to continue in its current form, meaning reduced service for those CYP with a confirmed diagnosis of LD&A, and that the cohort of CYP that the M-power supports may not receive the intensive support that the require to avoid a hospital admission. If the money is not made available and if the service continues then this will be a cost pressure to SOLAR.

Controls in place	**Assurances**
- At present the funding is in place until 31st March 2025 and there are ongoing discussions with the transformation lead for LD&A.	- Data is being supported around the clinical activity for M-power to support the case for recurrent funding. - Discussions at Solar CGC and FPP.

Gaps/weaknesses in Controls/mitigations

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
2017	Risk of staff burn out and a reduction in moral within the SOLAR management team due to vacancies.	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
		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.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR031/2016/ 001**	Ongoing discussions with the transformation lead for LD&A	Stephen Harrison	31/07/25	Secure funding for the M Power service	
	CRR031/2016/ 002	Data is being supported around the clinical activity for M-power to support the case for recurrent funding. This is	Stephen Harrison	31/07/25	Secure funding for the M Power service	

		being work done by the informatics team, manager and service manager.				

Key:

	On track to delivery on time
	Completed
	Outstanding or delayed

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
20/02/2025	Risk newly added onto the CRR.
04/02/2025	Risk reviewed by Steve Harrison- controls added
23/04/2025	Risk reviewed at Solar EIS CGC- Awaiting to see if funding will be made recurrent. It was agreed that this level of risk remains the same. Ownership of this risk to be transferred to Steve Scrimshaw.

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	Risk of the Trust not meeting its Governance requirements on July 1st 2025 with regards to the transfer of the Children & Young People Service (CYP)	**Current Risk Rating**	3 Moderate	5 Almost Certain	15		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	10/04/2025
CRR ID	**CRR033/2049**	**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 range 6-8			**Last Update on Eclipse**	01/08/2025

Risk description
There is a risk of the Trust not meeting its Governance requirements on July 1st 2025 with regards to the transfer of the Children & Young People Service (CYP). This may be caused by CYP not having access to Governance systems at the time of the transfer. This could lead to a lack of oversight and failure to meet local and national reporting requirements of the CYP service.

Controls in place	**Assurances**
CYP will continue to use Governance Systems at Birmingham Women and Children's Hospital (BWC)	Oversight and reporting will remain under BWC

Gaps/weaknesses in Controls/mitigations
Despite discussions about creating a process to update BSMHFT these processes would be manual therefore updates may not be timely and information limited. Training on the Eclipse system would need to be provided.

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
		SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR033/2049/ 001**	Working with the Head of IT, look at alternative options of allowing CYP access to our Governance systems by working with the system provider, Ulysses.	Bhu Patel	31/03/26	Ensure BSMHFT has oversight of CYP risks	

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
19/06/2025	Risk newly added onto the CRR.
01/08/2025	Agreement has been made that CYP directorate will remain on the Datix system until phase 2 of the transfer project. A number of BSMHFT staff will have access to Datix for reporting purposes. Processes for reporting incident, complaints, and risk information are in the process of being drawn up.

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Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	Delayed recognition, poor infection prevention and control (IPC) practices, and heightened exposure HCID risk to staff, patients, and visitors caused by mental health trust not been given access to HCID training	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	3 Possible	9	**Date opened**	12/05/2025
		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 range 6-8			**Last Update on Eclipse**	14/07/2025
CRR ID	**CRR034/2055**						

Risk description
There is a risk that Staff within the trust do not have access to appropriate training on High Consequence Infectious Diseases (HCIDs) and clear national guidance for mental health & community settings, resulting in limited awareness and preparedness to respond effectively in the event of an HCID case. This increases the likelihood of delayed recognition, poor infection prevention and control (IPC) practices, and heightened exposure risk to staff, patients, and visitors. This is/may be caused by mental health trust not been given access to HCID training as acute hospitals have been prioritised with limited spaces available.

Controls in place	**Assurances**
-General IPC training delivered trust-wide. -Basic outbreak and escalation procedures in place -IPC team provides reactive advice when infection risks are identified.	-Regular IPC audits are conducted and reported through governance channels. -Staff compliance with standard infection prevention procedures is monitored via routine observation. -Incident reporting system in place for suspected infection control breaches -EPRR annual review and tabletop exercise for HCID.

Gaps/weaknesses in Controls/mitigations

-No specific HCID-focused training for frontline staff.

-Lack of clear local protocols for HCID response.

-No formal liaison with HCID designated units or UKHSA

-No Internal audit or simulation exercise planned to test readiness for infectious disease scenarios.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1717	Risk of HCID infection due to low compliance with FFP3 mask face fitting	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR034/2055/ 001**	-Development of HCID procedures. -To have the appropriate HCID-specific training package for mental health & community settings.	Zalika Geohaghon	31/10/25	Ensure appropriate level of training is in place	

		-Staff to attend training for HCID once available to the mental health trust				

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
19/06/2025	Risk newly added onto the CRR.
14/07/2025	Risk reviewed with Timea Vig (Deputy IPC Lead Nurse)- risk remains the same and action updated. Risk identified during Operation Tangra and we are working alongside NHSE. It has been confirmed that we will receive training which we will then be able to roll out across the trust.

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	Risk of harm to service users and the general public due to the lack of AMHP provision in Birmingham.	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	4 Major	2 Unlikely	8	**Date opened**	05/06/2025
		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 range 6-8			**Last Update on Eclipse**	none
CRR ID	**CRR035/2058**						

Risk description
There is a risk of a serious incident or harm to service users and the general public due to delay to access of appropriate care because of the lack of AMHP provision in Birmingham, alongside reputational and financial risks. This may be caused because Birmingham City Council, who are commissioned to provide this service, not having an appropriate provision of AMHPs for assessments which means that people are being kept inappropriately in A&E or out in the community, or leaving those safe spaces posing a danger to themselves and/or the public. Also S117 orders are not being completed meaning that beds are blocked and those who need them cannot be admitted. There are repeated issues when attempting to contact the emergency mental health line with lack of out of hours escalation. It has been difficult to engagge BCC in escalation processes despite engagement by BSMHFT. BCC have also not engaged in the Birmingham Pathways Review. Forensics, Dementia & Frailty, Acute and Urgent services are all affected. The lack of AMHP availability may result in public safety incidents, delays to unwell people receiving care and deteriorating, delayed transfer of care, delays in warrants, delays in treatment, increased pressure on our community teams and HTT, increased pressure on A&E departments, increased financial costs due to utilisation of out of area beds, fear in the community, and reputational risk if any incidents were to occur as they may be covered by the media.

Controls in place	**Assurances**
All affected directorates have risks regarding the potential impact of lack of AMHP availability on their local risk registers. BSMHFT have participated in the Birmingham Pathways Review and completed all actions. Discussed and reviewed in Safety Huddles.	Incidents raised on Eclipse and reviewed. Oversight at Trust CGC. Monitored by HTT teams and fed into Acute Care CGC and Bed management meetings.

Shortage of AMHP provision in Birmingham is reflected on the Social Care risk register. Daily escalation meeting with AMHPs in place HTT continue to escalate issues, delays and eclipse related incidents to Head of Social Care (JL). Work actively with the bed management team to ensure that beds available when needed. Urgent Care continually review 72 hour breaches and feedback to BCC. AMHPs recruited to FIRST service Two additional Nurse AMHPs have been employed through the trust to support in the Place Of Safety Escalation to Chief Nurse	Monitored via incident reporting and feedback into Urgent Care CGC. Discussed at Bed Management meetings.

Gaps/weaknesses in Controls/mitigations
Emergency MH line is sometimes not manned, and no access to the on call director even for senior staff. The LA has limited resource specially at the transition hours of early evening and again in the early hours of the morning when often there is only one AMHP on duty but the demand is high. BCC have not participated in the Birmingham Pathways Review. Limited to actions we can take due to lack of engagement by BCC. We are currently unable to train our own AMHPs as this needs to be done by BCC who are contracted to provide this service, and there are financial implications for them.

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1236	Risk of undue delays in timely and prompt MHA assessments of HTT patients requiring psychiatric inpatient admission due to the shortage of AMHP provision in Birmingham.	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
1913	Risk of the out of hours on call AMHP Rota for the forensic Intensive Recovery Support Service not being covered by a qualified AMHP	SR7	Failure to deliver optimal outcomes with available resources.
1929	Risk that individuals presenting at General Hospitals, Place of Safety, and PDU may face long waits for a Mental Health Assessment caused by a lack of AMHP availability	SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.
		SR9	Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR035/2058/ 001**	A clear escalation process for AMHPs to be created, agreed by BSMHFT and BCC, and implemented.	Lisa Stalley-Green			
	CRR035/2058/	To obtain data/ KPIs from BCC so we understand the scope of the risk	Lisa Stalley-Green			

Birmingham and Solihull Mental Health NHS Foundation Trust

	002					
	CRR035/2058/ 003	Ongoing with conversations with support of the ICB to understand the challenges and resource issues.	Tariro Nyarumbu	31/03/2026		

Date	**Risk Reviews and Progress made since last Committee review/scrutiny of risk:**
19/06/2025	Risk newly added onto the CRR.

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Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	5 Catastrophic	4 Likely	20	QPES	
Title of risk	Risk that emergency services will not be able to access the Oleaster or Barberry sites in case of a fire, medical emergency, or any other emergency.	**Current Risk Rating**	5 Catastrophic	3 Possible	15		
		Target Risk Score	4 Major	2 Unlikely	8	**Date opened**	07/11/2023
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. **Target risk score range 6-8.**			**Last Update on Eclipse**	25/09/2025
CRR ID	**CRR038/1875**						

Risk description
There is a risk that emergency services will not be able to access the Oleaster and Barberry sites site in case of a fire, medical emergency, or any other emergency. This may be caused by staff and visitors parking in an unsafe manner at the site. Parking is limited in the area as it was designed with a green agenda in mind, with the Oleaster site having the lowest parking fines which means that commuters, those visiting UHB, and students all choose to park here as opposed to other areas. There is no access control and habitual poor parking practices with no onsite enforcement. The low parking fines mean it is not viable to persue PCNs through the DVLA. This may result in death or serious injury. There are also consequences of further risk of accidents on site, access concerns, potential damage to parked vehicles and pedestrian safety due to inconsiderate parking across operational sites.

Controls in place	**Assurances**
Monitored by estates and senior management, staff are asked to move if their car can be identified. Considerable uptake in car park scheme Regular comms and signage on safe parking Dedicated on-call spaces	Eclipsing of incidents- reviewed at Acute Care CGC Discussed at Health and Safety committee

Gaps/weaknesses in Controls/mitigations

Strong evidence that drivers visiting other areas on combined site leave cars where they choose blocking access - Discussions in place with Q-park to increase frequency of checks and NCP notice charge.

No leadership/ oversight of the situation across the Oleaster and Barberry sites.

Parking fines were set at a low rate as charges were not in place at other sites across BSMHFT. These fines are not a deterrent and do not cover costs of enforcement through the DVLA.

Staff have come to expect parking as part of their employment and therefore expect to be able to park, even in unsafe areas.

Staff on call are unable to park when moving between sites, meaning that clinics and patients are disadvantaged. Whilst there are on call spaces allocated these are often taken by other motorists.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
		SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
		SR4	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.
		SR6	Failure to maintain acceptable governance and environmental standards

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**

Actions being implemented to achieve target risk score	**CRR038/1875/ 001**	Actions to be completed by newly established Parking Group- See attachments for updates - Develop a clear policy for car parking management at different sites. - Create and communicate a detailed eligibility criteria for car parking spaces to staff, ensuring it is signed off and implemented and integrated into policy. - Ensure that all new starters are advised of the limited parking spaces at most sites in the Trust and the need to use public transportation unless they are in roles where a car is required. - Discussion to be had regarding aligning penalties with surrounding organisations to act as a deterrent for unsafe parking and make it enforceable by the DVLA. - Identify a single person responsible for the overall management of the Barberry and Oleaster buildings to ensure governance and control.	Natassia James	31/10/2025		

		- Obtain quotes for installing barriers and other physical measures to manage access to the sites and prevent parking on pavements.				

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
21/08/2025	Risk newly added onto the CRR
25/09/2025	Task and finish group established exploring options. Taken to H&S Committee for further review.

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Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	5 Catastrophic	4 Likely	20	QPES	
Title of risk	Complex patients who struggle to engage with mental health services and treatments may cause significant harm to themselves or the public.	**Current Risk Rating**	5 Catastrophic	3 Possible	15		
		Target Risk Score	5 Catastrophic	2 Unlikely	10	**Date opened**	23/07/2025
CRR ID	**CRR039/2072**	**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.			**Last Update on Eclipse**	none

Risk description
There is a risk that complex patients who struggle to engage with mental health services and treatments may cause significant harm to themselves or the public. This has come to light following attacks on the public in Nottingham in 2023 by Valdo Calocane and the independent investigation into his treatment which followed, which highlighted nationally a potential lack of oversight for complex patients who have poor engagement with treatment or lack of insight, poor discharge planning, lack of shared decision making, need for strengthening risk management, that medication compliance improvements are needed, structured family and carer involvement are needed, issues around staffing and workforce, and response to crisis. BSMHFT has completed a gap analysis which has been clinically reviewed by NHS England, and from this an action plan has been created. This may result in serious incidents, death, fear in the community, pressures on our services and the wider system, poor publicity and reputational damage, loss of confidence from internal and external stakeholders, action against the trust by CQC and other authorities, loss of provider contracts, and financial impact.

Controls in place	**Assurances**
BSMHFT already has an established Assertive Outreach service, with 6 AO teams covering the BSOL localities Gap analysis completed and fed back to NHSE, with feedback received. Ongoing support from NHSE Policies have been reviewed to ensure that patient family and carers are involved, particularly at times of non-engagement	Executive SRO leadership and oversight – Lisa Stalley-Green, Fabida Aria, Vanessa Devlin Reviewed monthly at QPES, Trust CGC, MHPC Executive Steering Group Support and oversight from NHS England

Crisis Line Work completed around enhancing duty standards with senior leads having oversight and clear escalation guidelines Eliminated 'blanket' policies and practices of using DNA as a reason for discharge	

Gaps/weaknesses in Controls/mitigations
Reliance on other areas within the trust to complete some of the actions on the action plan

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
		SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
		SR4	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.
		SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.
		SR9	Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR039/2072/ 001**	Assertive Intensive Action Plan with 34 points in place and reviewed fortnightly which includes: - Identification of individuals who may need more intensive support - Workforce needs, including recruitment of Advanced Clinical Practitioners (ACPs) to provide oversight for complex cohort. - Systems in place to respond when they disengage - Clear pathways in place to 'step up' care, and to ensure transition and flow to make sure that there is capacity when needed - Response to crisis - Care planning - Our relationship with other services - Appropriate governance in place, including monitoring people who are discontinuing medication against advice and risk management processes - Involvement of Experts By Experience, families, and carers	AD and CDs for ICCR plus other actions for other teams within the trust		Address the gaps established following the review to ensure that complex patients who disengage are looked after	

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
21/08/2025	Risk newly added to CRR

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Appendix 2: Details of the FPP Corporate Risk Register (CRR)

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	5	5	25	FPP	
Title of risk	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	**Current Risk Rating**	5	5	25		
		Target Risk Score	3	3	9	**Date opened**	16/4/2015
		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 9 - 10.***			**Last updated on Eclipse**	03/11/2025
CRR ID	**CRR010/108**						

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

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

Gaps/weaknesses in Controls/mitigations
• Consequences of poor financial performance, or non-delivery of savings do not attract any further review.

- Attendance at Sustainability Board variable.
- Trust has not been able to develop a pipeline for delivery of savings.

Links to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk IDs	**Risk Titles**	**BAF Number**	**BAF Risk Title**
		SR5	Failure to maintain a sustainable financial position.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR010/108/ 01**	To develop a financial management policy – work is underway to progress this	Richard Sollars, Deputy Director of Finance.	31/10/2024	Action will mitigate the impact of the risk were it to crystallise.	Complete

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
12/02/2024	Risk newly added onto the CRR.
27/03/2024	Risk reviewed by Richard Sollars- March FPP meeting received update on savings schemes identified to date for 24/25 - currently at circa £10m on £14.5m target. Challenge as to identifying further recurrent schemes
03/05/2024	Risk reviewed by Richard Sollars- FPP received an update confirming that the draft Annual Plan submission had fully identified plans to deliver the savings target at that time - 71% of it on a recurrent basis. Subsequent adjustments to the planning submission have increased the savings target still further with £1.5m now unidentified
17/06/2024	Risk reviewed by Richard Sollars- Balance of £1.8m unidentified for 24/25 out of circa £17.8m requirement. Sustainability Board and execs briefed on latest position - agreement to write to senior leaders asking for plans for 1% for this current year and to start 2% planning for 25/26

17/07/2024	Risk reviewed by Richard Sollars- re 24/25 delivery still £1.8m unidentified. Requests for operational and corporate areas to review opportunities and submit plans by end of July. Other underperforming element is out of area where there is a £5m savings plan. Re 25/26 - requests for 2% delivery to be submitted by September
16/08/2024	Risk reviewed by Richard Sollars- limited response to requests for savings - escalated via Exec Team and reminder issued. Key requirement is to identify plans to meet current unidentified elements - finance team identifying mitigations
16/09/2024	Risk reviewed by Richard Sollars- opportunities being reviewed to offset remaining gap in 24/25 programme - likely to be through agency savings running ahead of plan. Submissions made by some teams for 25/26 which will be reviewed during September
16/10/2024	Risk reviewed by Richard Sollars- level of improvement on agency spend means that we can offset the remaining unidentified savings balance for 24/25 against that - this would mean that we could demonstrate a full plan in place. Only significant area of non delivery in 24/25 is OOA. Operational plans submitted in full to meet 2% savings requirement - CQEIAs being developed for presentation back to November Sustainability Board
15/11/2024	Risk reviewed by Richard Sollars- agency spend reduction of circa £5m which will offset shortfalls in OOA. Plans submitted by ops portfolios for 25/26 - still awaiting balance of corporate portfolios. CQEIAs will go to Sustainability Board in November to enable mobilisation
16/12/2024	Risk reviewed by Richard Sollars- agency spend reductions continue to offset overspends on OOA. CQEIAs being developed for 25/26 plans
15/01/2025	Risk reviewed by Richard Sollars- OOA savings target will not deliver in year but being offset by agency reduction. Plans being developed for 25/26 with CQEIAs requested for schemes submitted so far. Presentation to board strategy session highlighted circa £20m gap that would need offsetting from OOA and bank spend
14/02/2025	Risk reviewed by Richard Sollars- 24/25 savings shortfall will be offset by underspends and balance sheet flexibility. Increased surplus will be delivered in 24/25. Plans for 25/26 suggest a considerable level of financial uncertainty which is being reviewed as part of the operational planning process
17/03/2025	Risk reviewed by Richard Sollars- 24/25 savings offset by other non recurrent opportunities. Savings target for 25/26 identified at £36m - plans for full value in place - need to monitor delivery
16/04/2025	Risk reviewed by Richard Sollars- 25/26 submitted plan identifies £36.4m of savings with 100% identified - detailed delivery plans needed, especially for high risk schemes such as beds. April FPP agenda devoted to discussions on deliverability. No financial flexibility available to offset any non delivery
23/05/2025	Risk reviewed by Richard Sollars- £15m delivered as at mth 1 with identified plans for the balance. May FPP requested further details on mitigations for under delivery, and separate paper received on non contracted beds shortfall

26/06/2025	Risk reviewed by Richard Sollars- Forecasts being developed by senior leaders and financial management teams indicate a shortfall in savings delivery. Presentation to Exec team 23/6/25 to present additional proposals to mitigate non delivery. Presentation at Sustainability Board 26/6/25
28/07/2025	Risk reviewed by Richard Sollars- forecast identifies current shortfall. Sustainability Board in July requesting recovery action plans to deliver. NHSE also asking for updates. Trust Board receiving private board session on finance
03/09/2025	Risk reviewed by Richard Sollars- financial forecast has been recalibrated to take account of potential shortfalls in savings delivery. Additional mitigations have been identified including further bank reductions and potential utilisation of provider collaborative resources
03/10/2025	Risk reviewed by Richard Sollars- savings shortfall being offset by other flexibilities and improvement in beds position. Deficit driven by savings shortfall has caused the Trust to be assigned segment 4 on the Q1 NOF score - financial recovery plan submitted to ensure Trust meets plan surplus by the end of the year

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Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	5 Catastrophic	5 Almost Certain	25	FPP	
Title of risk	Risk that the Trust is unable to deliver its financial plan caused by a lack of control and delivery of plans in relation to the key drivers of financial spend in the Trust	**Current Risk Rating**	5 Catastrophic	5 Almost Certain	25		
		Target Risk Score	3 Moderate	3 Possible	9	**Date opened**	14/8/2024
		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 9 - 10.***				
CRR ID	**CRR022/2004**					**Last updated on Eclipse**	05/10/2025

Risk description
There is a risk that the Trust is unable to deliver its financial plan. This may be caused by a lack of control and delivery of plans in relation to the key drivers of financial spend in the Trust – namely out of area, bank and savings. This may result in the Trust missing its financial plan target (£2m surplus for 2024/25) necessitating usage of limited balance sheet flexibility, under-spends in other areas or ultimately enhanced restrictions on spend.

Controls in place	**Assurances**
▪ SFIs describe limits of financial control and review ▪ Sustainability Board, FPP and Board receive monthly updates on financial position ▪ Targeted actions on areas of key financial risk – OOA, Bank and Agency spend ▪ System wide requirement for medium term financial planning (Submit in August 24) ▪ System wide requirement for financial recovery plans for providers off target (Submit in August 24) ▪ Request already issued for 2% transformational savings ideas for 25/26	Reports into Trust FPP through Integrated Performance Report Also referenced at Sustainability Board, FPP and Trust Board

Gaps/Weaknesses in Controls/Mitigations
▪ Significant increase in OOA usage in recent weeks with no identifiable new plans identified at this stage to mitigate the impact

- Directorates not submitting or identifying savings ideas

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
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	SR5	Failure to maintain a sustainable financial position.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR022/2004/ 01**	Internal Audit to include Financial Controls as part of 24/25 audit programme	Richard Sollars, Deputy Director of Finance	31/10/2024	Confirmation (August 24) that audit scheduled for October 24 with report to be issued for future Audit Committee	
	CRR022/2004/ 02	Escalation of financial risk so organisation understands implications of continued spend	Richard Sollars, Deputy Director of Finance	August 2024	Completed – presentation shared with Steering Group (9/8/24), Exec Team (12/8/24) and OMT (13/8/24) highlighting increased forecast	
	CRR022/2004/ 03	Identification of actions to reduce demand for OOA beds and ensure existing patients repatriated	Operational and clinical colleagues via Steering Group	31/10/2024	To be developed	

	CRR22/2004/ 04	Completion of System requested medium term financial plan – this will identify level of underlying deficit and scale of recurrent challenge	Richard Sollars, Deputy Director of Finance	31/10/2024	Work underway – deadline for initial submission end of August 24	

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
14/8/24	New risk identified
22/08/24	Risk accepted onto CRR by RMG
28/11/2024	Risk reviewed by Richard Sollars- briefing given to November 2024 Trust FPP that we remain confident of hitting in year financial target but underlying position deteriorating. Presentation to Senior leaders 2/12/24 to update on full financial picture
30/12/2024	Risk reviewed by Richard Sollars- remain confident of delivering target surplus - given wider BSOL financial position likely that BSMHFT will be required to improve its surplus further and work continues to explore opportunities
29/01/2025	Risk reviewed by Richard Sollars- BSMHFT has offered increased level of surplus in 24/25 based on utilisation on balance sheet flex and additional income from provider collaboratives. Risk for 25/26 - presentation to board strategy session indicating gap at £21m before mitigations - this will be before impact of planning guidance which is yet to be published
28/02/2025	Risk reviewed by Richard Sollars- risk for 24/25 minimised and increased surplus offered to support system financial position. Position for 25/26 being reviewed as part of planning process but significant challenges
31/03/2025	Risk reviewed by Richard Sollars- plans in place to deliver increased levels of surplus in 24/25 on the back of release of balance sheet provisions and increased provider collaborative income. Mitigations need to be developed for 25/26 position given significant levels of savings required
30/04/2025	Risk reviewed by Richard Sollars- financial plans for 25/26 have been submitted to NHSE as part of the planning round - including a savings target of £36.4m of which circa £11m is high risk with no detailed implementation plans in place for elements. Balance sheet flexibility limited
01/06/2025	Risk reviewed by Richard Sollars- financial risk continues at highest level - month 1 already reported a £1m deficit. Mitigations currently being identified and linked to increased oversight from NHSE and ICB

01/07/2025	Risk reviewed by Richard Sollars- month 2 financial position deteriorated. Trust now placed in level 3 SOF and risk of further oversight and intervention from NHSE. Paper presented to Execs 23/6/25 with further proposals to mitigate deficit. Medium term financial planning also commencing
31/07/2025	Risk reviewed by Richard Sollars- While there was an improvement in month 3 (delivering a surplus) - Trust is off plan by £3.2m at the end of Q1 and NHSE Trust Board papers showed BSMHFT fifteenth worst position in the country based on variance to plan. Recovery action plan requested by NHSE and submitted early August
25/09/2025	Risk reviewed by Richard Sollars- further in month underspend in month 4 and 5 but Trust remains off plan. Submission of financial recovery plan to NHSE - further request and greater breakdown on trajectory to go in early September
05/10/2025	Risk reviewed by Richard Sollars- Trust over delivered against the recovery trajectory in month 6 by £100k and delivered a £1.1m surplus. Still significant risks remain to the delivery of the in year position, specifically around savings performance

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Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	5 Almost Certain	5 Catastrophic	25	FPP	
Title of risk	Risk of significant overspend on Out of Area beds for 2024/25 caused by the number of patients requiring inpatients beds continuing to exceed the number of contracted beds and productivity plans to reduce demand.	**Current Risk Rating**	5 Almost Certain	5 Catastrophic	25		
		Target Risk Score	3 Moderate	3 Possible	9	**Date opened**	13/8/2024
		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 9 - 10.***				
CRR ID	**CRR023/2003**					**Last updated on Eclipse**	05/10/2025

Risk description
There is a risk of significant overspend on Out of Area beds for 2024/25. This may be caused by the number of patients requiring inpatients beds (for which the Trust has financial responsibility) continuing to exceed the number of contracted beds and productivity plans to reduce demand. This may result in the level of overspend exceeding the level of flexibility elsewhere in the Trust to offset it, leading to the Trust to miss its agreed year end target. This could then lead to external intervention and additional financial controls being required on pay and non pay spend.

Controls in place	**Assurances**
Productivity Plan in place with objectives for delivery Weekly steering group with commissioner, BSMHFT and FTB representation to review plan Detailed financial monitoring	Reports into Trust FPP through Integrated Performance Report Also referenced at Sustainability Board, Executive Steering Group

Gaps/weaknesses in Controls/mitigations

Operational risk identified through directorate risk register – impact on financial position serious enough to warrant dedicated financial risk
There is an existing risk on Eclipse (1932) but this sits within Acute and Urgent Care and includes both financial and clinical risk – needs dedicated finance risk
Significant increase in OOA usage in recent weeks with no identifiable new plans identified at this stage to mitigate the impact

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1932	There is a financial risk to the organisation and also a clinical risk to patients as patients may be placed in out of area beds.	SR5	Failure to maintain a sustainable financial position.
		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.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR023/2003/ 01**	Financial reporting to be included for OOA steering group giving visibility on spend and forecast	Mark Godwin, Finance Manager	June 2024	Completed – information continuing to be refined based on discussions at steering group	
	CRR23/2003/ 02	Escalation of financial risk so organisation understands implications of continued spend	Richard Sollars, Deputy Director of Finance	August 2024	Completed – presentation shared with Steering Group (9/8/24), Exec Team (12/8/24) and OMT (13/8/24) highlighting increased forecast	

	CRR23/2003/03	Identification of actions to reduce demand for OOA beds and ensure existing patients repatriated	Operational and clinical colleagues via Steering Group	October 2024	To be developed	

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
13/8/24	New risk identified
22/08/24	Risk accepted onto CRR by RMG
20/11/2024	Risk reviewed by Richard Sollars- forecast has deteriorated in October 2024 and likely to have worsened again in November 2024. Actions - updates provided to Trust FPP November 2024 Presentation to Senior leaders team on financial position and impact 2/12/24 Acute and Urgent Care asked to deliver financial recovery plan Locality based financial modelling underway to highlight specific areas Procurement imminent for new provider
30/12/2024	Risk reviewed by Richard Sollars- Risk continues with no improvement in financial forecast - financial recovery plan requested from acute and urgent care by end of January 25
29/01/2025	Risk reviewed by Richard Sollars- Risk continues - presentations to FPP and included in financial recovery plan presentation on 30/1/25. Financial modelling underway to understand implications for 25/26
28/02/2025	Risk reviewed by Richard Sollars- Risk continues - report at 28/2/25 patient flow meeting shows number of BSMHFT patients in non NHS beds at highest level for 12 months. Financial information being reported into meeting and FPP. Modelling for 25/26 continually reviewed
31/03/2025	Risk reviewed by Richard Sollars- risk continues - level of patients placed in non contracted beds continues to grow. Savings target equivalent to £7.5m already set for 25/26 but might need further mitigations depending on levels reached in March
30/04/2025	Risk reviewed by Richard Sollars- risk continues - savings target set for beds of a £7.5m reduction. Finance team indicated a level of beds that could be commissioned using that budget. Procurement exercise currently underway which will also offer further reductions
01/06/2025	Risk reviewed by Richard Sollars- risk and overspend continues. Bed usage has reduced slightly and service developed quarterly action plan

01/07/2025	Risk reviewed by Richard Sollars- risk and overspend continues - while there had been some improvement in early June this has reversed as the month continues. Recovery action plan in place but results not yet delivering. Further controls will be needed
31/07/2025	Risk reviewed by Richard Sollars- risk and overspend continues. Further recovery action plan developed focusing on spot purchases with ambition to reduce adult usage to zero spot by end of August. Current modelling suggests will be able to deliver reduction to 3 places with balance of financial gap covered through reductions in contract
05/09/2025	Risk reviewed by Richard Sollars- significant improvement in performance during August 2025 leading to underspend against plan and clawback on year to date overspend. Plans continue to be operationalised in line with recovery plan
05/10/2025	Risk reviewed by Richard Sollars- sustained improvement through September although adult beds has trended upwards in recent days. Current forecast is to meet the savings requirement set for beds for 25/26 but uncertainty over recent increases, changes in procurement provider and onset of winter have caused the risk score to remain the same

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Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	FPP	
Title of risk	Lack of available capital funding and investment requirements	**Current Risk Rating**	4 Major	5 Almost Certain	20		
		Target Risk Score	3 Moderate	3 Possible	9	**Date opened**	05/03/2020
CRR ID	**CRR029/1225**	**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 9 - 10.***			**Last updated on Eclipse**	29/09/2025

Risk description
There is a risk that the lack of available capital funding and investment requirements could lead to misunderstandings, over commitment and inter-departmental tension meaning that the capital envelope is not utilised in the most effective manner for the Group as a whole (including value for money, addressing health and safety, physical and IT infrastructure requirements). Also, lack of funding will lead to dilapidated assets as we do not have the available allocation to undertake all necessary maintenance. This could then impact health and safety, increased cost of repairs, increased revenue costs, patient outcomes, staff retention etc. In addition to this, we may not have access to SCIF funding due to competing demands accross the ICS, which could further exacerbate the problem.

Controls in place	**Assurances**
• Estates colleagues regularly review maintenance schedules and escalate any significant issues that we have not identified funding for. • Senior management continue to link in with system colleagues to identify any additional capital funding that may become available. • Senior management to monitor any national funding available for specific programmes such as ICT and carbon neutralisation grants. • A list of capital schemes is circulated to operational and corporate leads regularly to maintain visibility of requirements • A multidisciplinary prioritisation process is in place to ensure that spend is in the right areas.	Monitored at FPP

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Gaps/weaknesses in Controls/mitigations
Our budget is allocated by the ICB, there is not a great deal that we can do.

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
650	Business plans from different service areas have overlapping objectives and capacity planning is insufficient.	SR5	Failure to maintain a sustainable financial position.
651	Underspend in one financial year leading to pressures in the following year as we attempt to complete delayed programmes.	SR7	Failure to deliver optimal outcomes with available resources.
659	Risk of adverse impact on service provision as a result of capital works.	SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.
759	Risk that we will exceed our capital allocation for several reasons.		
1989	Risk that there will be a lack of capital availability to fund major capital works at Highcroft and Reaside		
1990	Risk that we do not have the staffing or wider resources to support large capital projects		

Actions to mitigate risk and attain target score:

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	**CRR029/1225/ 01**	Estates colleagues to regularly review maintenance schedules and escalate any significant issues that we have not identified funding for.	Neil Hathaway	31/12/24		
	CRR029/1225/ 02	Link in with system colleagues to identify any additional capital funding that may become available.	Richard Sollars	31/12/24		
	CRR029/1225/ 03	Senior management to monitor any national funding available for specific programmes such as ICT and carbon neutralisation grants. Joint action between several leads.	Neil Hathaway	31/12/24		
	CRR029/1225/ 04	A list of capital schemes is circulated to operational and corporate leads regularly to maintain visibility of requirements. This is done via circulation of CRG papers each month.	Rose Stonehouse-Stanton	31/12/24		

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
09/12/2024	Risk accepted onto CRR at RMG
18/12/2024	Risk reviewed by Rose Stonehouse-Stanton- Reviewed at CRG on 17/12/24 and uplifted likelihood score to a 5
01/04/2025	Risk reviewed by Louise Merrison- Risk reviewed at CRG, no change to risk

30/06/2025	Risk reviewed by Louise Merrison- Risk reviewed at CRG, no change to risk
29/09/2025	Risk reviewed by Louise Merrison- Reviewed at CRG 16/09/25 Narrative requires update - Neil Hathaway to provide, will be updated ASAP to reflect current situation

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Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	5 Catastrophic	5 Almost Certain	25	FPP	
Title of risk	There may be a lack of capital availability to fund major capital works at Reaside.	**Current Risk Rating**	5 Catastrophic	5 Almost Certain	25		
		Target Risk Score	3 Moderate	3 Possible	9	**Date opened**	15/10/2024
CRR ID	**CRR032/1989**	**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 9 - 10.***			**Last updated on Eclipse**	29/09/2025

Risk description
There is a risk that there may be a lack of capital availability to fund major capital works at Reaside. This may be caused by lack of cash availibility or lack of capital availability within the system. This could lead to an impact/effect on precommitted expenditure if works had already began (at this stage they have not) or delapidated buildings that are no longer fit for purpose.

Controls in place	**Assurances**
• Senior management continue to link in with system colleagues to identify any additional capital funding that may become available. • Senior management to monitor any national funding available for specific programmes such as ICT and carbon neutralisation grants. • A list of capital schemes is circulated to operational and corporate leads regularly to maintain visibility of requirements	Monitored at FPP

Gaps/weaknesses in Controls/mitigations

This risk is separate to the remedial improvements and is for the complete rebuild project and forms part of the larger strategic scheme.

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
1225	Lack of available capital funding and investment requirements	SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
651	Underspend in one financial year leading to pressures in the following year as we attempt to complete delayed programmes.	SR5	Failure to maintain a sustainable financial position.
659	Risk of adverse impact on service provision as a result of capital works.	SR7	Failure to deliver optimal outcomes with available resources.
759	Risk that we will exceed our capital allocation for several reasons.	SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.
1990	Risk that we do not have the staffing or wider resources to support large capital projects		

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**

Actions being implemented to achieve target risk score	**CRR032/1989/ 01**	Link in with system colleagues to identify any additional capital funding that may become available.	Richard Sollars	31/03/26		

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
17/04/2025	Risk accepted onto CRR at RMG
29/05/2025	Risk reviewed by Louise Merrison- reviewed at CRG and agreed to remain the same
30/07/2025	Risk reviewed by Louise Merrison- Reviewed by finance and agreed to remain the same for now, a meeting is to be scheduled to review all capital risks and amend if required
29/09/2025	Risk reviewed by Louise Merrison- Change required as per discussion at CRG on 16/09/25 Highcroft to be removed and shown as a separate risk as the risk rating for Highcroft has now reduced

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	5 Catastrophic	3 Possible	15	FPP	
Title of risk	Risk of a cyber security incident caused by Microsoft ending support/ security patches/ updates for PC's running windows 10 operating system beyond October 2025.	**Current Risk Rating**	5 Catastrophic	3 Possible	15		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	08/04/2025
		Risk Appetite	**Open:** Systems / technology developments considered to enable improved delivery, enhanced cyber security and greater awareness of cyber threats. Agile principles may be followed. **Target 6-8**			**Last Update on Eclipse**	17/10/2025
CRR ID	**CRR037/2047**						

Risk description
There is a risk of a cyber security incident. This may be caused by PC's running windows 10 operating system beyond October 2025, when Microsoft end support for this version which will result in no further security updates/ patches. This could lead to an impact on Trust services, loss of data and an impact on the Trusts reputation due to a cyber attack.

Controls in place	**Assurances**
Funding for new devices has been secured	Oversight at FPP

Gaps/weaknesses in Controls/mitigations
Reliance on trust staff to be responsive to updating

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
774	Risk of loss/stolen of patient identifiable data (PID) and loss of access to electronic systems impacting all clinical services due to a Cyber Security Breach		No BAF Risks re cyber security
973	ICT data security risk which may be caused by users lack of cybersecurity awareness. This could lead to loss of access to ICT systems, services and information		
974	Risk of a cyber security breach caused by IoT devices (internet of Things) This could lead to an impact on staff accessing ICT systems , services and information.		
1012	ICT systems are less responsive or system functionality is affected due to a Cyber Security patch being applied.		
1865	Risk that staff are unaware of the associated cyber fraud risks and their actions can expose the Organisation to security breaches		
1983	Risk of failure to successfully comply with the Cyber Assurance Framework (CAF) - Data Security and Protection Toolkit (DSPT)		

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**

Actions being implemented to achieve target risk score	**CRR037/2047/ 001**	Identify funding to replace all PC's which are not window 11 compliant	Mark Thornton	30/04/2025	Ensure that we have funding for replacements	Complete
	CRR037/2047/ 002	Design new process for staff to install windows 11 on their own devices.	Mark Thornton	31/10/2025	Enable staff to update without IT support, so that resources can be directed where needed	
	CRR037/2047/ 003	To procure laptops/ desktops for Project and replace devices not compatible with windows 11	Mark Thornton	31/10/2025	Eliminate risk by replacing all PC's that are not windows 11 compliant	
					.	

Date	**Risk Reviews and Progress made since last Committee review/scrutiny of risk:**
19/06/2025	Risk newly added onto the CRR.
15/08/2025	Risk reviewed and actions updated on Eclipse
07/10/2025	Risk reviewed by Mark Thornton- risk reviewed and actions updated

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Details of People Committee Corporate Risk Register (CRR)

Executive Lead	Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	People Committee	
Title of risk	Efficiency and accuracy risks associated with the administration workforce not utilising new technology and modernising admin practices	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	4 Major	2 Unlikely	8	**Date opened**	07/08/2025
		Risk Appetite	**Open (9-10)-** Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.				
CRR ID	**CRR040/2099**					**Last Update on Eclipse**	new

Risk description
There are risks associated with the administration workforce not utilising new technology and modernising admin practices, including risks to operational efficiency, accuracy and availability of information, staff retention, and financial and regulatory risk. This may be caused by lack of training and skills to use new technology, investment, and buy in from both admin staff and clinical colleagues. There is further risk created by these new technologies being used incorrectly if staff are not adequately trained or systems are not kept up to date. This could lead to an impact operational efficiency, lack of reliability and consistency, affordability, patient and staff experience, and failure to deliver effective, futureproof services

Controls in place	**Assurances**
Copilot pilot Clear terms of reference Newly established Modernising Admin Practices Steering group	Steering Group in place Progress to be monitored through Shaping our Future Workforce into People Committee Report to Execs in the autumn

Gaps/weaknesses in Controls/mitigations

TBC by the steering group Resistance to change Competing priorities may impact attendance at the steering group and capacity to take work forward. Fear of AI/ technology i.e. replacing jobs might impact people's willingness to engage.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
		SR2	Inability to attract, retain or transform our workforce in response to the needs of our communities
		SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR040/ 2099/01**	Develop a tool, collect and analyse feedback from admin staff	Sarah Emery	30/09/2026		

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
16/10/2025	Risk newly added onto the CRR.

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Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	People Committee	
Title of risk	Risk that BSMHFT are unable to workforce plan effectively.	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	3 Possible	9	**Date opened**	07/08/2025
		Risk Appetite	**Open (9-10)-** Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.				
CRR ID	**CRR041/2100**					**Last updated on Eclipse**	new

Risk description
There is a risk that BSMHFT's current workforce plan may not be effective in meeting the demands of the future due to the rapidly changing workforce profiles, gap in integration of organisational data and variances in supply from educational institutions. This could lead to an impact on succession planning, not having the right staff in the right place at the right time to deliver effective healthcare and high temporary staffing costs.

Controls in place	**Assurances**
ESR Stakeholder Group System Workforce Planning group Workforce planning specialist in post Data available from local universities on graduate numbers. Annual Multi-disciplinary Training Education Programme exercise Training demand template)	Workforce planning specialist in post Oversight by Shaping Our Future Workforce sub committee up to People Committee Integrated Planning Group Set up - finance, workforce, activity

Gaps/weaknesses in Controls/mitigations
Integration of data between funded establishment in integra and workforce in ESR problematic. Data quality in ESR poor Annual planning too short-term to plan for longer term i.e. 3 years

Funding for training courses can be complex and ambiguous.

Link to other risks on Eclipse		Links to Strategic Priorities - Principal Risks	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
		SR2	Inability to attract, retain or transform our workforce in response to the needs of our communities
		SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR041 /2100/01**	Work with the ESR Optimisation Team on data quality, integration with finance and processes to maintain	Sarah Emery	31/03/2026		
	CRR041 /2100/02	Complete the 2026 planning round	Sarah Emery	31/01/2026		
	CRR041 /2100/03	Develop terms of reference for the integrated planning group	Sarah Emery	30/11/2025		

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
16/10/2025	Risk accepted onto CRR at RMG

Birmingham and Solihull Mental Health NHS Foundation Trust

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	People Committee	
Title of risk	Risk that persistently high rates of DNA's among both substantive and temporary staff, particularly in face-to-face training sessions, will place additional demands on training teams.	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	3 Possible	9	**Date opened**	22/09/2025
		Risk Appetite	**Open (9-10)-** Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.				
CRR ID	**CRR042/2119**					**Last updated on Eclipse**	new

Risk description
There is a risk that persistently high rates of DNA's among both substantive and temporary staff, particularly in face-to-face training sessions, will place additional demands on training teams. This increased demand can create bottlenecks within service delivery and limit the flexibility to provide additional capacity. Such constraints may result in staff not acquiring the necessary skills required for their roles, and the overall skill mix within teams may become problematic when scheduling rotas. Furthermore, high DNA rates in management skills training reduce the organisation's ability to achieve people-related objectives tied to the quality of service provision and staff experience. There is a consequent risk that staff turnover and absence rates may increase, and staff motivation could be adversely affected.

Controls in place	**Assurances**
Provide DNA rates/reports to line managers and senior leaders, who can then follow up with individuals or teams where attendance is below expectations Develop incentives or recognition schemes for teams or individuals who demonstrate high attendance and engagement in training, encouraging greater participation. Clear escalation procedures when DNA rates exceed a certain threshold, including reporting to senior management for targeted interventions.	Automated systems to send timely reminders and follow-up communications to staff regarding upcoming training sessions. L&D Offer includes a variety of training delivery formats, such as eLearning modules, recorded sessions, and multiple time slots, to accommodate

Obtain feedback from staff on barriers to attending training and use this information to refine training approaches and schedules.	varying staff schedules and reduce barriers to attendance. Provide regular assurance reports to senior leadership and governance committees, detailing mitigation activities, trends, and outcomes. Regularly reinforce the value of training for professional development, patient safety, and service quality through internal communications, ensuring all staff understand its significance. Integrate mandatory training completion into performance appraisals and compliance audits, making it a core requirement for progression or ongoing employment where appropriate. Regularly monitor DNA rates and analyse patterns to identify departments or staff groups with higher non-attendance, enabling targeted interventions.

Gaps/weaknesses in Controls/mitigations
Support and buy in of senior leadership teams to release staff to attend training Understanding amongst staff and managers of the appropriate notice period to cancel training in order to release the slot to another member of staff Capacity of L&D team to provide additional training sessions and in a multidisciplinary way

Link to other risks on Eclipse	**Links to Strategic Priorities - Principal Risks**

Risk ID	Risk Title	BAF Number	BAF Risk Title
		SR2	Inability to attract, retain or transform our workforce in response to the needs of our communities
		SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR042 /2119/01**	L&D manager to facilitate communication of DNA protocol to managers and staff via existing meeting structures and through ESR & LMS notifications where applicable by December 2025. Quarterly DNA data will be made available to ADs and senior managers through FPP meetings from November onwards	Diane Phipps	16/12/2025		

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:

16/10/2025	Risk accepted onto CRR at RMG

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Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	People Committee	
Title of risk	Risk that we may lose out on future workforce because we cannot afford financially to over establish at a band 5 level.	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	3 Possible	9	**Date opened**	22/09/2025
		Risk Appetite	**Open (9-10)-** Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.				
CRR ID	**CRR043/2119**					**Last updated on Eclipse**	new

Risk description
There is a risk that we may lose out on future workforce because we cannot afford financially to over establish at a band 5 level. This may be caused by issues with the nursing supply pipeline as we do not have enough vacancies for band 5 newly qualified mental health nurses and a vacancy gap for more experienced nurses. This may result in -Inability to fulfil the NHSE graduate offer -Poor experience of recruitment for newly qualified nurses as those who have offers have delayed start dates as unable to place in a vacancy. - Promoting too quickly into higher bands before staff have the appropriate clinical and/ or managerial skills. - Continued bank / agency usage at band 6 and above

Controls in place	**Assurances**
Regular reviewing of vacancy information Holding band 5 vacancies for newly qualified staff All vacancies entered on to TRAC	Regular reporting to Shaping our future Workforce and Safer Staffing Committee

Gaps/weaknesses in Controls/mitigations

Clarity around band 6 essential criteria and shortlisting managers adhering to this. MHOST data not robust enough to increase establishments Reasons for booking bank staff not always clear Vacancies not always entered in a timely manner Separate systems for funded establishment and staff in post are not integrated leading to poor data quality regarding vacancies.

Link to other risks on Eclipse		**Links to Strategic Priorities - Principal Risks**	
Risk ID	**Risk Title**	**BAF Number**	**BAF Risk Title**
		SR2	Inability to attract, retain or transform our workforce in response to the needs of our communities
		SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.

Actions to mitigate risk and attain target score:						
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	**CRR043 /2121/01**	Improve modelling and planning analysing demand and supply data such as MHOST, university numbers etc	Sarah Emery	31/01/2026		

	CRR043 /2121/02	Review pathway in light of the new nursing profiles	Sarah Emery	31/01/2026		
	CRR043 /2121/03	Explore band 5 to 6 development programme with the corporate nursing team	Sarah Emery	31/01/2026		
	CRR043 /2121/04	Bank & agency reduction programmes to improve financial position and potential scope for increase in substantive roles in collaboration with the safer staffing lead and the Bank Gold group	Sarah Emery	31/01/2026		

Progress since last Committee review/scrutiny of risk:

Date	Risk Reviews and Progress made since last Committee review/scrutiny of risk:
16/10/2025	Risk accepted onto CRR at RMG

Report to All Committees and Board

Agenda item:	
Date	20th November 2025
Title	Integrated Performance Report
Author/Presenter	Richard Sollars, Deputy Director of Finance Sam Munbodh, Clinical Governance Team Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information
Executive Director	Dave Tomlinson, Director of Finance

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

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

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

- **New: Update on the National Oversight Framework Metrics (see Appendix I for detail)**
  FPPC is also asked to note that due to the Trust being in segment 4, Low Performing, NHSE has commenced monthly Joint Improvement, Oversight and Assurance meetings with the first meeting with the Executive Team taking place on 17th October 2005. The agenda was wider than the NOF metrics.

  As a subset of the Trust's inpatient Productivity Plan, a targeted plan has been developed focusing on the two adult acute NOF measures, reducing LOS and improving response to patients in crisis receiving face-to-face contact within 24 hours. The action plans are attached as Appendices Ib and Ic

- **New:** Recovery house launched on the 5th November providing 24/7 residential service delivered in partnership with Birmingham Mind, offering intensive support for adults experiencing acute mental health needs.

- **New:** A new adult inpatient bed contract with Cygnet private provider is now in place. Currently placements at these hospitals are being classified as 'inappropriate' as the Standard Operating Protocol demonstrating that local clinical care and qualiatative criteria are in place has yet to be approved by NHSE. Once agreed, it is anticipated these beds will be classified as 'appropriate'.

- **New:** Board members are reminded that as part of the FTB CYP transfer to BSMHFT, a risk that was identified at the outset related to the impact of the in-year break in national MHSDS data submissions by BWC up to end June 2025 and BSMHFT from July 2025 and that this would make national reporting on CYP metrics unreliable as contacts/activity undertaken by BWC would not be identified in BSMHFT submissions. NHSE and Mental Health Collaborative Leads requested a meeting to better understand the detail of the issues impacting. The meeting took place on 5th November. In summary, it was acknowledged that the trust had followed national guidance regarding the CYP transfer, and it was recommended that local data be used for an interim period until the national MHSDS reporting becomes reliable.

- **New:** Talking Therapies - The MH Provider Collaborative issued a performance notice in September 2025 relating to the Talking Therapies underperformance in activity and reliable recovery and reliable improvement rates. As at Month 7 there is an income deficit of £415.9k related to underperformance on activity to date. The service action plan is attached as Appendix IIIa.

Performance Report - summary points:

- Inappropriate and Appropriate Out of area placements remain key priorities for action. October 2025 data for inappropriate out of area placements at 11 acute and10 PICU patients above trajectory of 10. Patient are placed in Cygnet Hospitals. Improving trend being achieved in reducing all out of area placements impacting on improving the financial recovery plan.
- Clinically Ready for Discharges – a reduction in the trend observed but continues to impact on available Trust capacity to repatriate out of area placements for adult inpatients. System level escalations continue to be taken.
- 2025/26 national Length of Stay (LOS) for adult and older adult inpatient services remain above trajectory, detail is outlined in Appendix III. To note that as the LOS methodology is based on discharge, long stay discharge will increase overall LOS.
- 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 absence has decreased to 5.9%
- Bank and agency reduction – bank and agency above trajectory for October
- Appraisals – improved to 83.6%.
- Vacancies – Vacancy rate at 7.7%, in October.
- Fundamental Training increased in last month but below 95% target.
- Incidents of Self Harm have increased from 84 to 108 in October.
- Physical harm (staff/third party) has increased to 7 this month.
- Reported incidents have increased to 2619 from 2189 in October.
- Staff assaults have increased to 126 from 79 in October

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 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 III.

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

Domain and metric	On Track	Plan in Place	Progress	Pages
Performance				
Inappropriate out of area Number of placements			Deterioration in last month above the national trajectory	3, 12-14
People				
Vacancies			Improvement in last 4 months. October at 7.7% below trajectory	6
Sickness			Decreased to 5.9% in last month above trajectory	6, 21-22
Appraisals			Increased to 83.6% above improvement trajectory but below 90% Trust standard	6, 23-24

Table 3: People

	On Track	Plan in Place	Progress	Page
Talking Therapies - Service users moving to recovery			Improving trend in last month (48.08%) and below national 50% target	
Talking Therapies Reliable Recovery Rate			Improving trend in last month (45.19%) and below national target of 50%	4, 19-20
Talking Therapies Reliable improvement rate			Improving trend in last month (68.47%) and above the national target of 68%	4, 17-18
Clinically Ready for Discharge: percentage of bed days			Improvement in last 3 months. October 2025 at 9.32%.	5,
Clinically Ready for Discharge: Number of delayed days			Improving trend in last 3 months. October 2025 at 1513 bed days.	5, 15-16

Table 2: Performance

	On Track	Plan in Place	Progress	Page
Fundamental Training			Improving trend in last 3 months (94.2%) below Trust target of 95%.	6, 25-26

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Incidents resulting in self-harm			Increasing trend in last month. Reviewed at QPES.	5, 27
Physical Harm – staff/third party			Increased from 5 to 7 in last month. Reviewed at QPES.	5, 28
Reported Incidents			Increased from 2189 to 2619 in last month	29
Staff Assaults			Increased from 79 to 126 in last month	5, 30

Table 5: CYP

Talking Therapies 6 weeks			Sustained performance in last seven months above target	
Talking Therapies 18 weeks			Sustained Performance in last seven months above target	
Talking Therapies Moving to recovery			Sustained performance in last 4 months (51%) above target	
Non-Contract > 18 beds charged of (ave weekly Snapshot)			Reduction in last 3 months (4) above target of 0	3
All > 18 beds charged for (ave weekly Snapshot)			Total number of beds used (70) below target of 92	

CYP Division	**On Track**	**Plan in Place**	**Progress**	**Page**
Eliminate Out of Area Placements			Improvement in last 3 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 October (awaiting final update)	2
National <18 eating disorders waiting times (Routine inc ARFID)			Improvement in last month (85%) below 95% target. Small numbers	2
National <18 eating disorders waiting times (Urgent inc ARFID)			Sustained performance at 100% for last seven months	2
Local Adult >18 eating disorders (routine)			Improvement in last month (100%)	2
EIP – Suspected First episode of Psychosis seen in 2 weeks			Sustained performance in last 4 months above 60% target	

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 November 2025 Performance Report and Integrated Performance Dashboard

Appendix I FPPC November 2025 NOF Update

Appendix Ia BSMHFT LOS Action plan – context Nov 25

Appendix Ib NOF LOS Reduction Action Plan Nov 25

Appendix Ic NOF Crisis referrals seen F-F in 24 hours Action Plan Nov 25

Appendix II FPPC November 2025 CYP Division Performance Report

Appendix III FPPC November 2025 FPPC Performance Improvement Metrics

Appendix IIIa FPPC November 2025 Talking Therapies Recovery Action Plan - Summary

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 III 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.

New: Inpatient Bed Framework contract with private providers

Since 29th September a new contract with the private provider Cygnet hospitals has been agreed for out of area placements. A Standard Operating Protocol (SOP) is currently being finalised for approval by NHSE to support the classification of these placements as being 'appropriate' and is subject to the SOP meeting NHSEs qualitative criteria. During this transition phase placements to Cygnet hospitals are currently being classified as 'inappropriate' as the SOP has not yet been approved. Sign off is expected in November 2025. If approved, these placements will be categorized as being appropriate.

If the standard operating protocol were in place now there would be no inappropriate out of area placements for October.

NEW: Update on the National Oversight Framework Metrics (Appendix I)

Please see appendix 1 which outlines the work undertaken to date with relevant service leads. This includes the following metrics:

- Percentage of adult inpatients with > 60-day length of stay (on discharge) – Please see Appendix Ib for the Trust's Action Plan.
- Percentage of patients in crisis receiving face-to-face contact within 24 hours – Please see Appendix Ic for the Trust's action plan.
- Annual change in number of CYP accessing NHS-funded MH services
- Sickness absence rate
- Financial plan - year-to-date variance

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.
A short-life working group has been established to focus on action to improve the adult inpatients LOS above 60 days on discharge and crisis referrals receiving face to face

contact within 24 hours.

FPPC is also asked to note that due to the Trust being in segment 4, Low Performing, NHSE has commenced monthly Joint Improvement, Oversight and Assurance meetings. The first meeting with the Executive Team took place on 17th October 2025. It should be noted that the agenda was wider than just the NOF performance.

NEW: Children and Young People (CYP) Performance Report

As previously reported to FPPC, in the short term the CYP monthly performance report will be presented as a separate report, (Appendix II) 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.

Board members are reminded that as part of the FTB CYP transfer to BSMHFT, a risk that was identified at the outset related to the impact of the in-year break in national MHSDS data submissions by BWC up to end June 2025 and BSMHFT from July 2025 and that this would make national reporting on CYP metrics unreliable as contacts/activity undertaken by BWC would not be identified in BSMHFT submissions. National guidance sought at the time confirmed that there were no mitigations and that this risk would have to be accepted.

More recently as national data post July 2025 is now being published, NHSE leads and MH Provider Collaborative Leads asked for detailed clarification on this issue which was discussed at a joint meeting on 5th November.

It was acknowledged at the meeting that the Trust had followed national guidance which has the impact of making national reporting unreliable. As a result, it was agreed that local data would be used for monitoring until the national MHSDS reporting becomes reliable.

Further details can be found in appendix II.

The BSMHFT informatics team have also been undertaking a full review of data quality and reporting methodologies for key metrics relating to FTB services following transfer to establish and ensure consistency of reporting across CYP and Solar services.

In summary, there are four 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 –** Although performance is below the contractual target, CYP division and partners have achieved a level of access which remains 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. **CYP ED National waiting time – Routine (target 95%)** – Performance has improved but remains below the national target this month (October) the number of patients is small so a small change in the numerator will impact adversely

3. **ED adult waiting times routine (Local CYP division target of 95% for 18+ service users, to be seen within 4 weeks of referral) –** performance has improved and is at 100% (October) and above the local CYP division standard of 95% for adult eating disorders waiting times.

4. **Non-contract over 18s - beds purchased** –There has been a significant reduction in the number of spot purchase beds being used in the 18-25 patient cohort since April 2025. By the end of October, there were four patients in spot purchase beds with plans to reduce that to 2 patients. Two patients had clinical presentations that meant repatriations were not yet possible and this was being supported by ICB colleagues and patient advocacy.

Trust Performance in October 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.

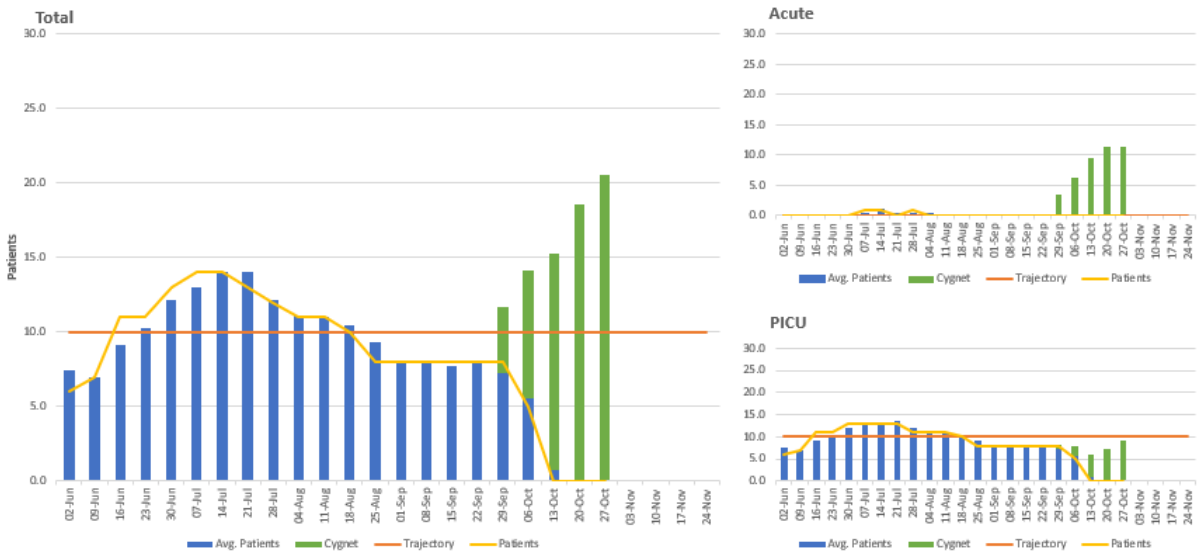
As part of the move to a new framework arrangement with private providers, patients are being placed in Cygnet hospitals. During the transition phase we are classifying this bed use as ‘inappropriate’ but it is anticipated these beds will be classified as ‘appropriate’ following review and approval of the Trust’s Standard Operating Protocol (SOP) for these beds by NHSE. It should be noted that if the SOP was in place now there would be no inappropriate out of area placements for October.

Based on the current agreement as at the end of October 2025, the performance is above trajectory with 11 acute (target 0) inappropriate placements and 10 PICU (target 10). It should also be noted that good progress is being achieved in reducing the numbers of all out of area placements, this 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.

Although there is an observed recent reduction in Clinically Ready for Discharge patients, the pressure remains and impacts on our ability to maintain patient flow and reduce out of area placements.

Q3 productivity plan actions (see Slide 8 of Appendix III) include the opening of a recovery house, transition to a new framework contract for beds, continue integration with CYP and complete Home Treatment staffing review and any associated business cases.



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 III. The Adult and Older adult LOS is over trajectory for the last 3 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.

In addition to the LOS productivity plan and patient flow meeting a short life working group has been put in place to focus on action to improve the adult inpatients with LOS above 60 days on discharge – NOF measure.

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 III, slide 4; Adults/ Older Adult LOS Trajectory 2025/26.

Talking Therapies – 2025/26 Recovery action plan

The provider Collaborative have issued a performance notice in September 2025 relating to underperformance in activity levels and reliable recovery and reliable improvement rates. The Trusts action plan is attached as Appendix IIIa.

As requested at March 2025 FPPC a summary of the action plan developed by the Talking Therapies service Leads was shared at May's FPPC meeting and this month's October's position on activity and income trajectory included. In summary the action plan is focusing 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 just below trajectory and also remains under the ICB activity plan requirements, with a related financial deficit of £415,900 for April - October 2025.

Recovery rates for October have improved with the Reliable Improvement rate to 68.47% meeting the 68% target and Reliable Recovery Rate at 45.19% an improvement from last month but remaining below the 50% target.

Clinically Ready For Discharge (CRFD) - bed days lost to CRFD have seen improvement, with the latest Trust position showing a reduction to 9.32%. The main drivers for this are reduced delays in older adult acute services. CRFD in October 2025 in Adult Acute & Urgent Care was at 9.2% - a 0.2% increase (33 patients) and in Older Adult Services at 22.9% - a 5% reduction (31 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.

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. Barriers have also been escalated to senior system wide level discussions.

Quality - The detailed position on these metric areas is discussed at QPES committee. Data below based on October 2025.

- Incidents of Self Harm have increased from 84 to 108 in October with decreases in acute inpatients, and older people inpatients.
- Physical harm (staff/third party) has increased to 7 from 5 this month.
- Reported incidents in October have increased to 2619 from 2189
- Staff Assaults have increased to 126 from 79 in October.

People workforce measures – The detailed position on these metrics is discussed at the People Committee. FPPC is asked to note that there has been an improvement in a number of the set performance standards.

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.

The CYP data is now included within the IPD people metrics. These are detailed in Appendix II.

- Bank and Agency WTE reduction – The figures for October show that bank WTE is above trajectory at 627.25 WTE and agency is above trajectory at 45.86 WTE

- Staff Appraisals at 83.6% as at October 2025, above improvement trajectory and below the 90% Trust standard.

  The L&D team are continuing to support service users and are undertaking bespoke training sessions with services.

- Staff vacancy levels Vacancy rate at 7.7% in October- below trajectory.

- Mandatory Training at 94.2%, improvement in month but below the 95% target. This is being impacted by the grace period for patient safety level 1 and 2 and dual diagnosis training coming to an end. The grace period for CYP (FTB) staff to receive face to face training has also affected compliance.

Sustainability – (details in finance report)

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

Performance

Bed Occupancy (%)	92
Clinically Ready for Discharge: Bed Days	1513 ↗
Clinically Ready for Discharge: Bed Days (%)	9 ↗
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	515 ↑
Out of Area: Inappropriate Placements Active	21
People on CPA with a Formal Review in last 12 Months (%)	94 ↓
Referrals over 3 Months with no Contact	3998 ↓
Talking Therapies: Reliable Improvement Rate (%)	68 ↑
Talking Therapies: Moving to Recovery (%)	48
Talking Therapies: Reliable Recovery Rate (%)	45
Talking Therapies: Seen in 18 Weeks (%)	100 ↑
Talking Therapies: Seen in 6 weeks (%)	96 ↑

People

Bank & Agency Fill Rate (%)	94 ↑
Fundamental Training (%)	94
Staff Appraisals (%)	84 ↑
Staff Sickness (%)	6
Staff Turnover: Rolling 12m (%)	5 ↑
Staff Vacancies (%)	8 ↑

Quality

Abscondions from Inpatient Units	2
Commissioner Reportable Incidents	0
Community Confirmed Suicides	0
Community Suspected Suicides	1
Failure to Return	20
Harm (physical) – patients (%)	18
Harm (physical) – staff/third party (%)	7
Harm (psychological) – patients (%)	18
Harm (psychological) – staff/third party (%)	2
Incidents of Self Harm	108 ↑
Inpatient Confirmed Suicides	0
Inpatient Suspected Suicides	0
Ligature no Anchor Point	14
Ligature with Anchor Point	1
Patient Assaults	39
Patient Assaults / 1000 OBDs	2.0
Physical Restraints	255
Physical Restraints / 1000 OBDs	13.3
Prone restraints	48
Prone restraints / 1000 OBDs	2.5
Reported Incidents	2619 ↑
Staff Assaults	126 ↓
Staff Assaults / 1000 OBDs	6.6 ↓

Sustainability

Agency as % of Pay Spend	1 ↗
Agency Staff Spend	£395k ↑
Bank as % of Pay Spend	8 ↑
Capital Expenditure	£734k
Cost Improvement Programmes	£2,557k ↑
Group Cash Balance	£101,115k ↑
Info Governance (%)	100 ↑
Operating Surplus	-£970k

Last refreshed 12th Nov 2025

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

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Measure	Latest Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Clinically Ready for Discharge: Bed Days		2543	2242	2339	2055	1614	1513 ↗
Clinically Ready for Discharge: Bed Days (%)		16	14	14	13	10	9 ↗
CPA 3 Day Follow Up (%)	80	85	83	80	87	82	87
CPA 7 Day Follow Up (%)	95	94	91	90	95	90	95
Eating Disorders: Waiting Time - Routine (%)	95	90	90	80	100	100	100
Eating Disorders: Waiting Time - Urgent (%)	95	100	100				
First Episode Psychosis: Waiting Time (%)	60	100	100	100	100	50	100 ↑
Out of Area: Inappropriate Placement Bed Days	328	345	264	435	346	370	515 ↑
Out of Area: Inappropriate Placements Active	10	10	12	12	8	11	21
People on CPA with a Formal Review in last 12 Months (%)	95	97	96	96	95	95	94 ↓
Referrals over 3 Months with no Contact		3789	3651	3906	4054	3988	3998 ↓
Talking Therapies: Reliable Improvement Rate (%)	68	63	66	68	69	66	68 ↑
Talking Therapies: Moving to Recovery (%)	50	46	48	46	49	47	48
Talking Therapies: Reliable Recovery Rate (%)	50	43	44	44	47	45	45
Talking Therapies: Seen in 18 Weeks (%)	95	100	100	99	100	100	100 ↑
Talking Therapies: Seen in 6 weeks (%)	75	93	94	94	94	93	96 ↑

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

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Measure	Latest Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Bank & Agency Fill Rate (%)		95	95	93	93	94	94 ↑
Fundamental Training (%)	95	94	93	92	93	94	94
Staff Appraisals (%)	90	80	80	81	82	82	84 ↑
Staff Sickness (%)	4	5	5	5	6	6	6
Staff Turnover: Rolling 12m (%)		6	5	5	5	5	5 ↑
Staff Vacancies (%)		8	9	9	9	8	8 ↑

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

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HOME


PERFORMANCE


PEOPLE


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SUSTAINABILITY

Trust | Acute & Urgent Care | ICCR

Corporate | Specialties | Secure Services & Offender Health

Measure	Latest Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Absconsions from Inpatient Units		2	3	5	3	1	2
Commissioner Reportable Incidents		0	0	0	0	0	0
Community Confirmed Suicides		0	0	0	0	0	0
Community Suspected Suicides		0	6	3	3	2	1
Failure to Return		11	13	15	12	18	20
Harm (physical) – patients (%)		20	17	18	19	17	18
Harm (physical) – staff/third party (%)		5	4	5	5	5	7
Harm (psychological) – patients (%)		16	17	15	17	14	18
Harm (psychological) – staff/third party (%)		2	2	2	3	2	2
Incidents of Self Harm		156	111	163	159	84	108 ↑
Inpatient Confirmed Suicides		0	0	0	0	0	0
Inpatient Suspected Suicides		0	1	0	0	0	0
Ligature no Anchor Point		29	17	22	16	5	14
Ligature with Anchor Point		2	1	0	1	2	1
Patient Assaults		59	35	45	38	27	39
Patient Assaults / 1000 OBDs		3.1	1.9	2.3	2.0	1.5	2.0
Physical Restraints		259	246	246	283	211	255
Physical Restraints / 1000 OBDs		13.4	13.1	12.7	14.8	11.3	13.3
Prone restraints		56	38	40	48	51	48
Prone restraints / 1000 OBDs		2.9	2.0	2.1	2.5	2.7	2.5
Reported Incidents		2615	2794	2919	2692	2189	2619 ↑
Staff Assaults		116	96	96	86	79	126 ↓
Staff Assaults / 1000 OBDs		6.0	5.1	5.0	4.5	4.2	6.6 ↓

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

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Measure	Latest Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	
Agency as % of Pay Spend		1	1	0	1	1	1	↗
Agency Staff Spend		£383k	£320k	£431k	£468k	£374k	£395k	↑
Bank as % of Pay Spend		10	9	9	11	8	8	↑
Capital Expenditure		£597k	£370k	£297k	£299k	£1,050k	£734k	
Cost Improvement Programmes		£2,166k	£2,189k	£2,764k	£2,623k	£5,050k	£2,557k	↑
Group Cash Balance		£78,998k	£83,597k	£83,825k	£97,920k	£89,383k	£101,115k	↑
Info Governance (%)		95	100	100	100	100	100	↑
Operating Surplus		£1,204k	-£384k	-£528k	-£739k	-£1,389k	-£970k	

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

Out of Area: Inappropriate Placements Active

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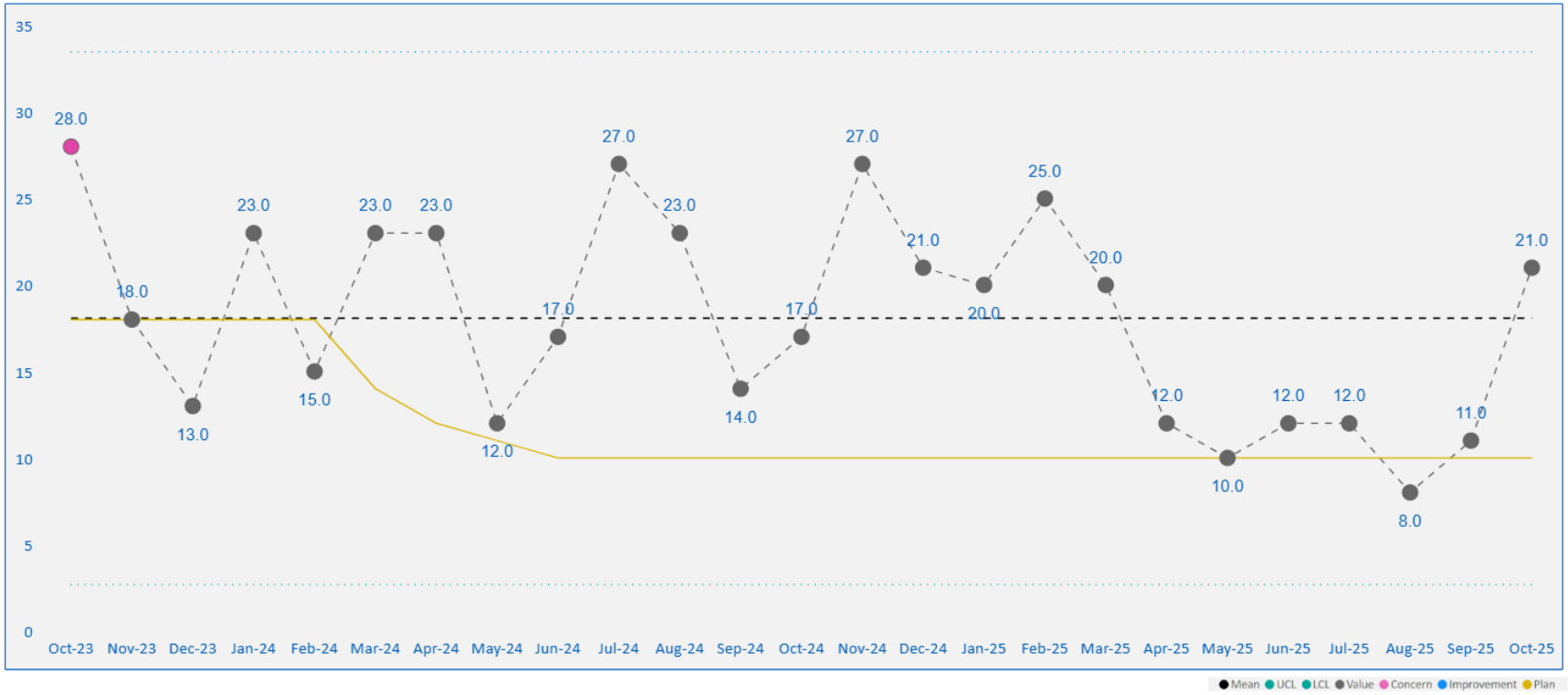

Question	Answers
A: What has happened?	The number of inappropriate out of area placements at each month end remains a metric in the 2025/26 national planning guidance. A Trust trajectory agreed with NHSE as part of the 2024/25 national planning requirements will continue in 2025/26 with zero acute inappropriate 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. October has increased to 21 placements with 11 in acute beds and 10 in PICU beds above the trajectory of 10 for October 2025. There were 24 inappropriate admissions during October, an increase of 16 from last month with 12 acute and 12 PICU. As part of the move to a new framework arrangement with private providers, patients are being placed in Cygnet hospitals. During the transition phase we are classifying this bed use as 'inappropriate' but it is anticipated they will be counted as appropriate once reviewed and agreed by NHSE as part of the Standard Operating Protocol (SOP). This is due for sign off in November 2025. If this was in place now we would have no 'inappropriate' out of area placements at the end of October. 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 2024/25 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 reducing over the 7 months with delay reasons attributed to community which is not in the Trust's immediate control. CRFD at 1497 overall in october with adults at 625 lost bed days which equates to 9.2%, an increase of 0.2%. Adult bed occupancy has seen a decrease to 94.9% and length of stay has increased to an average of 107 days in october, however the number of discharges in the month has increased. 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 acute and PICU beds has remained high resulting in patients being placed in units outside BSMHFT. Staffing has also remained a challenge in terms of sickness and vacancies levels. Appropriate bed days have reduced in October with a reduction in the numbers placed.
C: What are the implications and consequences?	Without a system wide approach and a review of patient flow across MH pathways, demand will continue to exceed available Trust capacity and risks to patients and staff potentially increasing without the reconfiguration of services needed to manage demand and manage patients in community teams that also have the staffing and skill mix levels to support. The bed waiting list identifies patients who are waiting to be admitted and are being risk managed in the community. Action plans continue to receive national and commissioner scrutiny which remain at a high level due to performance being above trajectory.

D: What are we doing about it?	As part of the move to a new framework arrangement with private providers, patients are being placed in Cygnet hospitals. During the transition phase we are classifying this bed use as "inappropriate" but it is anticipated they will be counted as appropriate once reviewed and agreed by NHSE as part of the Standard Operating Protocol (SOP). This is due for sign off in November 2025. 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 Q3 actions include: Admission avoidance • launch Recovery House as an alternative care setting, supporting admission avoidance • Undertake Home treatment Staffing review • To refresh Length of stay action plan in partnership with ICCR and other collegues as part of the work on the national Oversight Framework Actions include: Recovery House has now opened, HTT business case developed to increase HTT capacity and will be taken forward as assurance is built on financial improvments due to reductions in spot purchasing of beds Inpatient Care & Reducing Length of Stay • launch new framework contract for beds • continued integration of CYP to ensure clinical prioritisatoipn of 18+ admissions Actions include: Transition to new framework has comenced and monitoring in place to ensure that number of beds aligns to financial recovery trajectory. 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

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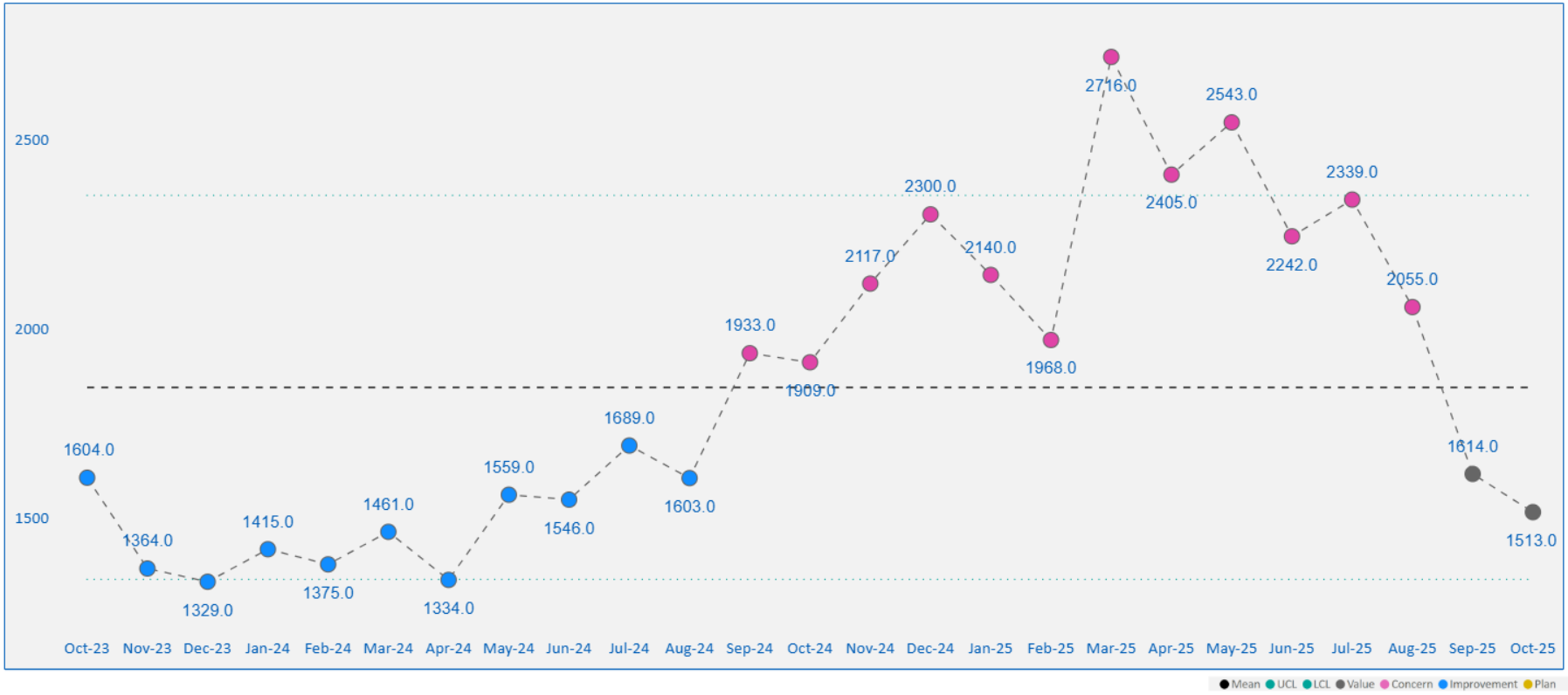

Question	Answers
A: What has happened?	The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. The number of CRFD bed days has been on an increasing trend since May 24 and reaching a peak in March 2025 at 2716 bed days. Since August 2025 there has been an overall decrease with October at 1513 days with Adults moved from 594 days in September to 641 days in October, which related to 33 patients, with a main delay reason of Social Worker allocation and supported accommodation and older adults moved from 568 days in September to 488 in October and related to 31 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 activities 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 Discharge 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 (%)

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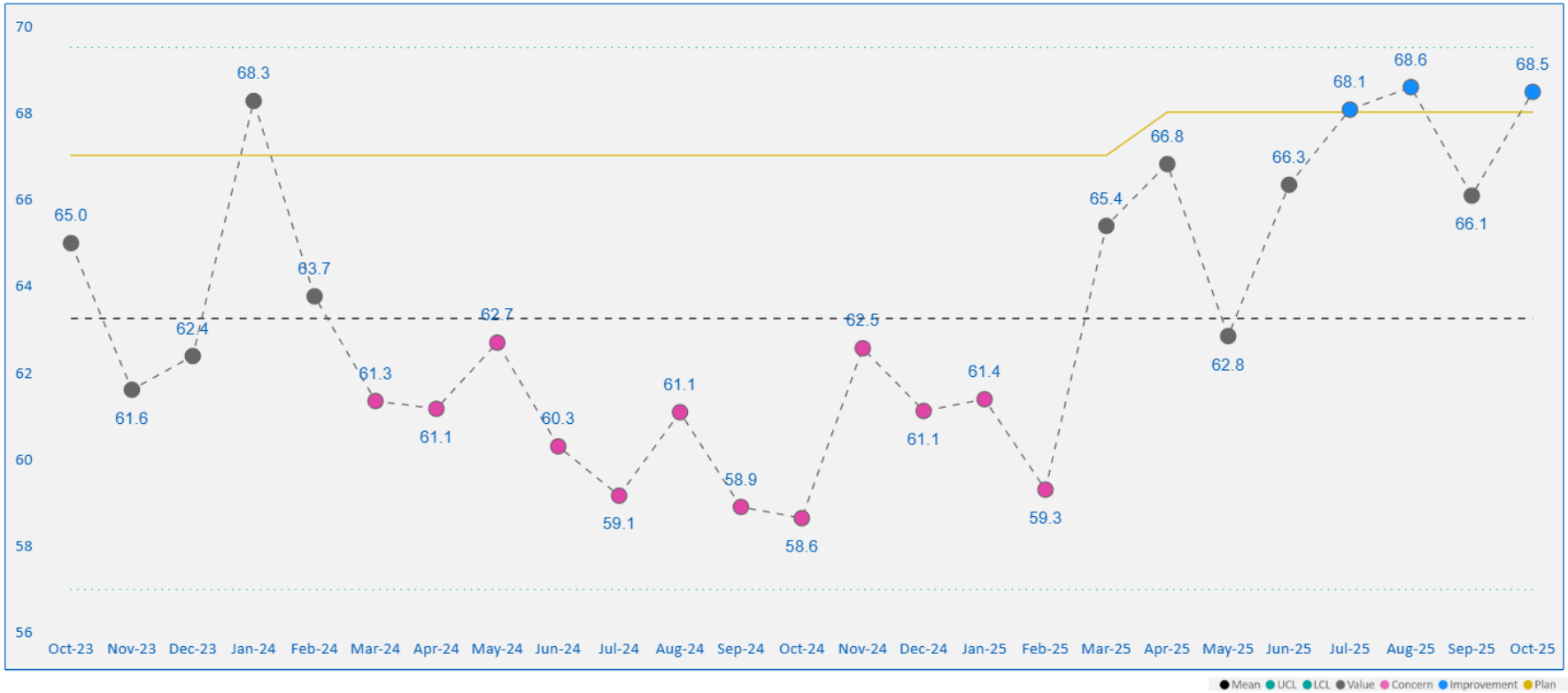

Question	Answers
A: What has happened?	This was a new national metric for 2024/25 with an increased focus on recovery and the target has increased 68% from April 2025. October 2025 at 68.47% above the 68% target. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression has reliably improved at the end of their treatment.
B: Why has it happened?	A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria. A person has shown reliable improvement if their scores on the depression and/ or the relevant anxiety/ medically unexplained symptoms measure have reduced by a reliable amount, whether or not they met caseness at the start of treatment. The service is providing sessions to new starters so understand the expectation and key milestones within the service and the business intelligence team has created a report which indicates the number of people contributing to recovery and which ones have not yet recovered so they know which people to offer further appointments to.
C: What are the implications and consequences?	Service users needs are not being met and the national 68% standard is not being met. The provider Collaborative have issued a performance notice in relation to recovery rates.
D: What are we doing about it?	The provider Collaborative have issued a performance notice in September 2025 relating to the Talking Therapies current reliable recovery and reliable improvement rates. A range of further supportive measures are being put in place by the commissioners to review the recovery action plan which is in place. 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. increasing face to face groups including Step 3 Anxiety group and Compassion Focussed Therapy to start across areas on September and October 2025. The DNA rate has started to fall and was 11% in October 2025
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 (%)

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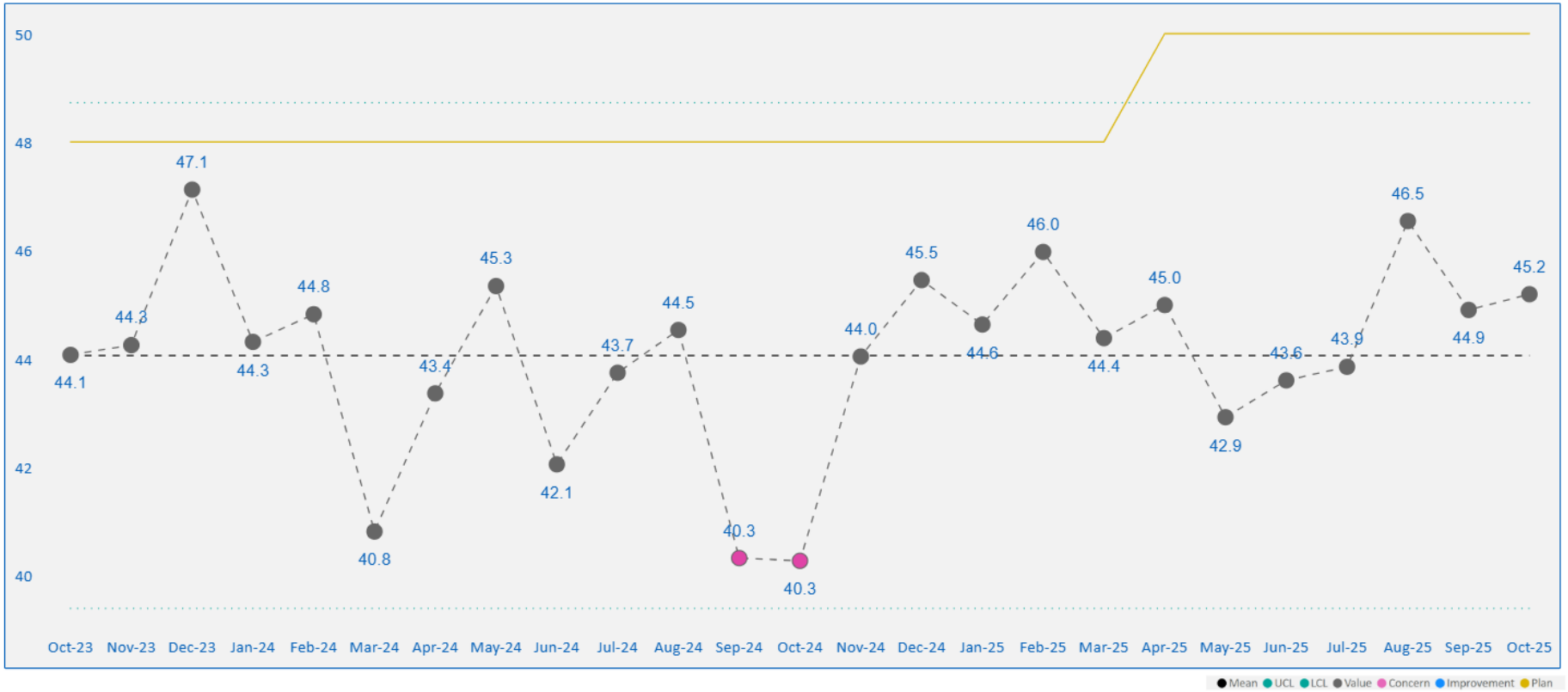


Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery and the target has increased 50% from April 2025. The Reliable Recovery rate has fluctuated and is not meeting the 50% target. October 2025 position has seen an increase to 45.19%, below 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.
C: What are the implications and consequences?	Service users needs are not being met and the national 50% standard is not being met. The provider Collaborative have issued a performance notice in relation to recovery rates.
D: What are we doing about it?	The provider Collaborative have issued a performance notice in September 2025 relating to the Talking Therapies current reliable recovery and reliable improvement rates. A range of further supportive measures are being put in place by the commissioners to review the recovery action plan which is in place. 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. 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. Increasing face to face groups including Step 3 Anxiety group and Compassion Focussed Therapy to start across areas on September and October 2025. The DNA rate has started to fall and was 11% in October 2025.
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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness (%)

October 2025

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

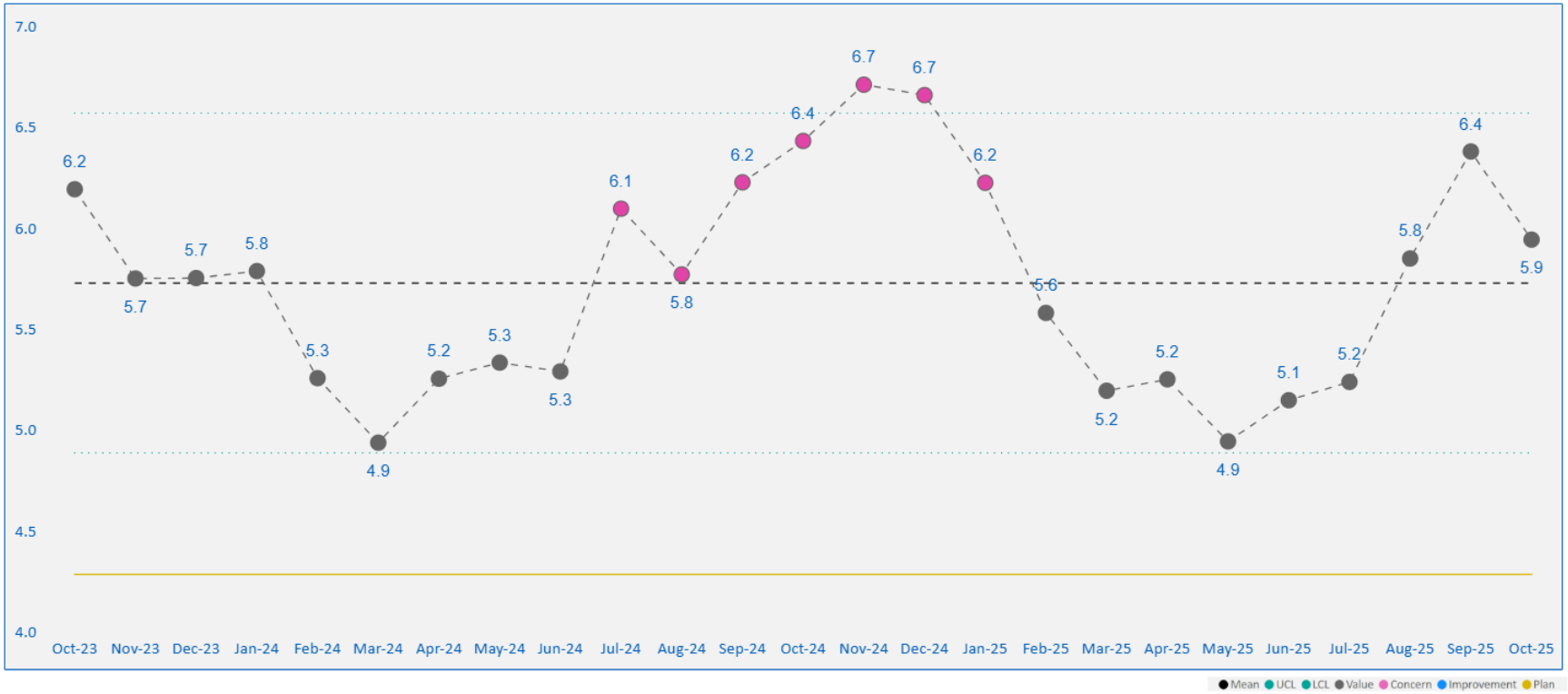
Trust

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?	Trust wide sickness absence rate for October 2025 was 5.9% against 6.4% in September 2025, 5.8% in August 2025 and 6.0% in July 2025. This represents a decrease in the absence level and was accounted for by a 0.1% decrease in long-term absence and a 0.3% decrease in short-term absence. Across the divisions, the following services had the highest absence rates: - Secure Services and Offender Health 7.6% (0.5% increase on previous month, 2.5% Short Term and 5.1% Long Term) - Children and Young People 6.5% (4.3% Long-Term and 2.2% Short-Term) - ICCR 6.1% (4.0% Long-Term and 2.1% Short-Term) An increase in Return to Work Meeting compliance was observed, standing at 66% against 64.9% in the previous month.
B: Why has it happened?	Proactive ongoing management, combined with seasonality, has resulted in a reduction in short-term absence .
C: What are the implications and consequences?	Operational Inefficiencies: High sickness rates in teams could lead to delays and added workload for remaining staff, potentially impacting service quality and efficiency. Operational Costs: Sickness rates, particularly long-term, present a significant cost to the Trust in the opportunity lost, skill drift and backfill (including bank and agency spend). Increased Risk of Burnout: Ongoing vacancies and low RTW contact rates mean that some employees may experience greater strain, increasing burnout risk and potentially leading to a cycle of recurring sickness.
D: What are we doing about it?	Occupational Health: The new provider is now active and work is ongoing to support managers and employees to understand how to access these new services, alongside close contract management. Training Reach: Masterclass delivery on Managing Health and Wellbeing continues, with a focus on reaching divisions with higher levels of absences. Tailored sessions are also being offered to divisions to support group upskilling. Return to Work Focus: Key activities are ongoing to measure Return to Work and sickness support compliance, including divisionally targetted support.
E: What do we expect to happen?	Insight-driven targetted actions, led by divisonal teams and supported by the People Partners, will continue to support the management of sickness across the Trust and a net reduction will be observed.
F: How will we know when we have addressed issues?	Sickness absence levels will improve; outcomes will be achieved within parameters set by Trust Policies, reduction of high levels of stress and anxiety across the Trust.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Appraisals (%)

October 2025

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

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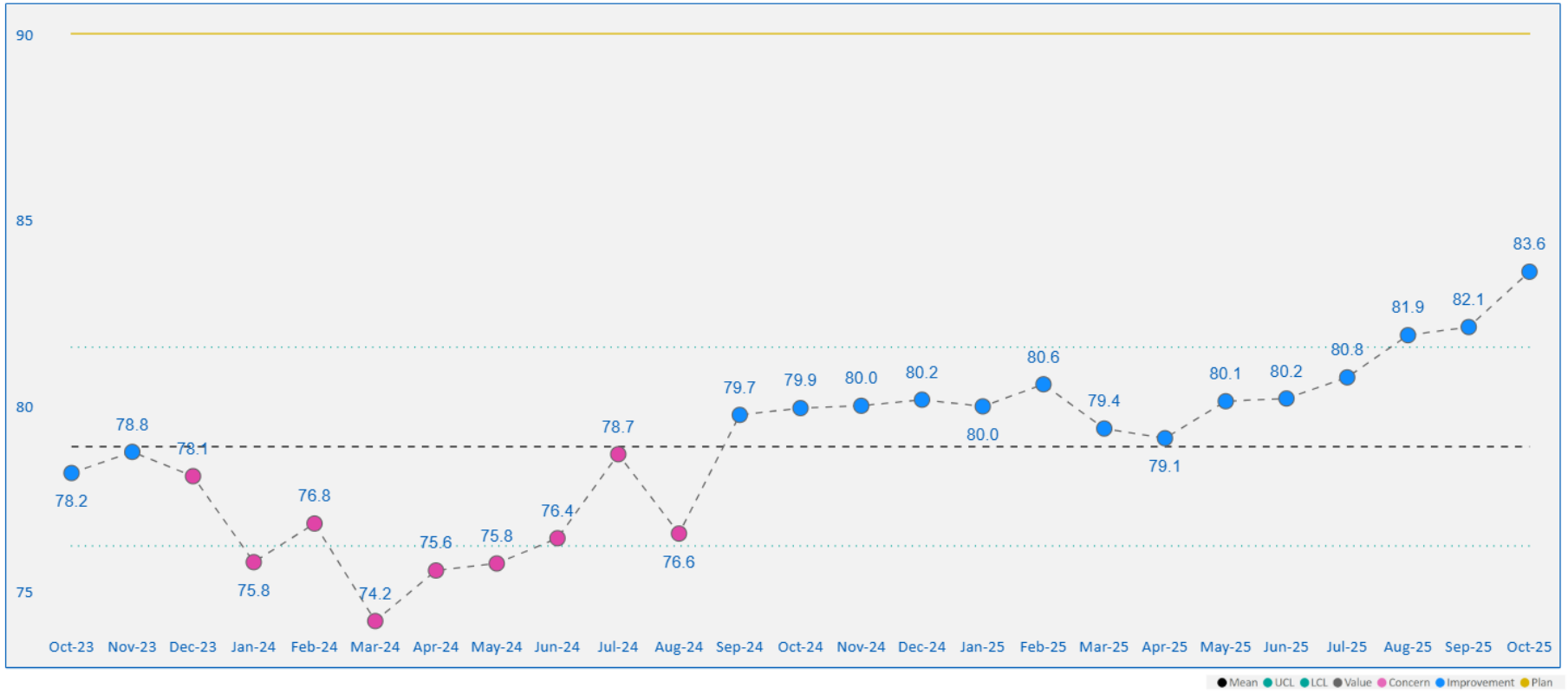

Question	Answers
A: What has happened?	October data shows an appraisal compliance of 83.6 %. This is a 3.5% increase from May's report (80.1%.) This remains below Trust target of 90 % and commissioners target of 85%.
B: Why has it happened?	The teams within the Trust are below 75% compliance are: , Chief Exec - 61.5%, CYP - 44.4% Exec - Resources - 64.9%, Exec - Nursing 74.9%, and New Care Models 41.1%, Trustwide 55.6%
C: What are the implications and consequences?	The above information demonstrates a stabilised compliance figure 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, including refreshed resources on connect Supporting bespoke Value Based Appraisal training sessions for services NB- CYP 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 (%)

Birmingham and Solihull Mental Health NHS Foundation Trust

October 2025

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

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Commentary

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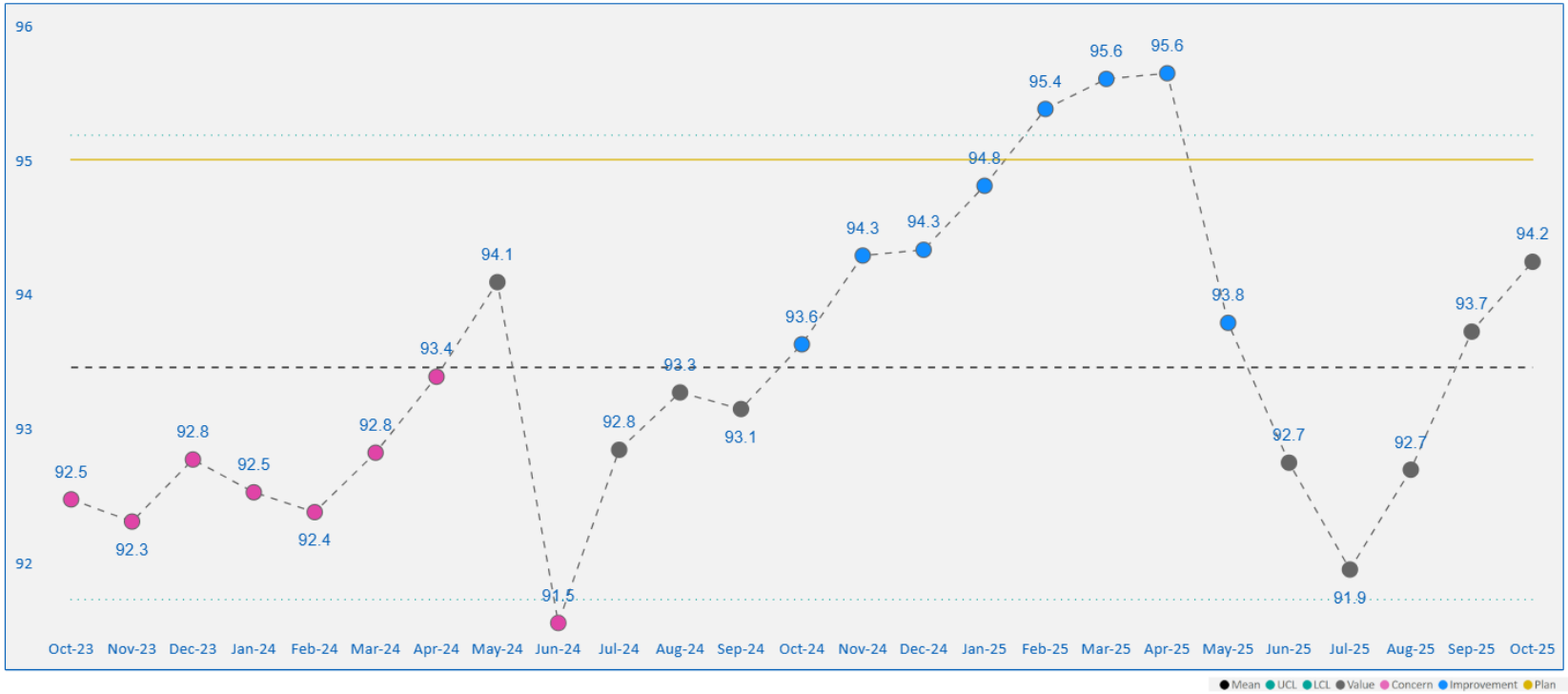

Question	Answers
A: What has happened?	Fundamental Training compliance increased from 93.7% in September to 94.5% in October, falling below the Trust's 95% target for substantive staff, though remaining above the Commissioners' target. Areas currently below 95% compliance include: - Chief Exec - 77%, - Exec- Medical - 93.7% - CYP - 83.1% - New Care Models - 88.9%, - Strat and People - 94.5% -Trustwide- 73.1% Temporary staffing compliance also increased from 88.6% to 88.8%, and 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 number of factors. Patient Safety and Dual Diagnosis's grace periods have ended. 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 grace period has also ended for face to face training for those who have transferred over from FTB. The following subjects are below 90%:CRAM - 87.3% PS L2 - 88.3%, ELS - 79.6%, ILS - 73.8%, SRS 67.2%, Care Certificate 89.3%
C: What are the implications and consequences?	• Low FT compliance is a risk to patient safety and the safety of our staff. There is a risk staff will not have the competence required to practice safely in clinical areas. • Breach of commissioners' compliance contracts which can result in financial penalties that can cost in excess of £210,000 per subject for every month that BSMHFT remains non-compliant. • The Trust is adding more FT training on the traffic light and this can impact on the overall Trust compliance. • TSS are not included in overall Trust compliance however are required to undertake training. The required training needs to provide TSS staff on time to be practice safely. If TSS staff cannot undertake the necessary training they will be unable to book to work on inpatient wards.
D: What are we doing about it?	• For Fundamental Subjects with less than 95% compliance, a recovery plan with monthly trajectories is in place. • ILS spaces have been purchased for the rest of 2025, we have placed a number of courses out in the areas (Oleaster, Northcroft, Reaside, Tamarind, Barberry, etc) as well as the Uffculme Centre to support compliance. • Business as usual activities are in place such as o emailing employees and managers to inform them of DNAs and requesting they re-book o reminder emails to both employees and managers regarding training that is booked. o All DNA's are sent on a monthly basis to the Clinical Directors and Heads of Services for them to follow up with their teams o Monthly chase up emails to those who have expired or approaching expiry to book onto training • At least one month prior to the new training going live, the FT team sends out an email to each staff member allocated to complete it. The training will also have a six-month grace period on the traffic light to enable staff members sufficient time to complete it.
E: What do we expect to happen?	Based on recovery plans we expect to stay below 95% due to the end of the grace period for Dual Diagnosis, Patient Safety and the TUPE transfer of CYP staff. Increasing the grace period for the new Fundamental Training subjects will not affect the overall Trust compliance in that give period as it will enable staff to become compliant before the grace period expires.
F: How will we know when we have addressed issues?	Once Substantive Fundamental Training compliance will reach 95% on Insight Reporting System

Incidents of Self Harm

October 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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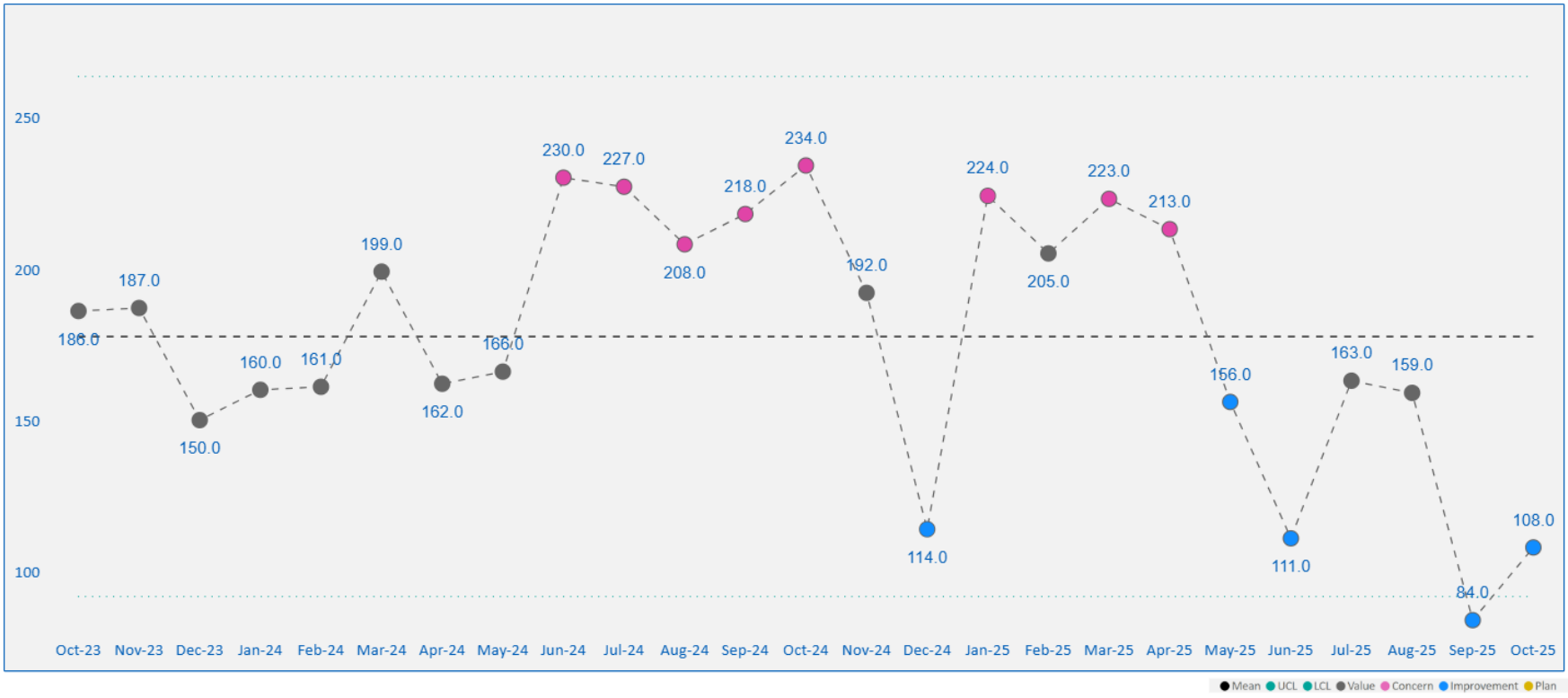

Harm (physical) – staff/third party (%)

October 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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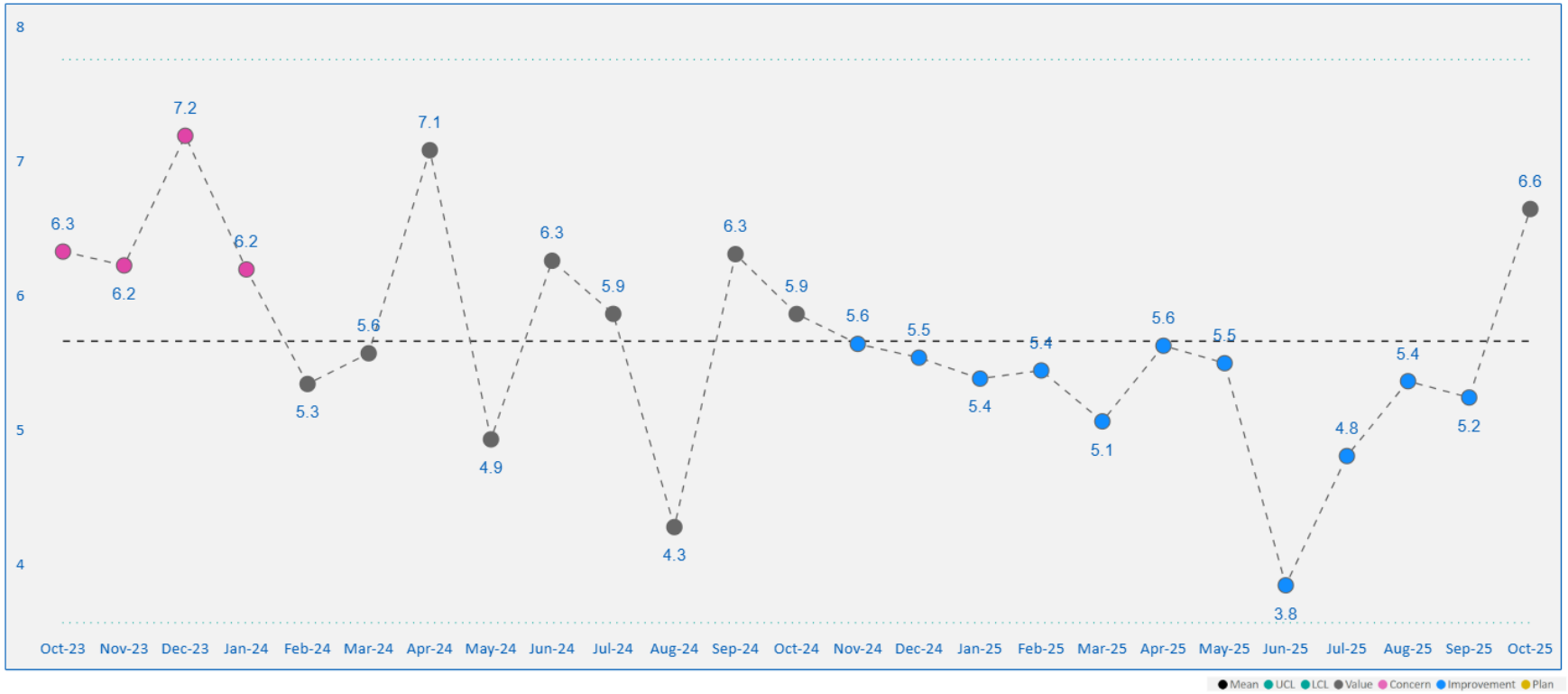

Reported Incidents

October 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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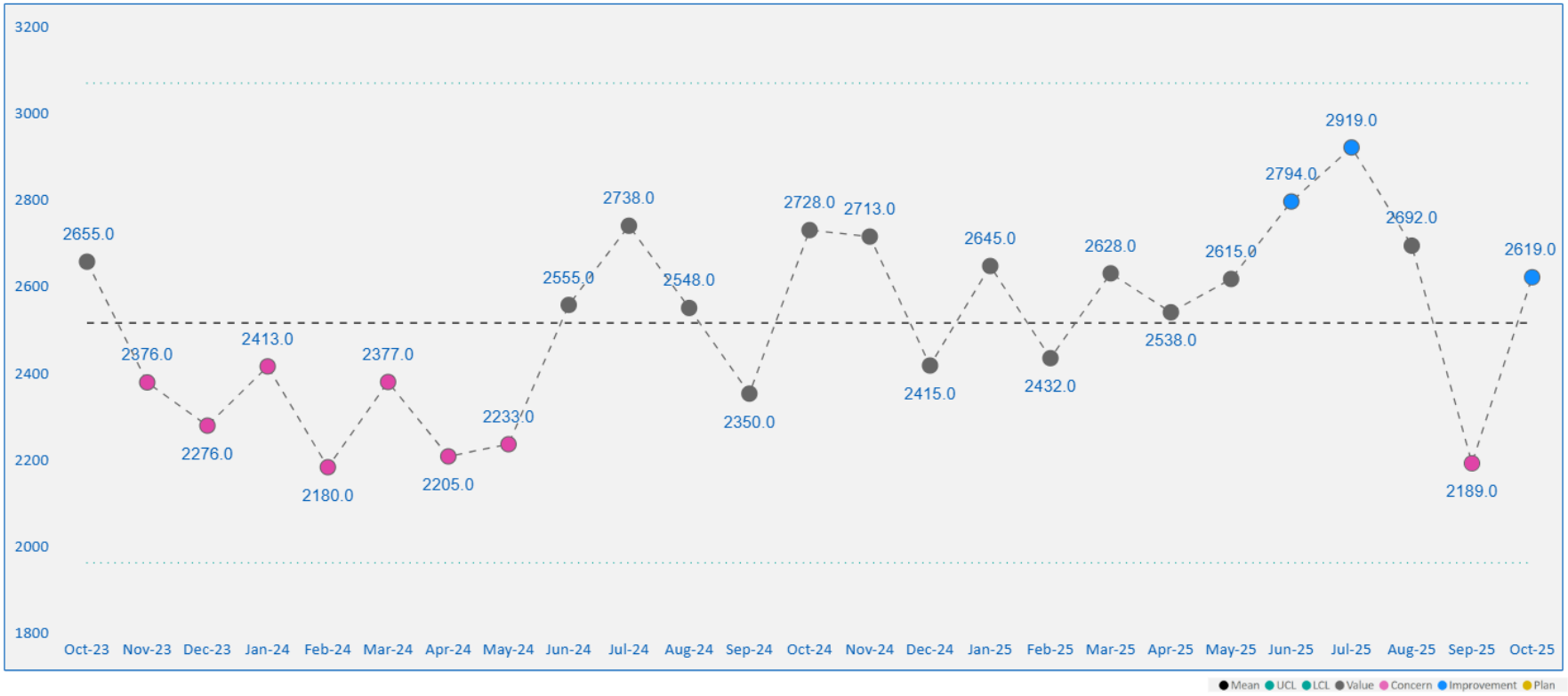

Staff Assaults

October 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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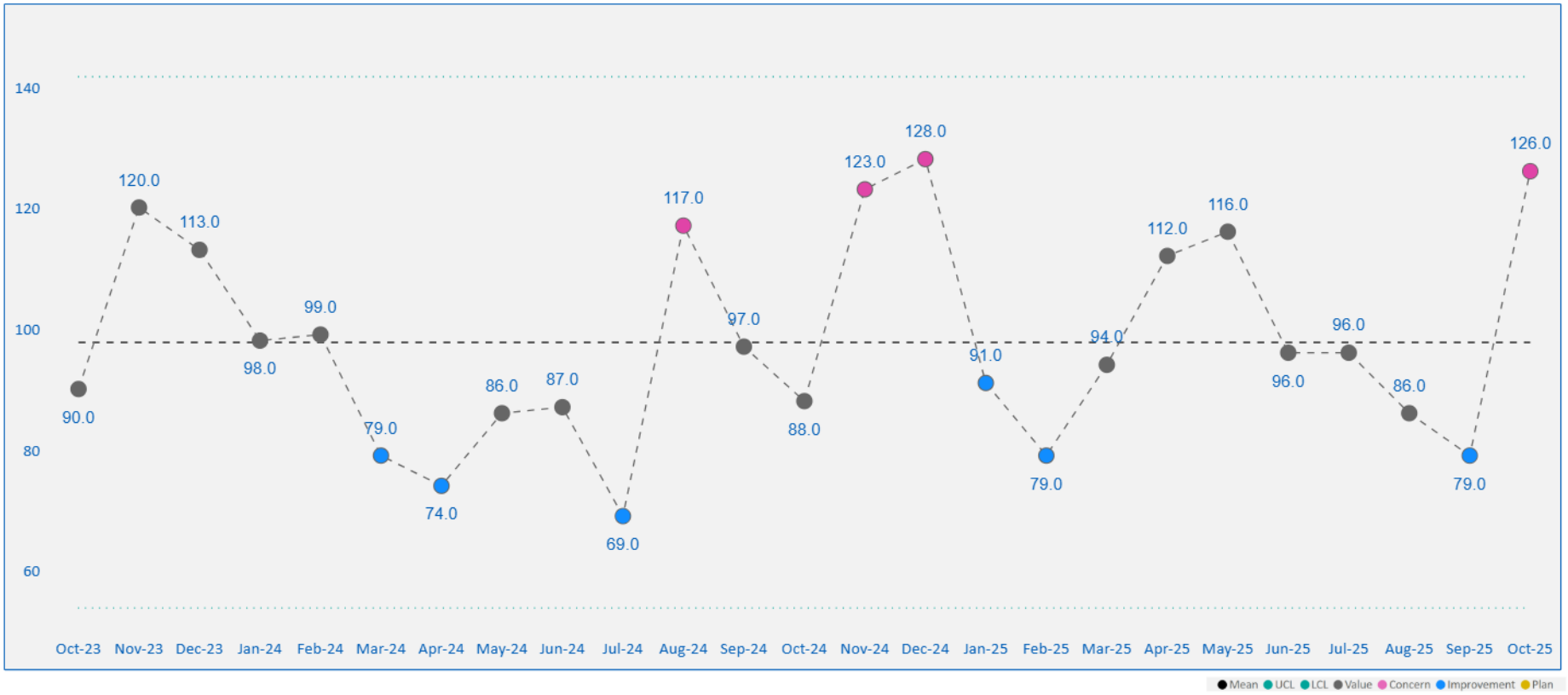


Birmingham and Solihull Mental Health Foundation Trust

Reducing Length of Stay Action Plan – see Appendix Ia

Update on the Trust's Productivity Plan which includes Reducing Length of Stay as an outcome:

Within BSMHFT we have maintained a strong focus on improving patient flow. Our Three-Year Inpatient Mobilisation Plan sets out three core workstreams–Admission Avoidance, Inpatient Care and Reducing Length of Stay, and Discharge Planning and support - which together form the foundation of our flow-improvement approach. To support these priorities, we have established a clear governance framework, detailed below. Each locality holds regular operational flow meetings and contributes to a weekly deep dive with the Local Authority to address complex cases. Our Business Intelligence colleagues play a central role by providing robust, actionable data that informs decision-making and performance oversight.

This work has progressed against a challenging backdrop. The Trust has delivered an ambitious financial remediation programme with a strong emphasis on eliminating the use of high-cost spot-purchase beds. We have made substantial progress in this area and currently have no patients placed in spot-purchase beds. This achievement improves the patient experience, strengthens our financial position, and enables reinvestment in key areas, including the development of Home Treatment Teams, and allows us to focus on collaborative transformation priorities aligned with system needs.

Home Treatment Teams

We have strengthened the Home Treatment Team (HTT) function through recent recruitment and the implementation of an Advanced Clinical Practitioner model. This has enhanced our ability to improve patient flow by enabling proactive, timely assessments, in-reach to inpatient wards and community mental health teams, facilitating early intervention to prevent unnecessary inpatient stays. The ACPs provide senior clinical oversight, strengthening the wider service development by building advanced clinical assessment capability, enabling complex case management, and driving innovation in both service delivery and clinical practice.

Alongside this, a business case has been developed to uplift and standardise HTT's across Birmingham & Solihull. The proposal aims to build capacity, ensure consistency and elevate the quality of crisis care, aligning with our systems ambition to deliver safe, least restrictive community-based alternatives to admission. A central component of the proposed redesign is the strengthening of the gatekeeping function, ensuring HTTs are consistently present and clinically active at the front door of services and supporting with capacity to provide intensive community interventions that safely manage risk and maintain stability in the least restrictive setting. While further work is required to fully restore fidelity to the national HTT model, meaningful progress has been made and provides a strong platform for further development.

Community Services

As a Trust, we continue to face capacity challenges across community mental health services, particularly within CMHTs. High and complex caseloads limit the teams' ability to deliver proactive engagement, early intervention, and timely discharge support –factors that directly influence patient flow and length of stay. Despite these pressures, we have improved integration with community teams and the interface arrangements with our acute services. Continued work is underway to build capacity and support our improvements.

Local Authority and Social Care

To further support flow and reduce avoidable delays, we are working closely with Local Authority partners to establish a more effective interface and clearer escalation routes for patients awaiting Mental Health Act Assessment. Plans are in place to introduce senior level joint oversight to monitor demand, improve responsiveness so individuals are assessed promptly reducing instances where delays in assessment can contribute to lengthier and more complex inpatient admissions experiencing longer lengths of stay.

We continue to experience system pressures that contribute to extended inpatient stays, particularly regarding access to Approved Mental Health Professionals (AMHPs) and Local Authority social workers. Once admitted, delayed social worker involvement in discharge planning including inconsistent attendance at S117 meetings–creates further barriers to progressing timely discharge. These issues are compounded by significant constraints in housing, especially for individuals with complex needs who require specialist or enhanced accommodation. Limited availability of appropriate placements frequently extends inpatient stays, highlighting the need for strengthened joint working, clearer escalation processes, and a coordinated system-wide response.

Learning Disabilities and Autism (LD&A)

Improving the Learning Disability & Autism pathway remains a strategic priority for the Trust. We are allocating more resources to the Dynamic Support Register Pathway, collaborating with mental health providers, and increasing uptake of community Care and Treatment Reviews to lower admissions. Recruitment continues for the Adult Autism Enhanced Support Team, and we now partnered with VCFSE colleagues like Autism West Midlands and Barnardo keyworker services.

Children and Young People

The integration of the Children and Young People (CYP) Trust with BSMHFT represents a major step toward developing life-course pathways and unified governance arrangements. We are actively harmonising bed management, escalation procedures, and flow processes across CYP and adult services to ensure coordinated use of inpatient capacity, consistent admission and discharge standards, and improved collaboration across locality teams. While the integration is ongoing, it offers a strong platform for a whole-system approach to flow and improved outcomes for children, young people, families, and adults.

Recovery House

The Recovery House opened at the start of November '25. This offers a short-term (up to 7 nights), 24/7 residential service delivered in partnership with Birmingham Mind, offering intensive support for adults experiencing acute mental health needs. It provides a safe,

therapeutic space that can prevent escalation to hospital admission and offers a structured step-down option from inpatient wards for individuals who no longer require acute care but need additional support to transition home. The Recovery House will help reduce avoidable admissions, support earlier discharge, and improve overall patient flow.

Partnership and System wide working and support

We recognise that reducing acute length of stay cannot be addressed through inpatient action alone; it is a system-wide responsibility requiring alignment across community services, social care, acute trusts, voluntary sector partners, and Local Authority colleagues. To support this, we have increasingly aligned our transformation work with system partners. For example:

- We have established a monthly Urgent Care Pathways Group that brings together Local Authority, community health, voluntary sector, police, and acute trust colleagues to address flow issues, identify bottlenecks, and agree actions.
- We continue to develop a system dashboard that tracks key flow metrics across organisations, including admissions, discharges, transfers, bed waits, length of stay, and numbers of patients no longer meeting the criteria to reside.
- We have strengthened locality working by appointing locality clinical leads who support local flow performance, initiate escalation where required, and provide a link between community teams, inpatient wards, and social care.

Governance and Monitoring Arrangements : to include monitoring and review of the Trust's action plan to reduce Length of Stay

- The Patient Flow Improvement Group, chaired by the Associate Director of Operations for Acute and Urgent Care, provides overarching governance, supported by routine Business Intelligence reporting on key performance indicators, including length of stay.
- A weekly Gold Escalation Meeting enables locality flow teams to escalate barriers and secure senior clinical and operational support.
- The monthly Urgent Care Pathways Group functions as the primary system forum for identifying exceptions, resolving cross-agency issues, and reviewing performance.
- The system dashboard is refreshed monthly and reviewed at the Urgent Care Pathways Group, with a focus on crisis alternatives and discharge pathways.

BSMHFT - Action Plan to achieve Reduced Length of Stay as an outcome of improving patient flow

1. Number of Admissions	Lead	Due Date
Goal: Reduce unnecessary admissions and improve admission appropriateness.		
Actions:		
Identification of frequent users of inpatient beds - Develop admission avoidance plans to prevent repeat admissions.	**Lead:** *AD for ICCR*	
Maintain and Improve performance of CMHT follow-up standard - Better community follow-up reduces crisis-driven admissions.	**Lead:** *AD for ICCR*	**Current/Ongoing**
Re-establish fidelity of Home Treatment Team (HTT) - Enhanced HTT can manage patients in the community, avoiding admission.	**Lead:** *AD for A&UC*	**Q2 26/27**
Impact: These actions reduce inappropriate or preventable admissions amd readmissions by strengthening community support and proactive planning.		
2. Number of Discharges		
Goal: Increase timely discharges and reduce delays in discharge.		
Actions:		
Pilot Red2Green model - Drives daily progress toward discharge.	**Lead:** *AD for A&UC and Transformation Lead*	**Q4 25/26**
Establish and embed Estimated Discharge Date (EDD) practise including accurate and timely recording of EDD - Enables proactive discharge planning.	**Lead:** *AD for A&UC*	**Q3 25/26**
Implement discharge readiness checklist - Ensures patients are prepared for discharge during MDT reviews.	**Lead:** *AD for A&UC*	**Q4 25/26**
Service user follow up within 72 hours of discharge.	**Lead:** *AD for ICCR and AD for A&UC*	**Current/Ongoing**
Care coordinator allocation within 72 hrs - Early involvement accelerates discharge planning.	**Lead:** *AD for ICCR and AD for CYP Division*	**Q4 25/26**
Mobilise Framework contract bed Inreach SOP - Improves flow from contracted beds back to community.	**Lead:** *AD for A&UC*	**Q4 25/26**
Impact: These actions streamline discharge processes and remove social/administrative delays.		
3. Clinically Ready for Discharge (CRFD)		
Goal: Reduce time patients remain in hospital after being clinically ready.		
Actions:		
Improve recording of CRFD data - Accurate tracking highlights delays and reasons for delay.	**Lead:** *AD for A&UC*	**Q4 25/26**
Alerts to HTT/Care Coordinator at 28 days LOS or CRFD - Triggers escalation for delayed discharges.	**Lead:** *AD for U&AC*	**Q3 25/26**
Introduce escalation process for LOS >28 days - Ensures senior oversight for long-stay patients.	**Lead:** *AD for U&AC*	**Q3 25/26**
AUC collaboration for reviews of patients >60 days - Focused clinical reviews to expedite discharge.	**Lead:** *Head of Nursing A&UC*	**Q3 25/26**
Early escalation of barriers to discharge including partnership led CRFD delays and undertake complex case reviews for extended delays	**Lead:** *AD for U&AC*	**Current/Ongoing**
Ensure Local Authority meets statutory obligations (AMHP, Social Worker availability) - Removes social care delays.	**Lead:** *AD for A&UC*	**Current/Ongoing**
Impact: These actions target systemic and social delays after clinical readiness, reducing unnecessary bed occupancy.		
4. Gatekeeping		
Goal: Ensure admissions are appropriate and alternatives are considered.		
Actions:		
Admissions are gatekept by HTT - to ensure appropriateness	**Lead:** *AD for U&AC*	**Current/Ongoing**
CMHT attendance at locality meetings - Improves coordination and gatekeeping decisions.	**Lead:** *AD for ICCR and AD for CYP Division*	**Q3 25/26**
Alerts to HTT/Care Coordinator approaching 28 days LOS - Supports proactive intervention before admission becomes prolonged.	**Lead:** *AD for U&AC*	**Q3 25/26**
Standardisation of MDT standards - Ensures robust decision-making before admission.	**Lead:** *AD for A&UC*	**Q1 26/27**
Robust care plans for psychosis at admission - Improves clarity and reduces unnecessary escalation.	**Lead:** *AD for A&UC and Transformation Lead*	**Q4 25/26** *(aligned with Red2Green pilot)*
Impact: These actions strengthen pre-admission checks and community alternatives, reducing inappropriate admissions.		
5. Local Monitoring and Reporting		
Goal: Active use of date to inform reporting and decision making		
Actions:		
Utilise established reports on a suite of measures at ward level, consultant and patient level including, inpatient numbers - admissions/discharges, LoS (ward level, consultant level and patient level as needed), bed waiting lists - including transfer times, HTT gatekeeping, CRFDs & contribution to LOS, EDDs.	**Lead:** *AD for Performance & Information*	**Ongoing**
Impact: Provides real-time visibility of performance, enables earlier identification of delays and risks, and drives faster, evidence-based decision-making that improves patient flow and overall quality of care.		
6. Service plan developments to support patient flow and LOS as outcomes		
Goal: To strengthen inpatient care by reducing unnecessary admissions, improving HTT and MDT practice, and enhancing trauma-informed and inreach support.		
Actions:		
Reduce unnecessary admissions and improve discharge experience in acute inpatients for patients with LDA	**Lead:** *LDA Lead and AD for U&AC*	**TBC**
Implement agreed inreach SOP with our framework contract providers clarifying staff roles and responsibilities to manage patient flow and discharge.	**Lead:** *AD for A&UC*	**Q4 25/26**
Build upon trauma informed care work through improved protocol following violence to staff & patients including strengthen presence and actions of West Midlands Police and criminal justice system to ensure appropriate support/response to staff and patient experience to reduce related staff absences from work.	**Lead:** *AD for A&UC*	**Q1 26/27**
Impact: This will improve patient flow, enhance safety and experience, and support a more resilient and confident workforce.		

Action	Who	When	Progress	Status
Reproduce national methodology on local data to validate measure and understand local issues. Q1 NOF score 49.37%	Head of Informatics (PP)	7-Oct-25	Urgent Referral metric built based on national methodology	Complete
Add NOF access measure to Trust KPI Explorer and exception reports	Head of Informatics (PP)	14-Oct-25	UC11 % Urgent Referrals seen F:F within 24 hours now available on KPI explorer with drill thorugh to patient level	Complete
Review and improve data capture on referral urgency to ensure measure covers appropriate referrals	Head of Informatics (PP)	31-Oct-25	On Track. Definitions agreed and recording changes to be implemented on Rio before 1st November.	Complete
Review October referrals and contacts recording for accuracy and correct as necessary	CRHTT Service Lead (CM)	10-Nov-25	Review has confirmed that recording issues are a major cause of the apparent low performance. October corrections will be completed before next MHSDS submission. Ongoing checks have been built into working practices.	On Track
Improve reliability and consistency of diary contact recording and outcoming for all appointments across home treatment teams	CRHTT Service Lead (CM)	ongoing action	Expectations around recording are being made clear to all staff, and fortnightly meetings have been established to monitor improvement and take further action as necessary. Extra measures have been put in place to overcome barriers making it more difficult for bank staff to record contacts.	On Track
Home Treatment Teams to routinely add referral times to team whiteboards and take into account in visit prioritisation where practicable	Service Associate & Clinical Directors (TN/NB/HA/AD)	ongoing action	Team managers are aware of the new standard and the need to monitor it, and will be holding meetings to discuss with their teams routinely. A project to implement electronic whiteboards for home treatment teams is planned, and the opportunity will be used to build access standard monitoring and alerts into the design.	On Track
Review options for arranging visit priorities around achieving 24-hour contact standard (in place of current 'next day' standard)	Service Associate & Clinical Directors (TN/NB/HA/AD)	14-Nov-25	Teams are aware of revised interpretation of the 24-hour standard and will adjust day-to-day prioritisation to reflect this	Complete

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix II - FPPC 20th November 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	Sep-25	Oct-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	0	0	⇔	15	0			
Increase CYP accessing services (MHSDS figures, month behind)	18163	18163	12865	13590	14270	13828	13875	14013	13113			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%	81.8%	60.0%	85%	25%	⇑	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%	100.0%	100.0%	100.0%	0%	⇔	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%	100.0%	66.7%	100.0%	33%	⇑	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%	72.7%	61.5%	-11%	⇓	50%	60%			
IAPT Six Weeks**	75%	75%	81.0%	84.0%	80.0%	80.6%	75.2%	83.3%	81.7%	-2%	⇓	65%	75%			
IAPT 18 Weeks**	95%	95%	98.0%	97.0%	96.0%	98.3%	98.1%	98.6%	98.1%	-1%	⇓	85%	95%			
IAPT Moving to Recovery Rate**	50%	50%	48.0%	49.0%	45.0%	55.2%	53.4%	59.0%	51.2%	-8%	⇓	40%	50%			
Non Contract >18 beds charged for (avge of wkly snapshot)*	zero		19	16	14	12	7	6	4	-2	⇓	10	0	n/a	n/a	
All >18 beds charged for (avge of weekly snapshot)*	92		74	72	68	65	71	66	70	4	⇑	105	92	n/a	n/a	

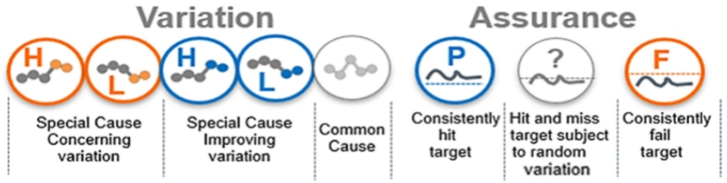
CYP Access data not yet finalised as waiting for a partner update

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 – National Reporting Issues

- Board members are reminded that as part of the FTB CYP transfer to BSMHFT, a risk that was identified at the outset related to the impact of the in-year break in national MHSDS data submissions by BWC up to end June 2025 and BSMHFT from July 2025 and that this would make national reporting on CYP metrics unreliable as contacts/activity undertaken by BWC would not be identified in BSMHFT submissions.
- National guidance sought at the time confirmed that there were no mitigations and that this risk would have to be accepted.
- More recently as national data post July 2025 is now being published, NHSE leads and MH Provider Collaborative Leads asked for detailed clarification on this issue which was discussed at a joint meeting on 5th November.
- The metrics impacted are CYP Access, First Episode Psychosis (FEP) waits and CYP Eating Disorders access measures as they rely on contact data prior to the July transfer to stop the ‘clock’.

CYP – National Reporting Issues Cont.

- It was acknowledged at the meeting that the Trust had followed national guidance which has the impact of making national reporting unreliable. As a result it was agreed that local data would be used for monitoring until the national MHSDS reporting becomes reliable, end March for 3 month rolling average metrics and end of June 2026 for 12 month rolling metrics. .
- BSMHFT has also reviewed data for key metrics for transferred services and is implementing some data quality and reporting improvements.
- CYP eating disorders methodology has been updated and October's figures reflect these initial changes. Further data quality work is being undertaken.

CYP – Update on Local Reporting/ Integration with BSMHFT data

- The BSMHFT informatics team have also been undertaking a full review of data quality and reporting methodologies for key metrics relating to FTB services following transfer to establish and ensure consistency of reporting.
- This work to date has found two areas for action relating to practice from before the transfer that has needed addressing:
  - Some ‘FTB’ clock stop data has been incomplete in national submissions due to local recording issues. Local FTB reporting was accurate but national data was not updated. Teams have now been working to address and eliminate these discrepancies. We expect October MHSDS data to be accurate and we will also re-submit data back to July once the work is completed.
  - Detailed comparisons of local reporting algorithms for key metrics between FTB and Solar has also revealed some differences. A reconciliation process is being undertaken.

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CYP Access Target – Improvement Action Plan

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

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Appendix III - FPPC 20th November 2025

2025/26 Performance metrics Improvement Trajectory updates

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

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

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

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

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

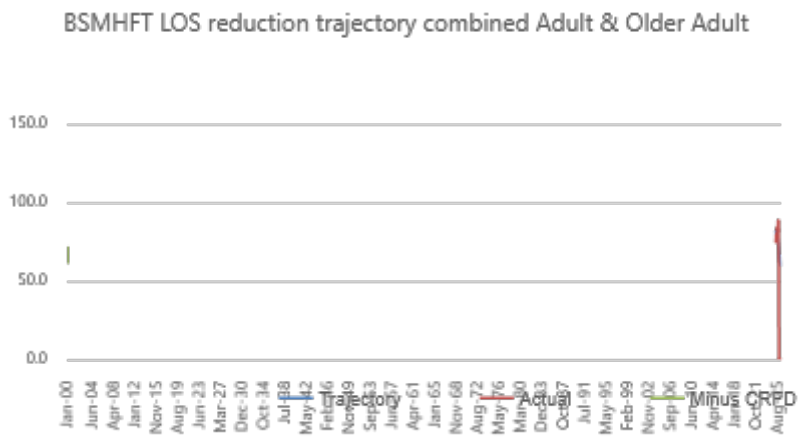
NHSE methodology – Factors to note:

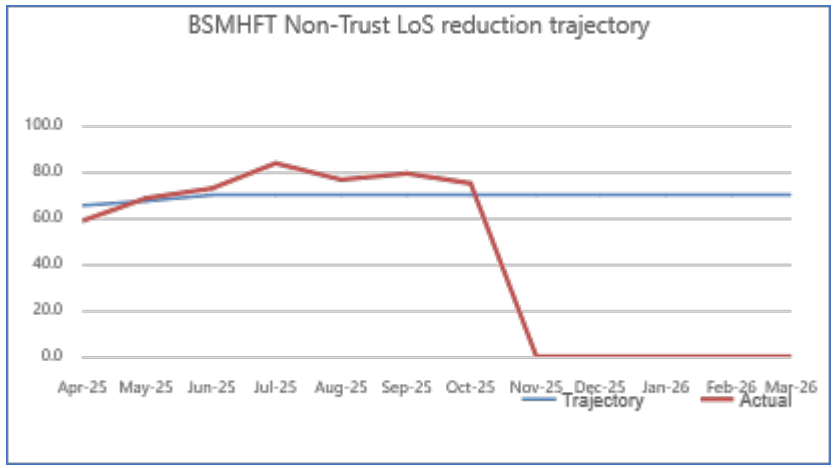
- As the methodology is based on discharge, discharging service users with long lengths of stay will have a negative impact on performance against trajectory.
- Achieving significant length of stay reductions on this methodology will require more discharges of people with longer lengths of stay during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

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

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

NHSE 2025/26 Length of Stay Reduction Trajectories





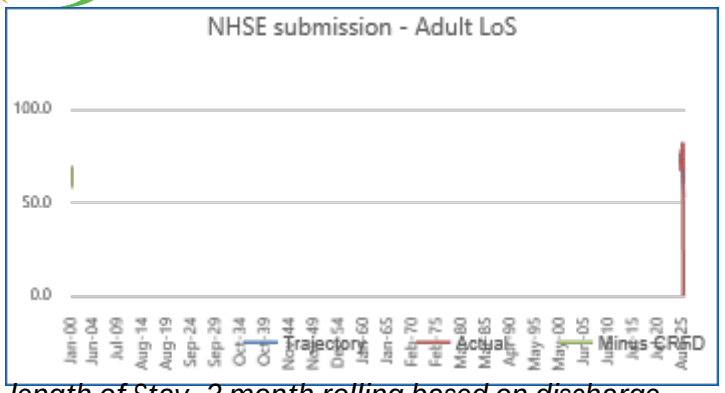
The 3-month rolling length of stay has seen an increase in the period July – September and the non trust has seen a small increase.

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

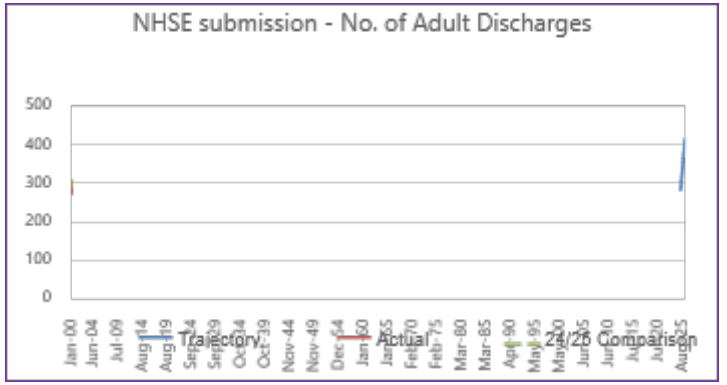
NEW – As requested at June 2025 FPPC meeting, additional data has been added (see next slide 4) which includes the NHSE LOS measures compared to 'active' current length of stay position as well as showing the impact of CRFDs on LOS.

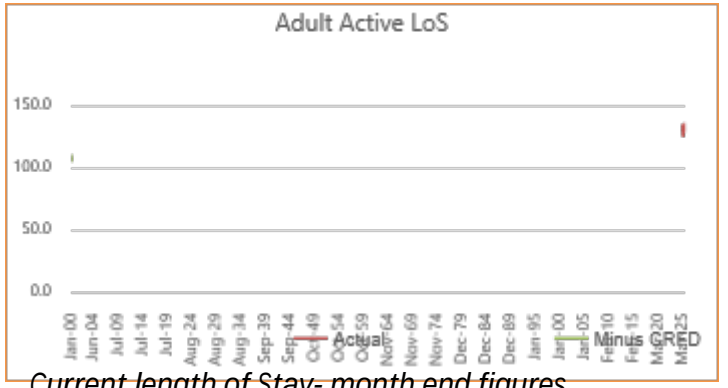
Adults/ Older Adult LOS Trajectory 2025/26

Birmingham and Solihull Mental Health NHS Foundation Trust

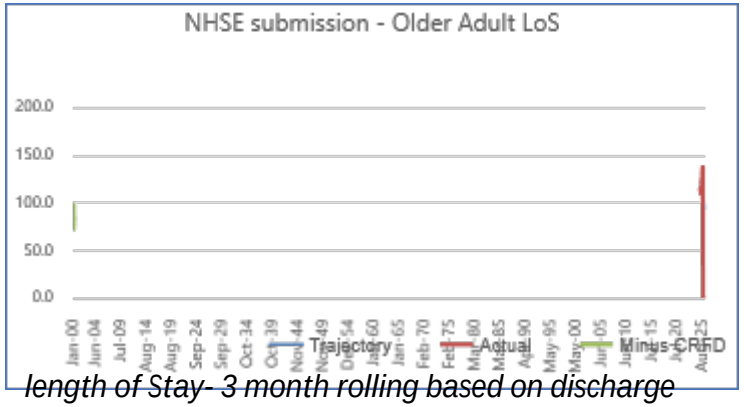


length of Stay- 3 month rolling based on discharge

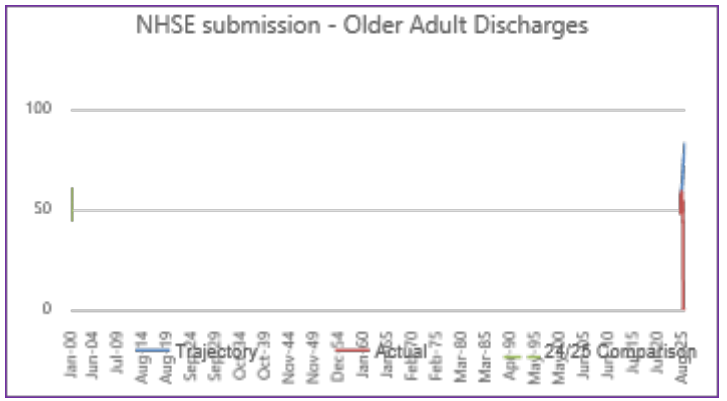


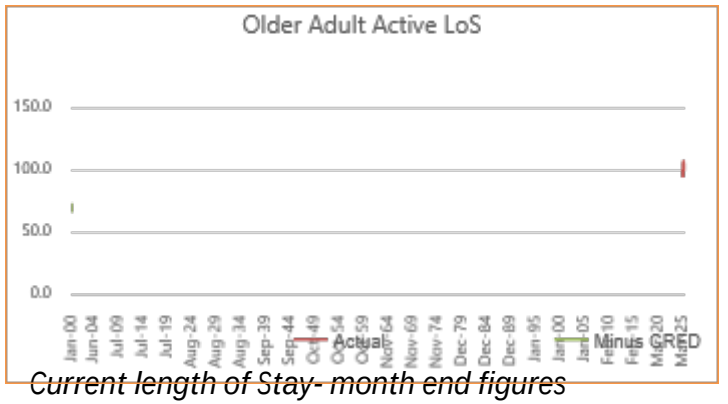


Current length of Stay- month end figures



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.

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

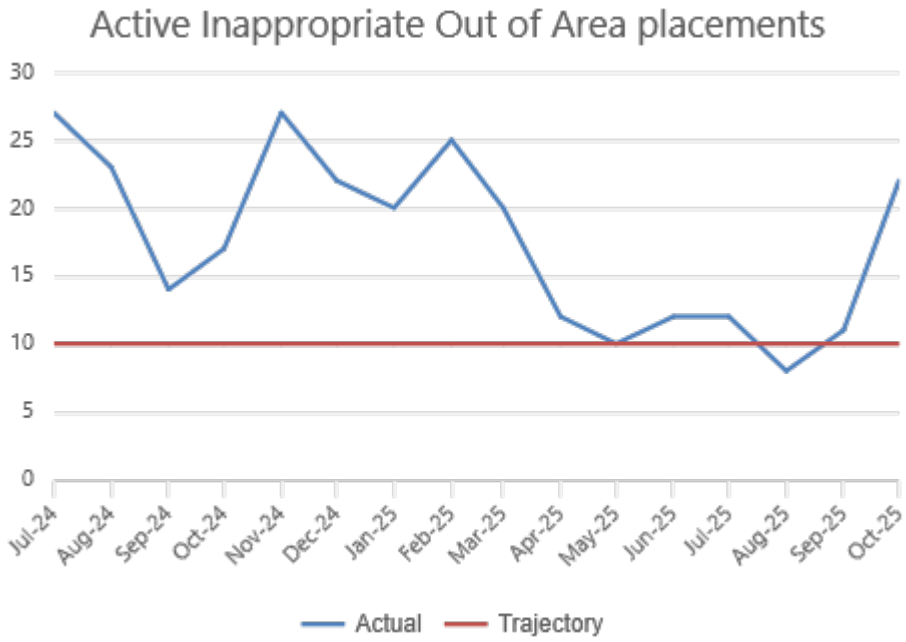
Discharge of long stay patients will impact negatively on the agreed trajectories in the short to medium term and once LOS improvements are achieved routinely with a reduction in longer lengths of stay, this impact will reduce over time. .

Birmingham and Solihull Mental Health NHS Foundation Trust

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

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

Active Inappropriate Out of Area Placements



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

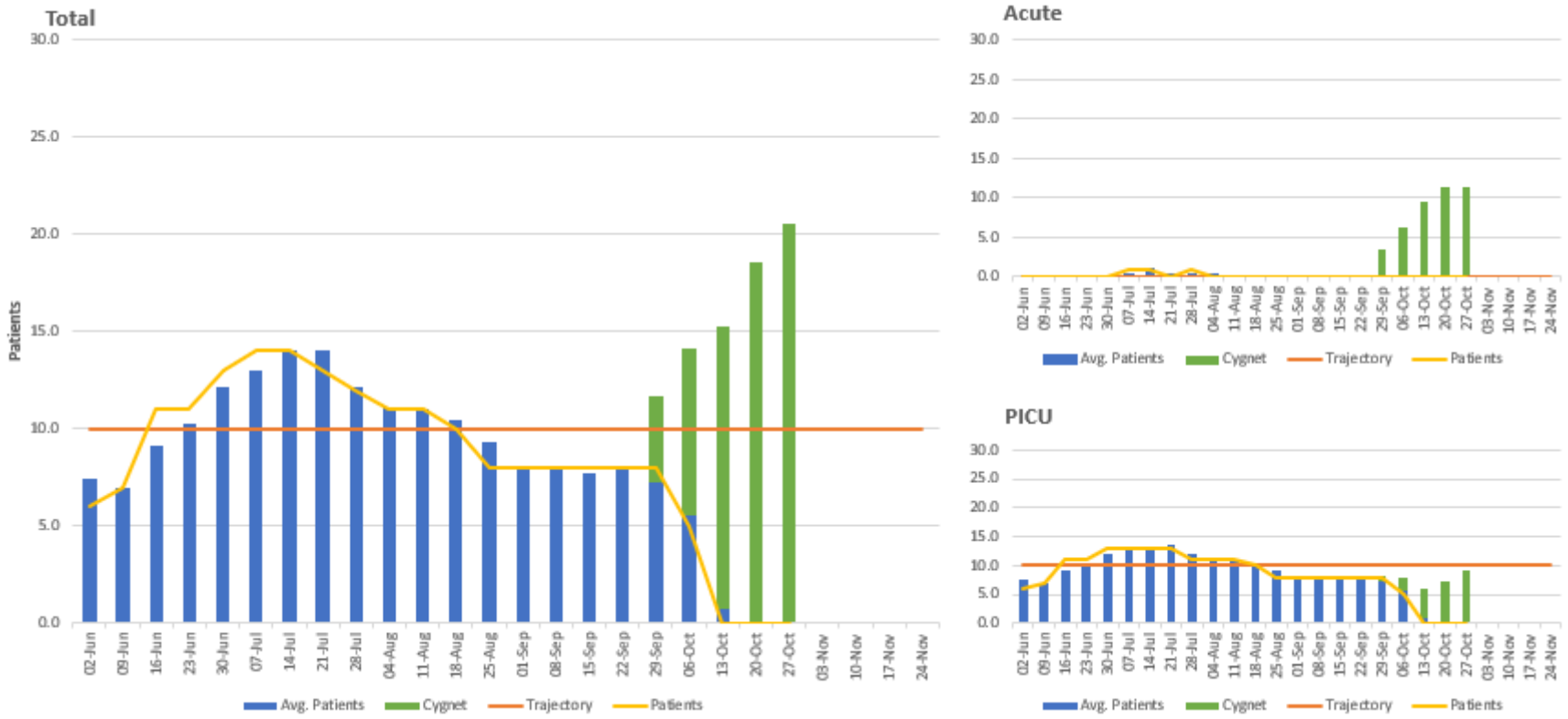
NOTE: Since 29th September a new contract with private provider Cygnet hospitals has been agreed for out of area placements. A Standard Operating Protocol (SOP) is currently being finalised for approval by NHSE to support the classification of these placements as being 'appropriate' subject to the SOP meeting NHSEs qualitative criteria. During this transition phase placements to Cygnet hospitals are currently being classified as 'inappropriate' as the SOP has not yet been approved. Sign off is expected in November 2025. If approved, these placements will be categorized as being appropriate.

October 2025 position – Total inappropriate number of placements at 21 (target 10), 11 acute (target 0) and 10 PICU (target 10).
However, if the patients in Cygnet beds were classed as 'appropriate', there would be no 'inappropriate' out of area placements at the end of October.

The Trust's productivity action plan continues to focus on workstreams to better manage demand, focus on reducing CRFD patients which has seen improvement, 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.
Whilst Clinically Ready for Discharge (CRFD) patients not within Trust control, particularly social care and housing remain, overall CRFDs have reduced and this is supporting patient flow/capacity and reduction in the number of all out of area placements.

Inappropriate Out of Area Placements - BSMHFT



Admissions to Cygnet hospitals, highlighted in green. Being classified as 'inappropriate' as the SOP has yet to be approved by NHSE.

Slides 8 outline a summary of key actions from the productivity plan for Q3.

Q3 2025/26 Productivity Plan Update

1. **Launch Recovery House**

   Impact: Provides an alternative care setting, supporting admission avoidance and optimising discharge planning.

   Update: Recovery House launched on the 5th November providing 24/7 residential service delivered in partnership with Birmingham Mind, offering intensive support for adults experiencing acute mental health needs.

2. **Launch Framework Contract Beds** – Transition from previous contract to new framework contract.

   Update: The transition has commenced with monthly RAG monitoring of Acute and PICU numbers within these contracted beds. A 'Get to Green' model is in place to ensure the number of beds aligns to our financial recovery trajectory.

3. **Continued integration of CYP**

   Update: Work continues with CYP directorate to ensure clinical prioritisation of 18+ admissions within allocated bed stock (trust and framework contracted). There is some early alignment with bed management and the 'Get to Green' approach and the in-reach approach with the framework contract beds.

4. **Home Treatment Staffing Review**

   Update: A business case for increasing HTT capacity has been developed and aim to take this forward as we build assurance over the financial improvements due to the reductions in Spot Purchase bed usage.

5. **Developing Local Capacity**

   Update:–As part of the NOF, an action plan focusing on reducing LOS has been developed, see Appendices Ia and Ib. This work is led by the Acute & Urgent Care division but recognises that a whole pathways approach is required as well as system and partnership support to facilitate effective and timely patient flow.

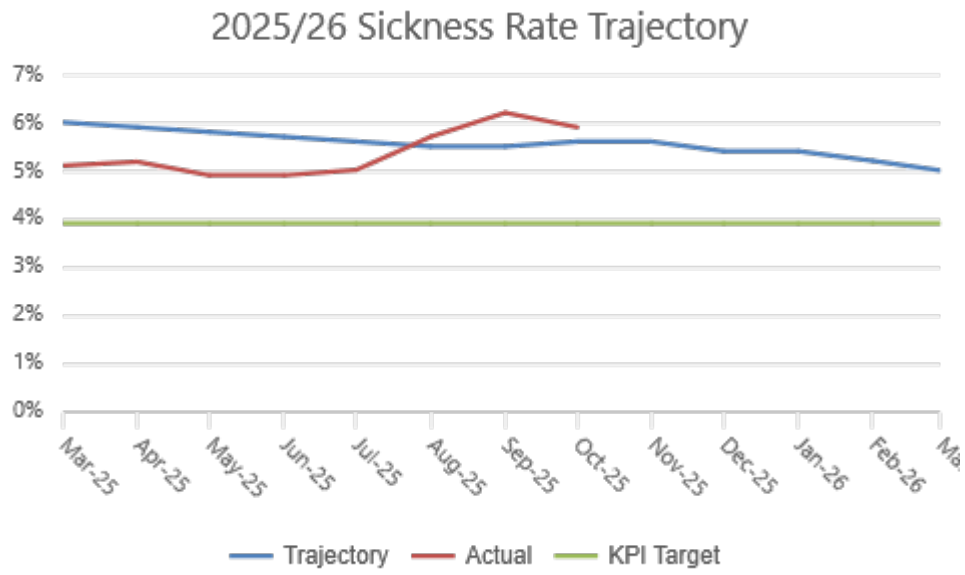
Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce trajectories – 2025/26 update.

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

Sickness Absence

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



A revised trajectory has been provided for 2025/26 to reduce sickness levels by 1% reaching 5% by March 2026. October 2025 at 5.9% marginally above the monthly improvement trajectory of 5.6%. Short term sickness has increased to 2% and Long-term sickness has decreased to 4%.

Action Plan:

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

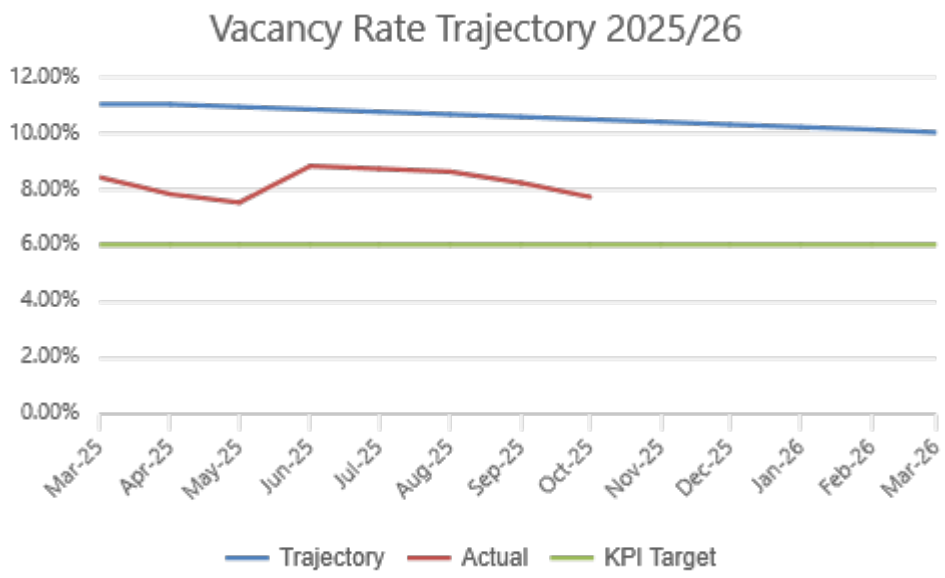
Training Reach: Masterclass delivery on Managing Health and Wellbeing continues, with a focus on reaching divisions with higher levels of absences. Tailored sessions are also being offered to divisions to support group upskilling.

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

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

Vacancies

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



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%. October at 7.7% and below the monthly trajectory.

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.

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

Vacancies

Action Plan update cont:

The trust, in conjunction with universities, education facilities, and with the assistance of ICB members, is currently rolling out actions from its working group meetings 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.

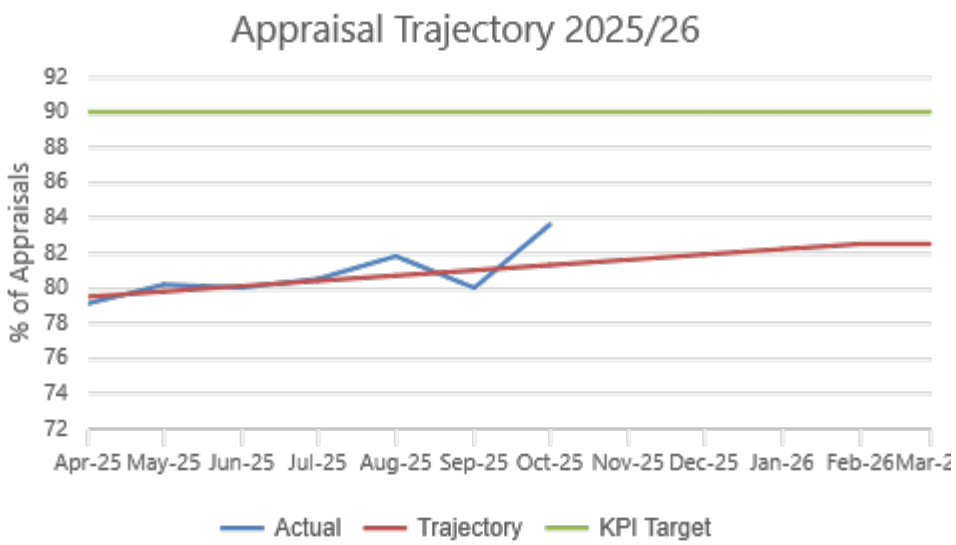
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- 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 October 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.

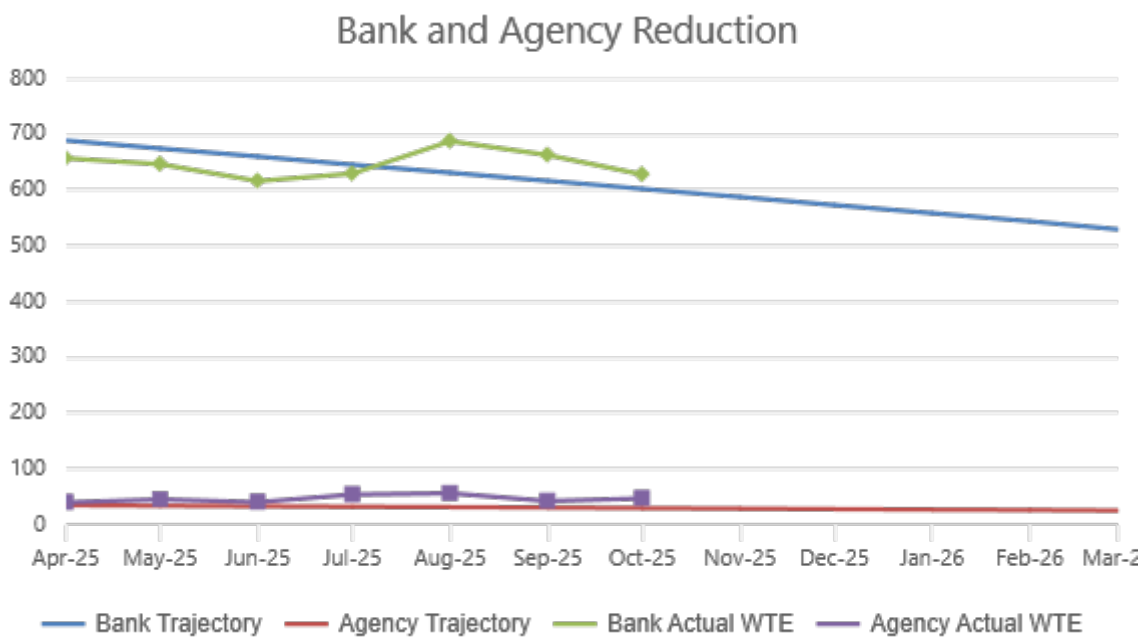
October 2025 appraisal performance increased to 83.6% and above the monthly and year end trajectory.

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

- Continuing current practice to raise compliance and Monitoring.
- Continue to review system and process to improve user experience, including refreshed resources on connect
- Supporting bespoke Value Based Appraisal training sessions for services
- NB- CYP 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 reduced but remains above trajectory for last three month with October at 627.25 WTE
Agency remains above trajectory for the last 4 months with October at 45.86 WTE

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability

Monthly Agency costs

- A detailed agency reduction programme mentioned above is in progress working in conjunction with ICB / NHSE policies and restrictions and the Midlands and Lancashire CSU. Two areas of renewed focus are the expediating of the TSS bank workers to substantive process and the finishing of agency block bookings. Currently all HCA agency requests require Exec approval. The NHSE Midlands above cap improvement workgroup requirements ensured that all agency standard nursing bookings were fully compliant with cap rates as at the end of January 2025.

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

- Direct Engagement for Medical Agency is also live, with the aim of meeting potential ICB and NHSE requirements. Direct Engagement has a significant effect on fill rates and also have significant, tangible cost saving implications.

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix IIIa - FPPC 20th November 2025

2025/26 Talking Therapies Recovery Action Plan Summary

MH Provider Collaborative Performance Improvement Notice

- The Mental Health Provider Collaborative issued a performance notice to the Trust in September 2025 relating to activity underperformance and Reliable Recovery Rates and Reliable Improvement rates.
- A range of further supportive measures are being put in place by the commissioners to review the Trust's recovery action plan. This includes a deep dive and an NHS Talking Therapies system workshop.

Activity and Performance update

Update as at October 2025:

- The reliable recovery rate performance reached the 68% target.
- Reliable recovery rate has improved in last month 45.2% but remains below trajectory of 50%.
- October completed cases at 759 below the target of 811.
- Income below trajectory and activity remains under the ICB activity plan requirements, with a related financial deficit of £415,900 for April - October 2025.
- National waiting time standards of 6 (75% standard) and 18 weeks (95% standard) continue to be maintained.
- The DNA rate has reduced to 11% in October 2025 13%.

A power BI report has been developed for the service covering key KPIs, with team level breakdowns. It also has individual clinician activity for monitoring and use in supervision.

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

Workforce Action Plan

The key workforce areas of action include:

- Skill Mix review
- Identify funding stream for band 8A post for each team
- Recruit to locality clinical lead posts for each team
- Staff wellbeing focus groups (work with OD)
- Establish Action Learning Sets for Managers
- Establish and implement Employment Advice Groups
- L&D have been asked to support the action learning sets
- Establishment of Employment advice groups – Get ready for Opportunities to Work and Empowering Employees. Aim to start groups in November.

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	£459,919	£517,966	-£58,047
Jun	812	710	669	£452,901	£426,748	£517,966	-£91,218
Jul	812	750	776	£478,417	£495,003	£517,966	-£22,963
Aug	811	670	638	£427,386	£406,974	£517,966	-£110,992
Sep	811	760	726	£484,796	£463,108	£517,966	-£54,858
Oct	811	800	759	£510,312	£484,159	£517,966	-£33,807
Nov	811	800		£510,312		£517,966	
Dec	811	800		£510,312		£517,966	
Jan	811	812		£517,966		£517,966	
Feb	811	812		£517,966		£517,966	
Mar	801	812		£517,966		£517,966	
Total	9,736	9,106	5,032	£5,808,621	£3,209,862	£6,215,600	-£415,900

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 December 2025**
Date(s) of Committee Meeting(s) reported	**19 November 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Corporate Risk Register • Safe Care Today Dashboard • Patient Safety Report • Regulatory Compliance Report • Fire Safety Report • Infection Prevention and Control Report • Integrated Performance Report • Clinical Governance Committee Assurance Report • Patient Experience and Recovery (PEAR) Group Assurance Report • Customer Relations Report • Safer Staffing Report • Mental Health Legislation Committee Escalation Report *(appended to this report for information)* • Quality and Clinical Services Q2 Strategy Update • Assertive and Intensive Action Plan Progress Report • Clinical Effectiveness Advisory Group Assurance Report • Reducing Restrictive Practice Report • Safeguarding Management Board Assurance Report • Terms of Reference Review • Committee Effectiveness Self-Assessment Review
Alert:	The Committee wished to alert the Board of Directors to the following: • AMHP availability issues continued, leading to an increase in delays and incidents. A joint review had been commissioned with Birmingham City Council; the resulting action plan would be monitored by the Clinical Governance Committee. • An increased risk related to immediate release from prison without sufficient mental health support was raised. The Committee noted the established bronze, silver, gold framework in place. • Drug use in secure services remained a key issue. • The Committee was alerted to a recently identified risk area related to staffing and capacity in North and South Home Treatment Teams. • There was a high number of clinically ready for discharge patients in older people's services, as onward housing and care package constraints continued.

	• The Committee noted the high number of safeguarding referrals and statutory reviews in Birmingham, with increased Safeguarding Adults Reviews anticipated. • CYP had been identified as having gaps in safeguarding compliance, support and oversight. • An increase in in PALS/Complaints related to Children and Young People's services was noted. • Larimar ward recorded as having breaches in search policy. • Integrated Performance Dashboard showed an increase in reported incidents and self-harm in October	
Assure:	The Committee was assured by the following: • The Patient Safety Report highlighted a reduction in incidents such as self-harm and absconsions in September, which was attributed to improved staffing, leadership and environment • The Committee noted positive feedback on fire safety plans. • The Committee noted that remaining Section 29A notices had been lifted. • The Mental Health Legislation Committee reported good compliance with audits and no statutory breaches. • The Safer Staffing Report provided positive assurance around low vacancy rates, reduced sickness absence, good retention of internationally educated nurses and improved rostering use and controls.	
Advise:	The Committee noted the ongoing development of performance dashboards, which provide greater clarity around data and reporting trends. The Committee highlighted the need to ensure health inequalities was applied to all reporting and data, with increased divisional ownership.	
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:	Nick Moor Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**Mental Health Legislation Committee (MHLC)**
Report presented at	**QPES Committee**
Date of meeting	
Date(s) of Committee Meeting(s) reported	**22nd October 2025**
Quoracy	**Membership quorate: yes**

Agenda	The MHLC considered an agenda which included the following items:
	• Annual Consent to Treatment (CTT) Audit
	• Head of Mental Health Legislation reports
	  • MHL Service Update
	  • Integrated report
	  • Compliance
	• Risk Review
	• Associate Medical Director MHL reports
	  • Mental Health Bill
	  • Use of Force
	  • DoLS / LPS update
	  • Restrictive Practice update
	• Legal report
	• Associate Hospital Manager Report

Alert:	The MHLC wishes to alert the committee to the following: • AMHP incidents increased in Q2 to 40, a 13% increase and the 3rd consecutive quarter reporting an increase. • Consideration may wish to be given to a s75 arrangement (NHS Act 2006) where AMHP services are provided by the Trust. • Associate Hospital Managers (AHM) reported 5 concerns from hearings 1 in relation to no AMHP available to discuss a CTO; delay in confirming the funding for identified accommodation; delay in Appointeeship for a patient's financial affairs; patient unaware of the hearing and issues with ward laptop; and a safeguarding issue (potential financial abuse). • Full AHM report attached as per Code of Practice (CoP) requirement.
Assure:	The Committee was assured on the following: • Review of risks from a legal point of view and no major concerns. • At the end of the AMaT pilot there was no feedback from clinicians to say that the system didn't work for the MHA audits and will therefore continue.

	• Compliance for quarter 2 increased to the levels reported prior to AMaT use, and the overall Trust compliance for both inpatient MHA and CTO is 89.3%. This score was affected by 1 team non-submission.

Advise:	The Committee was advised of the following matters:
	
	• 1305 people under detention during quarter 2 including an average of 297 people on CTO per month (but no change in demographics or unusual activity noted). This is a small increase in use of detention.
	• There were 4 formal complaints in relation to staff attitude / communication
	• We received 6 CQC MHA inspections in Q2 to Dove, Eden PICU, Endeavour House, Swift, FCAMHS and Larimar. The visits to Eden PICU and FCAMHS will not be receiving reports due to the CQC reviewer going off sick shortly after the inspections. They advise these visits will need to be repeated
	• There was no overarching theme emerging, but a variety of individual issues were noted relating to quality of mental capacity assessments; information for family to enable them to participate in decision making and provide with contingency plans for s17 leave; how patients can complain to the CQC; safe patient access to the garden; holistic care planning for a patient who is visually impaired; staffing levels, and review of treatment authorisation certificates
	• There were 21 incidents reported in relation to MH hearings, the highest ever reported. The main reason for Associate Hospital Manager hearing incidents were in relation to either RCs not being available or not submitting the renewal documents in time for the hearing. The main reason for the Tribunal incidents was tribunal cancellation due to panel issues.
	• The committee had a further update on the MHA Bill; the key points for noting are:
	  • the change in detention criteria likely to be implemented in the coming months - Detention only for psychiatric disorder (previously mental disorder) which will exclude autism and learning disability.
	  • changes in definition from harm to serious harm for detention and necessity rather than appropriate; and
	  • 28-day limit for section 47/ 48 transfer meaning increased pressure on Secure Care beds.
	• The committee were advised of the Supreme Court review of what counts as a deprivation of liberty in a case put forward by Northern Ireland. This has prompted the UK government to do a second consultation on the Liberty Protection Safeguards (LPS) which will be launched in the first half of next year (2026). Previous consultation in 2022 did not lead to any changes.
	• The focus for BSMHFT will be to concentrate on:
	  • improving our Culture of Care (in line with the Standards of inpatient culture of care) and reduction of restrictive practices.

	• Record and consider the patient voice (expressed views and feelings) in everything we do, irrespective of detention and capacity status. • Prepare to deploy a rapid change to MHA detention criteria and DoLS in the coming year.	
Board Assurance Framework		
	New risks identified: impact of AMHP availability; preparation for change in detention criteria and the 28-day s47/48 transfer	
Report compiled by:	**Louise McLanachan, Head of Mental Health Legislation**	**Minutes available from: Louise McLanachan or Christiana Sodomala**

Committee Escalation and Assurance Report

Name of Committee	**Associate Hospital Managers Meeting**
Report presented at	**Mental Health Legislation Committee**
Agenda item:	**10**
Date of meeting	**22 October 2025**
Date(s) of Committee Meeting(s) reported	**25 September 2025**
Quoracy	**Membership quorate: yes**
Agenda	The Committee considered an agenda which included the following items: • Training and updates for Associate Hospital Managers – Right Care, Right Person; and Mental Capacity Act overview in relation to the AHM role • Minutes of meeting held Thursday 26th June 2025 • Matters Arising • Chair & Deputy Senior Lay Manager comments • Mental Health Legislation Team Feedback • Managers' Concerns • Update from MHLC (report summaries)
Alert:	The Committee wishes to alert the committee to the following: AHMs raised 5 concerns from hearings. They were: 1. **Northcroft, 30/06/25**: The panel noted the clinical team's concerns that there was no AMHP available to discuss Mr. Raheem's being placed on a possible CTO until the 12 August 2025 • **Response received** from the MH Lead at BCC: We are generally able to comply with most requests within the 8-week timeframe. We frequently bring forward requests when informed of cancellations to ensure we meet this deadline in the majority of cases. Additionally, we are currently working on our workforce plan to increase capacity, which should further help us meet this requirement consistently. However, it's worth noting that with the upcoming reforms to the MHA due to come into force this year, RCs will be required to carefully consider alternatives to CTOs. We anticipate that these reforms will lead to a reduction in the number of CTOs over the following year 2. **Eden, 08/08/25**: The panel was concerned that there has been a delay in confirming the funding for the patient's identified accommodation. This needs to be resolved rapidly to maintain the wellbeing of the patient. • **No response received**. 3. **Endeavour Court, 18/09/25**: Application was apparently made in July 2025 via BCC for Appointeeship for the patient's financial affairs. This is because there is a strong possibility that the patient's father is financially abusing his son. The Father's reluctance to co-operate is delaying the patient's discharge on to a CTO. This matter needs escalating to speed up the Appointeeship process and mitigate the risk of a delayed discharge

	• **Response received**: An appointee is now in place, and the clinical team are planning for discharge on 2nd of October. 4. **Reaside, 26/09/25**: The panel were concerned that the patient was only given his rights on the day of the hearing. The hearing was significantly delayed, adding additional stress to the patient as the ward laptop camera function was faulty. S/N A had to source another laptop which took time. • **No response received**. 5. **CMHT Osborne House, 02/10/25**: During the hearing it became evident that patient's friend who is also a member of her church seemed to have an undue influence over her and at one stage was overheard telling her to shut up in Punjabi ('Chup kar'). She seems to be aware of patient's financial arrangements with the bank and was highly critical of patient's family. Due to this presentation at the hearing the fact the panel felt concerned enough to raise the issue of her influence over patient with the CPN. The CPN concurred with the panel when this was discussed • **Response**: Care Co-ordinator is going to contact the family to find out more about this friend and raise a safeguarding
Assure:	The Committee was assured on the following: • AHMs were given updates and highlights regarding compliance and delivery of their role • Mental Health Legislation Team were able to feed back any concerns or updates from Mental Health Legislation Administrators • AHMs were given the opportunity to raise any concerns at the meeting
Advise:	The Committee was advised of the following matters: • AHMs received the front sheets of all MHLC reports from July committee • Quarter 2 saw 179 Associate Hospital Manager (AHM) hearings (0 discharges) • There was an action from July MHLC to monitor how many AHM hearings were held late due to AMHP availability. There were none. • The main reasons for the increase in AHM hearing incidents were in relation to either RCs not being available or not submitting the renewal documents in time for the hearing.
Board Assurance Framework	
	New risks identified: None
Report compiled by:	**Jan Prior** **Louise McLanachan**
	Minutes available from: **Louise McLanachan or Christiana Sodomala**

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 December 2025**
Date(s) of Committee Meeting(s) reported	**22 October 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Safe Care Today Dashboard (inc Bronze, Silver, Gold Audits) • North Acute Wards Assurance Report • Learning Disability and Autism Assurance Report • Regulatory Compliance Report • Integrated Performance Report • Patient Safety Report • Clinical Governance Committee Assurance Report • Patient Experience and Recovery (PEAR) Group Assurance Report • Customer Relations Report • Freedom to Speak Up Guardian Report • Reducing Restrictive Practice Report • Culture of Care Programme Report • Learning from Deaths Annual Themed Review • Clinical Effectiveness Advisory Group Assurance Report • Terms of Reference Review
Alert:	The Committee wished to alert the Board of Directors to the following: • There were high caseloads reported in Home Treatment Teams, and the Committee noted the plan to review staffing establishments to ensure robust management. • The Committee highlighted the internal review into the Larimar incident, which had now begun. • Amendments to the Trust's Search Policy were underway, following a number of recent incidents. • An arrangement was now in place for more robust fire safety management; however, this remained an alert until outstanding compliance work had been completed. • There were no immediate solutions available to address management of medical devices within the organisation. • The Committee sought additional assurance on understanding psychological harm, which would be received in January. • The Committee was alerted to the review of allocation of patients into appropriate settings and the ongoing work with bed management to realise this.

	• The Committee was alerted to the need for clear governance and oversight structures for the Right Care Right Person implementation.	
Assure:	The Committee was assured by the following: • Good assurance was received on the Learning Disability and Autism awareness and trajectory of improvement. • Members of the Committee fed back on night visits they had attended in October; members had visited staff working night shifts across some acute wards and had been encouraged by the awareness of new policies during handover meetings. Further night visits would be arranged. • Assurance was received on the leadership plans for the North acute wards. • The Committee approved the Staff Safety Strategy. • Positive feedback on the implementation of the Culture of Care Programme was received, and the Committee was encouraged by plans to roll the programme out across the organisation.	
Advise:	The Committee received some assurance on the progress and rollout of the Culture of Care programme, which triangulated with feedback from night visits undertaken by Board members in October. However, there was more work to be done to ensure patient safety in relation to the procurement of illegal substances. The Committee was advised of the development of the Safe Care dashboard, which would continue to mature over the next few months. The work of the Freedom to Speak Up Guardian was highlighted through an animated video; the Committee was asked to consider colleagues who might be interested in being involved.	
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

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors						
Agenda item:	**12**					
Date	3 December 2025					
Title	Quality and Safety Report					
Author/Presenter	Lisa Stalley-Green, Executive Director for Quality & 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, Safety and Regulatory Compliance within BSMHFT Services and activities and to provide assurance on regulatory responsiveness and progress, continuous learning and quality improvement.

Patient Safety

This report provides an overview of key safety trends, learning and improvement work for September 2025, using Statistical Process Control (SPC) analysis to identify variation and inform assurance. It aligns with the Patient Safety Incident Response Framework (PSIRF) and the NHS Patient Safety Strategy, focusing on openness, learning and compassionate engagement. Incident reporting decreased by 18.7% compared with August (2168 incidents including 47 anonymous). This is within normal variation but will continue to be monitored. Duty of candour compliance remains at 100%.

Implementation of PSIRF continues to strengthen the Trust's safety governance arrangements. Investigations are increasingly system focused using SEIPS methodology. Recent investigations have highlighted variation in safety huddle practice across services. A review framework is being developed to understand what works well, share good practice and support consistent learning.

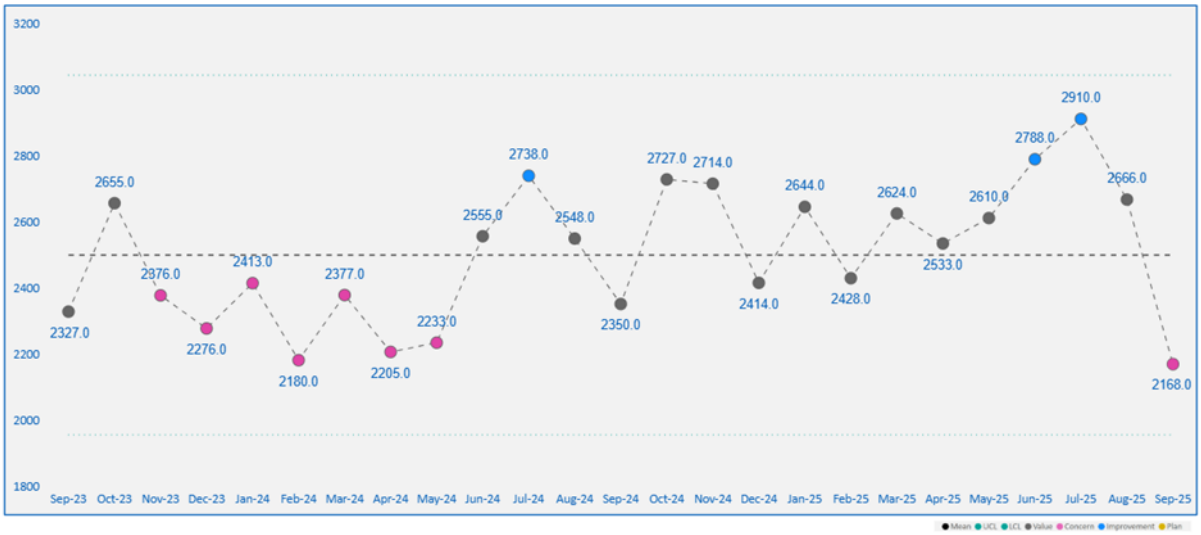
Suicide and self-harm incidents have reduced significantly (from 159 to 84). The revised safety plan form (v2) is being reviewed with Safety Partners and staff before implementation to ensure usability and consistency. Work continues on the review of the Suicide Prevention training. Work to update the missing patient risk assessment is progressing, alongside the pre-leave form.

Restrictive practice incidents continue to reduce with physical restraints decreasing to 211 (from 282). Ongoing work aims to reduce seclusion and restraint through pro-active de-escalation and staff confidence in deltoid rapid tranquilisation. A seclusion audit has been commissioned as well as a

review of bedroom seclusion through the PSIRF Horizon Scanning tool. Staff have fed back concerns about placement of patients at times in Acute Wards when a PICU may be more appropriate.

Incident Reporting and Safety Culture

Incident reporting is a key measure of safety culture and organisational openness. In September 2025, 2168 incidents were reported, including 47 anonymous submissions. This represents an 18.7% decrease from August and breaks the upward trend observed over recent months. Incidents continue to be discussed at the weekly Trust wide Huddle, significant incidents are outlined in Appendix 1.



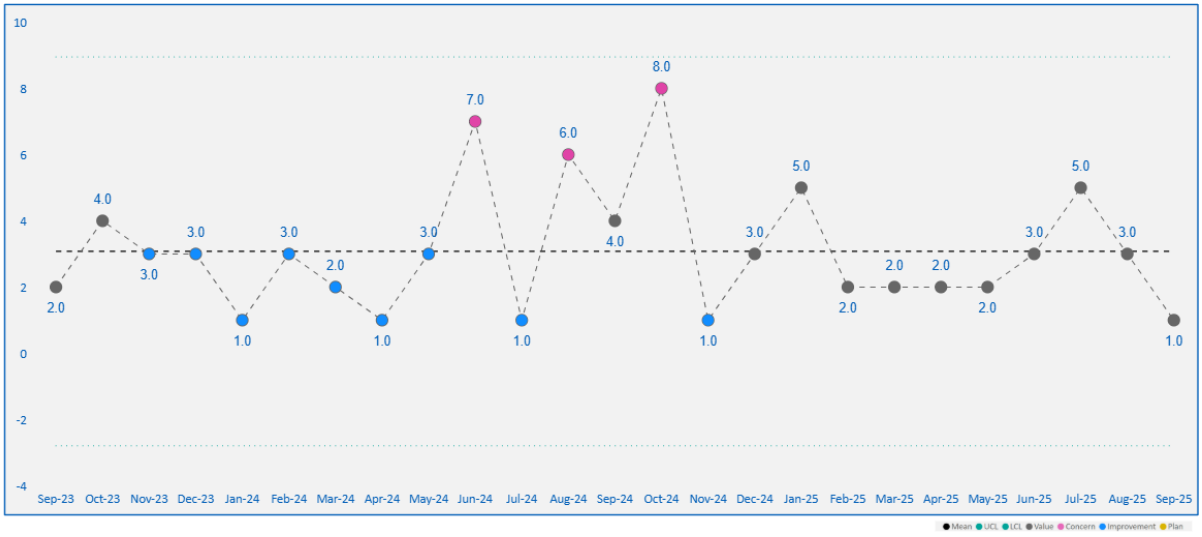
Analysis by Division shows that Specialities (411) accounted for most of the reduction, falling below its mean. Acute and Urgent Care (718) ICCR (236) and Secure and Offender Health (752) also recorded small decreases but remained within expected variation.

Duty of Candour compliance remains at 100%. Oversight has been strengthened through updated governance measures and an audit schedule to confirm compliance with compassionate engagement standards. The Chief Medical Officer and Chief Nurse recently met with the family of a patient who sadly died in the Trust and provided a personal apology to family members and a commitment to ensure their voice and the true personal presentation of the patient in the investigation process. The apology and commitment have been followed up in writing.

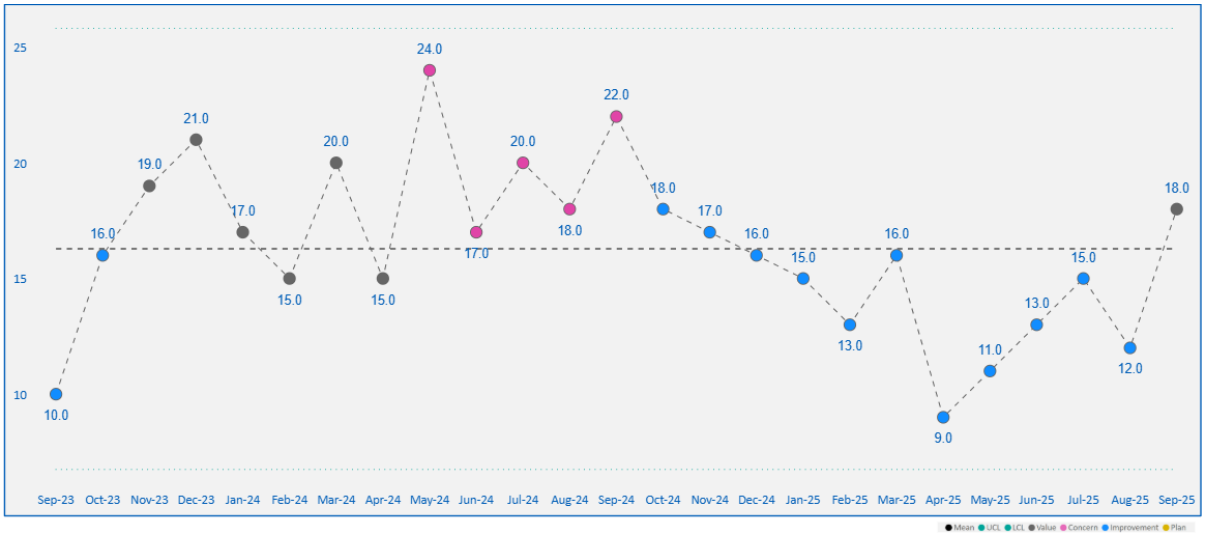
There are 2680 awaiting post incident sign off beyond the seven day standard. Oversight continues through divisional safety panels. The sign off training is being reviewed to improve consistency and accountability and to ensure learning is captured and shared. The update process embeds SEIPS principles and post incident support and will be introduced via the First Line Managers Programme and refresher training, which will be starting in acute care as part of the Culture of Care Programme.

3.1 Missing Patients

Absconsions decreased to 1 incident in September, reaching below the mean, this incident occurred on an older people's inpatient area when they were inadvertently let off the ward. This incident was reviewed locally for learning.



Failure to Return



Failure to Return increased to 18, following a decrease last month. Most incidents occurred in Acute Care (14), ICCR (3) and Secure Services (1). All incidents were reviewed with appropriate follow-up. Of these incidents, 1 patient from secure services was on overnight leave, absconding from his property and was later arrested for drug driving and assaulting 2 emergency workers, another service user was found at New Street unconscious due to taking drugs, taken to A&E following assessment by PLT he returned to ward when bed identified and medically fit. Work is in progress to update the missing patient risk assessment which is shared with the police to strengthen communication and understanding of risk, as well as the staff notifications which have to be made. Improvements are also being made within RIO so relevant data automatically pre-populates, reducing duplication for staff whilst maintaining robust assurance.

Suicide Prevention and Self Harm

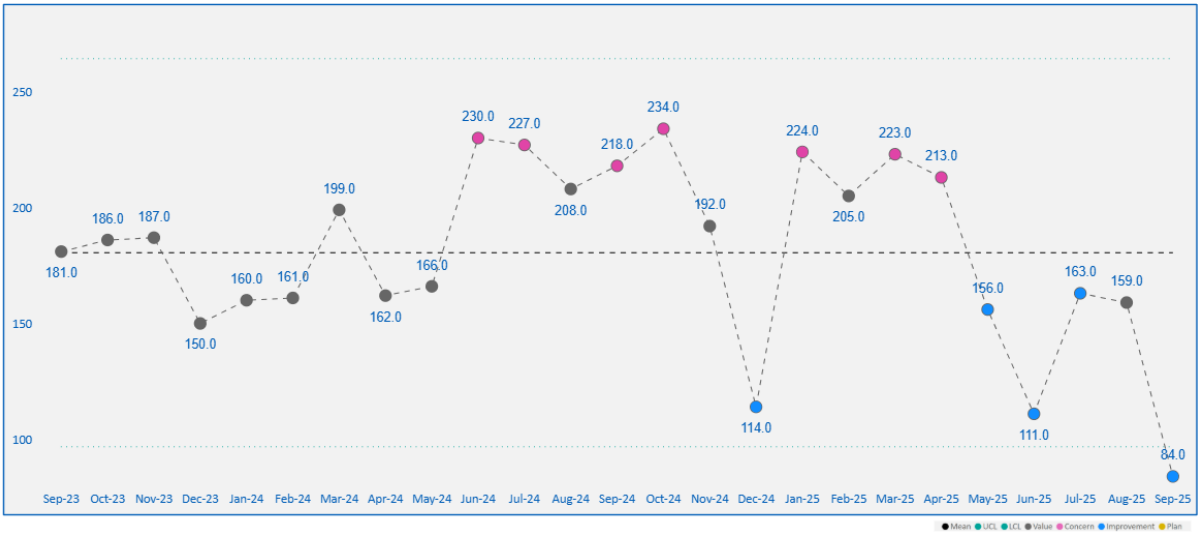
Suicide prevention and management of self-harm remain key Trust priorities. There is a recognised link between suicide and self-harm with many people who die by suicide having a history of self-harm behaviour.

In September 2025, 4 suspected suicides were reported, all in the community and currently undergoing Structured Judgment Reviews (SJRs).

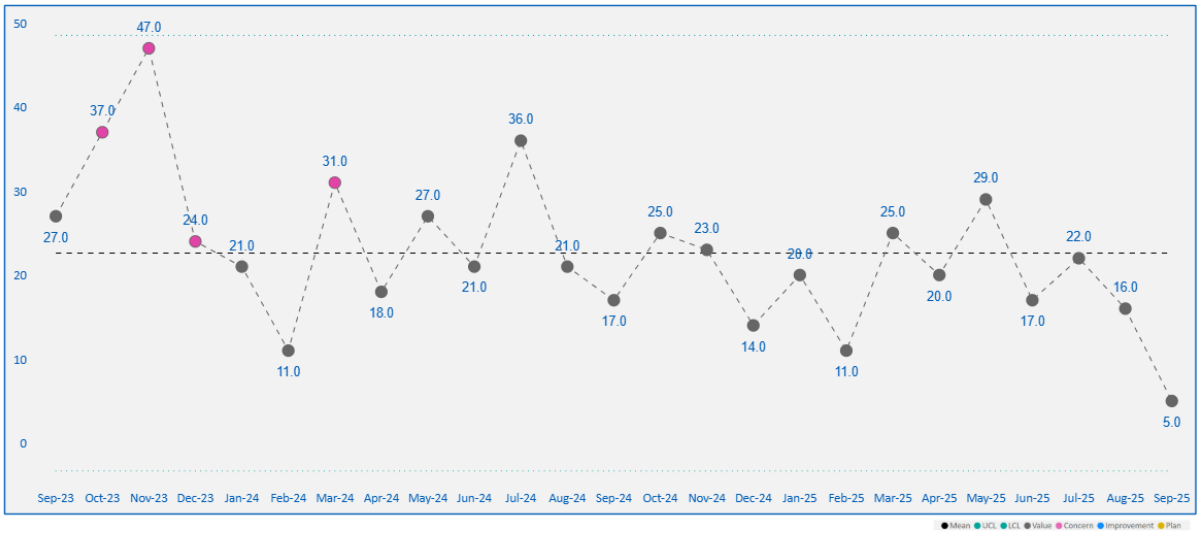
Trust-wide self-harm incidents continued to decline, falling to 84 in September from 159 in August. Ligature without anchor incidents decreased significantly to five, remaining well below the mean of 24. Ligature with anchor point incidents rose slightly to two, both within the Secure Inpatient Women's Ward.

In line with the HSSIB recommendation noting the absence of national guidance on non-anchor ligature points, the Trust continues to manage this risk through observations, environmental risk assessments and individualised safety plans. Work continues on safety plans, version 2 of the form, is being reviewed by Patient Safety Partners with staff feedback being sourced by QI facilitators in November/December to ensure usability and relevance. The Patient Safety Partners are also producing a Trust Talk feature to highlight the new Safety Plan, and filming for updated Suicide Prevention training on 1 December 2025 will feature a service user to reinforce compassionate learning. Taking from national learning identified in the NCISH annual report and our own learning from incidents, a Trust wide learning event on suicide prevention for service users being treated for bi-polar is scheduled for January 2026. The Dementia and Frailty Division will present its Suicide Prevention Plan to the Learning from Deaths Group for assurance and alignment to the Trust Suicide Prevention plan.

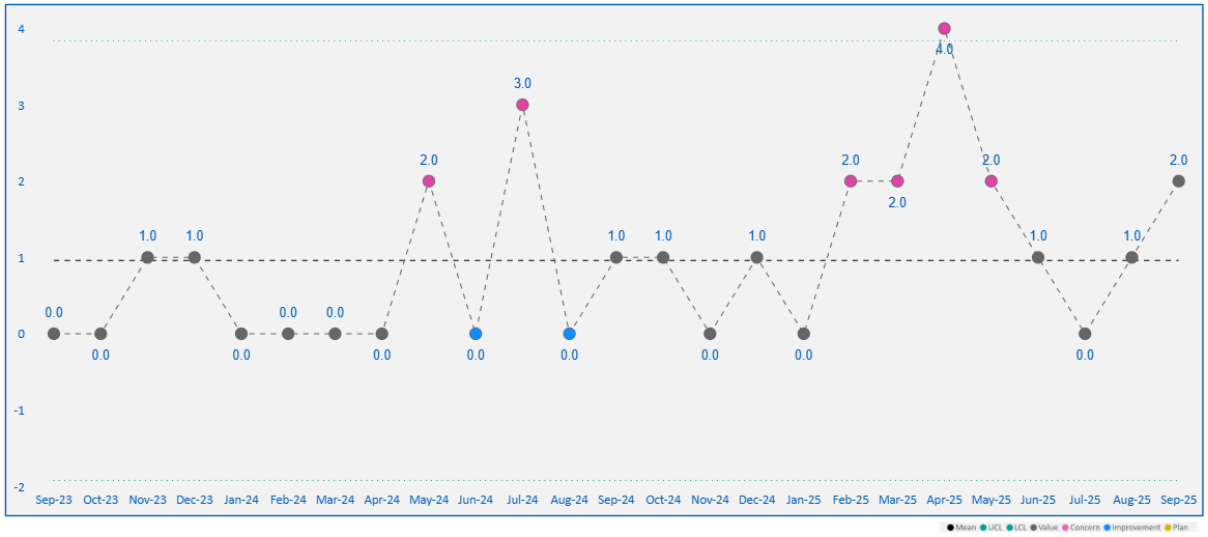
Trust Wide Self-Harm



Ligature no anchor point



Ligature with anchor point



3.3

Restrictive Practice and Restraints

The Trust continues to focus on reducing restrictive practice interventions and promoting therapeutic safe environments. Physical restraint incidents decreased to 211 in September, down from 282 in August, representing a notable overall reduction. The largest decreases were observed in Specialties (falling to 36 from 75) and Secure Services & Offender Health (down to 43 from 84). Acute Care saw a slight increase, rising to 132 from 124, while ICCR had no recorded incidents.

Prone restraints showed a small overall increase to 51 from 48 last month. This rise was primarily driven by Acute Care, where incidents increased from 25 to 41, and Specialties, which recorded 5 incidents compared to 0 in August. In contrast, Secure Services showed a marked improvement, reducing from 23 to 5, while ICCR again reported no incidents. Work to reduce restrictive practice continues through early intervention and strengthened de-escalation. To support improvement a seclusion audit has been commissioned, which has been registered on AMAT. In Acute Care this is included in the Culture of Care Programme. A bedroom seclusion review has commenced using the PSIRF Horizon Scanning tool, this is scheduled to be completed by January 2026. And an improvement plan and trajectory agreed.

Regulatory Compliance
Acute Care Inpatient Wards – Care Quality Commission Inspection June 2025

We have now received the final report for this inspection. Overall, the services were rated as Requires Improvement. The ratings for the Division improved in three areas with Safe moving from Inadequate to Requires Improvement, Effective and Responsive from RI to Good and Caring and Well led remaining at requires Improvement. The CQC acknowledged the responsiveness of the Trust, actions to strengthen leadership, positive feedback from most patients and an improvement in activities. They noted three breaches of regulation for the Trust to address: These related to staff gender mix, attitudes towards staff sleeping on duty, equal opportunities for progression, knowledge of managing heat risks with medications, consistency in care planning and risk assessment for both patients and the service. A number of these concerns were addressed at the time of inspection, and the Trust will provide a further detailed plan of actions in respect of the outstanding areas. This will be presented to and monitored through the QPES Committee and System Quality Improvement Group, and provided to the CQC by 18th December.

- Ensure the care and treatment of patients was appropriate, met their needs and reflected their preferences (Regulation 9)
- Ensure care and treatment was provided in a safe way to patients (Regulation 12)
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care (Regulation 17(1))

Between October 13th and 16th, there was a joint inspection of HMP Birmingham. The team included a total of 18 inspectors – 10 His Majesty's Inspectorate of Prisons, 5 Ofsted and 3 CQC. The initial high-level feedback for healthcare has generally been a positive one, with recognition of improvement in staffing and practices since the last inspection. The healthcare teams were praised 'as one of the best the CQC inspectors had seen in the country'. However, there was also a requirement for an action plan from the Birmingham Recovery team to demonstrate how they would improve care planning and risk assessments for prisoners. We now await the final report. The Trust received a letter of thanks for the Prison Governor for the conduct and professionalism of the staff during the inspection.

West Midlands Fire Service made a routine visit to Ardenleigh hospital on October 2nd and 13th. They shared their findings with the Trust on October 21st, which asked for actions to address key areas of fire safety related to fire compartmentation, the integrity of fire doors, fire safety training and access to call points. The Trust has been given 3 months to complete these actions, at which point the Fire Service will revisit site. These points had already been noted in the Fire Risk Assessment completed for the site in September 2025 and Estates colleagues were already in the process of obtaining quotes for these works to be completed. The fire evacuation plans for the site and any patients with individual needs have been updated to ensure safety should there be an increased risk of fire.

Recommendation

- The Board is asked to note the improvements in Regulatory Compliance and the very positive feedback received about the health services provided at HMP Birmingham
- Discuss the actions being taken in respect of learning and actions being taken to improve Patient Safety
- Endorse a deep dive into Learning from Homicides at the QPESC Sub-Committee in December 2025

Triple A Escalation and Assurance Report Area: Regulatory Compliance Report to: Trust Board Date: November 24, 2025 Author: Head of Health and Safety and Regulatory Compliance				
Subject	**Description**	**Action or Decision to be Taken**	**By Whom**	**Target Date**
Alert: Highlight matters that need attention or action, eg a new area of non-compliance or risk				
CQC Draft Report – Inspection in North Acute Care Wards and inpatient wards at Zinnia Centre – June and July 2025	We have now received the final report for this inspection. Overall, the services were rated as Requires Improvement and noted 3 breaches of regulations as listed below. Although these no longer exists, these would equate to the old style 'Must Dos' that were included in inspection reports before the introduction of the Single Assessment Framework. • Ensure the care and treatment of patients was appropriate, met their needs and reflected their preferences (Regulation 9) • Ensure care and treatment was provided in a safe way to patients (Regulation 12) • Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care (Regulation 17(1))	The final report has been shared with the Senior Leadership Team. The service's Senior Leadership team along with relevant corporate colleagues are meeting to develop and finalise the action plan. Any areas within this plan that are not already included in the overall Culture of Care improvement plan will be added and reporting on progress will be through the agreed governance framework for this workstream.	Head of Health and Safety and Regulatory Compliance and Divisional Leadership team for Acute Care	December 10, 2025
Compliance with the Regulatory Reform (Fire Safety) Order	Findings from recent Fire Risk Assessments for the Trust have indicated the need for more in-depth fire surveys to determine the standard of fire compartmentation throughout our buildings. The first of these surveys for the retained estate (managed by SSL) has indicated the need for several actions at Reaside to improve these standards.	Establish a Fire Safety Group that reports into the Trust Health and Safety Committee. This group will focus in detail on the findings of FRAs and fire surveys and make decisions on mitigations and the best approach to enable improvement.	Head of Health and Safety and Regulatory Compliance	Completed – First meeting held on November 24, 2025

		Obtain quotes and appoint contractors to commence remedial works at Reaside.	Head of Estates and Facilities (SSL)	December 31, 2025
		Create a specific risk on the Trust risk register for fire compartmentation in Trust buildings and the proposed mitigation strategy.	Head of Health and Safety and Regulatory Compliance	Completed
		Create service and site-specific risks for fire compartmentation for Secure Care	Associate Director and Clinical Director for Secure Care and Offender Health	Completed
	West Midlands Fire Service made a routine visit to Ardenleigh hospital on October 2nd and 13th. They shared their findings with the Trust on October 21st, which asked for actions to address key areas of fire safety related to fire compartmentation, the integrity of fire doors, fire safety training and access to call points. The Trust has been given 3 months to complete these actions, at which point the Fire Service will revisit site. These points had already been noted in the Fire Risk Assessment completed for the site in September 2025 and Estates colleagues were already in the process of obtaining quotes for these works to be completed.	Completion of improvement plan to address findings.	Head of Health and Safety and Regulatory Compliance	Completed
		Review of local emergency evacuation procedures	Fire Safety Advisor and Senior Leadership team	Completed
Management of Medical Devices	The Trust does not currently have an agreed resource for the management of medical devices. There is a Medical Devices policy in place and basic administrative support from SSL who act as the touchpoint for the current EBME (Avensys). However, to adequately address the gaps identified as part of the benchmarking exercise on this subject, a dedicated resource is needed to enable this.	Explore options for recruit a dedicated resource for a Medical Devices Lead. Meeting is being held between the Head of Health and Safety and Regulatory Compliance and the Director for Estates and Facilities (SSL) to consider options for the role sitting in this team.	Head of Health and Safety and Regulatory Compliance	Completed – initial meeting took place.
Management of Contractors	Recent capital projects, specifically at Reaside, have highlighted gaps in the selection and management of contractors. These gaps have included the quality and timeliness of receipt of risk assessments and method	Escalation to the Director of Estates and Facilities (SSL)	Head of Health and Safety and Regulatory Compliance	Completed

	statements, quality of workmanship and the sign-off and commissioning of those projects. Such gaps could have resulted in both staff and service user injury and have also caused negative impact on service user experience due to the need for pausing jobs to ensure safety standards are being met.	Risk Register entry on the management of contractors.	Health and Safety Advisor	Completed
		Exploration of an electronic system for the management of contractors.	Fire Safety Officer and Health and Safety Advisor	January 31, 2026

Advise: Highlight areas subject to ongoing monitoring, development or where assurance is or is becoming uncertain

Subject	Description	Action or Decision to be Taken	By Whom	Target Date
CQC State of Care Report	The CQC's annual State of Care report was published on October 24, 2025. Key findings as summarised by Mind are: • Community services need significant investment in order to help realise the vision of the 10-year plan. • There has been an increase of 15% in monthly referrals for mental health services since 2022/23. • Longer waits are linked to worsening mental health. Although an improvement on the 2023 survey findings, more than two fifths of respondents said they felt their mental health got worse while waiting for care. • There is a lack of holistic care that properly addresses both physical and mental health due to system pressures. Services often focus on medical treatment rather than addressing social, emotional and physical needs. • Systemic recruitment and retention issues remain, which are creating significant challenges around staff experience and skills. Staff reported feeling burned out and overworked. • Over a third of respondents to the community mental health survey said they were not given a choice about how their care and treatment would be delivered, and over 1 in 4 (28%) said they did not feel in control of their care.			

	• There remain longstanding health inequalities faced by Black people. The CQC commissioned Queen Mary University and University College London to carry out a rapid review of what 'good' looks like in relation to care for Black men. Black people are 3 to 5 times more likely to be diagnosed and admitted to hospital with schizophrenia compared with all other ethnic groups. • Several mental health inpatient providers have raised concerns that ageing estates are increasingly unfit for purpose and do not meet the needs, or even safety requirements, of patients and staff.			
Joint Inspection of HMP Birmingham	Between October 13th and 16th, there was a joint inspection of HMP Birmingham. The team included a total of 18 inspectors – 10 His Majesty's Inspectorate of Prisons, 5 Ofsted and 3 CQC. The initial high-level feedback for healthcare has generally been a positive one, with recognition of improvement in staffing and practices since the last inspection. The healthcare teams were praised 'as one of the best the CQC inspectors had seen in the country'. However, there was also a requirement for an action plan from the Birmingham Recovery team to demonstrate how they would improve care planning and risk assessments for prisoners. We now await the draft report.			
Well-led Preparation	We continue to prepare for the anticipated CQC well-led inspection. We have now completed the Deck of Cards and awaiting publication. We have also scheduled workshops with each service area on November 6th, 7th and 13th to better understand their position and to provide any required support for the preparation.	Workshops delivered to all 5 service areas and corporate services.	Executive Director for Quality and Safety and Head of Health and Safety and Regulatory Compliance	Completed
CQC Enquiries	During October, we received a total of 11 complaints/ queries from the CQC. Of these 8 were for Acute Care across 3 sites, 2 for Secure Care and 1 for Specialties.	Responses shared with the CQC.		

	The theme was patient care and treatment with 2 follow up for further information.			
Assure: Highlight where assurance has been received				
Subject	**Description**	**Action or Decision to be Taken**	**By Whom**	**Target Date**
CQC Draft Report – Inspection in North Acute Care Wards and inpatient wards at Zinnia Centre – June and July 2025	The final report for this CQC inspection has shown improvement in three domains since the last inspection as indicated in the table below. Both Effective and Responsive have changed from Requires Improvement to Good and Safe has been changed from Inadequate to Requires Improvement.			
Completion of environmental and ligature risk assessments	As per the requirements of the Trust Health and Safety Management and Ligature Risk Reduction policies, these risk assessments must be reviewed at least annually.	Schedule and complete outstanding risk assessments.	Health and Safety Advisor/ Officer	November 30, 2025

Domain	**North Wards & Zinnia June 2025 Inspection**	**Zinnia October 2024 Inspection**
Overall Rating	Requires Improvement	Requires Improvement
Safe	Requires Improvement	Inadequate
Effective	Good	Requires Improvement
Caring	Requires Improvement	Requires Improvement
Responsive	Good	Requires Improvement
Well-led	Requires Improvement	Requires Improvement

	Current compliance is 96% and those that need to be completed are scheduled.			
Celebrate: Highlight good practice, developments or innovations				
Subject	**Description**	**Action or Decision to be Taken**	**By Whom**	**Target Date**
Section 29A Warning Notices – Zinnia inpatient wards	The final CQC report for the Acute Care inspection in June 2025 confirms that the CQC has received adequate evidence to provide assurance that these Section 29As that were in place at the Zinnia Centre have been removed. With this removal, the Trust will have no regulatory warning notices in place.			

Report to Board of Directors						
Agenda item:	**13**					
Date	3 December 2025					
Title	Safer Staffing Report					
Author/Presenter	Katie Atcherley – Lead Nurse for Safer Staffing					
Executive Director	Lisa Stalley Green – Chief Nurse/Executive Director of Quality and Safety	**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**	✓

Executive Summary – Safer Staffing

During the last six months a number of priority workstreams have combined to continued to evidence improvement in Safer Staffing at the Trust.

Right People

Successful international and local recruitment and retention schemes have continued to reduce registered and non-registered workforce vacancies. RMN vacancies are at % and unregistered staff at %

98.9% of our IENS have remained with the Trust.

There is a just in time pipeline of local undergraduates for whom we are offering guaranteed employment with NHS Trusts for those who opt to join.

Shift fill remains over plan. Gaps remain at senior staff nurse level in Community and Home Treatment. Plan, so we are rolling out our progression programme.

Gaps in rotas and establishments are being addressed by divisional leadership teams with risk areas improving the Bronze, Silver, Gold Framework. These include:

- Solihull and South Home Treatment Team
- Specialised inpatient settings
- Ardenleigh Hospital

- Larimar Ward

Right Skills

Access to Intermediate Life Support and Enhanced Life Support training has been a challenge for the Trust this year, creating gaps in compliance. Additional places are being offered and uptake has been monitored through Safe Staffing Committee.

Clinical Supervision, Fundamental Training have achieved improved compliance in all areas apart from Acute wards where improvement is being led through the Culture of Care Programme.

The Trust Programme of support for post-graduation preceptorship has won a national award this year and participant nurses have reported increased confidence in practice.

Learning from incidents and issues in practice has led to the development of further training and skills for:

- Staff and Matrons
- Enhanced Therapeutic Observations of Care
- Dialog and risk assessment + safety planning
- E-roster rules and completion
- Door alarm checks
- Matrons development days

Right Place

A programme of training has been completed for ward and team level managers setting rotas and more senior leaders in approvals. Additional rota rules have been implemented to bring in greater controls and assurance for the deployment of staff to meet the needs of patients.

Compliance remains variable for sign off with 42 days of rota staff and percentage of changes following sign off.

Monitoring now forms part of the Quality and People oversight elements of the Trust Performance Management approach. In addition, temporary staffing allocations will not be made where rotas are non-compliant.

A review has been completed of the Trust Temporary Staffing Solutions provision. The number of staff retained has been reduced following removal of colleagues who have not worked shifts and are non-compliant with fundamental and mandatory training.

The Bank Gold Group has delivered on reductions in temporary staffing use in line with a plan agreed.

For this financial year, four further actions are planned for Quarter 4 to achieve the required reductions for the period. These include:

- Implementation of the Acute Ward MHOST review
- Establishment of escorts substantive team for secure & offender health
- Removing funded additional care allocations for secure & offender health workers from the Bank line
- Implementing capped allowances of aligned Bank staff to Divisions.

There are more substantive staff in the Trust. Clearer controls and monitoring is in place. Training and development will be the priority going into 2026/27.

Recommendation

The Board is asked to receive the report for assurance.

Enclosures

Safer Staffing Board Report

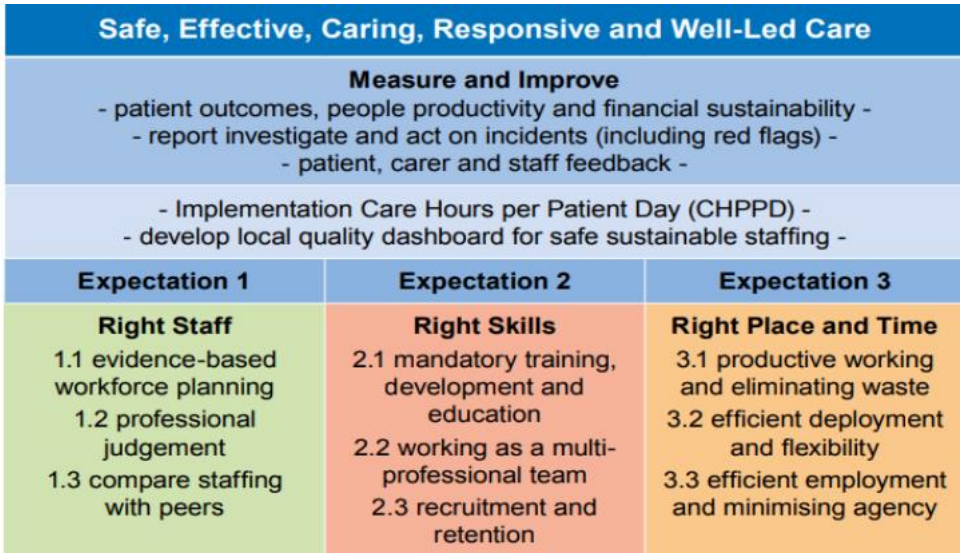
1. Introduction

1.1 The purpose of the paper is to provide the assurance to the Trust Board of current position of safer staffing.

1.2 BSMHFT is committed to work to meet the requirements set out in the National Quality Board (NQB): Developing Workforce Safeguards (DWS). This governs us to provide high quality care to our service users through safe and effective staffing.

1.3 The NQB guidance requests that we ensure that there are staff working in our clinical areas are providing safe and effective care to all our service users.

The report structure aligns the NQB (2016) Guidance.



Right Staff

2. Staffing

2.1 Our deployment of the workforce considers effective management of rostering in clinical areas where applicable. We have an escalation process in local areas and at Trust level of our staffing levels.

2.2 It is a requirement that all NHS provider trusts publish nursing staffing data every month. This is for all funded units that operate 24 hours per day, 7 days of the week and include overnight stays for patients.

2.3 The data includes planned staffing hours, this is planned in our rosters, against the actual staffing, this is actual hours worked by substantive and bank staff). Additionally, to this we also report on care hours per patient per day (CHPPD) metric. This information is published on the BSMHFT website.

2.4 Variance in fill rates is discussed at divisional level to have a greater understanding of variation. It is highlighted that our fill rates are often impacted by;

(a) Clinical Acuity in our inpatient wards
(b) Vacancies
(c) Sickness both short term and long term
(d) Maternity/Adoption/Parenting Leave
(e) Other Leave unpaid/paid.

2.5 The trust embraces a multi professional workforce, our Allied Health Professionals (AHP's), psychological professionals and medical workforce are additional to the funded establishment.

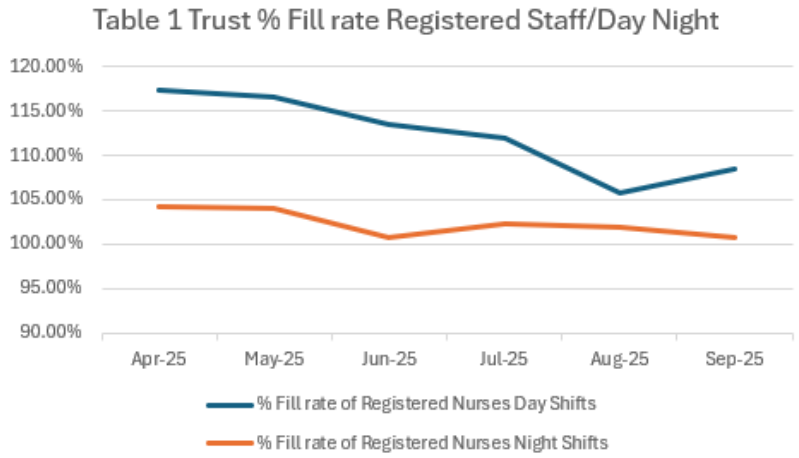
2.6 Table 1 and Table 2 show us the actual staffing levels that we achieved across our 49 inpatient wards between April 2025 and September 2025.

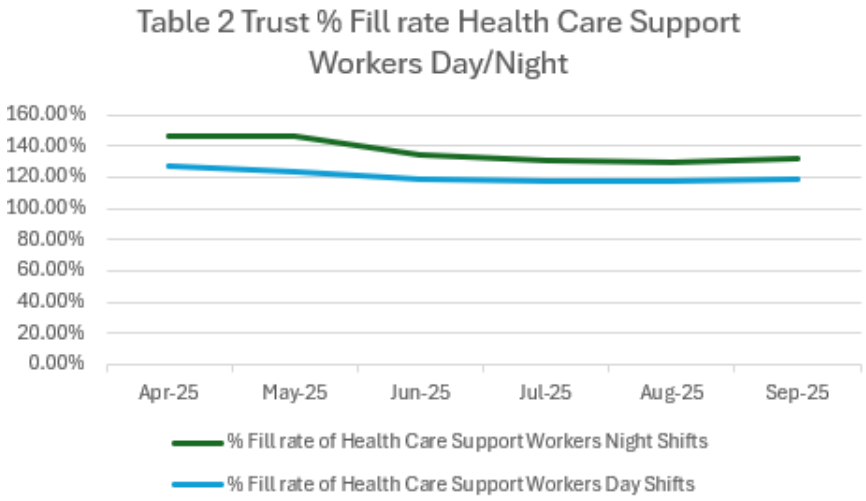
2.7 Table 1 shows us that we have been able to consistently work towards having adequate registered nurses on the inpatient wards. Where there has been spikes in the registered nurses this is where we were over recruited with our registered nurse workforce.

2.8 Table 2 shows we have had a consistent percentage fill rate for our healthcare support workers (HCSW).

2.9 The current shift pattern for our nursing workforce is.
(a) Day shift – 07:00 – 14:00 or 13:00 – 20:00 or 07:00 – 20:00
(b) Night shift – 19:30 – 07:30.

2.10 The data will not show us the gaps in planned workforce for that day and how this is mitigated with either redeployment from other clinical areas or other professionals who are supporting on the wards.





3. Current Position

3.1 We currently capture our vacancy position through Electronic Service Records (ESR). Each of wards/teams will have a funded establishment of registrants and health care support workers.

3.2 Staff who are identified withing the funded establishment is calculated by our finance teams as one whole time equivalent (wte), this is a contracted member of staff who will work 37.5 hours per week. We are committed to support our workforce and will have staff who are 0.6 wte and will be contracted to work 22.5 hours a week.

3.3 The Trust process currently is to review establishments, TSS deployment and workforce data through our monthly Safer Staffing Committee (SSC). This is chaired by our Chief Nurse/ Executive Director of Quality and Safety monthly.

3.4 Table 3 shows our current registered nurse vacancy position across the Trust. Our predominant nurse vacancies are the Band 6 (B6) role. To mitigate any gaps, we use

TSS to provide consistency in care to our service users, this is often done on a block booking.

3.5 We are supportive of Band 5 (B5) to B6 development pathway to support our junior colleagues develop the right skills for a senior nurse role.

3.6 Where there are B5 vacancies we have a healthy pipeline of newly qualified nurses to go straight into those posts following being successful at interview. We currently have 31 nurses awaiting offers to one of our clinical areas.

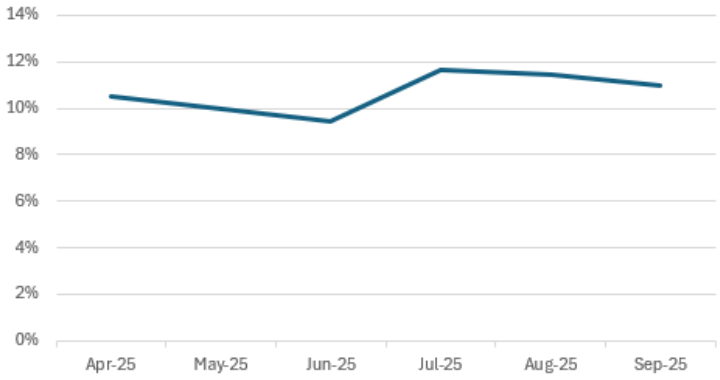
3.7 We are interviewing 50 student nurses who are due to qualify in January 2026.

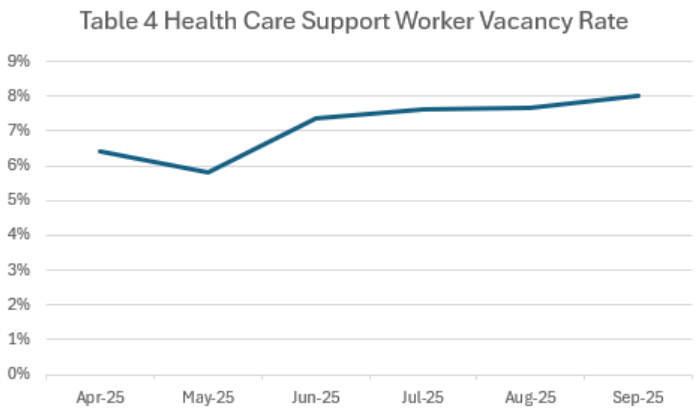
3.8 To increase our graduate pipeline we will need to do the following.
- No band 5 roles are advertised externally unless approved at senior level
- All band 6 roles are advertised internally only in first instance to try and encourage band 5 to 6 movement
- Review of band 6 roles and skill mix for band 5 roles
- Getting managers to consider band 5 to 6 development roles
- Offering preceptorship to NQNs who join TSS as band 5s

3.9 Table 4 shows our current HCSW position across the organisation. We have seen an increase in HCSW vacancies in September 2025.

3.10 We have a process in place to support our TSS workforce in transferring to a substantive post. This mitigates further risk of HCSW vacancies.

Table 3 - Registered Nurse Vacancy Rate





4. Temporary Staffing Solutions

4.1 There are times due to the clinical demand and other factors i.e. sickness/ vacancies where are dependent on our Trust Temporary Staffing Solutions (TSS) service to fill the shift. Our substantive workforce can work this shift in addition to contracted hours or a TSS member of staff will pick this shift up.

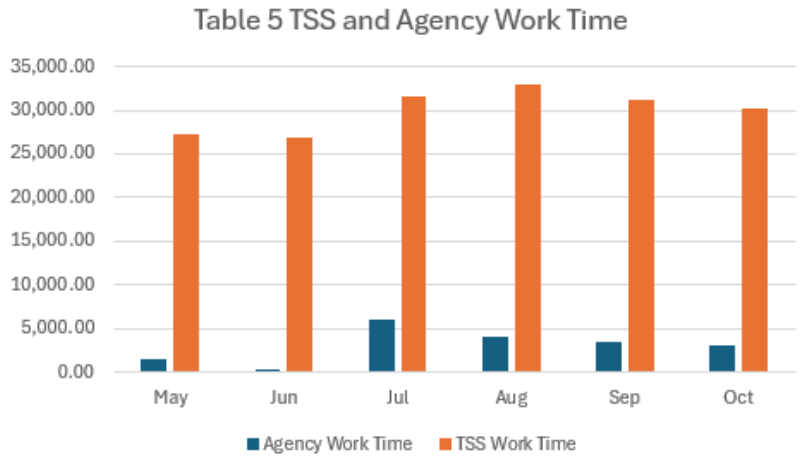
4.2 There have been exceptional circumstances where agency staff have been used, however this has been at senior level for specialist roles.

4.3 Table 5 shows the number of hours the trust has required TSS or Agency staff to fulfil a role in the clinical areas.

4.4 We saw an increase in agency spend when the Children's and Young People (CYP) Division of Nursing joined us in July 2025. We are supporting them with the reduction in the agency spend.

4.5 We saw a reduction in bank spend at our Low Secure Child and Adolescent Ward closed in September 2025. Staff have been redeployed across the Ardenleigh wards.

4.6 The Trust is committed to reducing both TSS and agency spend.



Right Skills

5. Skilled Workforce

5.1. It is outlined in the NQB that we need to ensure capability within our workforce, and they have the right skills and knowledge to be able to deliver safe and effective care.

4.2 It is set out in the NHS Longterm Workforce Plan (LTWP) (2023) to set clear goals for our workforce to be able train, retain and reform the NHS workforce.

5.3 The Trust supports the Student Nurse Associate (SNA) programme to continue to develop our current and future workforce.

5.4 Once registered as Nursing Associate (RNA) we continue to support individuals to top up onto the Nurse degree programme, this supports with our long-term plans to develop our own workforce.

6. Training Requirements

6.1 We have statutory and mandatory training requirements for our workforce.

6.2 The Trust position for those who are currently in a substantive position is at 94% compliancy. This is above our 90% target.

6.3 There is a variance in compliance Immediate Life Support (ILS) and Emergency Life Support (ELS) across all clinical areas. We mitigate this be requesting for bespoke sessions to be planned for our areas of our highest concern and managers are requested to plan this annually and have training

booked to support us in establishing our current position. We will continue to review and escalate this monthly.

6.4 The Trust position for those who are in TSS only position is 89%. This is currently below our 90% target.

6.5 Statutory and Mandatory training for those who are in substantive posts is discussed in Regular Management Supervision (RMS) every 4 – 6 weeks.

6.6 Statutory and Mandatory training for those in a TSS only position is reviewed by the TSS team and emails are sent to the individual recommending training must be completed within a period that is set out. TSS staff are informed that they could be restricted from working until training is seen.

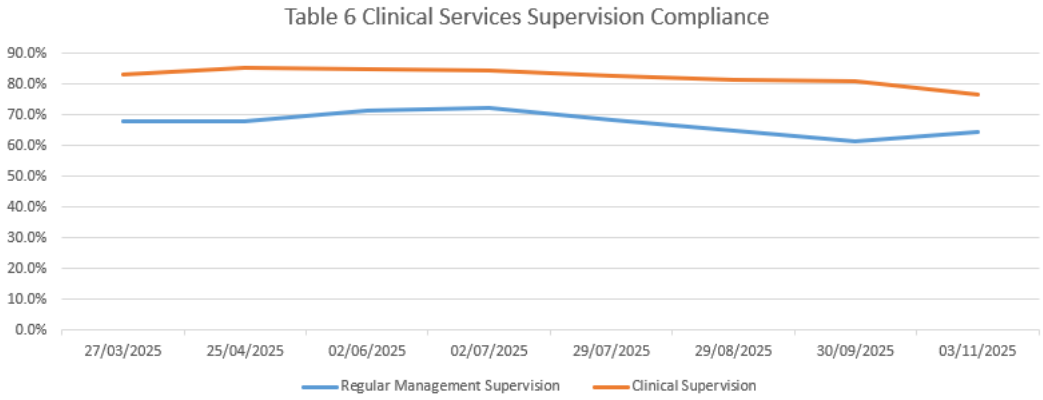
6.7 Following the initial piece of work completed around TSS compliancy, there are four hundred and six TSS workers who will be removed from our TSS. They have not worked a shift for more than three months and have not contacted the team to advise why training has not been completed.

7. Regular Management and Clinical Supervision.

7.1. The Trust endorses that all staff should have RMS every 4 – 6 weeks. This is an opportunity for staff to discuss development opportunities and current work.

7.2 The Trust endorses that all substantive registered professionals should have clinical supervision every 6 weeks. This is checked and staff should be able to access clinical supervision.

7.3 Table 6 shows our levels of supervision compliancy across clinical services.



8. Nursing Education

8.1 The Professional Education Teams clinical education programme is continuously evolving and aims to support safer staffing across inpatient and community mental health services. The programme is shaped by feedback from regulators, reviews of patient safety incidents and complaints, and aims to ensure staff are equipped with the right skills, confidence, and support to deliver safe, personalised, and recovery-focused care.

8.2 Multi-Professional Preceptorship Programme

A mandatory 12-month preceptorship is provided for all newly registered nurses joining BSMHFT. The programme has recently been reviewed and enhanced in collaboration with HoN/AHPs, and now includes:

- Expanded content on the Mental Health Act
- Robust transition to clinical education sessions aiming to build confidence in Preparing for and managing a clinical shift, Named Nurse responsibilities and documentation, Communication, Handovers, and challenging conversations
- IM injections and medication safety
- Strengthened Practice Assessor and Supervisor training
- Tailored AHP led sessions

A gap in pharmacy education was found, and a strengthened offer is being developed by Chief Pharmacist, with divisional pharmacy leads co-designing bespoke training packages.

8.4 Clinical Educator Core Programme – Registered Nurses
Fundamentals of Care

This programme consists of four modules designed to enhance clinical safety and care quality and was specifically developed in response to recent and past regulatory feedback and patient safety concerns.:

- Safety in Practice – Skills for keeping therapeutic environments and managing patient safety
- Planning Personalised Care – Collaborative care planning, therapeutic engagement, and documentation using Rio
- Inclusive Assessment – Legal, ethical, and trauma-informed approaches to assessment, linking findings to care planning and decision-making
- Transferring Care – Safe discharge planning aligned with national guidance, addressing barriers and social determinants of health
- Guided Reflection on Practice- Workshops to support staff with NMC revalidation and encourage reflection on professional standards
- Essential Nursing Skills- Injection technique refresher, Safe medication practices, Proactive observations and Effective handover and information sharing

Clinical educators are actively engaging with Heads of Nursing and Allied Health Professionals (HoN/AHPs, and Matrons to review and refine the content of the Fundamentals of Care programme. The review aims to ensure relevance across directorates. Uptake and impact will be checked via Matrons' reports to Clinical Governance Committees.

8.5 Clinical Educator Core Programme – Healthcare Assistants (HCAs)
Two part-time Band 7 clinical leads have been appointed to develop a tailored education programme for HCAs. Following a scoping exercise and thematic review, a core training package will be designed for Trust-wide delivery, with rollout expected by December January 2026.

8.6 Continuing Professional Development (CPD)
HoN/AHPs continue to access CPD opportunities to support service development. Individual nurses and AHPs also engage in CPD for personal and professional growth, contributing to enhanced clinical capability across the Trust.

Right Place

9. Rostering

9.1 The Trust currently uses ALLOCATE software to manage staff rostering. This is in practise across inpatient wards and limited community teams. We are committed to have rostering across the organisation for all areas.

9.2 The Trust also uses SAFECARE to check daily staffing levels, there is an expectation that this tool is used daily to check staffing and acuity and predict the next 48 hours should there be any deficits.

9.3 The corporate service team circulates a dashboard to service areas to check compliance.

9.4 Our Key Performance Indicators are.

Dashboard KPI (Key Performance Indicators). Broken down into Locality and Area:

(a) Roster 42 Day Approval: Are you approving your rota on time – 6 weeks in advance.

(b) Time Worked: % breakdown of time worked against staff.

(c) Unfilled Roster: Unfilled demand being left vacant, this includes added duties, unused shifts etc.

(d) Changes Since Approval: % of changes since the rota has been fully approved.

(e) Total Unavailability: % of total leave (A/L, sickness, study leave etc).

9.5 Table 6 shows are current compliancy with rostering, as a Trust we are committed to improve our compliancy to ensure that we have rosters ahead of schedule with staff who are in right place at the right time with the right skills.

9.6 Factors around compliancy are often cited as clinical demand, supporting staff to swap shifts and any unforeseen circumstances such as sickness and other leave (i.e. special leave).

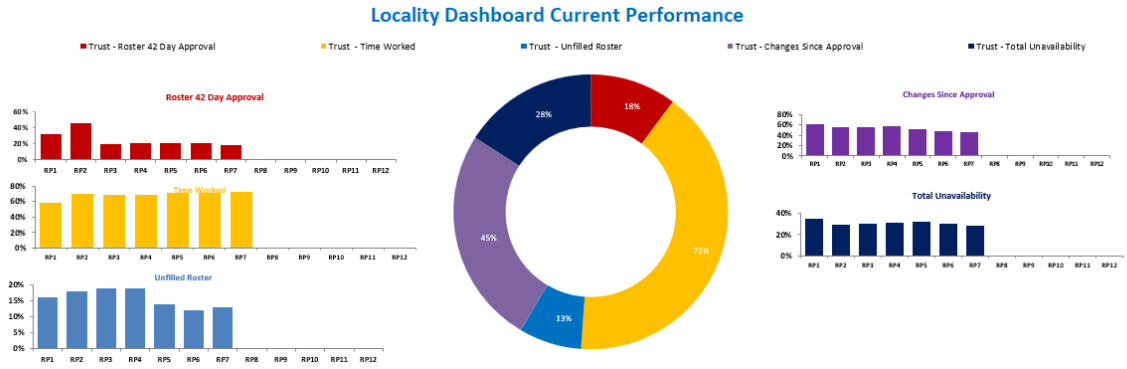
9.7 Extensive training including face to face and e – learning has been provided to those who require access to the rosters. Access is no longer provided to new staff until completion of e – learning and certificate has been seen.

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Metrics by Locality

Select Locality >>
- Acute & Urgent Care Service Locality
- ICCR Locality
- PCDS Locality
- Secure Care and Offender Health Locality
- Trust

KPI Measure – Roster Period	Roster Period 1 7th April	Roster Period 2 5th May	Roster Period 3 2nd Jun	Roster Period 4 30th Jun	Roster Period 5 28th Jul	Roster Period 6 25th Aug	Roster Period 7 22nd Sep	Roster Period 8	Roster Period 9	Roster Period 10	Roster Period 11	Roster Period 12
Trust - Roster 42 Day Approval	32%	45%	19%	21%	21%	20%	18%					
Trust - Time Worked	58%	70%	69%	68%	71%	71%	72%					
Trust - Unfilled Roster	16%	18%	19%	19%	14%	12%	13%					
Trust - Changes Since Approval	61%	56%	55%	57%	51%	47%	45%					
Trust - Total Unavailability	35%	29%	30%	31%	32%	30%	28%					



Professional Standards and Fitness to Practise.

10. We have a supportive process in place to support those who may be open to the Nursing and Midwifery Council (NMC).

10.1 We work with NMC to ensure our staff are supported and send required information when necessary

10.2 Table 7 shows our current position as Trust with the NMC.

10.3 We do have cases who are still awaiting casework within the NMC, in these circumstances we have completed what is required from a trust perspective.

10.4 As a Trust we have made 3 of these of referrals

10.5 The remaining referrals are anonymous or from a previous employer.

Table 7

Cases	Screening Stage	Awaiting Case Manager	Investigation Stage	Final Stage
15	7	3	3	2

Future Planning for BSMHFT

11. Advanced Practise for our Nursing Workforce

11.1 Governance

11.1.1 The organisation has now established a comprehensive advanced practice training framework, designed to underpin the training, education, and operational development of advanced clinical practice roles.

11.1.2 This framework provides clear guidance regarding the expected standards of practice for advanced clinical practitioners, ensuring alignment with national benchmarks. Ongoing refinements are being made to standardise both qualified and trainee job descriptions, person specifications and training contracts, thereby addressing role variability and ensuring that practitioners operate across all pillars of advanced practice.

11.1.3 This framework will also link in with the organisational development team to triangulate advanced practice development with training, coaching, mentoring, talent management and succession planning frameworks.

11.1.4 These measures are expected to enhance the overall quality and consistency of the workforce, leading to improved standards of patient care and more effective service delivery. The next step in this process will be the development of an advanced practice policy, which will further support these aims.

11.1.5 A formal ICS Advanced Practice strategy will be established through the newly formed community of practice for advanced practice, which has been developed and will be chaired by the BSMHFT Professional Lead for Advanced Practice. This initiative will provide input into our local HEI's, the education collaborative and the professional faculties.

11.2 Workforce

11.2.1 Monthly updates are now received from the People Team regarding the advanced practice workforce, utilising ESR data to capture all roles with 'advanced' in the job title.

11.2.2 There are 65 employees occupying these positions, equating to 57.8 WTE, with a range of role titles distributed across all divisions and reflecting varying WTE allocations.

11.2.3 Comprehensive data cleansing exercise is currently underway to ensure the accuracy and integrity of the ESR data.

11.2.4 Using a systematic approach to workforce data management will enhance the quality and reliability of the workforce, enabling more effective workforce planning and deployment.

11.2.4 Accurate identification and standardisation of advanced practice roles will support the delivery of high-quality patient care, facilitate benchmarking against national standards, and underpin ongoing professional development and governance.

11.3 Leadership

11.3.1 The organisation is recognised as an early adopter site, collaborating with the Nursing and Midwifery Council (NMC) on the development of regulatory frameworks surrounding advanced practice.

11.3.2 This work is being supported through our governance structures, with the recently published principles now being integrated into our developing advanced practice governance processes.

11.3.3 Additionally, a quality improvement (QI) project will be initiated within the Home Treatment Teams to evaluate the impact of introducing advanced practice roles on urgent and acute care pathways and service user care.

12. Celebrating our Achievements

12.1 The trust successfully adopted the values-based interview programme to support with our future nursing workforce.

12.2 The Trust's Multi-Professional Preceptorship Programme has been shortlisted for the Nursing Times Awards – Preceptorship of the Year. This national recognition highlights the programme's impact on retention, confidence-building, and smooth transition into practice, directly supporting safer staffing and workforce sustainability.

12.3 The Trust is advancing workforce development in the field of advanced practice, with this initiative increasingly becoming an integral part of strategic discussions, encouraging teams to explore innovative roles beyond traditional models. The Professional Lead for Advanced Practice, in collaboration with another Advanced Clinical Practitioner (ACP), has submitted an abstract to the International Council of Nurses/Advanced Practice Conference, focusing on the training framework and the quality improvement (QI) project. Should this submission be accepted, it will provide an opportunity to present our work to an international audience, thereby enhancing the visibility and reputation of BSMHFT on a global stage. Furthermore, the organisation is engaged in a twinning project with Vanderbilt University in Nashville, United States, aimed at examining and comparing advanced practice approaches within psychiatric care across both countries. This collaboration presentation is scheduled for January 2026.

12.4 In March 2025 we celebrated International Nurses Recruitment Project. We appointed to 140 International Nurses bringing a combined 400 years' worth of experience with them.

12.5 September 2025 saw the introduction of monthly Matron development days

Report to Board of Directors							
Agenda item:	**14**						
Date	3 December 2025						
Title	BSMHFT Assertive and Intensive Action Plan						
Author/Presenter	Renu Bhopal Padhiar, Associate Director – ICCR Liz Thurling, Head of Nursing & Allied Healthcare Professions/Clinical Director - ICCR						
Executive Director	Lisa Stalley-Green, Executive Director of Quality and Safety (Chief Nurse) Fabida Aria, Executive Medical Director	**Approved**	**Y**	**x**	**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

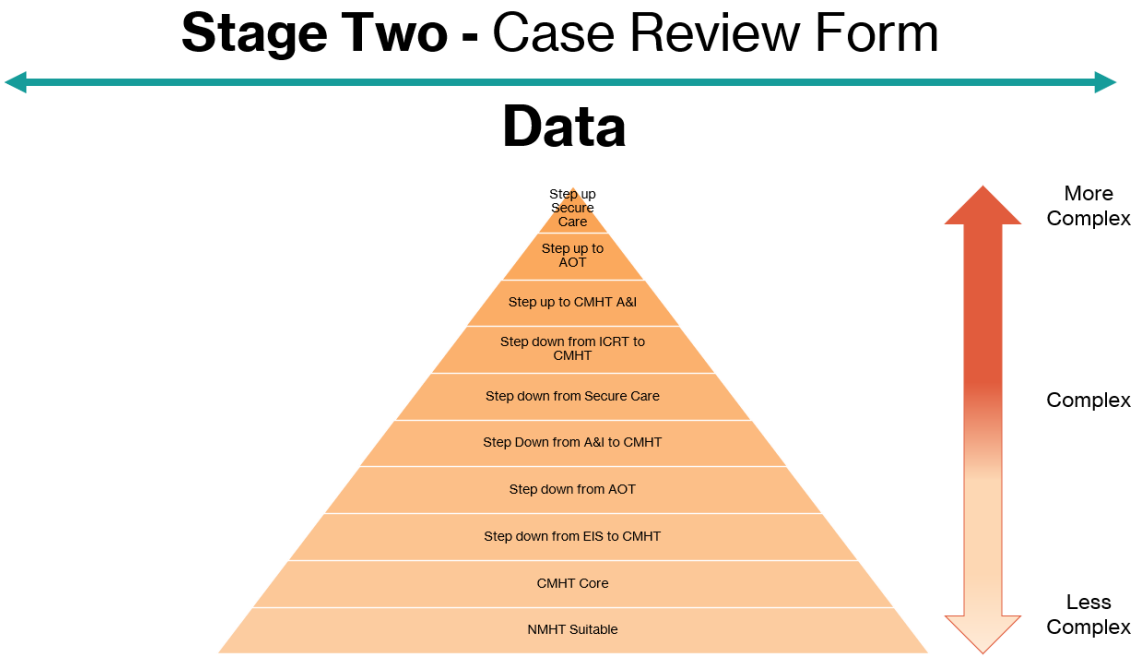
The MH Assertive Intensive Review Action Plan 2025 is a comprehensive and detailed document. outlining a multi-agency, system wide approach to improving mental health services for individuals with complex needs and aims to:

- 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

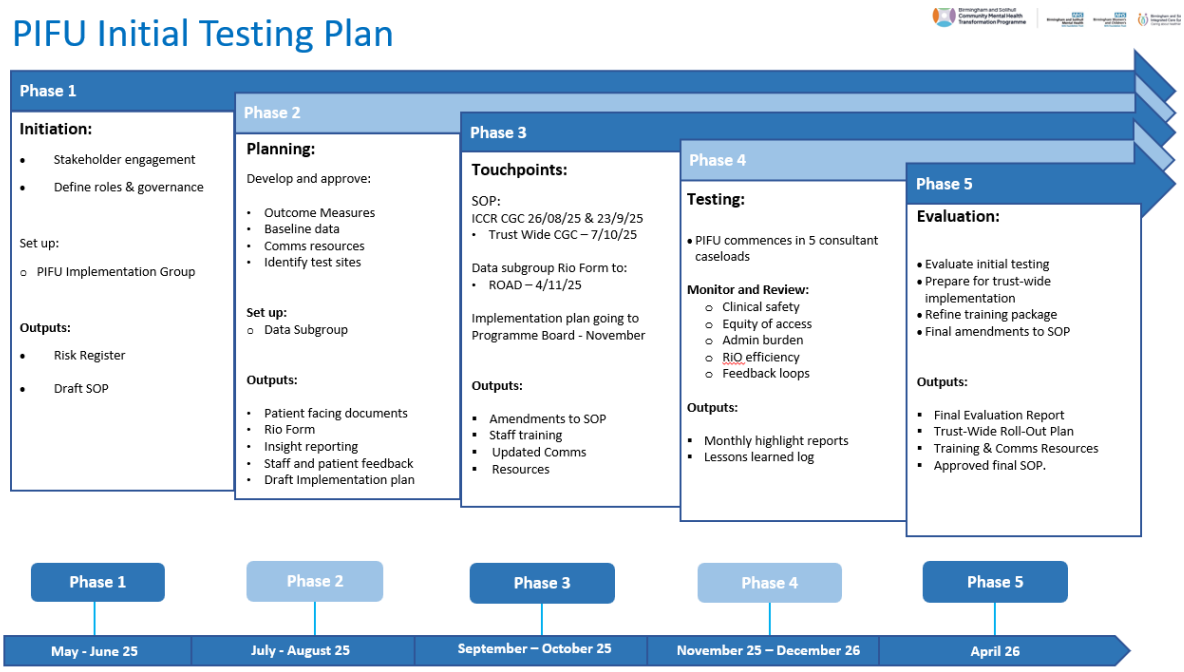
This report provides an update on the Assertive and Intensive Action plan actions and a Progress Summary for August - September 2025:

Summary of Action Updates Following 2nd October Touch Point:

- **Data & Caseload Validation**
  - 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. Further work around the Case Review Form to be completed to support the November reporting cycle following feedback received from reviewers.
  - Feedback from medic colleagues has now been received and this is being incorporated into the complexity metrics.
  - Diagnostic data monitoring continues through monthly FPP cycles, with immediate escalation of identified gaps. This is a longer piece of work which has been feedback into the trust's performance assurance panel for additional support.
  - 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 15th 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.



- PIFU SOP has been completed and presented through governance committees and is due to be taken to ROAD in November 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. Second post has been recruited to and awaiting a start date in December.
  - Link worker 1 will support AUEC alerts from Locality Hubs to consider pathways of service users coming through the system.
  - Red Flag Process for calls from Family/Carers and Support Roles has been rolled out across CMHTS and in the process of being reviewed.
  - Piloting of a "frequent duty callers tracker" in East CMHT to log and review repeat contacts, In the process of being reviewed**.**

- **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 15th October.

- **Medication Monitoring**
  - Discussions are ongoing about using non-collection of medication as a flag for follow-up, with options being scoped.

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- ICB colleagues are supporting discussions with ICB GP leads. Liz Thurling is working with Matthew Heggarty and Angel Baker as to the system wide approach to shared care.

- **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. Sunny Kalsy-Lillico supporting.
  - Bipolar and Psychosis Training roll out has commence across the North and West CMHT teams with a focus on Carer voice and involvement.

Recommendation

The Board is asked to review the report and confirm assurance.

Enclosures

A& I action plan v21

Report – Trust Board							
Agenda item:							
Date	3 December 2025						
Title	BSMHFT Assertive & Intensive Action Plan						
Author/Presenter	Renu Bhopal Padhiar, Associate Director – ICCR Liz Thurling, Head of Nursing & Allied Healthcare Professions/Clinical Director - ICCR						
Executive Director	Lisa Stalley-Green, Executive Director of Quality and Safety (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**
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Summary of Report					
Alert		**Advise**	**ü**	**Assure**	**ü**

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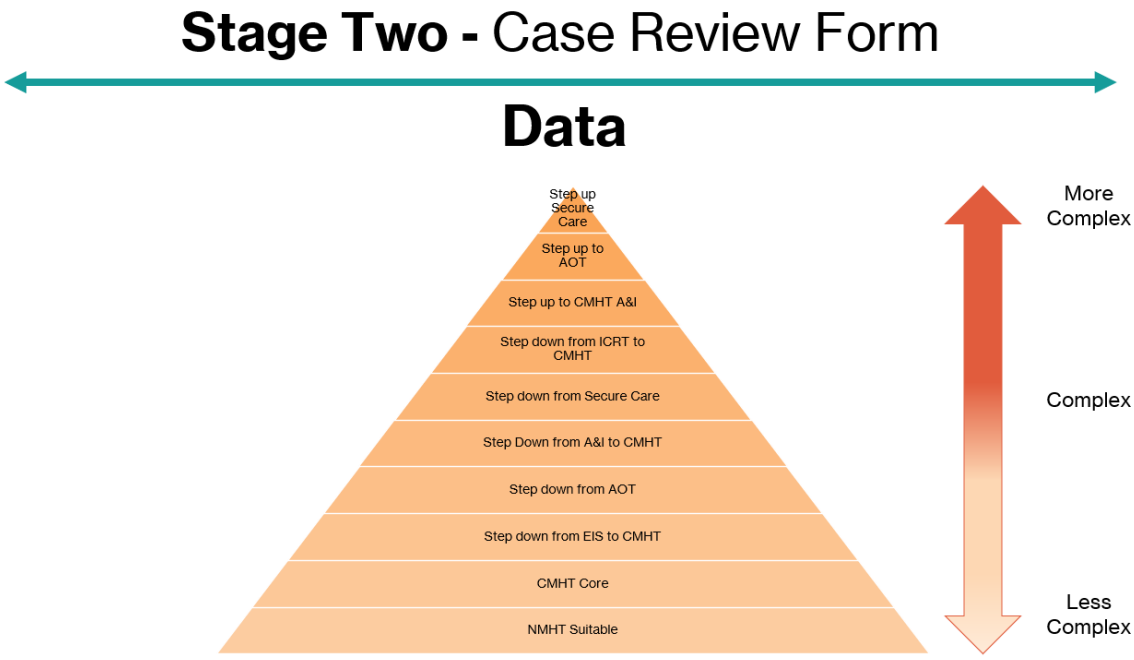

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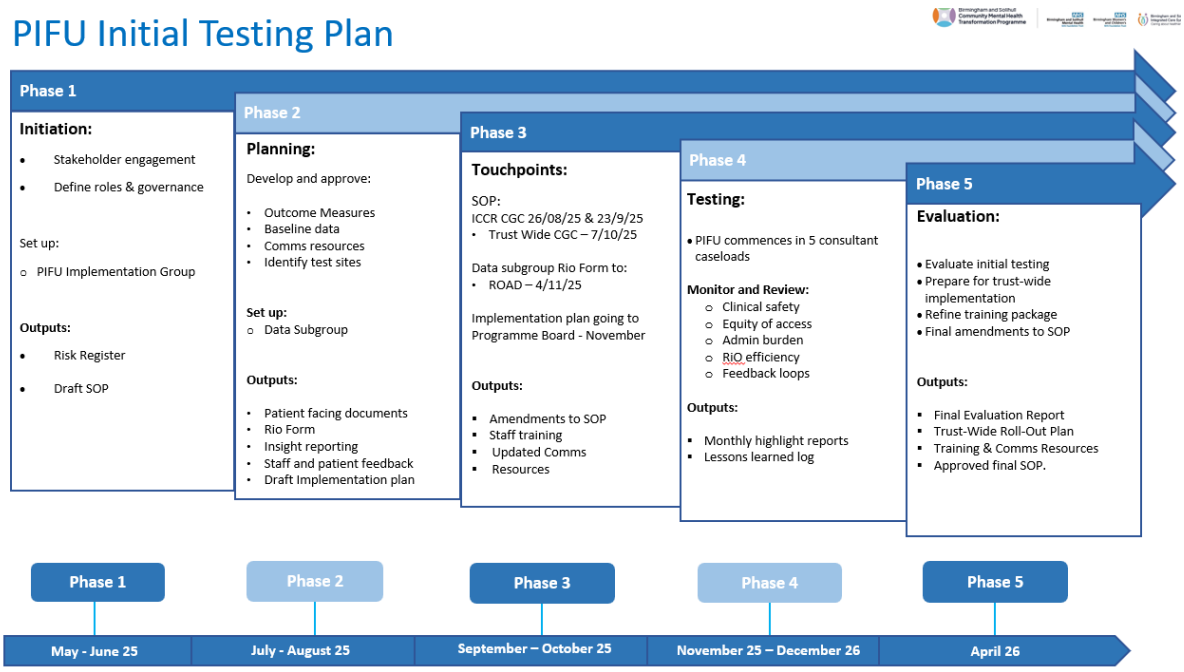

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Recommendation
Confirmation of Assurance from the Board

Enclosures
A& I action plan v21

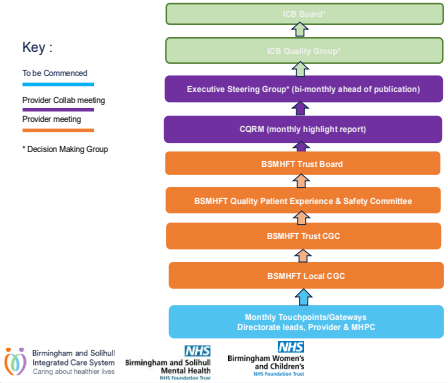
Report Title

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



Roles & Reps:

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Additional oversight: Dr Selvaraj Vincent
Senior Responsible Officer: Fabida Aria
Additional oversight: Vanessa Devlin & Sadira Teeluckdharry
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Additional rep to consider for touchpoints: [To confirm]
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Older Adults: Keisha Dell
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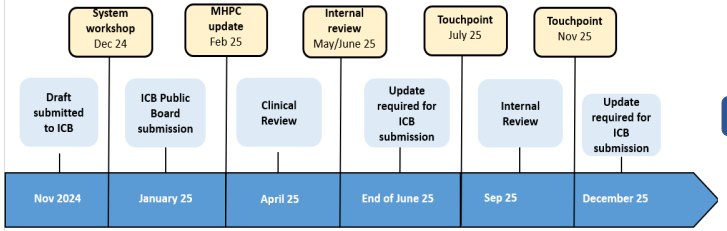
Secure care: Dinesh Maganty

Birmingham and Solihull Integrated Care System
Caring about healthier lives
Birmingham and Solihull Mental Health NHS Foundation Trust
Birmingham Women's and Children's NHS Foundation Trust

Assertive and Intensive Review

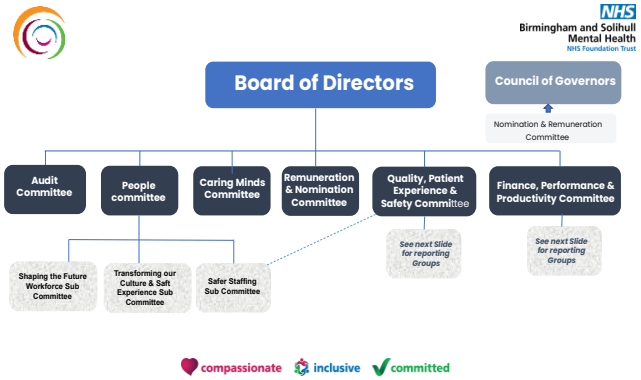


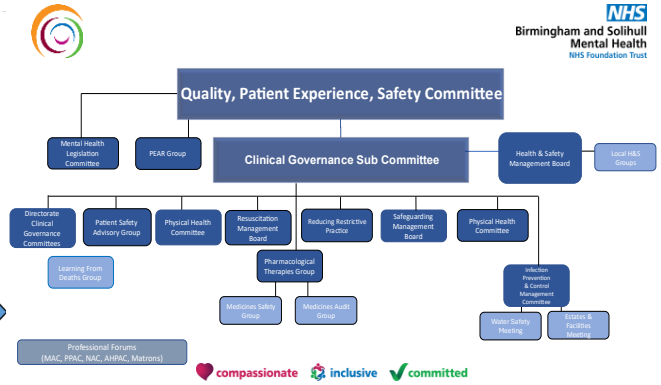
Focus Areas

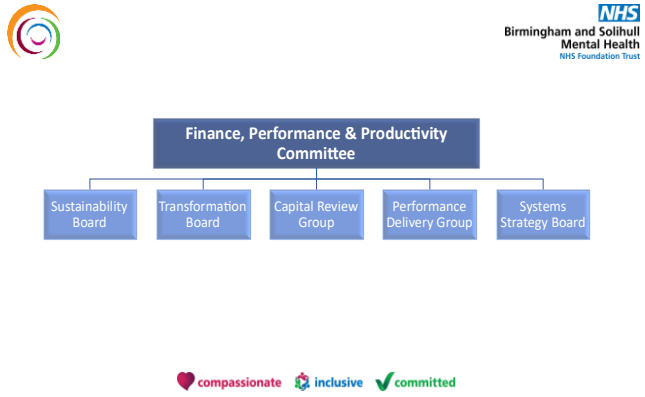
Birmingham and Solihull Community Mental Health Transformation Programme

Dear Adele,

Joe Merriman (CC'd) for Creating a Mentally Healthy City
Tim & Myself for POC – Janine has dates, every 6 weeks on a Thursday pm 2-3.30pm
Helen Wadley for the VCFSE Panel Members Space
PSW Steering Group Space Tim & Liz Walker – again Janine for dates etc Adele







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	Quarterley	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	Emmanual Agiam	?
	Monthly	Specialities	Highlight report inc. action plan	Leona Tasab	?
	Monthly	Childrens	Highlight report inc. action plan	Emma Cooper	?
Touch Point Meeitngs - Directorate leads	Monthly				

Assertive and Intensive Review System Governance

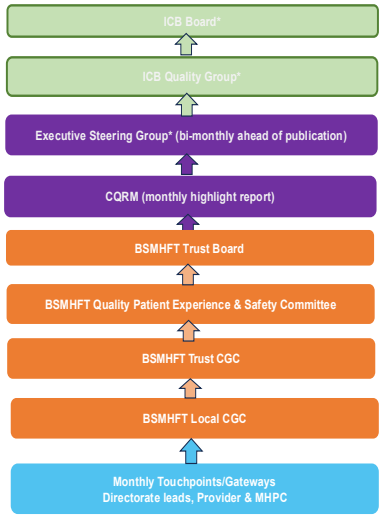
Key :

To be Commenced

Provider Collab meeting

Provider meeting

* Decision Making Group



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Caring about healthier lives

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

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Theme	Ref.	Source	Link to Action Plan Guidance	Owner	Division /Trust	Action	Time scale	Tasks/Assurance	Update 02.10.25	Update 13.11.25	RAG rating
Policies	1	**AIAP**	Policies have been reviewed to ensure that patient family and carers are involved, particularly at times of non-engagement	Head of Service Community Transformation ICCR & Clinical Director Rehabilitation	ICCR	**DNA policy review - AOT and CMHT If amendments required then plan for review and sign-off**	Short Term	**COMPLETED**			
	2	**AIAP**	Eliminate 'blanket' policies and practices of using DNA as a reason for discharge	Head of Service Community Transformation ICCR & Clinical Director Rehabilitation	ICCR	**DNA policy review - AOT and CMHT If amendments required then plan for review and sign-off**	Short Term	**COMPLETED**			
Data	3	**AIAP**	All providers will be able to identify the population of people with serious mental illness where engagement is a challenge	Sunday Olotu Liz Thurling		**Undertake focused work around improving diagnosis completion**		**1.** To support with the identification of this cohort - diagnostic data completion rates are being monitored through FPP and fortnightly KPI Meeting, working with CDs to identify diagnostic completion by medic via BAU process following clinical review of complexity across CMHT caseload	**02.10.25** Workshop with leads sheduled for the 15th Ocotber, complexity triangle to be outlined to confirm - level of complexity 'criteria' for each, interventions, supervision and training levels for each. Data dashboard draft has been completed. BAU reporting has commenced beut needs refinding, Emma B and Liz to link with Siobhan to review how this can be captured and consdier use of the Case Review Form RBP, Siobhan to meet with Richard Taylor and Sarah Badger to consider learning fromt eh 24.7 work around recording, also need to consider goverannce around any changes being generated from the 24.7 pilot that would benefit wider teams.		
	4	**AIAP**	Service Users are assessed to see if they are eligible for intensive and assertive community treatment	Sunday Olotu Liz Thurling Richard Salkeld	ICCR	**Agree metric and ensure staff are clear on their responsibilities and process for identifying this cohort**	Medium Term	**1.** Once the Case Review Form is live on RIO the medics will be required to update confirming eligibility for Intensive and Assertive Community Treatment - Cases will be reviewed by locality CMHTs to confirm package of care. **2.** Learning needs to be captured from 24.7 pilot to consider how processes are being streamlined and information captured			
	5	**CLR**	Consideration of strengthening this area in the action plan in relation to knowing level of contact with emergency services.	Renu Bhopal-Padhiar Tim Newbold Siobhan Blackwell	Trust	**Review current reports around how A&E presentations are captured and ensure this can be built in with standardised comms to accompany.**	Medium Term	**1.** Complexity Tool has now been launched on Insight showing: More Complex, Complex and Less Complex cases and this incorporates referrals opened to PLT, PDU/POS/Street Triage. **2.** Associate Director to work with informatics and wider system partners to consider how information around individuals that attend A&E but dont get referred to PLT. Consider whether any updates s are required to the dashboard and how this interacts with locality hub and daily sitreps. Meeting with UHB ICT Director scheduled for 18th June. **3.** AOT will receive notification from PLT around contact with emergency services and AOT will aim to undertake a visit same day. Reporting needs strengthening for alerts. Tim working with Victoria Willis to confirm auto alert email to CMHTs - ongoing	**02.10.25** Update needed from Victorua Willis around alerts, PLT alerts are now up and live.		
Workforce		**AIAP**	Ensure all service users in this group have an assigned, and appropriately experenced and competent key worker (or care coodinator)	Tim Newbold Munya Mwerenga	ICCR		Short Term				
	6	**AIAP**	There is a dedicated provision in place that can support this service user group	Cindy Miekle Tim Newbold Nicola Wadge Emma Brogan Liz Thurling	Trust	**Ensure there is sufficient capacity across the pathway to support caseloads and service users receiving the most appropriate service and level of support.**	Short Term	**1. NMHT (Primary Care) are fully recruited to support overall flow and capacity to ensure individuals who require assertive and intensive engagement are receiving the right service i.e. AOT or CMHT. NMHT roles recruited to - BAU - COMPLETED** **2.** In addition to the above caseloads are being reviewed and monitored with the Patient Initiated Follow Up being piloted to explore if consultants can have more capacity to see individuals responsively who require this engagement. (This is currently being piloted in West with full roll-out expected by September 2025)	**02.10.25** PIFU SOP due to go to ROAD in November timetable for first 5 consultants, work will go on until March 26, between December 25 and January 26 further 15 will be identified for phase 2.		
	6.1			Renu Bhopal-Padhiar Head of Service Recovery			Longer Term	**1.** Reach Out business case (BC) is in the process of being finalised, the BC aims to provide resource to deliver an Assertive and Intensive provision in CMHTS. Submitted to provider collaborative leads 16th June 2025.	**02.10.25** Workshop with leads sheduled for the 15th Ocotber, complexity triangle to be outlined to confirm - level of complexity 'criteria' for each, interventions, supervision and training levels for each.		
	7	**AIAP**	There is a dedicated provision in place that can support this service user group	Renu Bhopal-Padhiar Liz Thurling Zoe Lawson	Trust	**Review effectiveness of ACP roles in NMHT's and consider expansion into CMHT's**	Longer Term	**1.** Zoe Lawson is working with QI to understand how impact of ACP roles in NMHTs can be measured and provide us with and evidence base around these roles and level of practise. Regarding CMHTs further work is needed due to ANP roles also in Situ. Pilot area to be identified to gain insight into level of practise to provide data to analyse next steps to enhancing skill sets within the team, this has already been completed by AHPs.	**02.10.25** Workshop with leads sheduled for the 15th Ocotber, complexity triangle to be outlined to confirm - level of complexity 'criteria' for each, interventions, supervision and training levels for each. Zoe Lawson to provide steer on next steps around ACP action		

AIAP Assertive & Intensive Action Plan

CLR Clinically Led Review

NR National Return Actions

	8	AIAP	Holistic support is provided, including support with housing and substance misuse	Tim Newbold Steve S Claire Rigby Munya Mwerenga Lisa SG	ICCR	**Undertake deep dive around what's already taking place, what else might be needed and consideration of what workforce could do differently as well as the wider VCFSE offer**	Longer Term	**1.** In relation to substance misuse: BSMHFT has existing contracts with CGL, Compass and SIAS around substance use and these partners feed into MDTs and triage hubs. This is working consistently across AOT but more work is required around attendance at MDTs within CMHTs to ensure consistency. **2.** Work has already commenced with VCSFE providers around support for service users dependent on locality need. Claire Rigby VCFSE Manager has established a reporting framework allowing contracted partners to raise the profile of their offer and VCSFE independent providers to link with teams across the community setting. **3.** Roles that support with sourcing housing are embedded in Intensive Community Rehab Team and acute and the new Out Of Trust Team currently being recruited will also have a housing expert role embedded. **4.** Transformation Lead to link Heads of Service to link with Explore Discharge to Assess service to explore whether there they can support with providing housing support to this service user group where risk of homeless or breakdown of housing is a feature. **5.** MDTs being explored for this specific group and colleagues to ensure that housing rep are included. **6.** Explore Discharge to Assess service and whether they can support with providing housing support to this service user group where risk of homeless or breakdown of housing is a feature. **7.** Head of Service to lead interface working with key housing	**02.10.25** Awarensss of COMPASS provision to be reviewed, RBP met with leads w.c 13th October. Review to be completed across ICCR teams to gauge how much teams know of the COMPASS offer, once completed comms piece to follow - Steve S holding action.		
Training and upskilling	9	AIAP	Providing access to a full range of evidence-based treatment and interventions, including psychological therapies ∞	Rose Carter Catherine Amphlet Katie Lucre Fred Clements	Trust	**Consider Compassionate Mind Training as an intervention to be delivered and review other opportunities for the workforce in line with higher acuity caseload.**	Longer Term	1. Discussions have commenced with Kate Lucre around Compassionate Mind Therapy 2. Review psychological interventions offered in ICRT, AOT, EIS to consider if any should be considered within offer from new Reach Out business case for this caseload. 2. Complex Emotion and Trauma project has mapped out psychological interventions and services available with final pathway mapping due for completion July 25. 3. Pathway mapping and guidance produced as part of Bipolar & Psychosis Working group to be shared and identify any additional psychological therapies that could be considered.	**02.10.25** Workshop with leads sheduled for the 15th Ocotber, complexity triangle to be outlined to confirm - level of complexity 'criteria' for each, interventions, supervision and training levels for each.		
	10	CLR	**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.	David Ryan Fred Clements (Training Consultant) Rose Carter Cindy Miekle	Trust	**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.**	Longer Term	**1.** Dave Ryan (ICCR Matron) completed training needs analysis, confirming priorities for the next 12 months. **2.** Include new Training Consultant role to explore if any additional priorities need to be included following the previous training needs analysis and support with roll-out. **3.** Reach OUT will provide an additional element of upskilling from FIRST Team for supervision to the new roles. **4.** Link in with Talent for Care to explore whether any training can be sourced to support upskilling staff with supporting higher complexity caseload. (TN)	**02.10.25** Workshop with leads sheduled for the 15th Ocotber, complexity triangle to be outlined to confirm - level of complexity 'criteria' for each, interventions, supervision and training levels for each.		
	11	AIAP	Staff have access to relevant training and clinical supervision to support them to work with this service user group ∞	Bipolar and Psychosis Working Group (Nicola Wadge) Fred Clements (Training Consultant) Munya Mwerenga Cindy Miekle	Trust	**Tap into research focus and findings around effectiveness of certain interventions for higher acuity caseload and consider any appropriate upskilling opportunities within CMHT (AOT, ICRT and EI provisions to consider)**	Longer Term	**1. Consultation offer from the Enhanced Team, SPS and CASCADE Group live and working well. LIVE - COMPLETE** **2.** Discussions have commenced with Meridan leads and Bipolar and Psychosis leads to support training roll out for complex/more complex service users (launched under community transformation) ***July update around 4 day roll-out*** **3.** Scope possibility of group supervision/consultation slots with EI, AOT and ICRT 1:4 virtual sessions allowing for case discussion **4.** Review of clinical supervision for CPN's holding more complex cases **5.** Review of MDT standards to ensure alignment with more complex cases. **6.** Link with secure care colleagues to scope options around enhanced supervision and formulation spaces	**02.10.25** Workshop with leads sheduled for the 15th Ocotber, complexity triangle to be outlined to confirm - level of complexity 'criteria' for each, interventions, supervision and training levels for each. BiPolar and Psychosis Training has commenced with the first cohort being the North and East BiPolar and Psychosis Early Identification Pilot - taking place in the south and due to be evaluated in November.		
	12	CLR	**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.	**Sadira Teeluckdharry** **Bipolar & Psychosis Working Group (Nicola Wadge)** Tim Newbold Sunday Olotu Liz Thurling CSMs	Trust	**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**	Longer Term	**1.** Roll out of Safety Plan and Safety Log - Initial Scoping session held to do initial draft (April 2025) roll-out timelines to follow (4-6 months). **2.** Timeline for safety plan and safety log completion in the patient pathway - Initial contact with DIALOG+ care plan v subsequent appt- Current guidance is to complete only if it is relevant in that initial contact. The safety log will take some more working through as some information might need to be automatically pulled in terms of when we migrate from Risk Ax Level 1 form, which some conscious tidying up by clinicians at the next appointment (i.e.. delete all the "No risk, no risk" statements that clog up the form). Current Care planning reporting is not yet mandating a Safety plan to be done at the same time as Dialog+ Care plan, follow up Reporting and Assurance meeting planned with Dialog+ Lead Trainer and Clinical Service Managers due to attend (July 2025). Consideration required around Care planning reporting and assurance with this. **3.** Clarity around relapse plan and early warning signs documentation Bipolar & Psychosis Working group have identified suggested recommendations for the completion of EWS - update required around whether this can be incorporated into Dialog+ **General update**: As a minimum standard aspects of Relapse Prevention and recognition of Early Warning signs already naturally sit in Care planning and safety planning. E.g. Dialog+ Care plan domains of Medication, mental Health, personal Safety can cover	**02.10.25** Early Warnings Signs Audit subgroup is reviewing quality of the EWS documentation - Feedback due in November		

Pathway, transition and flow	14	**AIAP**	Daily planning meetings and weekly MDT's take place for all service users requiring intensive and assertive community treatment	Liz Thurling Sunday Olotu Tim Newbold Head of Service Recovery *Consider CSM rep*	ICCR	**Set up initial interface meetings and explore next steps around dedicated MDT.**	Longer Term	**1.** Decision required around when/how to set this up following MDT standards work, caseload identification and resource from Reach Out Business Case. (September 2025)	**02.10.25** Workshop with leads sheduled for the 15th Ocotber, complexity triangle to be outlined to confirm - level of complexity 'criteria' for each, interventions, supervision and training levels for each.		On Hold
	15	**AIAP**	Clear pathways are in place to 'step up' care to services such as rehab & assertive outreach	Tim Newbold Munya Mwerenga	ICCR	**Pull together task and finish group around focused approaches to supporting transition and develop clear action plan for "safer transition"** **Inclusive of:** **Expand step-down caseload validation beyond 1a + 1b** **East Discharge Pilot** **Solihull Pilot** **Re-access plans**	Medium Term	**1.** Existing pathway in place for stepping up individuals to AOT from CMHT. This is being reviewed by exploring prioritisation on the waiting list through a dedicated AOT and CMHT transition task and finish group. **2**.list has been reviewed with 20 cases identified as suitable to 'swap' cases to be moved over across teams by the **11th July** **3**. Staff transitions groups to review cases identified to allow for robust clinical discussion around package of care and process for safe transition.	**02.10.25** Workshop with leads sheduled for the 15th Ocotber, complexity triangle to be outlined to confirm - level of complexity 'criteria' for each, interventions, supervision and training levels for each.		
	16	**AIAP**	Rapid re-referral/easy access is possible in the case a service user is discharged but requires additional support due to increasing needs.	Tim Newbold Head of Service Recovery	ICCR	**Ensure clear and consistent approach around rapid re-referral/easy access.**	Medium Term	**1.** Rapid recess functionality and testing forms part of PIFU working group in CMHTs. Standardised approach, timelines and communication to be agreed as part of this working group. **2.** There is a period of testing that takes place whilst individuals are still under AOT but are considered suitable for transition to ensure suitable step-down. This process needs to be reviewed and formalised.	**02.10.25** PIFU SOP due to go to ROAD in November timetable for first 5 consultants, work will go on until March 26, between December 25 and January 26 further 15 will be identified for phase 2.		
	17	**CLR**	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	Tim Newbold Head of Service Recovery Claire Rigby	ICCR	**Ensure clear and consistent approach around rapid re-referral/easy access - linked to VCFSE**	Medium Term	**1.** Where individuals are stepped down from AOT to CMHT they will be supported by dedicated workforce to support transition and assess whether any further support is required. This staff will link appropriately with any VCFSE or wider partners to bridge into any ongoing support needed. **2.** VCFSE Lead to work closely with Service Managers around embedding and linking wider VCFSE partners into service delivery. Commissioned online service directory to support navigation and dedicated meeting live bringing together contracted and wider VCFSE organisations with operational managers across BSOL.	**02.10.25** PIFU SOP due to go to ROAD in November timetable for first 5 consultants, work will go on until March 26, between December 25 and January 26 further 15 will be identified for phase 2.		
	18	**CLR**	**People who are not attending or cancelling appointments/dropping out of service and discharge from services:** 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.	Liz Thurling Sunday Olotu	ICCR	**People who are not attending or cancelling appointments/dropping out of service and discharge from services: Ensure we are involving GPs around discharge and meaningful MDT discussions are taking place**	Medium Term	**1.** NMHT MAT meetings are in place to support cases with transition **2**. Ongoing work to finalise the formal around consultation clinics offered to GP's from our NMHT Consultants. **3.** Shared Care Meetings also in place around shared care processes in readiness for discharge. GP's will be provided with directory to streamline and support queries and Clinical Director to link with GP leads around most suitable approach for GP's to be included in discussions around DNAs for this cohort. **4.** Build on exposure in dedicated GP spaces including CRG and LMC's to encourage better attendance at MAT meetings for individuals who are under NMHT.			

	19	CLR	**People who are not attending or cancelling appointments/dropping out of service:** Questions to consider helping strengthen your action plan in this area: Do we know if our community mental health services have a low threshold for readmittance? Do we know if staff identify any relapse indicators and known harms/risks of relapse if not responded to promptly? Consideration of strengthening these areas in the action plan.	Liz Thurling Sunday Olotu Tim Newbold	ICCR	**Do we know if our community mental health services have a low threshold for readmittance?** **Do we know if staff identify any relapse indicators and known harms/risks of relapse if not responded to promptly? Consideration of strengthening these areas in the action plan.**	Medium Term	**1.** Refresh around MDT standards to include escalation of concerns from third parties i.e. friends and families, other partnership organisations. Repeat DNA's is also included in the refresh - this requires MDT discussion. This is currently going through Clinical Governance. **2.** Rapid recess review is ongoing to agree threshold, process and timeframes with a view to standardising this across all CMHT's. Cohort identified under PIFU also to be considered with this rapid re-access. **3.** Ongoing work around relapse planning and early warning signs - learnings to be rolled out from Bipolar & Psychosis Working group. Agree the minimum timelines for completion and review around Early Warning Signs.	**02.10.25** Dr Onuba has commenced work looking at process for Rapid Reassess (suitability and timelines for recess) to be aligned with PIFU SOP		
	20	CLR	**People who are not attending or cancelling appointments/dropping out of service and discharge from services:** Do we know the number of non-agreed discharges to ensure trends can be identified: Consider if action plan fully addresses this question. In the policy review for non-engagement consider how the themes identified are embedded into services and frequency/process of policy review.	Renu Bhopal-Padhiar Tim Newbold Steve S Informatics support	ICCR	**People who are not attending or cancelling appointments/dropping out of service and discharge from services: Do we know the number of non-agreed discharges to ensure trends can be identified: Consider if action plan fully addresses this question. In the policy review for non-engagement consider how the themes identified are embedded into services and frequency/process of policy review.**	Medium Term	Undertake deep dive with the following: **1** .Ask for data pull around reason for discharge recorded as non-engagement and DNA with services. **2.** Look at re-referral rates or contacts post discharge with other BSMHFT services such as POS and HTT. **3.** Consider any learnings from SJR **4.** Link with complaints team around complaints relating to non mutually agreed discharge (BO)	**02.10.25** DNA Data is being reviewed and scoping is underway around its inclusion in the data dashboard which is being developed.		
	21	CLR	**People with a history of high use of inpatient services and where people are having difficulty maintaining lasting or consenting contact:** 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	Tariro Nyarumbu Renu Bhopal-Padhiar Tim Newbold Liz Thurling	Trust	**People with a history of high use of inpatient services - inpatient services contribution in action planning to safely meet the needs of this cohort**	Medium Term	**1.** Ongoing workshops are taking place to strengthen interface between Community and Inpatient. Recommendations and task and finish groups to follow (June 2025) **2.** Where individuals are under CPA and they are currently on an inpatient ward, the care coordinator will link in with inpatient services around ongoing treatment and discharge planning through ward round attendance. Compliance with this standard is monitored fortnightly.			
Flow and capacity	22	AIAP	Staff working with this service user group have small caseloads	Liz Thurling Sunday Olotu Tim Newbold	ICCR	**Continue piloting and implementing PIFU (Patient Initiated Follow-ups) to explore whether this creates more capacity for Consultants**	Medium Term	**1.** Cohort of staff linked to Reach Out Business Case to have smaller caseload 10-15 to offer the intensive support required for this cohort. Looking to replicate/build-on the AOT model.	**02.10.25** PIFU SOP due to go to ROAD in November timetable for first 5 consultants, work will go on until March 26, between December 25 and January 26 further 15 will be identified for phase 2. This is to enable smaller caseloads. Reach Out Business case will allow for dedicated workforce alsongside CMHT staff - 15th October workshop planned.		On Hold
	23	CLR	**Smaller caseloads (10-12 per staff member):** Consider strengthening this in the action plan through caseload management review of CMH current level caseloads if the CMH has assertive outreach type patients. Does caseload size impact on ability to maintain contact and meet the medicines management compliance action?	Tim Newbold Sunday Olotu Liz Thurling Head of Service Recovery (when recruited)	ICCR	**Caseload management review of CMH current level caseloads if the CMH has assertive outreach type patients.** **Does caseload size impact on ability to maintain contact and meet the medicines management compliance action?**	Longer Term				On Hold
Care Planning	24	AIAP	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.	Nicola Wadge (Bipolar & Psychosis Working Group) Liz Thurling Sadira Teeluckdharry	Trust	**Ensure roll-out of Early Warning Sign/Relapse Prevention Plan (being developed in Bipolar & Psychosis Working Group)**	Medium Term	**1.** As a minimum standard aspects of Relapse Prevention and recognition of Early Warning signs already sit in Care planning and safety planning. E.g. Dialog+ Care plan domains of Medication, mental Health, personal Safety can cover how to prevent relapse and the current Dialog+ Safety Plan has Early Warning Signs. The next step will be to review what we think is a minimum standard for all staff to complete and how to we create space for more enhanced completion where necessary. **2.** To support with consent, consider a discharge letter (similar to	**02.10.25** Early Warnings Signs Audit subgroup is reviewing quality of the EWS documentation - Feedback due in November		
	25	CLR	Consider the needs of people with co-morbidities in clinical pathways with a particular focus on learning disabilities and autism	Renu Bhopal-Padhiar Helen Jones Viba Pavan Kumar Nina Ahuja	Trust	**Work with Helen Jones to fully integrate LDA service user tracking across the pathway and support DSR training and completion. Service Evaluation in Progress (CMHTs) to map out existing provisions (benchmarked against NICE guidelines). Working group set up to focus on provisions within ICCR CMHTs (Helen Jones, Nina Ahuja, Viba Pavan kumar, Jill Tunaley and Trainee Clinical Psychologist)**	Medium Term	**1.** Monthly meetings with ADs are in place to review cases flagged as LDA with trust lead to support discharge planning and flow across the pathways. **2.** Training continues across teams for DSR **3.** Operational Leads meeting is in place supported by senior ICCR leaders **4.** Clinical Managers and Matrons to consider training for staff to strengthen their understanding of co-morbidities. **5.** Continue to strengthen working relationship with LD services so that we can effectively joint work, seamless and appropriate transfers, and seek advice and consultation when needed. **6.** Monthly meetings in place for the working group (CMHTs).			

	26	CLR	Consider strengthening interventions for anti-social behaviour as an area in the action plan	Richard Salkeld Dinesh Maganty Munya Mwerenga Tim Newbold Kevin Heffernam		**interventions for anti-social behaviour as an area in the action plan**	Medium Term	**1.** Review current interventions that exclude individuals with anger / anti-social traits from accessing this i.e. BECS. Consider if there is a specific gap here that requires intervention/offer. **2.** Link in with AOT and Secure Care to understand if there are interventions that should be considered here. **3.** Capture support and training linked to Reach Out business case that may be appropriate. **4.** Capture in wider partnership working - Partnership Operations Group, **5.** Link in with Director for Urgent Care around potential offers.	**02.10.25** RBP to check with Fay Cook as to provision for anti-social behaviour within the PD provision enhanced connect pathway.		
Governance structure	27	AIAP	There are measures in place to evaluate the impact of services, including the regular reporting of appropriate outcomes	Clementine Parker Renu Bhopal-Padhiar Katie Holmes	Trust	**Commitment to ensure robust governance structure is in place to support delivery and provide assurance. MHPC to support developing Transformation board**	Short Term	**1.** Robust Governance Structure to be established both internally in BSMHFT and MHPC and with the ICB			
	28	CLR	**PCREF and JSNA:** Consider how this aligns and could be used in the action plan to help identify and reduce health inequalities and support improvement Joint Strategic Needs Analysis	Jas Kaur ADs Claire Rigby (ICCR lead) Steve Scrimshaw (ICCR)	Trust	**Work with Jas Kaur as part of directorates responses to Health Inequalities Plans**	Short Term	**1.** Directorate plans are already in place with reporting framework agreed within the trust governance structure - plans to be taken o QPES twice yearly. **2.** 9 areas of health inequalities focus for BSOL community teams have already been identified and extensive work has already commenced as a result of Community MH Transformation Funding, results of initial funding pilots now form part of intelligence for future commissioning. **3.** Work around demographic data collection in ICCR has already commended and support by the QI team, using national benchmarking and learning to improve the collection of demographic information, including Next of Kin details, this is monitored monthly via FPP. **4.** Cultural Competency: Roll-out in ICCR have been completed with 256 staff enrolling onto the training. There were 12 face-to-face sessions, co-facilitated with EBEs (CMHT staff in Phase 1; Other ICCR Teams in Phase 2). A meeting has been held with the Learning and Development team to discuss scaling for pan-Trust use. Jas Kaur has supported from EDI point of view and has assured that it			
	29	CLR	**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 social/cultural beliefs to help improve medication concordance.	Tim Newbold Head of Service Recovery Liz Thurling	Trust	**Are staff are monitoring people who are discontinuing medication against advice and disengaging from services?**	Medium Term	**1. Where individuals are attending depot then this can be monitored and there are MDT discussions for DNA's and when we are prescribing via TTO's we know they have collected by EPM.** Consideration required for where we are still using FP10's as this is not recorded on EPMA. **2. AOT & EIS have an intensive and assertive approach to include home visits where monitoring medication can take place.** **3**. As part of refreshed MDT standards in CMHTs individuals starting who start cancelling a few appointments and/or disengaging will require MDT discussions and any individual actions. For the most complex cohort they will be receiving more intensive support where medication monitoring could be incorporated. **4.** Consider if PCNs can flag with the relevant MH team should a service user not have requested / has not collected a prescription for medications where there is an ESCA in place.			
	30	CLR	**Risk management processes**: In the action plan consider how will the HSIB 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 identifying a liaison officer who acts as a contact for family/carers to enable a dynamic risk formulation. Consider oversight meetings where complex patients are reviewed, and risks are escalated to senior colleagues.	Sadira Teeluckdharry Emma Brogan Tim Newbold Liz Thurling Nicola Wadge	Trust	**Consider any work required around working with families in psychosocial/risk assessments.** **Consider identifying a liaison officer who acts as a contact for family/carers to enable a dynamic risk formulation. Consider oversight meetings where complex patients are reviewed, and risks are escalated to senior colleagues.**	Medium Term	**1.** Continued roll-out and encouragement of think family approach - this is embedded into training and induction. Quality and Assurance tool is being developed by Safeguarding Team with Lyndon CMHT - consider how this could be rolled out across all CMHTS as assurance test around the Think Family approach. **2**. Dialog+ continues to be a good opportunity to capture the view of families - need to consider how this can be done operationally - link with care planning group **3**. Wider trust work around risk assessment roll-out and how we work with/involve families. **4**. Link to action around setting up specific MDTs for the individuals that require assertive and intensive management where this review and escalation can be discussed. (Action 14) **5.** Build in learnings and updates from the roll-out of Bipolar & Psychosis project around Early Warning Signs & team training as this features specific theme around friends and family involvement. **6**. Incorporate learnings and updates from Meriden pilot in Solihull and the BFT focused roles in AOT which target family interventions.	**02.10.25** Early Warnings Signs Audit subgroup is reviewing quality of the EWS documentation - Feedback due in November		

	31	**CLR**	**Governance:** Consider how Risk Management Review will feed into the overall governance process.	Lisa Stalley-Green Sadira Teeluckdharry Samantha Munbodh Liz Thurling (ICCR lead)	Trust	**Governance: Consider how Risk Management Review will feed into the overall governance process.**	Short Term	Ensure Trust wide approach is captured and finalise local ICCR governance structure around risk management review to incorporate the following: **1.** ICCR Patient Risk Panel **2**. Complex Case Panel **3**. Table Top Review Process **4.** SJRs **5.** CGC review patient safety incidents **6.** Shared learning across CGC's (incorporate as not in place currently) **7**. Eclipse	**02.10.25** Discussion with group - agreed process needs to be considered to look at how learning could be shared across divisions - Sam Munbodh to support		
Experts by Experience, Families & Carers	32	**CLR**	**Experts by Experience**: Involved in policy development: Consider strengthening action plan by developing the role of Peer Support Workers in supporting Experts by Experience involvement in policy development. The BSOL CMH transformation programme had strong EBE representation and has/could this expertise and programme of work be used in action planning.	Katherine Allen Jazz Janagle Tim Newebold	Trust	**Experts by Experience: Involved in policy development.**	Short Term	**1.** Reached out to Katherine Allen around EBEs involvement in Policy Development - awaiting response, chased 28.5.2025 (query around policy being truly co-developed?) **2.** Peer Support offer has been developed with national leads IMROC and involves accredited training programme, recruitment and ongoing supervision and support of 22 Peer Support Workers. All recruitment t is reflective of the communities we support and is co-produced with them. **3.** JJ in relation to EBE's 4. Lived Experience roles to support us with action 32 & 33 going forward			
	33	**CLR**	**Experts by Experience:** We have involved people delivering and receiving services in having focused conversations about any concerns that may not be directly known to our core services. Consider if action plan fully addresses this question	Katherine Allen Jazz Janagle Tim Newebold	Trust	**Involve people delivering and receiving services by having focused conversations about any concerns that may not be directly known to our core services?**	Short Term	**1**. DIALOG+ Care Plans **2**. Drop-ins with our wider VCSFE partner - wider Partnership Operations and Co-production Group meeting where wider intelligence is gathered through partners that may be supporting individuals outside of core services or in addition to. **3**. Focus groups with EBE's to consider this further			
Claire Murdoch Directive	34	**CLR**	**Particular attention should be given to:** • 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.	Renu Bhopal-Padhiar Tariro Nyraumbu Liz Thurling	Trust	**Support interface, joint discharge planning, multi-agency working and supporting families and carers.**	Short Term	**1.** Interface meetings supporting with discharge planning to include CMHT attendance at HT MDTs & Ward rounds **2.** CMHT review of safety huddles and accompanying guidance to support closer collaborative working. Current review of MDT standards to support standardising and optimising joint working **3.** Dialog+ supports with personalised care and risk (in progress as acute and urgent care roll-out Dialog+ **4.**Eliminating OOA: Include the progress of the Out Of Trust team as part of the Recovery business case. Due to go live in Sep 25. **5**. 1 x band 6 Acute link worker to support multi-agency working across all emergency departments.			

No	Meeting Date	Action Plan Theme	Action Plan Number	Action/Decision	Description	Owner	Progress	Due Date	Status (RAG)	
1	04.09.25	Data	3, 4, 5	Action	Siobhan and Katie to meet to confirm what metrics can be used for data pull in CYP division & to confirm where gaps might be in RIO reporting	Siobhan, Katie	**13/11/25: Metrics have been shared with Katie. How can we map complexity done for 25+ population need to do this for the younger population. Damien Rachel once linked in with Katie update - Manoj advised Katie said there had been a delay in the data. Bernard to liaise with Katie update re the data in 1 weeks time.** **2nd October** - Siobhan & Kate to feddback at next meeting to confirm whether data can be pulled to be	13th November	In Progress	
3	04.09.25	Data	3, 4, 5	Action	Sofia to confirm sign off of the Data Dashboard for BSMHFT	Sofia Fletcher	The initial dashboard with metrics the trust collates has been devised and shared with the ICB . Further work to consider the metrics we currently do not collate and the value , the integration on safeguarding, safer staffing , audit , IPC , to be developed over the next 3 months with a red , amber , green rating		Completed	
4	04.09.25	Data	3, 4, 5	Action	Jason to confirm options around automatic alert process for service users who are presenting in AUEC settings (excluding PLT and PDU - where alert is already live)	Jason Nash	**13/11/25: Tim and Sunday attended the partnership group which will be attending every month - Police social care helpline. There are number of reports that urgent care do with PDU and Tim working with Victoria how we can access those wider reports. Tim and Siobhan link AUEC. To invite Matthew to this meeting.** **04/11/25:** CMHT should get a report from us that details all the patients who have had contact with the Urgent Care Centre. This needs to be used to identify patients that have been seen by one of our services. The only one that are required in realtime is PLT, as this was in connection with the link worker role. **2nd October** - Update needed for 13th November	13th November		
5	04.09.25	Data	3, 4, 5	Action	Liz and Sharon to Link with Emma Cooper and CYP colleagues to discuss PiFU next steps	Liz, Sharon	**13/11/25: Liz no update from Emma next PiFU meeting Thursday 20 Nov.** **17th October:** Liz and Sharon met with Emma Cooper and Anupam Dharma to present an overview of the Adult PiFU Project, covering early outcomes, SOP development, and implementation planning on 8th October 2025. We agreed to share the latest SOP and QIP data, and invited CYP to join the PiFU Implementation Group. Emma Cooper will lead internal discussions and request a CGC slot to present the model and assess interest within CYP. Next steps include engaging medical staff, evaluating service-specific impacts, and identifying a suitable timeline and format for a potential CYP pilot. **2 October:** Meeting with Emma Cooper has been arranged for Wednesday 8th October.		In Progress	
6	04.09.25	Data	3, 4, 5	Action	Vicky Willis to confirm alert process for when Police have been contact with the service users - Similar to A&E alert	Vicky Willis	**13/11/25: linked to the Urgent Care Partnership.** **7/11/25:** Tim N. to provide an update at the next meeting. **2nd October:** Tim Newbold to link with Victoria Willis to progress action - Update needed for 13th November	13th November		
7	04.09.25	Data	3, 4, 5	Action	Emma B & Tim to work with Kevin and Jason to complete SOP to confirm all routes into CMHT from AUEC for known Service Users - to be incorporated into Ops Framework	Emma B, Tim, Kevin, Jason	**13/11/25: Linked to the Urgent Care Partnership work.** **2nd October** - Bernard to support development of SOP and to progress action - Update needed for 13th November	13th November		
9	04.09.25	Data	3, 4, 5	Action	Emma B to link with Admin leads to ensure weekly Care Coordination lists are being sent to DLT, to commence from 8th Sept, Emma to confirm SOP, include in Ops Framework and confirm escalation process	Emma B	**13/11/25: Emailed Emma A and Liz Cooksey - expectation this will be completed by the next meeting.** **2nd October** - Finalise care coordination list process (weekly single table collation to report into KPI reporting meeting) Emma to link with admin leads to confirm process - to be finalised for next meeting 13th November	13th November	In Progress	
10	04.09.25	Data	3, 4, 5	Action	Emma B and Michelle B to confirm who will be responsible for reviewing September 20 CS case pull for CMHTs	Emma B, Michelle B	**2nd October** - Not completed as waiting for confirmation re the form and where this is recorded. Liz T, Emma B and Siobhan to meet to discuss. To pull a sample list for October to enable to pull the data.	13th November	In Progress	
11	04.09.25	Data	3, 4, 5	Decision	Liz confirmed 20 CPA case pull for CMHTs to be given to medic leads for review - CSMs to be copied in	Liz	24/10/25: Liz to re-contact Siobhan to confirm list is being sent to CSMs.			
15	04.09.25	Data	18,19,20	Decision	Single data deck to be presented to ICB - 18+	All				
16	04.09.25	Pathway, Transition & Flow DNA	18,19,20	Action	Emma C to share CYP Divisions approach to DNA management	Emma C	**13 Nov - Emma is still chasing this information** **17th October:** This referenced a specific piece of work our urgent colleagues are completing following a PSII and I am chasing the written protocol. **2nd October** - Emma C has requested - Updated needed for next meeting 13th November	13th November	In Progress	
17	04.09.25	Pathway, Transition & Flow DNA	18,19,20	Action	Emma to share "late to follow up" review process and actions that are taken	Emma C	**13/11/25 Bernard to share the document that Emma has shared. Document shared with group.** **17th October:** Emma has hared the ToR **2nd October** - Emma C has requested - Updated needed for next meeting 13th November	13th November	Completed	LPFU_ToR_OCT 25_FINAL.docx
18	04.09.25	Pathway, Transition & Flow DNA	18,19,20	Action	Siobhan to pull re- referral rates for those after discharge and those who were not seen as suitable – to be shared and presented at FFP – again look at CYP version and where this is reported	Siobhan, Katie	13/11/25 To discuss under the main agenda 13/11/25: Siobhan has submitted the data with comments alongside it. **2nd October** - Data to be a focus on next meeting agenda 13th November	13th November	In Progress	
19	04.09.25	Pathway, Transition & Flow DNA	18,19,20	Action	Emma B to review the steps that are outlined re actions for those that don't attend appts – clarity on process taken for DNA's – explore how this is audited for assurance that those steps are being taken - to be included in Ops framework	Emma B	**13/11/25 - Completed to agree the audit for assurance. Bring into the FPP data and KPI waits and this can then be monitored locally - Emma to look at the monitoring tool. Next steps and process have been completed.** **Siobhan to pull out the complexity breakdown and more complex and those portion of DNA for a period and then do a sample.** **2nd October** - To be completed in readiness for next meeting 13th November	13th November	In Progress	
20	04.09.25	Pathway, Transition & Flow DNA	18,19,20	Action	Group members to look at what information is held re those service users who are unhappy with their discharge and how this is captured. To consider scoping out what happened with this cohorts – may need a cross selection of info – ie directly from teams, PALS, complaints (internal and external). Look at what other systems are doing	All	**13/11/25 - Adele to chase Sarah** **2nd October** - Support needed from Sarah Jones to link with other systems, consider what they do	13th November		
21	02.10.25	Data	3, 4, 5	Action	Update on CYP Complexity Metrics completion to be added to 13th November agenda	Emma, Manoj	**19/11/25 - Manoj to chase Katie**	13th November		
22	02.10.25	Governance Structure	27	Action	Sarah Jones to confirm up and coming meetings as part of ICB governance	Sarah Jones	**13/11/25 - due to go to MHP ESG 18 Nov, QPES 19 Nov, CQRM 20 Nov and BSMHFT Trust Board 3 Dec.** 17 October: CQRM will be chaired by Mental Health Provider Collaborative on Wednesday, 29th October. The Assertive and Intensive Plan review is on the agenda and will remain a standing item going forward.	13th November		
23	02.10.25	Governance Structure	29	Action	Strengthen medication assurance processes (non-concordance, MDT standards).	Sunday O/Liz T	**13/11/25 - manually recording locally on a spreadsheet - ensure to record consistently, pharmacy with the provider of EPMA of development as EPMA does not support recording collecting prescriptions. Conversations on 20 November with OPs next meeting. Emma to include into the SOP around teh non collection of medication and the process of escalation.** **Siobhan** 24/10/25: Ongoing discussions at the ICCR Medicines management meeting about a process on how CMHTs	13th November		
24	02.10.25	Governance Structure	28	Action	Integrate health inequalities into A&I action planning.	Claire R & Stephen S, Vita, Neelam & Samantha	**13/11/25 Claire R ensure that this is including into the EDA work and to review the plan or updates. Renu to meet with Steve and Claire for health inequalities. To include Manoj, Damien and Rachel.**	13th November		
26	02.10.25	Data	3, 4, 5	Action	Provide case study material for Reach Out workshop.	All	**13/11/2025 - James Reed happy to get involved with the CMHTs.** All to think of real life cases	13th November	Completed	
27	02.10.25	Care Planning	24	Action	Dialog+. Training mandated for all clinical staff. Renu to seek agreement with the other ADs	Renu	**13/11/2025:** Megan will be looking at the roll out of the training. It will be on line and then face to face and will start in ICCR	13th November	Completed	
28	02.10.25	Governance Structure	27,28,29,30,31	Action	Patient safety incidents – confirmation from all directorates how this is captured and assurance is provided.	Sam/Sadira	**13/11/25 - Update from Sadra learning from incidents. Was discussed at Learning from Deaths and the learning was shared with all directorates. Sadira has sent an email all Heads of Nursing and ADs. Cross directorate is still being worked through.**	13th November		
29	02.10.25	Workforce	8	Action	Asylum seekers either being deported or being moved to different accommodation and how this is communicated from the BCC to healthcare. To ensure that sharing agreements between health and the police are embedded. Steve S to link in with the BCC leads and Claire and Steve to liaise.	Steve S/Claire R	**13/11/25 - Trying to triangiate with BCC and reachout with the resettlement and migration team and have a formal agreement how to improve the communication. Meeting on 10 Claire and the police and Tim will be meeting with Steve Taylor. Clair meeting with Asylum Seeker newly arrive ICB workstream migration policy chair. Steve H to be involved in the meetings with the meetings along with Tim. Meeting with Steve S, Tim, Renu and Clair**	13th November		

Chase Helen Jones update
Chase Fav Cook update
Atuomated email if Clozapine and depot clinic has been missed
Chase Sam around actions 30/31
Chase Soohia around actions 1 & 2 and policies

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		
Partnership working		
	RAG key	**ICB self-assessment**
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.	**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.
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 (GP's, 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 Devlivery Partnerships in readines for Winter and the year ahead, these are due to be presented to goverannce forums during September 25.	

Workforce		
	RAG key	**ICB self-assessment**

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.	**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.
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 Matron posts. Directorate leadership teams oversee skill mix considerations as vacancies arise, supported by a comprehensive vacancy management process. All roles 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 profiles, 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 (covering Adults of Working Age CMHTs), compliance currently stands at 95%, with some teams achieving between 98–100%. Compliance levels remain consistently high. All staff across the Trust receive automated reminders.	
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 means that 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 remains Medic recruitment and advance practise.	

Community based care - access and oversight		
	RAG key	**ICB self-assessment**
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? Consider: • 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.	**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** • Policies discourage discharge after DNAs but are not fully embedded or monitored. • Pathways exist but may vary between services or 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.	Amber - Some policies and governance arrangements exist, but they are inconsistently applied, under development, or lack full alignment with best practice.

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? In addition, 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 refined 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 though liaison with medics to include additional service users for completeness: **1. Currently receiving treatment/intervention by another service (e.g. OOA, HHT, Specialty Service).** **2. Reviewed by another clinician under consultant supervision (e.g. another doctor, ANP).**
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?	The above caseload profiling work has commened and will require further refining, workshops with leads are planned for September to consider complexity pyramid and presentation criterias 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 inplementation of Patient Initiated Follow Up (PIFU) this will focus on the less complex

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 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.	
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 alondside the aforementioned workshops with leads that are planned for September to consider complexity pyramid and presentation criterias 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 inplementation of Patient Initiated Follow Up (PIFU) this will focus on the less complex service users on the caseloads to enable service users to initate their own follow ups safety and create capacity in caseloads to focus on teh More Complex and Complex caseloads. All of the this information will provide us with a map of our population need and will determine how their needs	

Out of hours provision		
	RAG key	**ICB self-assessment**

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.	**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**	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 when 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 operating hours.	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 strengthern 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 a an agreed standardised process Continue with collaborative pathway development across ICCR and AUEC Safety summit to review thematic responses from PSIRF and SI that span both directorates to consider improvement actions	

Care delivery		
	RAG key	**ICB self-assessment**
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.	**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.	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. From a AWA CMHT point of view for Services Users on CPA the CMHTs complete a monthly audit on AMaT looking at 10 cases per team who are supported under CPA/care co-ordinated. From August the questions around Dialog+ have had a more quality approach to them, prior to that form completion was the primary metric.. In AOTs, are looking at developing the quality audit so it's more specific to their client group. The AOT one is not currently on AMaT (but this will
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 BCHC 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	
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 Heffernan 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. **Family and Carer Engagement** Acute and Urgent Care (AUEC) colleagues routinely collect admission details and ensure families are invited to multidisciplinary team (MDT) meetings. DIALOG+ is being used across teams to enhance structured conversations with service users and carers. A 'Red Flag' document has been approved and implemented across CMHT duty areas, setting out immediate actions required when concerns are raised by families, carers, housing officers, or others. This was developed in response to learning from previous Serious Incidents (SIs) and is supported by updated Duty and MDT Standards, which have been circulated to all teams.	
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 BSMHFT modelled on the Nottingham TRust 'Safe Now' Data set is in development with a deadlines of	
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 VCFSE is also established and continues to mature allowing access to partner offers across the system to holistically support
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*

Theme	Area for Consideration/Action	Rating
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.	Yes but needs improvement
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 HSIB 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.	

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 in need of intensive and assertive community treatment.	NICE, recommended medication principles are followed. Pharmacy expertise is available to staff supporting this cohort. Ensure Staff 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.

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 define 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 race 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***

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 December 2025**
Date(s) of Committee Meeting(s) reported	**18 November 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff story • Board Assurance Framework • Corporate Risk Register • People Dashboard • People Strategy Update Report • Freedom to Speak Up Guardian Quarterly Report • Shaping our Future Workforce Committee Assurance Report • Transforming our Culture and Staff Experience Group Assurance Report • Employee Relations Report • Health Inequalities Report • Multi-Professional, Education and Training Group Assurance Report • Safer Staffing Report • Terms of Reference • Committee Effectiveness Self-Assessment Review
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • Ongoing challenges in relation to ESR data quality were raised, particularly around correct coding for professional groups which was impacting on training, registration and workforce reporting. A data cleanse was underway to support improvements. • Legacy HR and casework issues from the CYP workforce transfer was impacting on capacity in the People team, however timely resolution and consistent values modelling was a key focus. • Employee relations data showed a reduction in active cases, however there were long-standing cases and over-representation of global majority staff and men subject to formal cases. • Attendance and engagement at some subcommittees required improvement to ensure robust governance and representation.
Assure:	• Vacancy rates were improving, and the Trust was in a strong position for registered nursing staff; a strong pipeline was in place and there was good retention of internationally educated nurses. • Strategic workforce planning was becoming more proactive, with multi-year planning, strong university partnerships and a focus on integrated, multidisciplinary teams. • There were no red-rated People goals for the quarter, reflecting progress on key metrics such as vacancy, training compliance and engagement.

	• The Committee was pleased to acknowledge the positive work of the Freedom to Speak Up Champions.	
Advise:	The Committee noted that a deep dive into employee relations would take place in the new year. There would be continued focus on behavioural and cultural change and accountability in data management, ESR and recruitment processes to ensure sustainable improvements. The Committee discussed the need to maintain and strengthen local accountability for health inequalities.	
Board Assurance Framework	The Committee scrutinised the following risks: • Failure to create a positive working culture that is anti-racist and anti-discriminatory. • Inability to attract, retain or transform our workforce in response to the needs of our communities. The Committee discussed the continued triangulation of workforce metrics, Freedom to Speak Up, and risk to identify gaps and drive joined-up improvements.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Monica Shafaq, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**People Committee**	
Report presented at	**Board of Directors**	
Date of meeting	**3 December 2025**	
Date(s) of Committee Meeting(s) reported	**21 October 2025**	
Quoracy	**Membership quorate: Y**	
Agenda	The Committee held a strategy session which focused on the Sexual Safety Charter and Policy.	
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • Concern was raised in relation to the capacity within the organisation to manage the potential increase in reported cases and associated investigation processes. • The Committee was keen to understand the zero tolerance approach and what this would mean for any members of staff or service users displaying sexual misconduct. • The Committee sought assurance that all staff working on wards were safe to come to work.	
Assure:	The Committee was assured by the plan for the launch of the Policy which started on 20 October, and was encouraged by the communications plan to raise awareness of sexual misconduct.	
Advise:	The Committee sought clarification on the data metrics and indicators that were used to measure impact of the Charter. The Committee discussed the need to ensure trauma-informed support for staff and sought further assurance on how this would be developed. The inclusion of Experts by Experience in development of new initiatives was raised and the Committee highlighted the significant contributions that could be made by those with lived experience.	
Board Assurance Framework	The Committee scrutinised the following risks: • Failure to create a positive working culture that is anti-racist and anti-discriminatory. • Inability to attract, retain or transform our workforce in response to the needs of our communities. The Committee discussed how the Sexual Safety Charter and Policy linked to the BAF risk to attract, retain and transform the workforce for the Trust to become an employer of choice.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Sue Bedward, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Report to Board of Directors

Agenda item:	**17**					
Date	3 December 2025					
Title	Guardian of Safe Working Hours Q2 Report					
Author/Presenter	Hari Shanmugaratnam, Guardian of Safe Working					
Executive Director	Fabida Aria, Executive Medical Director	**Approved**	**Y**	✓	**N**	

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

Summary of Report

Alert		**Advise**	✓	**Assure**	

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

- No immediate safety concerns were raised during this quarter.
- Exception reporting rates have increased slightly this quarter. 11 unique exception reports were raised during this quarter, of which 100% related to overtime working.
- 3 fines were levied against the Trust for breaches in safe working hours.
- The number of outstanding reports carried forward has increased to 7.
- The number of vacant shifts continues to be high. 421 locum bookings occurred in Q2 (in 2024-2025, Q1 had 370, Q2 had 260, Q3 had 191, Q4 had 280). 46% of the gaps were due to post vacancies. 419/421 on call locum vacancies during this period were filled.

Recommendation

The Board is asked to receive the report for assurance, noting that there is oversight of safe working hours for junior doctors in the Trust and that appropriate actions are being taken in response to concerns raised.

Enclosures

N/A

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

July– September 2025

High level data
Number of doctors / dentists in training (total): 147 in July, 138 in August, 137 in September

Number of doctors / dentists in training on 2016 TCS (total): 147 in July, 138 in August, 137 in September

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

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

a) Exception reports

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	1	1	0
CT1-3	2	8	5	5
ST 3-6	0	2	0	2
GPVTS	0	0	0	0
Total	2	11	6	7

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY2 – CT3 (Rotas 1-6)	2	9	6	5
ST North	0	0	0	0
ST South	0	2	0	2
ST Forensic	0	0	0	0
Total	0	11	6	7

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	0
F2	0	0	1	0
CT1-3	0	1	4	5
ST3-6	0	0	0	2
GPVTS	0	0	0	0
Total	0	1	5	7

b) Type of exceptions in the quarter:

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

Of the 11 exception reports; 11 related to working overtime.

c) Work Schedule Reviews

Status;

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

d) Locum bookings and vacancies

Locum bookings JULY 2025 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	10	10	114	114
Rota 2	15	15	159	159
Rota 3	5	5	60	60
Rota 4	18	18	180.25	180.25
Rota 5	15	15	158.50	158.50
Rota 6	26	26	229.50	229.50
CAMHS CT	2	2	48	48
ST4-6 North & East	15	15	122	122
ST4-6 Rea/Tam	9	9	152	152
ST4-6 South & Solihull	24	24	238	238
CAMHS ST	13	13	224	224
FTB (CYP) ST	10	10	168	168
Total	162	162	1853.25	1853.25
Locum bookings AUGUST 2025 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	10	10	98.50	98.50
Rota 2	12	12	122	122
Rota 3	15	15	157.50	157.50
Rota 4	7	5	63.50	46.50
Rota 5	17	17	167	167
Rota 6	19	19	186.50	186.50
CAMHS CT	4	4	80	80

ST4-6 North & East	25	25	244	244
ST4-6 Rea/Tam	5	5	88	88
ST4-6 South & Solihull	16	16	172	172
CAMHS ST	18	18	336	336
FTB (CYP) ST	3	3	56	56
Total	151	149	1771.00	1754.00

Locum bookings SEPTEMBER 2025 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	9	9	94.50	94.50
Rota 2	10	10	91	91
Rota 3	13	13	112	112
Rota 4	12	12	136.50	136.50
Rota 5	8	8	76.50	76.50
Rota 6	8	8	88.50	88.50
CAMHS CT	2	2	32	32
ST4-6 North & East	6	6	65.50	65.50
ST4-6 Rea/Tam	9	9	160	160
ST4-6 South & Solihull	15	15	143.50	143.50
CAMHS ST	16	16	296	296
Total	108	108	1296.00	1296.00

**It might also be useful to include a narrative explaining how the work left uncovered by unfilled requests was delivered. For example: Were clinics cancelled? Were teams left to cope with fewer staff? Did consultants pick up the slack? Did non-resident on-call staff have to come in and so breach rest requirements?*

Locum bookings JULY 2025 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	91	91	949.25	949.25
ST4-6	71	71	904.00	904.00
Total	162	162	1853.25	1853.25

Locum bookings August 2025 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	84	82	875	858
ST4-6	67	67	896	896
Total	151	149	1771.00	1754.00
Locum bookings September 2025 by grade				

Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	62	62	631	631
ST4-6	46	46	665	665
Total	108	108	1296.00	1296.00

Locum bookings JULY 2025 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
New Intake	0	0	0	0
Vacancy	68	68	805.00	805.00
Sickness	48	48	529.25	529.25
Off Rota	40	40	441.50	441.50
Study Leave	0	0	0	0
Emergency Leave / Bereavement	0	0	0	0
Maternity / Paternity / Paternal Leave	0	0	0	0
Prebooked Leave based on Rotas from Aug 24 to Feb 25	0	0	0	0
Acting Up Consultant	6	6	77.50	77.50
Total	162	162	1853.25	1853.25

Locum bookings AUGUST 2025 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	20	19	165	160.50
Vacancy	84	83	1067	1054.50
Sickness	20	20	233	233
COVID	0	0	0	0
Off Rota	18	18	185	185
Comp Leave / Bereavement	0	0	0	0
Parental Leave	0	0	0	0
Emergency Leave	1	1	4.50	4.50
Acting Up Consultant	7	7	92.50	92.50
Total	151	149	1771.00	1754.00

Locum bookings SEPTEMBER 2025 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	42	42	516.50	516.50
Sickness	18	18	203	203
UNPAID LEAVE	2	2	24	24
Off Rota	26	26	271	271

Coroners Court Preparations	2	2	24	24
Exam / Study Leave	7	7	84	84
Emergency Leave / Bereavement	0	0	0	0
Actg up Consultant	11	11	173.50	173.50
Total	108	108	1296.00	1296.00

Fines levied

Three fines have been levied in Q2. Ideas for disbursement of previously accrued fines will be discussed and agreed at the Junior Doctor Forum.

Issues arising

The overall number of exception reports has increased slightly, with 11 unique reports submitted during the quarter. Similar to the previous quarters for the year 2024-2025, the majority of exception reports related to overtime (working beyond scheduled hours) rather breaches of core rest requirements overnight.

The number of vacant shifts continues to be high. 421 locum bookings occurred in Q2 (in 2024-2025, Q1 had 370, Q2 had 260, Q3 had 191, Q4 had 280). 46% of the gaps were due to post vacancies. 419/421 on call locum vacancies during this period were filled.

Actions taken to resolve issues
See above.

Summary

No immediate safety concerns were raised during this quarter. Exception reporting rates have remained stable. 11 unique exception reports were raised during this quarter, of which 100% related to overtime working.

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

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

Out of the reports closed, only 0% were within 48 hours and a further 17% were within 7 days (however, its important to note there were very few exception reports this quarter so the sample size is low).

The number of vacant shifts continues to be high. 421 locum bookings occurred in Q2 (in 2024-2025, Q1 had 370, Q2 had 260, Q3 had 191, Q4 had 280). 46% of the gaps were due to post vacancies. 419/421 on call locum vacancies during this period were filled.

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

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 December 2025**
Date(s) of Committee Meeting(s) reported	**20 November 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Corporate Risk Register • Integrated Performance Report • Finance Report and Planning Update • Solar Contract Performance Notice • CYP Transfer Progress Report • Trust Strategy: Sustainability and Clinical Services Report • Terms of Reference • Committee Effectiveness Self-Assessment Review
Alert:	• The Month 7 position was a reported deficit of £0.1m, which was £2.5m adverse to plan but £0.1m ahead of the financial recovery trajectory. • There were some risks associated with the financial recovery plan, including reliance on reductions in non-trust bed expenditure and temporary staffing, and assumptions around provider collaborative income. The risk around the potential £2m tier 4 CYP service was also highlighted. • In the absence of national planning guidance for 2026/27, national allocations had yet to be finalised. The Committee received assurance that internal planning had been progressing for some time and that the Trust was proactively positioning itself to respond effectively once the national guidance is published. • The continued disproportionate reliance on non-recurrent savings—and its impact on long-term financial sustainability—was again discussed. The Committee was assured that, given the timing of the Trust's strategy refresh, elements of the refreshed strategy would be incorporated into the Trust's overall cost-reduction programme for 2026/27. • The Committee highlighted the continued issues within Talking Therapies, related to significant waiting times and delivery against plan, and requested assurance on actions to address these issues.

Assure:	There was acknowledgement of the amount of positive work that was happening across the organisation; particularly the improved bed management trajectory, bank spend and financial recovery trajectory. The Committee discussed the broader benefits and impact of the Trust managing its inappropriate out of area placements and spot purchase beds. Quality, Patient Experience and Safety Committee would review any potential adverse impact on quality. Whilst recognising the need for continued improvement in bed management and temporary staffing, the Committee was assured that the Trust was well positioned to achieve its year-end outcome.	
Advise:	The Committee noted the contract performance notice that had been issued to Solar and sought assurance that an escalation framework would be implemented in order to raise and mitigate issues sooner. Additionally, as some of the issues affecting Solar were systemic rather than solely operational, the Committee also sought assurance on how the Trust would identify and address these challenges in the long term. The Committee noted the good performance in relation to agency spend, although it was highlighted that CYP workforce had increased overall agency use.	
Board Assurance Framework	The Committee considered the three risks: • Failure to maintain a long-term, sustainable financial position • Failure to maintain acceptable governance and national standards • Failure to deliver optimal outcomes with available resources The Committee reflected on how well the BAF was driving discussions. Consideration would be given to how cyber security was incorporated.	
	New risks identified: No new risks were identified.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 December 2025**
Date(s) of Committee Meeting(s) reported	**23 October 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 • Digital and Technology Assurance Report • Green Plan • Terms of Reference Review
Alert:	• The Month 6 position was a reported deficit of £0.8m, which was £2.9m adverse to plan. This was an improvement of £0.7m compared to August, mainly driven by balance sheet flexibility in line with the financial recovery plan. The year-to-date position was £0.1m ahead of the financial recovery trajectory. • The Committee noted that the financial recovery plan trajectory should provide the Trust with a line of sight to an improved National Oversight Framework segmentation. • It was forecast that the savings target for 2025/26 would be achieved through non-recurrent means. The Committee noted that operational areas were submitting 2026/27 savings plans for assessment, but concern remained about transformational and sustainable long-term delivery. • The Committee remained concerned about the transformative nature of plans and the alignment between the strategy refresh, quality improvement initiatives, cost reduction programme, digital, estates and the Green Plan, and the pace of change. The Committee was not assured on the ability to convert plans and ideas into reality.
Assure:	The Committee approved the Green Plan in accordance with its delegated authority from the Board. There was acknowledgement of the amount of positive work that was happening across the organisation; particularly the continued evolution of the Integrated Performance Report; the inclusion of CYP; the good progress made on Out of Area placements and non-contracted beds; continued

	positive progress on agency spend and some progress being reported on bank spend.	
Advise:	The Committee noted the amount of work happening within digital and technology, however the need to link this to the strategy and overall transformational change was advised.	
Board Assurance Framework	The Committee considered the three risks: • Failure to maintain a long-term, sustainable financial position • Failure to maintain acceptable governance and national standards • Failure to deliver optimal outcomes with available resources The Committee reflected on how well the BAF was driving discussions. Consideration would be given to how cyber security was incorporated.	
	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

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors							
Agenda item:	**19**						
Date	3 December 2025						
Title	Month 7 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 7 year to date financial position.

Introduction

The month 7 year to date consolidated Group position is a deficit of £0.1m. This is £2.5m adverse to original plan and £0.1m ahead of the financial recovery trajectory.

The draft month 7 BSOL ICS financial position is a £40m deficit. This is £25m adverse to plan and £1m adverse to the financial recovery trajectory.

Key Issues and Risks

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

- **Deficit position and financial recovery plan** –The financial recovery plan, submitted to NHSE on 8.9.25 has been developed with a trajectory to recover year to date overspend and meet the original plan surplus of £4.2m. The month 7 year to date position is £0.1m better than trajectory, however, there are some risks in the financial recovery mitigations. These include reliance on non-trust bed expenditure and temporary staffing being reduced to meet original plan levels and an assumption that £2m Toucan Provider Collaborative income will be received – still to be confirmed.

- **Group Underlying position -** 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.

- **Savings** – The 2025/26 savings target is £36m. The month 7 year to date savings achieved is £19m, this is £2m 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. Work is underway to develop recurrent savings plans for 2026/27.

- **Temporary staffing** - The month 7 year to date spend of £20m is £0.6m above the temporary staffing trajectory set as part of the financial recovery plan.
- **Bank**: A reduction in spend of £0.2m per month is required from month 8 onwards to stay within the financial recovery trajectory. The Executive Director of Nursing is leading the Bank Reduction Gold project to progress actions to meet required expenditure reduction.
- **Agency:** The financial recovery trajectory requires a reduction in spend from the October level of £0.3m per month. There has been a significant reduction in non-CYP agency spend in recent months. This improvement has been offset by CYP agency spend which equates to 41% of the total year to date agency spend and is a risk to achievement of the agency trajectory.

Capital position:

The month 7 year to date 2025/26 Group capital expenditure is £3.5m, this is £6.2m adverse to plan and £2m behind forecast. The capital plan was phased equally across the year.

Cash position:

The Group cash position at the end of month 7 was £101m, including £32m Trust cash balance.

Recommendation

The Board is asked to review the month 7 year to date financial position and discuss the key alerts noted.

Enclosures

Month 7 2025/26 finance report

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2025 to 31st October 2025

Group financial position
£0.1m deficit YTD

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

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	414,681	409,038	(5,643)
Other Income	24,081	-	8,343	32,424	17,755	20,905	3,149
Total Income	**730,148**	**4,638**	**8,744**	**743,530**	**432,437**	**429,942**	**(2,494)**
Expenditure							
Pay	(319,512)	(2,750)	(24,460)	(346,722)	(198,812)	(198,030)	781
Other Non Pay Expenditure	(369,431)	(1,888)	18,112	(353,207)	(208,524)	(208,792)	(269)
Drugs	(6,058)	-	(1,320)	(7,378)	(4,120)	(5,478)	(1,357)
Clinical Supplies	(684)	-	(23)	(707)	(409)	(473)	(64)
PFI	(13,896)	-	-	(13,896)	(8,106)	(8,164)	(58)
EBITDA	**20,566**	**-**	**1,053**	**21,619**	**12,465**	**9,004**	**(3,462)**
Capital Financing							
Depreciation	(10,033)	-	(795)	(10,828)	(6,206)	(5,815)	391
PDC Dividend	(500)	-	-	(500)	(292)	(292)	(0)
Finance Lease	(6,939)	-	-	(6,939)	(5,153)	(5,187)	(34)
Loan Interest Payable	(882)	-	(258)	(1,140)	(629)	(532)	97
Loan Interest Receivable	3,376	-	-	3,376	1,969	2,440	470
Surplus / (Deficit) before taxation	**5,588**	**-**	**-**	**5,588**	**2,155**	**(382)**	**(2,537)**
Taxation	(380)	-	-	(380)	(222)	(228)	(6)
Surplus / (Deficit)	**5,208**	**-**	**-**	**5,208**	**1,933**	**(609)**	**(2,543)**
Adjusted Financial Performance:							
Remove capital donations/grants/peppercorn lease I&E impact	5	-	-	5	3	3	-
Adjust PFI revenue costs to UK GAAP basis	(1,013)	-	-	(1,013)	501	501	-
Adjusted financial performance Surplus / (Deficit)	**4,200**	**-**	**-**	**4,200**	**2,437**	**(106)**	**(2,543)**

The Group position is driven by a £10k deficit in the Trust, £106k deficit for Summerhill Services Limited (SSL), break even position for the Mental Health Provider Collaborative (MHPC) and a surplus of £146k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

Month 7 2025/26 Group Financial Position

The month 7 year to date consolidated Group position is a deficit of £0.1m (after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 of £0.5m). This is £2.5m adverse to original plan and £0.1m better than the year to date financial recovery plan submitted to NHSE in September.

There is a £2.2m shortfall on savings year to date, with a forecast £15m recurrent rollover savings target contributing to underlying deficit (page 9). Month 7 has seen non-Trust adult beds spend sustained at reduced level for the third consecutive month, this is ahead of the financial recovery trajectory (page 10). Temporary staffing spend in October has reduced by £0.1m compared to September but currently adverse to the financial recovery trajectory (page 11 to 13).

The BSMHFT NOF combined finance score published at quarter 1 was a 3. This improved to a 2 at the end of quarter 2 and remains a 2 at month 7 year to date (page 7)

NOF - Finance	Q1	Q2	M7 YTD
NOF variance YTD to plan score	4	3	3
NOF plan surplus/deficit score	1	1	1
NOF combined finance score	3	2	2

Group position Segmental summary – YTD Actual

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Trust	SSL	Reach Out	BSOL PC	Consolidation	Group
	Actual	Actual	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	248,869	-	98,332	279,393	(217,557)	409,038
Other Income	20,510	17,025	-	0	(16,630)	20,905
Total Income	**269,379**	**17,025**	**98,332**	**279,393**	**(234,187)**	**429,942**
Expenditure						
Pay	(186,651)	(7,846)	(1,608)	(2,118)	193	(198,030)
Other Non Pay Expenditure	(61,199)	(4,348)	(97,253)	(278,082)	232,090	(208,792)
Drugs	(5,719)	(1,443)	-	-	1,684	(5,478)
Clinical Supplies	(473)	-	-	-	-	(473)
PFI	(8,164)	-	-	-	-	(8,164)
EBITDA	**7,172**	**3,387**	**(529)**	**(807)**	**(220)**	**9,004**
Capital Financing						
Depreciation	(3,792)	(1,907)	-	-	(116)	(5,815)
PDC Dividend	(292)	-	-	-	-	(292)
Finance Lease	(5,179)	(208)	-	-	200	(5,187)
Loan Interest Payable	(527)	(1,183)	-	-	1,178	(532)
Loan Interest Receivable	2,105	32	675	807	(1,178)	2,440
Surplus / (Deficit) before Taxation	**(513)**	**122**	**146**	**0**	**(136)**	**(382)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(228)	-	-	-	(228)
Surplus / (Deficit)	**(513)**	**(106)**	**146**	**0**	**(136)**	**(609)**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	3	-	-	-	-	3
Adjust PFI revenue costs to UK GAAP basis	501					501
Adjusted financial performance Surplus / (Deficit)	**(10)**	**(106)**	**146**	**0**	**(136)**	**(106)**

Draft System position Month 7 YTD

The draft month 7 year to date financial position for Birmingham and Solihull Integrated Care System (BSOL ICS) is a deficit of £40m which is £25m adverse to plan. This is predominantly driven by UHB deficit of £31m, BWCH deficit of £6m and ICB deficit of £2m.

The £40m year to date system deficit is £1.1m adverse to the year to date financial recovery plan, with UHB £3.8m behind recovery plan.

Total Performance	YTD			FOT			Prior Month variance
	Current Plan £000s	Actual £000s	Variance £000s	Annual Plar £000s	FOT £000s	Variance £000s	£000s
BSOL ICB	-3,393	-2,247	1,146	0	0	0	1,280
BSMHT	2,437	-106	-2,543	4,200	4,200	0	-2,858
BCHC	408	-608	-1,016	0	0	0	-1,357
BWC	0	-5,624	-5,624	0	0	0	-4,741
ROH	-590	-587	3	35	35	0	68
UHB	-14,143	-31,216	-17,073	-4,200	-4,200	0	-13,640
Total	-15,281	-40,388	-25,107	35	35	0	-21,248

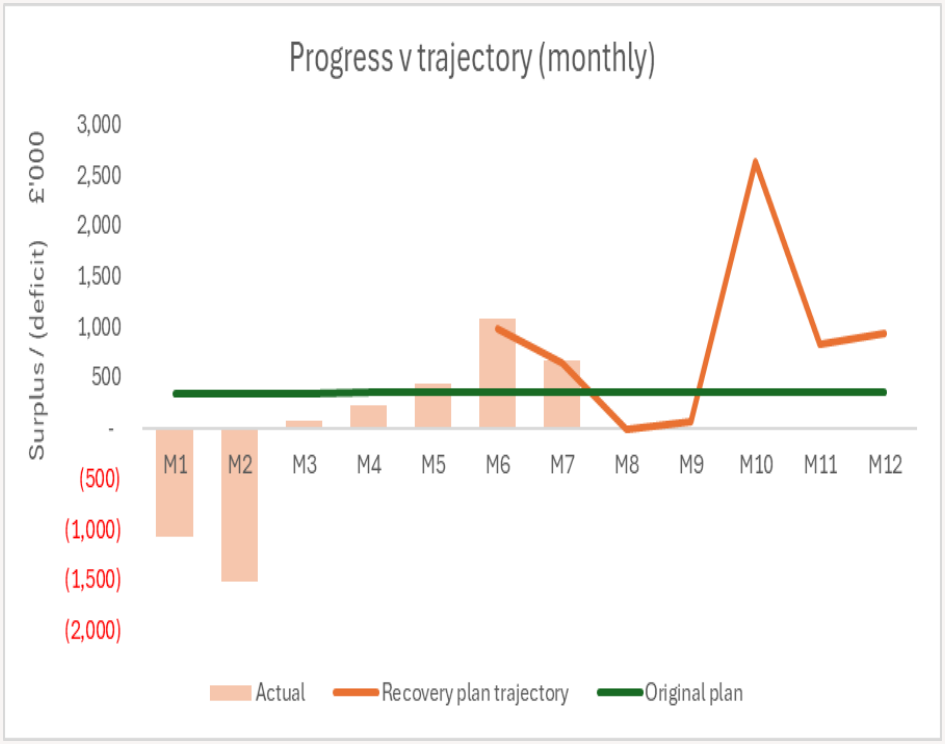
Total Performance	Revised FY Trajectory £000s	Original Plan £000s	Variance vs original plan £000s	Against Recovery plan YTD Trajectory £000s	Actual £000s	Variance £000s
BSOL ICB	0	0	0	-3,393	-2,247	1,146
BSMHT	4,209	4,200	9	-224	-106	118
BCHC	0	0	0	-935	-608	327
BWC	0	0	0	-6,667	-5,624	1,043
ROH	35	35	0	-590	-587	3
UHB	-15,318	-4,200	-11,118	-27,455	-31,216	-3,761
Total	-11,074	35	-11,109	-39,264	-40,388	-1,124

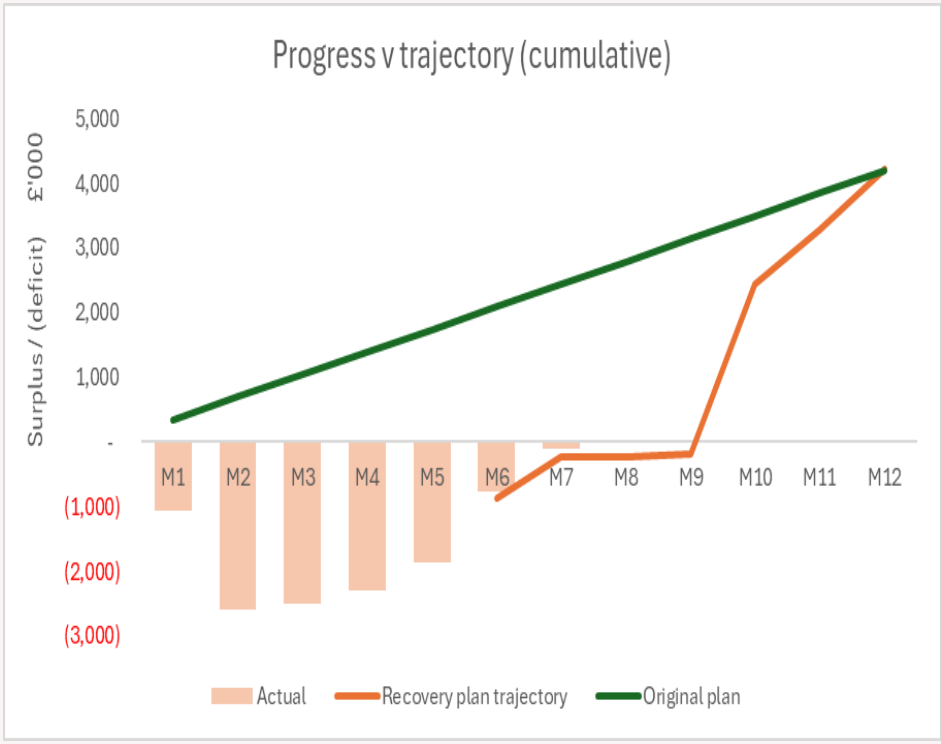
Actual v financial recovery trajectory

Birmingham and Solihull Mental Health NHS Foundation Trust

Financial Recovery Plan

Submitted to NHSE September 20025. Trajectory for month 6 to 12 to recover the financial position – forecast that the original 2025/26 plan surplus of £4.2m will be achieved. Month 7 year to date £0.1m ahead of trajectory.





Financial recovery mitigations

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total	Is mitigation still valid?	Impact on underlying?
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
M5 FOT surplus / (deficit)	(1,070)	(1,512)	76	221	432	(260)	(833)	(859)	(878)	(910)	(927)	(792)	(7,312)		
Bank back to plan	-	-	-	-	-	627	627	656	668	693	786	441	4,498	✓	✓
Agency back to plan	-	-	-	-	-	-	324	324	324	324	324	324	1,942	✓	✓
Beds updated trajectory	-	-	-	-	-	(31)	41	103	63	63	193	63	498	✓	✓
Technical adjustments	-	-	-	-	-	545	893	143	143	143	143	483	2,492	✓	☒
Provider Collaborative contribution	-	-	-	-	-	-	-	-	-	2,000	-	-	2,000	✓	☒
Bank pay award	-	-	-	-	-	(92)	(92)	(92)	(92)	(92)	(92)	(92)	(641)	✓	✓
Risk on bank achievement	-	-	-	-	-	(143)	(143)	(143)	(143)	(143)	(143)	(143)	(1,000)	✓	✓
BHM income recovery	-	-	-	-	-	-	-	-	-	133	133	133	400	☒	☒
Mpower funding NR	-	-	-	-	-	333	-	-	-	-	-	-	333	✓	☒
Recovery House staffing	-	-	-	-	-	-	(48)	(48)	(48)	(48)	(48)	(48)	(289)	✓	✓
Student nurse recruitment	-	-	-	-	-	-	(119)	(119)	(119)	(119)	(119)	(119)	(712)	☒	☒
E&T income	-	-	-	-	-	-	-	-	-	167	167	167	500	✓	☒
ICRT2 income	-	-	-	-	-	-	-	-	63	63	63	63	250	✓	✓
Drugs reduction	-	-	-	-	-	-	-	-	-	83	83	83	250	✓	✓
B1 running costs	-	-	-	-	-	-	-	-	40	40	40	40	160	✓	✓
B1 dilapidations	-	-	-	-	-	-	-	-	-	-	-	100	100	✓	✓
Admin review	-	-	-	-	-	-	-	20	40	60	60	60	240	✓	✓
OH & margin on new business	-	-	-	-	-	-	-	-	-	167	167	167	500	✓	☒
Revised FOT surplus / (deficit)	(1,070)	(1,512)	76	221	432	979	650	(14)	62	2,624	830	930	4,209		

The above table shows the financial recovery plan, set based on month 5 forecast. Due to additional release of prior year accruals, an element of balance sheet flexibility has not been utilised to date, with opportunity for use in future months.

National Oversight Framework (NOF)

NHS
Birmingham and Solihull Mental Health

	Actual £'000					Forecast £'000	
	Q1	M4 YTD	M5 YTD	Q2	M7 YTD	Q3	Q4
YTD actual	(2,506)	(2,286)	(1,853)	(770)	(104)	(3)	4,202
YTD variance to trajectory	-	-	-	104	120		
YTD plan	1,041	1,389	1,737	2,086	2,437	3,141	4,200
YTD variance to plan	(3,547)	(3,675)	(3,590)	(2,856)	(2,541)	(3,144)	2
YTD income	179,694	242,210	303,076	364,145	429,942	557,231	756,579
YTD variance to plan as % of YTD income	-1.97%	-1.52%	-1.18%	-0.78%	-0.59%	-0.56%	0.00%

National Oversight Framework

	Q1	M4 YTD	M5 YTD	Q2	M7 YTD	Q3	Q4
NOF - Finance							
NOF variance YTD to plan score	4	4	4	3	3	3	1
NOF plan surplus/deficit score	1	1	1	1	1	1	1
NOF combined finance score	3	3	3	2	2	2	1
NOF - Productivity							
Relative difference in costs score	2	2	2	2	2	2	2
NOF Finance & productivity domain score	3	3	3	2	2	2	2

NOF – Finance and Productivity domain score
Calculated by averaging the NOF combined finance score and the NOF – Productivity score. This is currently assessed as a score of 2 at month 7 year to date which is an improvement from the published quarter 1 score of 3 due to the improvement in the combined finance score.

NOF combined finance score
The NOF combined finance score is calculated by averaging:
(A) the year to date variance to financial plan score and
(B) the planned surplus/deficit score.

(A) YTD variance to plan score:
The year to date variance to plan as a percentage of year to date income, scored as follows:

1	On plan or better
2	Below 0.5% variance
3	Between 0.5% and 1% variance
4	Beyond 1% variance

The BSMHFT YTD variance to plan percentage has improved from 1.97% at quarter 1 (score 4) to 0.59% at month 7 year to date (score 3)

(B) Plan surplus/deficit score:

1	0% or surplus
2	below 1%
3	between 1% and 2%
4	beyond 2%

The BSMHFT will be a score of 1 for this metric for the whole year as the financial plan set for 2025/26 is a surplus.

BSMHFT NOF combined finance score
For month 7 year to date, this is a score of 2 (score of 3 published at quarter 1), which is an improvement due to a reduction in the year to date variance to plan. The score is forecast to improve to 1 by the end of the year in line with the financial recovery plan.

The NOF – Productivity score - relative difference in costs score published at quarter 1 was 2.09 based on our 2023/24 National Cost Collection index score. The 2024/25 score has shown an improvement in our score, the impact on the NOF productivity score is still to be determined based on our comparative cost value compared to other organisations – we await quarter 2 NOF scores (see appendix 2).

Underlying position

Group Underlying position

In line with discussions at month 5 and month 6 FPP Committee, the underlying position is currently assessed as £25.5m deficit:

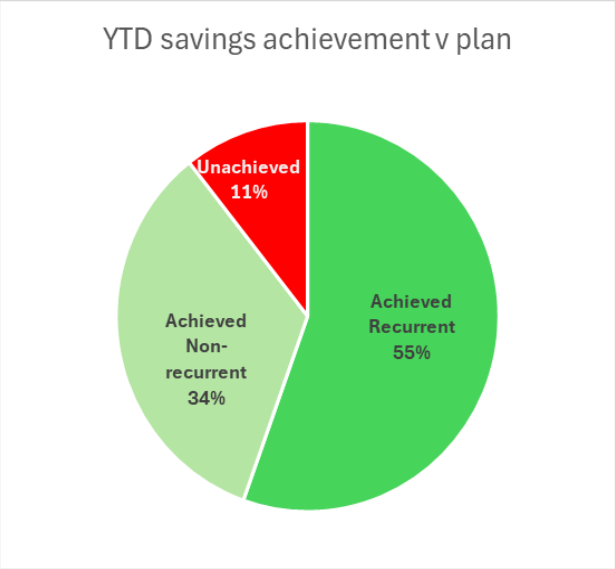
- £15m rollover of recurrent savings target (forecast to deliver non-recurrently in 2025/26 (see page 8).
- £5m underlying deficit in the Mental Health provider collaborative related to packages of care volume and inflation increases .
- £2m underlying deficit in Reach Out provider collaborative related to growth in secure inpatient beds usage.
- In addition, discussions continue between CFOs from BSMHFT and BWCH around the CYP underlying position which is currently showing a £3.5m to £4m recurrent deficit.

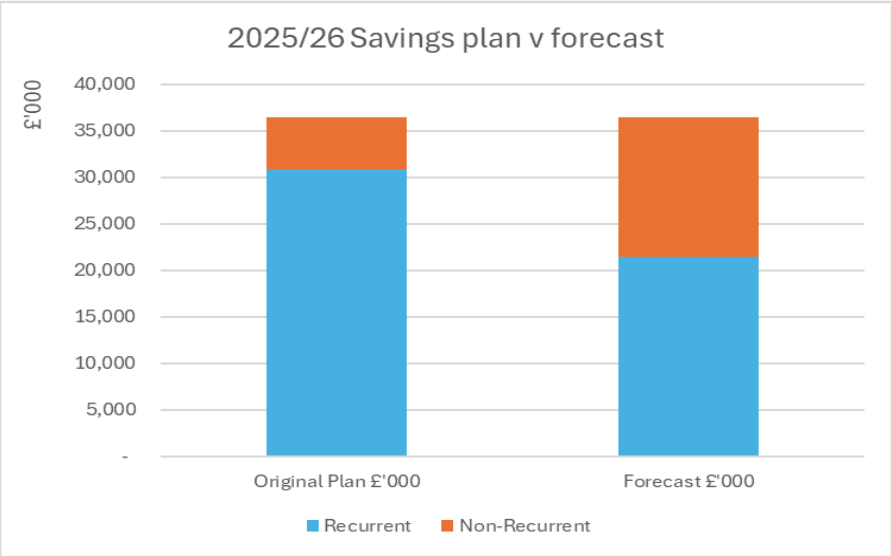
A meeting was held with regional NHSE finance and the ICB to discuss the underlying position on 5.11.25. In line with NHSE guidance, there is a requirement to identify mitigations across the Group to address the underlying deficit – work is underway. See appendix 1 for initial assessment against key lines of enquiry.

Provider Underlying position		27BRD04A	27BRD04B	27BRD04C	27BRD04D	27BRD04E	27BRD04F
	Expected Sign	Income Forecast 31/03/2026 Year ending £'000	Employee Expenses Forecast 31/03/2026 Year ending £'000	Operating expenses excluding employee expenses Forecast 31/03/2026 Year ending £'000	Non Operating Items Forecast 31/03/2026 Year ending £'000	Adjusted Financial Performance Forecast 31/03/2026 Year ending £'000	Commentary Desc 31/03/2026 Year ending FREE TEXT
2025/26 Forecast	+/-	756,580	(345,699)	(401,149)	(5,532)	4,200	
Forecast non-recurring efficiencies	+/-	(3,129)	(3,928)	(7,958)	0	(15,015)	
Forecast deficit support funding	+/-	0				0	
FYE of forecast recurring efficiencies - cash releasing	+/-	0	0	0	0	0	
FYE of forecast recurring efficiencies - non-cash releasing (Transformational / Other)	+/-	(0)	0	0	0	0	
FYE of forecast investments	+/-	0	0	0	0	0	
Gains and losses and donations	+/-	0		5	(5)	0	
Non-Recurring Redundancy costs	+/-		0	0		0	
Non-Recurring Cost of Change (Excluding redundancy)	+/-		0	0	0	0	
Other impacts - 1	+/-	(4,200)	0	0	0	(4,200)	Remove Non-Rec system reserve funding
Other impacts - 2	+/-	(3,500)	0	0	0	(3,500)	CYP Rec Income shortfall
Other impacts - 3	+/-	0	0	(5,000)	0	(5,000)	MHPC - Packages of care volume and inflation increases
Other impacts - 4	+/-	0	0	(2,000)	0	(2,000)	RO PC - Growth in Secure Inpatient beds
Other impacts - 5	+/-	0	0	0	0	0	
Other impacts - 6	+/-	0	0	0	0	0	
Other impacts - 7	+/-	0	0	0	0	0	
Other impacts - 8	+/-	0	0	0	0	0	
Other impacts - 9	+/-	0	0	0	0	0	
Other impacts - 10	+/-	0	0	0	0	0	
2025/26 Underlying Position	+/-	745,751	(349,627)	(416,102)	(5,537)	(25,515)	

Efficiencies

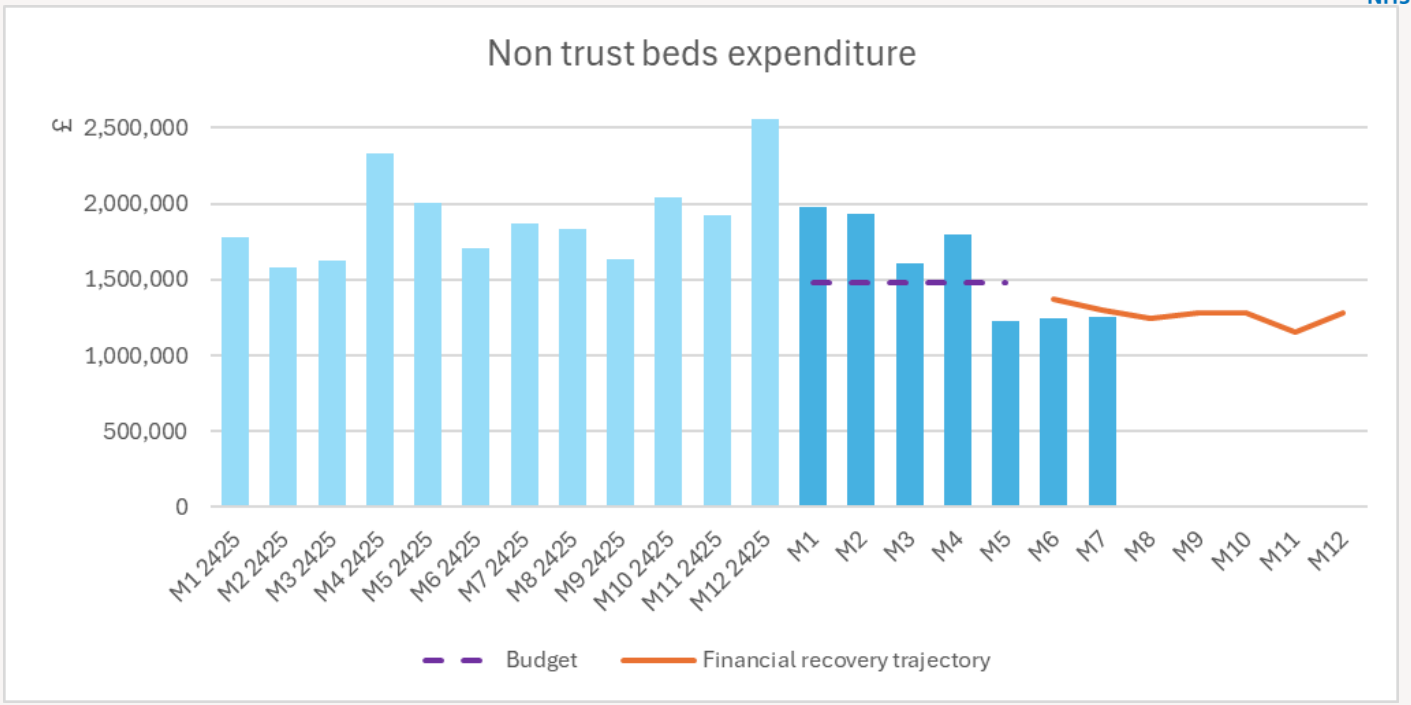
	Year to date			Annual		
	Original Plan £'000	Actual £'000	Variance £'000	Original Plan £'000	Forecast £'000	Variance £'000
Non-Recurrent	3,226	7,066	3,840	5,529	15,015	9,486
Recurrent	17,597	11,548	(6,049)	30,879	21,393	(9,486)
Total	**20,823**	**18,613**	**(2,210)**	**36,408**	**36,408**	**-**

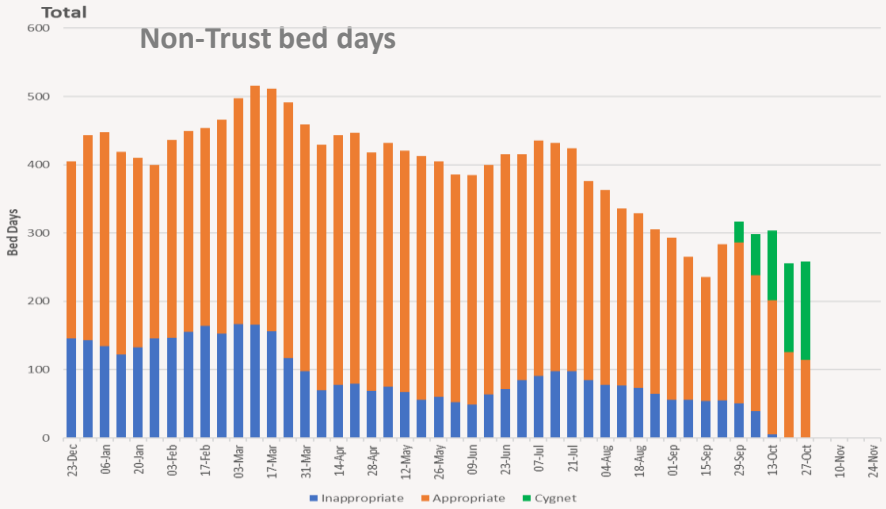




- The 2025/26 efficiency target is £36.4m. This comprises £30.9m recurrent and £5.5m non recurrent targets.
- The month 7 year to date savings achieved is £18.6m, this is £2.2m adverse to plan.
- It is forecast that £36m savings will be delivered but £15m savings will be achieved non-recurrently. This £15m savings target will roll forward to 2026/27 and is a key factor of the underlying position (page 8).

Non-Trust Beds overspend

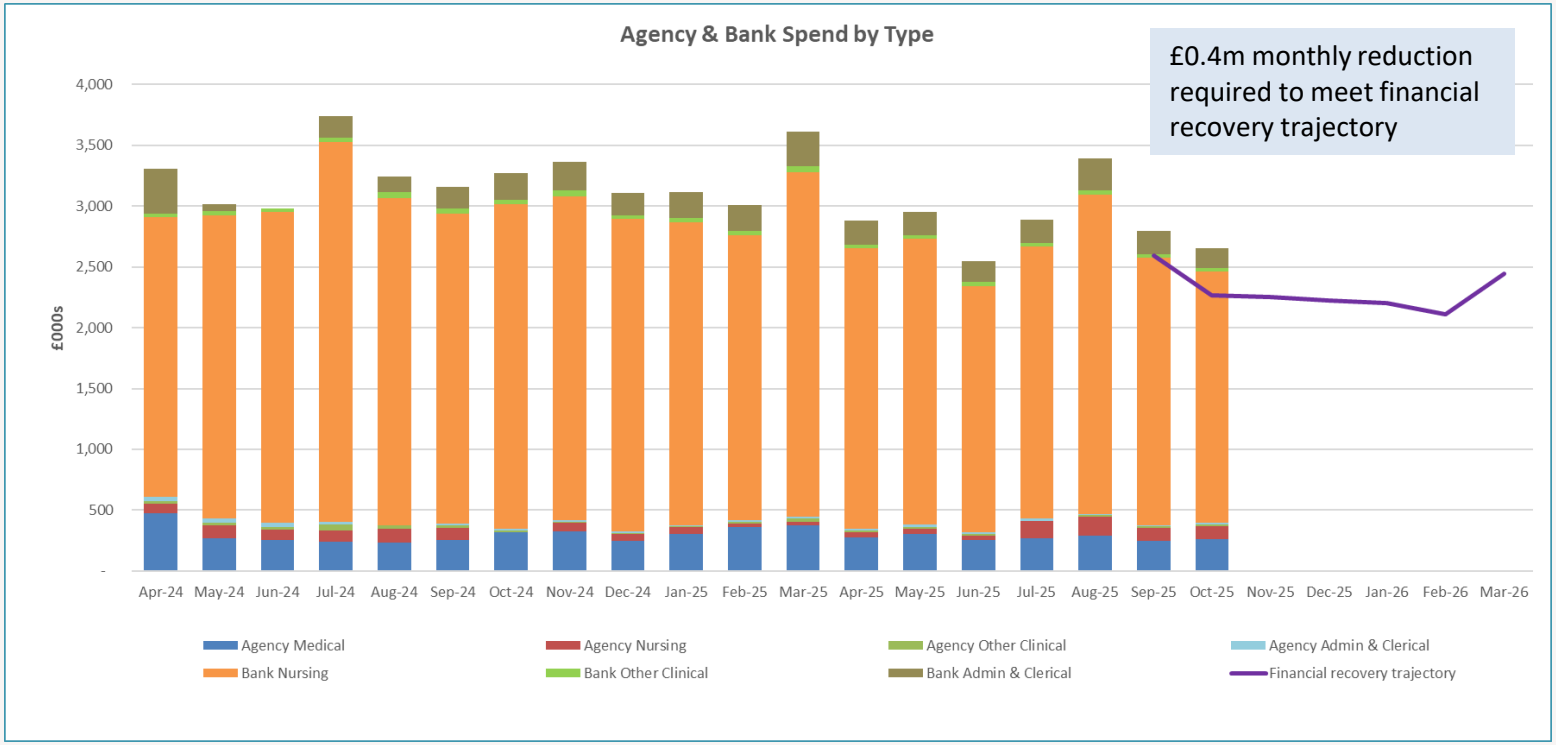




- The 2025/26 non-Trust bed budget is £17.8m.
- The month 7 year to date spend of £11m is an overspend of £0.7m. There was a significant reduction in spend in August as spot placements were reduced to zero. Spend has been consistent since month 5, at a monthly average of £1.2m, compared to an average of £1.8m for the first 4 months of the year. The year to date spend is £175k below the trajectory set as per the financial recovery plan.

Temporary staffing expenditure

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust



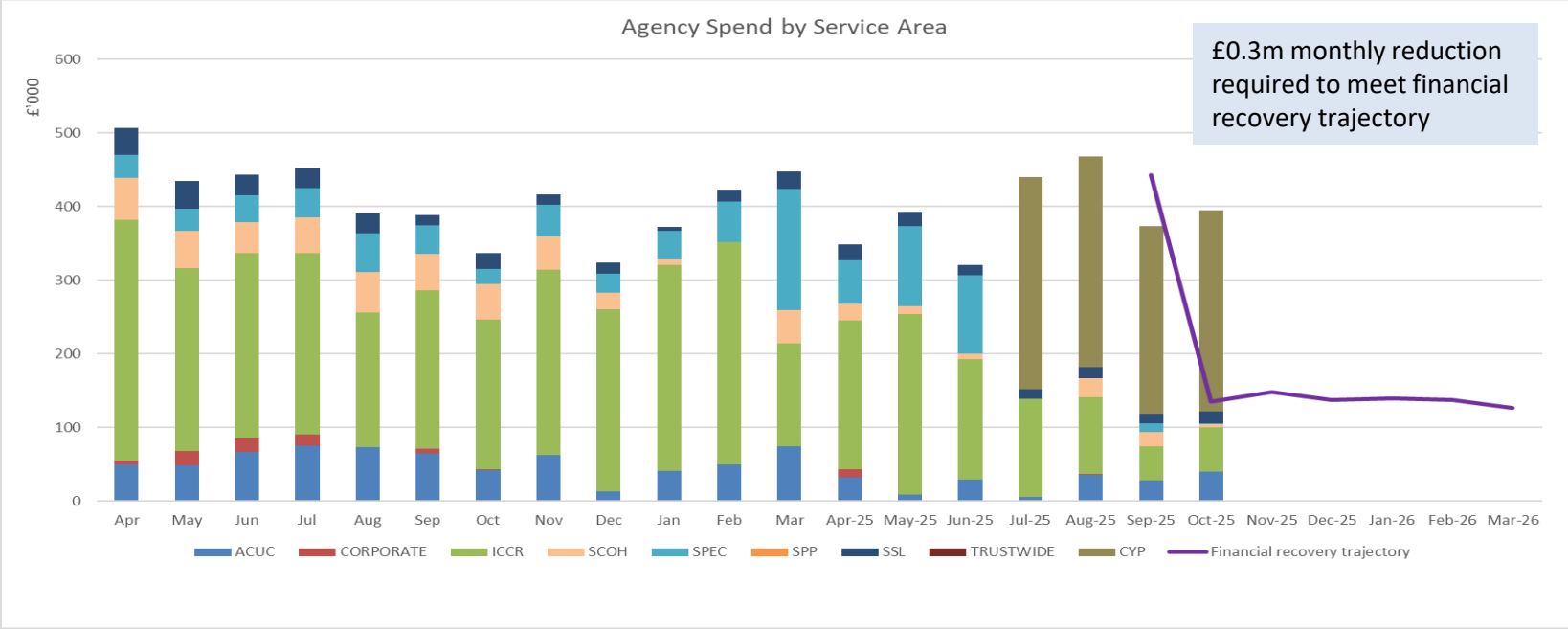
The month 7 year to date spend of £20.1m is £0.6m above the temporary staffing trajectory set as part of the financial recovery plan (bank £393k and agency £191k).

Temporary staffing spend in October is £144k less than September. A further reduction of £0.4m per month is required to meet the financial recovery trajectory.

Bank expenditure £17.4m (87%) – the majority of bank expenditure relates to nursing bank shifts - £15.8m

Agency expenditure £2.7m (13%) – the majority of agency expenditure relates to medical agency - £1.9m.

Agency expenditure



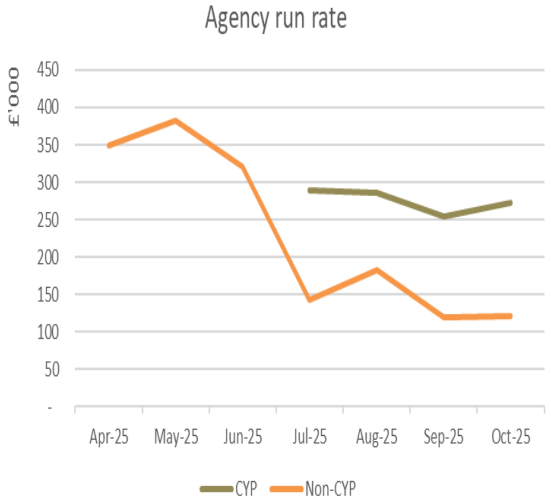
£0.3m monthly reduction required to meet financial recovery trajectory

Agency expenditure

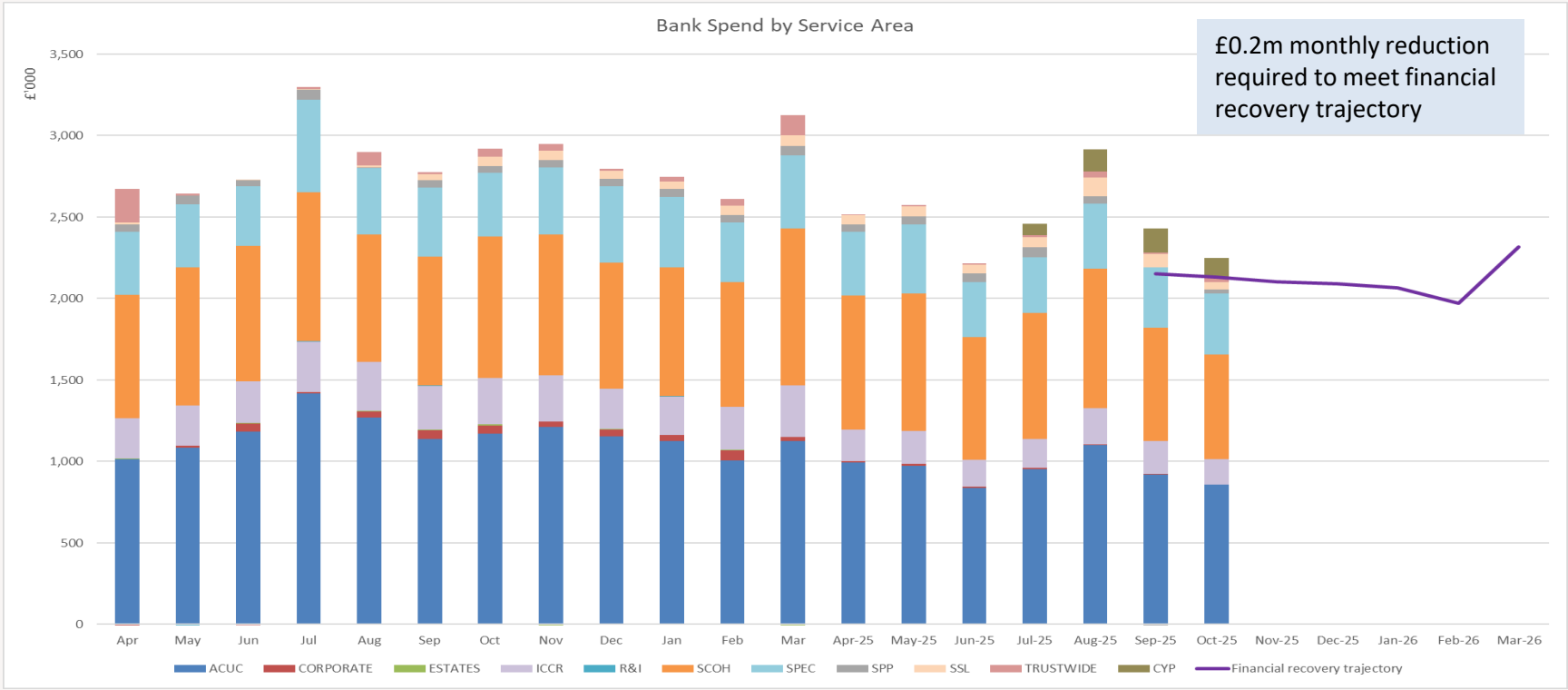
- The month 7 year to date agency expenditure is £2.7m which is £0.2m adverse to the agency trajectory set as part of the financial recovery plan.

- The graph opposite shows that non-CYP agency expenditure reduced significantly from £350k in April to £120k in September (the lowest spend month to date). October spend has remained consistent with the September level.
- The transfer of CYP to BSMHFT from 1 July 2025 has increased agency spend by £276k per month on average. This has offset the non-CYP agency reductions. CYP expenditure is £1.1m for July to October (this equates to 41% of total agency spend).
- October agency expenditure is £21k more than September, this is driven by CYP expenditure (£33k increase in agency nursing, part offset by £13k decrease in medical agency).

- The financial recovery trajectory assumes a significant reduction in spend for the remaining 5 months of the year, of £0.3m per month from the October level.



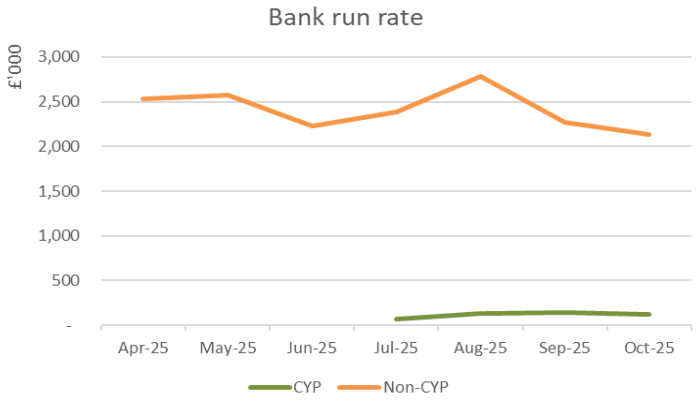
Bank expenditure



£0.2m monthly reduction required to meet financial recovery trajectory

Bank expenditure

- The month 7 year to date bank expenditure is £17.4m which is £0.4m adverse to the bank trajectory (set for months 6 to 12) as part of the financial recovery plan developed at the beginning of September.
- £165k decrease in spend in October compared to September (£64k Acute & Urgent Care, £49k Secure & Offender Health, £43k ICCR and £25k CYP). October is the second lowest monthly bank spend of the year to date and is £662k lower than in October 2024.
- A further £0.2m per month reduction is required from month 8 onwards to meet financial recovery trajectory for the remainder of the year.



Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - 'Audited' 31-Mar-25 £m's	NHSI Plan YTD 31-Oct-25 £m's	Actual YTD 31-Oct-25 £m's	NHSI Plan Forecast 31-Mar-26 £m's
Non-Current Assets				
Property, plant and equipment	221.1	224.9	218.7	227.5
Prepayments PFI	1.2	1.2	2.5	1.2
Finance Lease Receivable	0.0	-	(0.0)	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	222.4	226.1	221.3	228.8
Current assets				
Inventories	0.6	0.6	0.6	0.6
Trade and Other Receivables	31.0	31.0	17.4	31.0
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	86.4	83.9	101.1	83.0
Total Curent Assets	117.9	115.5	119.2	114.6
Current liabilities				
Trade and other payables	(86.2)	(86.3)	(74.3)	(86.2)
Tax payable	(6.7)	(6.7)	(8.5)	(6.7)
Loan and Borrowings	(2.6)	(2.6)	(2.3)	(2.6)
Finance Lease, current	(1.3)	(1.3)	(1.3)	(1.3)
Provisions	(1.3)	(1.3)	(0.9)	(1.3)
Deferred income	(35.6)	(35.6)	(45.1)	(35.6)
Total Current Liabilities	(133.7)	(133.7)	(132.5)	(133.7)
Non-current liabilities				
Deferred Tax Liability	0.2	0.2	0.2	0.2
Loan and Borrowings	(20.8)	(19.0)	(19.0)	(18.6)
PFI lease	(79.4)	(80.2)	(80.2)	(78.9)
Finance Lease, non current	(4.8)	(4.4)	(4.6)	(4.1)
Provisions	(2.4)	(2.4)	(2.4)	(2.4)
Total non-current liabilities	(107.1)	(105.7)	(105.9)	(103.8)
Total assets employed	99.6	102.2	102.1	105.9
Financed by (taxpayers' equity)				
Public Dividend Capital	117.9	118.6	121.0	119.1
Revaluation reserve	49.1	49.1	49.1	49.1
Income and expenditure reserve	(67.5)	(65.5)	(68.1)	(62.3)
Total taxpayers' equity	99.6	102.2	102.1	105.9

SOFP Highlights

The Group cash position at the end of October 2025 is £101.1m.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 15 to 16.

Current Assets & Current Liabilities

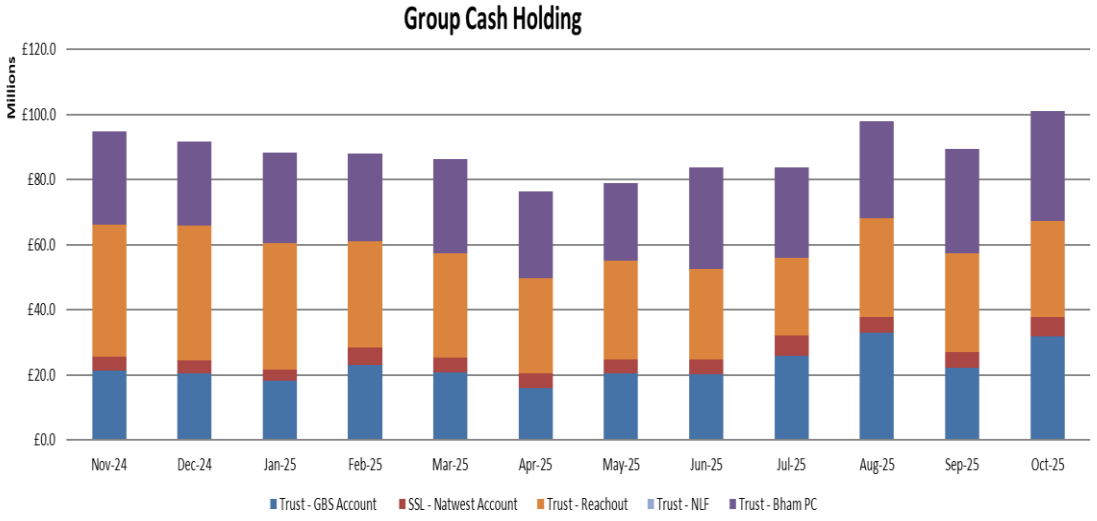
Ratios

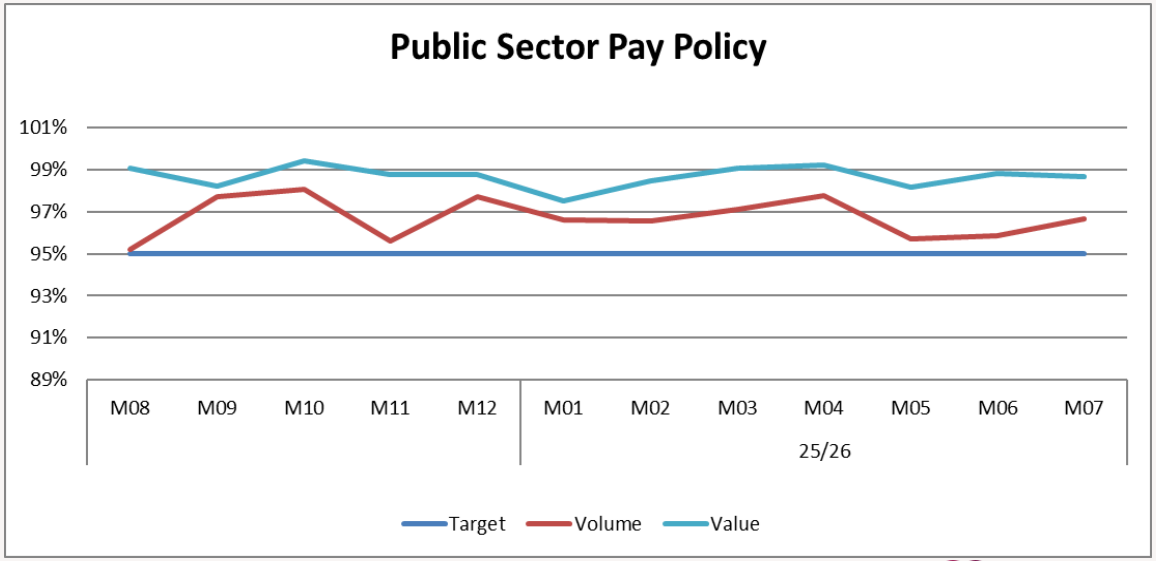
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	£m's
Current Assets	119.2
Current Liabilities	-132.5
Ratio	0.9

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

Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of October 2025 is £101.1m. This comprises of Trust £32m, SSL £5.7m, Reach Out Provider Collaborative 29.7m and Mental Health Provider Collaborative £33.7m.

At this present time, the National Loan Fund (NLF) is not offering more favourable interest rates for large deposits in comparison to Government Banking Service (GBS) hence we have not placed any short-term/long-term deposits.

Better Payments

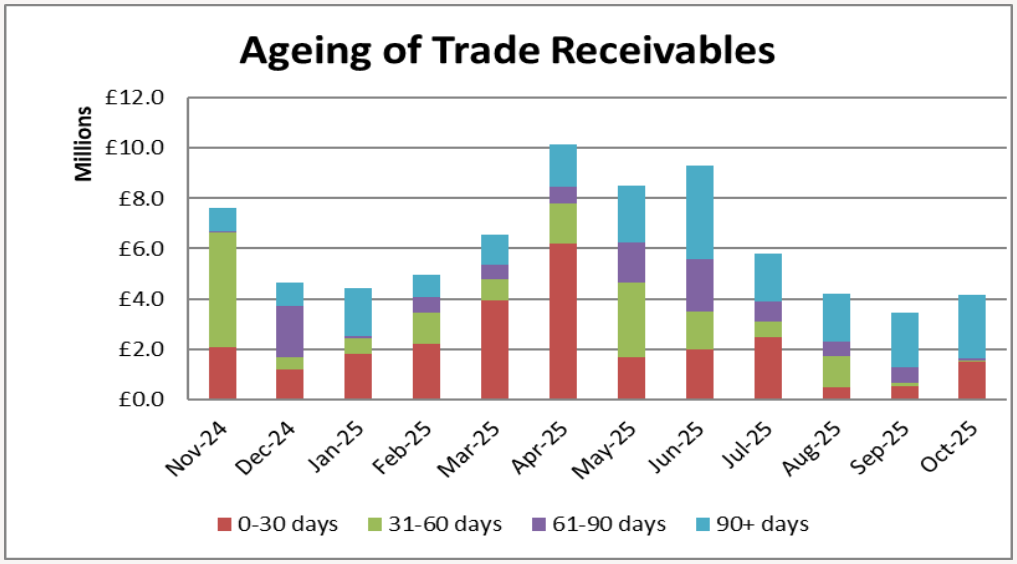
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

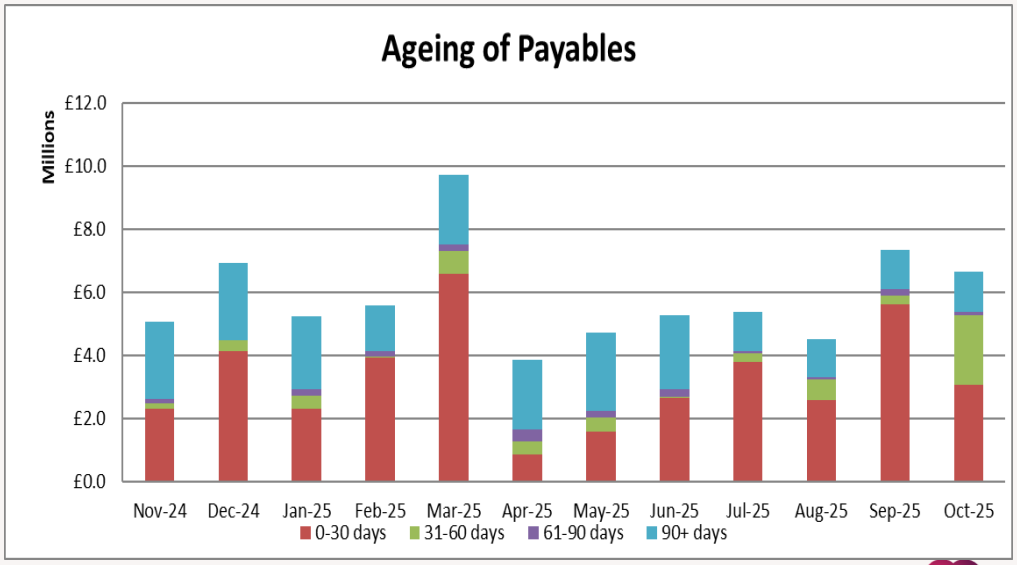
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

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

Trust Receivables and Payables





With a focus in the NHS currently around intra-NHS debts BSMHFT have been working with NHS colleagues to ensure as far as possible any issues are rectified. Where required, escalations to Deputy Director of Finance or Executive Director of Finance have been pursued between organisations.

Trade Receivables :

- **0-30 days-** Overall Balance £1.5m- increase in balance. Balance consists of monthly/daily ad hoc invoices waiting to be advised if approved or in query, some balances are awaiting approval/payment.

- **31-60 days-** Overall Balance £67k – decrease in balance. Several debts are awaiting approval/payment. Remaining balance mainly staff overpayments (on payment plans).

- **61-90 days-** Overall Balance £69k- decrease in balance. *Awaiting authorisation:* ATW - £20k, Mecury Pharm Ltd- £79k, some accounts in credit. Remaining balance mainly staff overpayments (on payment plans).

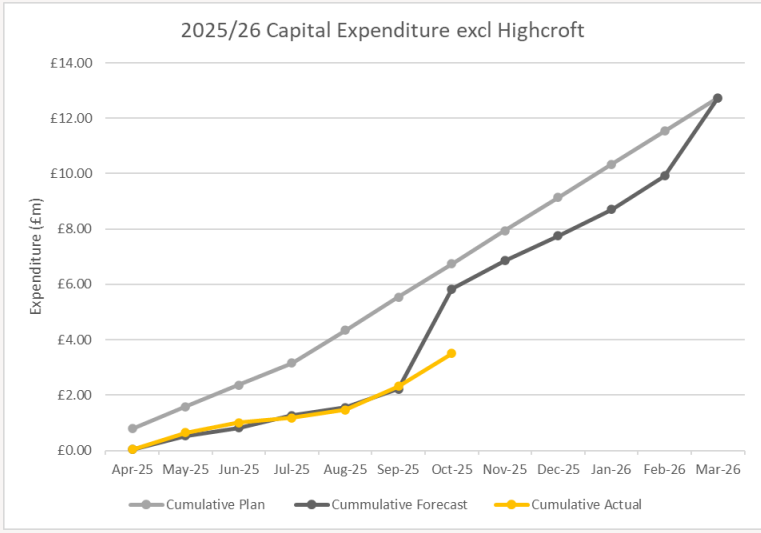
- **Over 90+ days-** Overall Balance £2.5m–increase in balance. *Awaiting authorisation:* BWC £1.1m, UHB - £789k, BSOL MHPC - £339k, University of Birmingham - £95k, ATW - £20k, SDSmy HC - £25k. Remaining balance mainly staff overpayments (on payment plans).

Trade Payables-Over 90 days:
NHS Suppliers £192k: UHB £82k in query (working directly with UHB to resolve accordingly), some approvals in Nov 25, CNWL £55k in query, Nottinghamshire £52k in query.

Non-NHS Suppliers (50+) £1.1m: 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 November 2025.

Capital Expenditure Month 7 YTD

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	0.5	0.0	0.5
ACUC Bathrooms	0.2	0.2		0.2	0.1	0.0	0.1
SSBM Works	2.1	2.1		2.1	0.5	0.9	(0.4)
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	0.6	0.2
Recognition of IFRS 16 Leases	0.3	0.3		0.3	0.2	0.0	0.2
ICT	0.1	0.1	0.4	0.5	0.4	0.2	0.2
Minor Works	4.0	4.0	(0.5)	3.5	0.7	1.3	(0.6)
2025/26 Estates Safety	1.1	1.1		1.1	0.1	0.0	0.1
24/7	0.0	0.0	3.2	3.2	2.7	0.5	2.2
Total	9.5	9.5	3.3	12.7	5.8	3.5	2.3
Highcroft New Build	6.1	6.1		6.1	0.5	0.4	0.1
Total	15.6	15.6	3.3	18.9	6.3	3.9	2.4



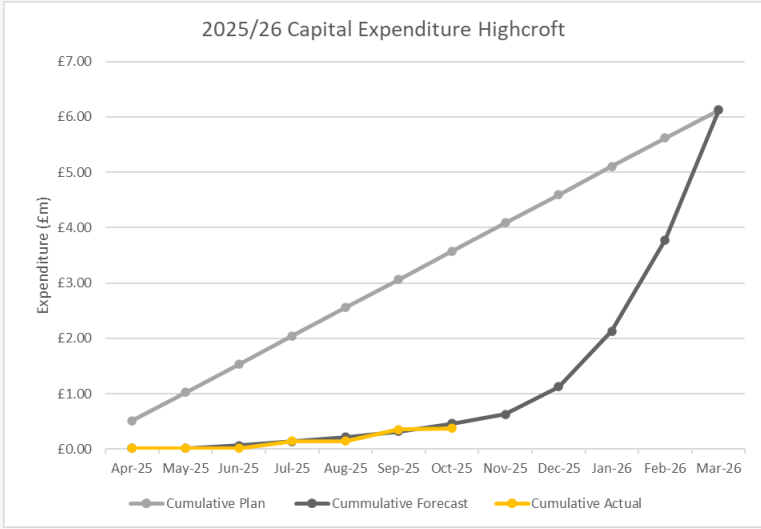
Group Capital Expenditure

The total revised planned capital for 2025/26 remains at £18.86m.

Capital Excl. Highcroft - As per the table above, there has been 3.5m year to date spend against a capital forecast of £5.8m in month 7, £2.3m behind forecast. This is mainly due to the 24/7 project spend being forecast fully in October and now due to complete in December.

Highcroft Project – Year to date spend £376k against a forecast spend of £465k, £89k behind forecast.

Approximately £5.6m is forecast to be spent in quarter 4.



Committee Escalation and Assurance Report

Name of Committee	**Audit Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 December 2025**
Date(s) of Committee Meeting(s) reported	**26 November 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework • Corporate Risk Register • External Risks Report • Commissioning Board Assurance Framework • SSL Risk Summary • Internal Audit Progress Report • Internal Audit Action Tracking Report • External Audit Progress Report • Committee Effectiveness Self-Assessment Review
Alert:	The Committee wished to alert the Board of Directors to the following: • The Committee discussed ongoing concern with the CYP service transfer, including IT, estates, finances and reputational risks. The Committee highlighted the need for a comprehensive update and assurance on all aspects of the CYP transition. • The Committee discussed external risks which were routinely assessed and monitored for potential impact on Trust business. Significant issues such as strike action, supply chain issues, council bankruptcies and cyber security were all tracked, but the Committee felt they required clearer scoring and board-level visibility. ***The external risks report received by the Committee is attached to this report for information.*** • The Committee raised concerns about some inconsistency in risk scoring across the Corporate Risk Register, especially between financial, people and quality risks. The need for moderation and risk management training was highlighted.
Assure:	The Committee was assured on the following areas: • The Committee was assured by the ongoing internal audit progress report and action tracking, noting that there were no significant delays. • Assurance was provided around risk registers and business disruption risk assessments which were regularly reviewed, with mitigation

	plans in place for all high-level risks. The process included committee oversight and escalation.	
Advise:	Internal audit reviews into appraisals, e-rostering and Mental Health Provider Collaborative governance were in progress. The Committee highlighted that a Single Tender Waivers Report and Losses and Special Payments Report had not been received for some time.	
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. The Committee challenged the Risk Management Group to review risk scoring consistency. The Committee received the Commissioning BAF and was satisfied with the significant improvements and notable progress made, noting the inclusion of Learning Disability and Autism. Positive assurance was received on the SSL Risk Summary, and the Committee noted that some of the risks had been escalated and discussed at Quality, Patient Experience and Safety Committee.	
	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:	**20b**						
Date	3 December 2025						
Title	Risk External to the Organisation						
Author/Presenter	Kate Smith, Risk Manager						
Executive Director	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
This report is to assure the Board of the work being done within the Trust around risks caused by external factors that may affect the Trust's ability to operate effectively.

Introduction
The Business Continuity and Emergency Preparedness Committee (BCEPC) meet every 2 months to discuss these risks as part of the wider meeting.

The Trust's EPRR Officer and Risk Manager attend the West Midlands and Warwickshire Health Risk Management Group meeting held on a quarterly basis to review and discuss external risks affecting the wider system. The group holds its own Risk Register to which the Trust contributes. We are in the process of aligning the Trust's internal EPRR risk register and Business Disruption Risk Assessments (BDRAs) with the wider West Midlands and Warwickshire risk register to ensure consistency across organisations, although scores are reviewed to ensure that they are relevant to BSMHFT.

We have also been using the Government's National Risk Register to identify risk relevant to the operation of the Trust. National Risk Register - 2025 edition

Detailed Business Continuity Incident Response Plans, Site and Service Continuity Plans, and Action Cards to ensure staff are aware of the steps to follow if any of any of these events take place are in hard copy on sites and available on Connect.

Current Risks on Risk Registers and BDRAs

Risk Title	Likelihood	Impact	Risk Level
Green- On RR and BDRA			
Severe pollution or widespread toxic release of a substance	3	3	Medium
Pandemic	2	4	Medium
Cyber Security (there are 6 different risks relating to different aspects on Eclipse)	3	4	Medium
Infectious disease outbreak and/or Emerging Infectious Disease Not endemic	2	4	Medium
Widespread fuel shortage and rise in fuel prices impacting on service delivery	3	3	Medium
High temperatures and heatwaves	3	4	Low

Low temperatures, snow and ice	4	4	High
Flooding (Fluvial/Surface Water)	3	3	Medium
Regional or National failure of the electricity network	3	4	Medium
Failure of gas supplies (utility)	3	4	Medium
Failure of water and sewerage	3	4	Medium
Strike Action affecting Healthcare	4	4	High
IT Failure	3	4	Medium
Medications Shortages/Loss (Pharmacy closure due to catastrophic incident)	1	3	Low
Amber- Not on RR but covered in BDRA			
Mass Casualty Incident (Non-Contaminated Casualties)	3	4	Medium
Mass Casualty Incident (Contaminated Casualties)	3	4	Medium
Prolonged, severe pressure on healthcare providers	4	3	Medium
Loss of Critical Supplier or Service	3	2	Medium
Evacuation of Bedded Healthcare Premises	2	4	Medium
Psychosocial Support	2	3	Low
Organisational Loss of Workforce/ Key Staff	2	3	Low
Public or Environmental Health Incident	3	3	Medium
Growth and Spread of Antimicrobial Resistance	3	3	Medium
Security Failure	3	3	Medium
Communications failure	3	3	Medium
Fire- non-clinical area	2	5	Medium
Fire- clinical area	3	5	Medium
Red- Not yet on RR or BDRA (Recently Identified)			
Medications Shortages/Loss (Supplier issues)- currently being looked at by MOC			
Major wider Social Care Provider Failure			
Storms			
Local accident on motorways and major trunk roads			
Political unrest			
Societal unrest/ Riots			

Recommendation

The Committee/Board is asked to:

1. Note the content of this report and gain assurance regarding the work being undertaken around external risks that may affect the T
2. rust's ability to operate effectively.

Enclosures

Detail of High Scoring EPRR Risks currently on BSMHFT Risk Registers

Executive Lead	Executive Director of Operations		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Risk to staff and inpatient health caused by extreme cold weather and snow	**Inherent Risk Rating**	4 Major	5 Almost Certain	20	Business Continuity and Emergency preparedness Committee (BCEPC)	
		Current Risk Rating	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	30/08/2023
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. **Target 6-8**			**Last Update on Eclipse**	15/10/2025
Risk ID	**1828**						

Risk description
Risk to staff and inpatient health caused by extreme cold weather and snow with temperatures reaching thresholds described in the Adverse Weather Plan. This may result in system pressures, an increase in cold related illness, difficult working conditions, building temperatures, staff inability to get to and from work and emergency transport (WMAS) inability to respond.

Controls in place	**Assurances**
- Trust Adverse Plan in place in compliance with UKHSA Adverse Weather Plan - Capacity escalation plans - Staff alternative working arrangements identified within BCP's - Alert level widely communicated by EPRR Officer - Regular cascades of severe weather in place - MOU with West Midlands 4x4 to provide staff and patient transport options - Regular maintenance plan for Trust operated sites	- Risk oversight and review at BPEPC. - Score currently high as in the winter period.

Executive Lead	Executive Director of Operations		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Risk to staff and community patient health caused by extreme cold weather and snow	**Inherent Risk Rating**	4 Major	5 Almost Certain	20	Business Continuity and Emergency preparedness Committee (BCEPC)	
		Current Risk Rating	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	30/08/2023
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. **Target 6-8**			**Last Update on Eclipse**	15/10/2025
Risk ID	**1892**						

Risk description
Risk to staff and community patient health and wellbeing caused by extreme cold weather, snow, and ice on the roads with temperatures reaching thresholds described in the Adverse Weather Plan. This may result in system pressures, an increase in cold related illness, difficult working conditions, staff inability to get to and from work/home visits, patients being unable to maintain adequate temperatures in their homes and emergency transport (WMAS) inability to respond.

Controls in place	**Assurances**
- Trust Adverse Plan in place in compliance with UKHSA Adverse Weather Plan - Capacity escalation plans - Staff alternative working arrangements identified within BCP's - Alert level widely communicated by EPRR Officer - Regular cascades of severe weather in place - MOU with West Midlands 4x4 to provide staff and patient transport options - Action cards to support staff at each level of alert - Regular communication of alert levels and promotion of Adverse Weather Plan and recommended actions	- Risk oversight and review at BPEPC. - Score currently high as in the winter period.

Executive Lead	Executive Director of Medicine		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Risk to the ability to run outpatient clinics, operate safely on the wards, and provide quality of care to patients as post-graduate doctors in training will be absent from work due to industrial action.	**Inherent Risk Rating**	4 Major	5 Almost Certain	20	Business Continuity and Emergency preparedness Committee (BCEPC)	
		Current Risk Rating	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	2 Unlikely	6	**Date opened**	07/03/2023
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. **Target 6-8**			**Last Update on Eclipse**	07/03/2025
Risk ID	**1769**						

Risk description
There is a risk to the ability to run outpatient clinics, operate safely on the wards, and being able to provide quality of care to patients as post-graduate doctors in training will be absent from work due to industrial action. Despite planning and mitigation we may not be aware of all of the gaps in services until the day of the planned action. This may be caused by national strike ballots giving a mandate to take industrial action. Whilst we are asking junior doctors to give advanced notice not everyone may declare this in advance, therefore there may be a gap in services. There may be further impact caused by external system pressures, for example action by junior doctors in A&E may impact on PLT. This may result in a significant reduction in services typically provided by this cohort of staff both in and out of hours and increased demand on other staff groups. This risk is further increased due to the cumulative impacts of repeated IA for a prolonged period.

Controls in place	**Assurances**
- Shadow rota has been created to cover all out of hour rota shifts. - Cancellation of outpatient clinics and all non urgent work on days when industrial action is taking place - Doctors (consultants and SAS doctors) have been asked to cross cover their juniors on strike days with clear cover arrangements circulated - The rest of the workforce have been advised to support medical cover - additional measures for physical health on the wards - Collection of data in relation to those staff taking industrial action being gathered using a QR	- Daily planning meetings with CDs, heads of nursing and ADs in advance and following a period of IA. - NHSE Workforce Sitrep - NHSE Rescheduled Activity Sitrep

code issued to staff - COO's attend daily system wide meeting during periods of IA - Hot & cold debriefs held following periods of industrial action including staff surveys to identify learning	

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4 Major	5 Almost Certain	20	QPES	
Title of risk	Delayed recognition, poor infection prevention and control (IPC) practices, and heightened exposure HCID risk to staff, patients, and visitors caused by mental health trust not been given access to HCID training	**Current Risk Rating**	4 Major	4 Likely	16		
		Target Risk Score	3 Moderate	3 Possible	9	**Date opened**	12/05/2025
		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 6-8**			**Last Update on Eclipse**	20/10/2025
Risk ID	**2055**						

Risk description
There is a risk that Staff within the trust do not have access to appropriate training on High Consequence Infectious Diseases (HCIDs) and clear national guidance for mental health & community settings, resulting in limited awareness and preparedness to respond effectively in the event of an HCID case. This increases the likelihood of delayed recognition, poor infection prevention and control (IPC) practices, and heightened exposure risk to staff, patients, and visitors. This is/may be caused by mental health trust not been given access to HCID training as acute hospitals have been prioritised with limited spaces available.

Controls in place	**Assurances**
-General IPC training delivered trust-wide. -Basic outbreak and escalation procedures in place -IPC team provides reactive advice when infection risks are identified. Ongoing Actions - Development of HCID procedures. -To have the appropriate HCID-specific training package for mental health & community settings. -Staff to attend training for HCID once available to the mental health trust.	-Regular IPC audits are conducted and reported through governance channels. -Staff compliance with standard infection prevention procedures is monitored via routine observation. -Incident reporting system in place for suspected infection control breaches -EPRR annual review and tabletop exercise for HCID.

Report to Board of Directors						
Agenda item:	**22**					
Date	3 December 2025					
Title	Trust Strategic Goals 2025/26 Mid-Year Update Report					
Author/Presenter	Presenter – Patrick Nyarumbu, Executive Director of Strategy People and Partnerships Author - Abi Broderick, Head of Strategy, Planning and Business Development					
Executive Director	Patrick Nyarumbu	**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

The purpose of this report is to:

- Provide an update on progress on the 2025/26 Clinical Services goals at the end of Quarter 2.
- Provide information on plans for the refresh of the Trust Strategy for 2026-31.

Introduction

- Our Trust Five Year Strategy was developed during 2019/20 and launched across the organisation April 2021. The Strategy was co-produced with colleagues, service users and carers, and partners. It comprises four strategic priorities, each of which has five-year strategic aims.
- The goals are developed through engagement with teams, service leads and experts by experience and this includes reviewing the previous year's goals, any internal or external changes that might impact plans and any new drivers we need to respond to. The 2025/26 goals were approved by Committees and Board in March and April and we report on them quarterly to Committees and bi-annually to Board.
- Across our four strategic priorities we have 44 Trust goals for 2025/26, the final year of our current Trust Strategy, each with a number of deliverables/outputs to support the achievement of the goal.
- Each goal is given a RAG rating at the end of each quarter with the definitions as follows:

  Red = not started on time / seriously behind / major issues

  Amber = partially met / moderate issues

  Green = fully met / fully on track / minor issues

Detailed reports relating to each strategic priority were taken to the relevant Board sub-committees in November as follows:

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

Sustainability: FPP Committee

Key Issues and Risks

- At the end of Q2 2025/26, 18 of the current goals were rated 'green' and 22 'amber'. The 4 'red' goals related to patient flow in older adults services, transforming and improving children and young people's services, improving access, experience and outcomes in Talking Therapies, and maximising opportunities through provider collaboratives.
- More detail on the current status of the Trust strategic goals is included in the enclosed report.

Strategy refresh for 2026-31

- We are now in the final year of the current strategy and during the quarter we embarked on a refresh of the strategy ready for launch in April 2026.
- This report gives an update on the engagement undertaken and next steps in developing the new strategy.

Recommendation

The Board is asked to:

1. **NOTE** the contents of this report.
2. **GAIN ASSURANCE** that good progress has been made in the first half of 2025/26and that plans are in place for where goals are not on track against milestones.
3. **GAIN ASSURANCE** that widespread engagement has been undertaken across the Trust on the refresh of the Trust Five Year Strategy and that the timeline and next steps are in place to ensure this is ready for launch in April 2026

Enclosures

2025/26 strategic goals – Mid-year update

Updates per goal are available in the reading room.

Our Trust Five Year Strategy

2025/26 strategic goals
Mid-year update

Trust Board
3 December 2025

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1. Introduction

Birmingham and Solihull Mental Health NHS Foundation Trust

Our Trust Five Year Strategy was developed during 2019/20 and launched across the organisation April 2021. The Strategy was co-produced with colleagues, service users and carers, and partners **four strategic priorities – Clinical Services, People, Quality and Sustainability**, each of which has a number of five-year strategic aims which describe our particular areas of focus. There are four key themes that are golden threads running throughout the Strategy. A summary of our Trust Strategy can be found on the next page.

Each year we agree goals for each strategic priority. The goals are developed through engagement with teams, service leads and experts by experience and this includes reviewing the previous year's goals, any internal or external changes that might impact plans and any new drivers we need to respond to. The 2025/26 goals were approved by Committees and Board in March and April and we report on them quarterly to Committees and bi-annually to Board.

We are now in the final year of the current strategy and are embarking on the refresh of the strategy ready for April 2026. The purpose of this report is to:

A. Provide an overview on progress on the 2025/26 goals at the mid-year point.
B. Provide an update on the refresh of the Trust Strategy for 2026-31.

Updates on the specific goals for each strategic priority were also reported to the relevant sub-committees in November 2025.

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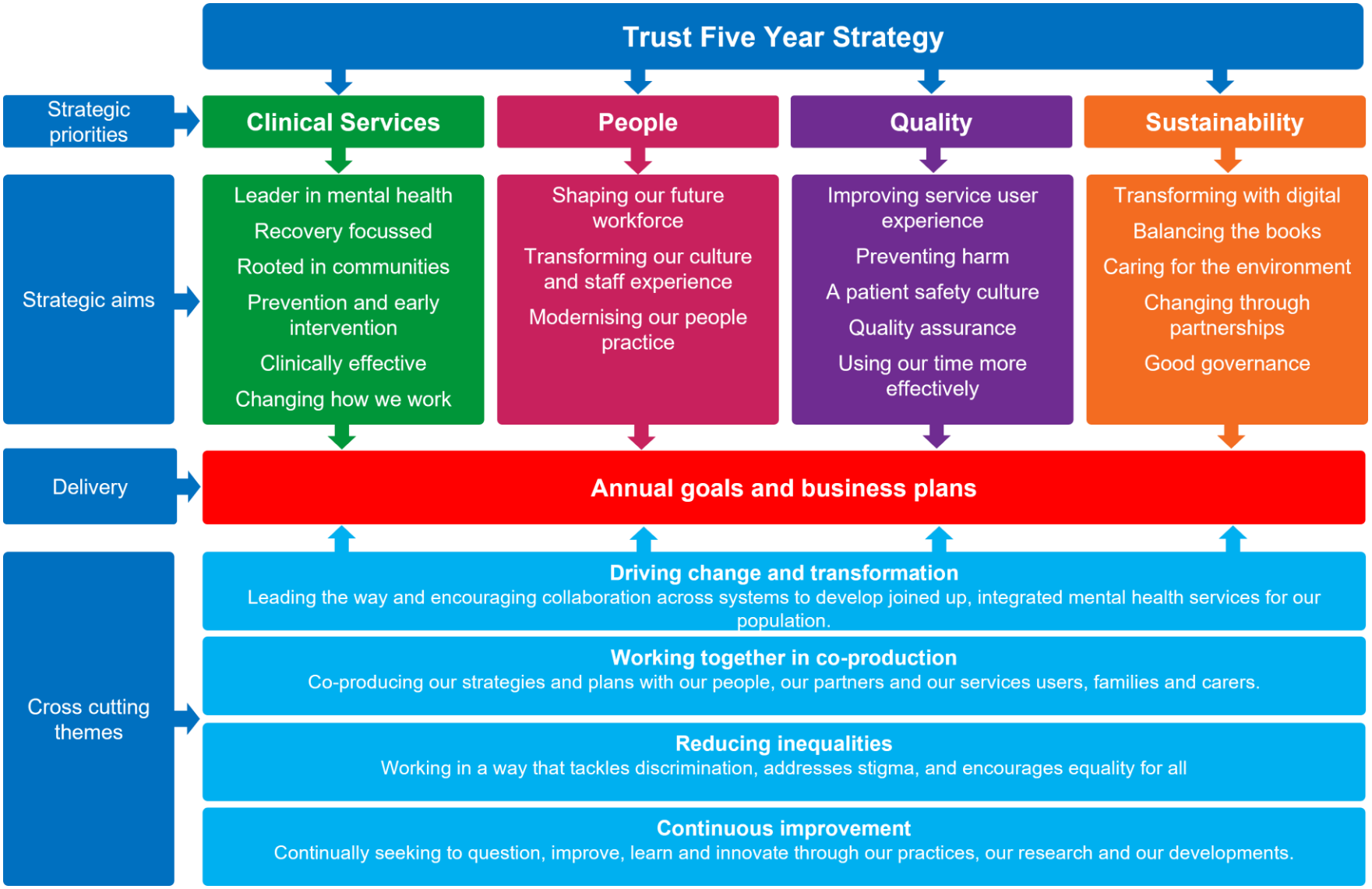
2. Our Trust Strategy

Birmingham and Solihull Mental Health NHS Foundation Trust



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NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

Part A:
2025/26 goals – Quarter 2 progress

3. 2025/26 goals at a glance

***** Addressing inequalities is woven throughout our strategic goals for 2025/26*****

Clinical Services (12 overarching goals)

Rooted in communities

- Joined up services and locality working
- Continue to progress transformation of community services
- 24/7 neighbourhood mental health pilot
- Improve patient flow (forensic)
- Improve patient flow (older adults)
- Improve patient flow (acute and rehabilitation services)

Prevention and early intervention

- Transform urgent care pathways
- Transforming and improving children and young people's services
- Specialist pathways to better meet needs of specific groups
- Improving access, experience and outcomes in Talking Therapies

Clinically effective

- Dialog+ and care planning implementation
- Better support for service users LDA

Quality (14 overarching goals)

Improving service user experience

- Improve patient experience and participation

Preventing harm

- Embed standards, skills and competencies, and learning
- Continue to deliver the AHP strategy
- Harm reduction and long term support for physical health
- Reducing restrictive practice
- Improve safeguarding awareness
- Implement positive risk management approaches
- Suicide prevention

Patient safety culture

- Foster a culture where service users, carers and staff can flourish

Quality assurance

- Robust audit and assurance of policies
- Improve quality data and monitoring

Using our time more effectively

- Effective use of resources and rostering
- Fit for the future clinical governance
- Quality improvement/Quality Management System methodology

People (11 overarching goals)

Shaping our future workforce

- Reduce vacancy and turnover rates
- Ensure workforce does not exceed funded establishment
- Increase fundamental training compliance
- Reduce average time to recruit

Transforming our culture and staff experience

- Reduce sickness levels
- Increase number of staff who would recommend the Trust
- Reduce harassment, bullying or abuse
- Improve staff engagement scores in staff survey
- Reduce disproportionality of racialised groups in people processes

Modernising our people practice

- Ensure workforce systems are fit for purpose
- Reduce response times to common casework

Sustainability (7 overarching goals)

Transforming with digital

- Use of technology to improve productivity
- Develop our business intelligence capability

Caring for the environment

- Implement refreshed estates and facilities strategy
- Work towards new sustainability targets

Changing through partnerships

- Maximising opportunities through provider collaborative

Balancing the books

- Improve the underlying financial position

Good governance

- Ensure the safe transfer of services and staff from Forward Thinking Birmingham

.

4. Trust goals: an overview at end of Q2

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

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

There are 44 **Trust goals in total** for 2025/26, which is year 5 of our strategy. A summary of the overall status at the end of Quarter 1 and Quarter 2 is shown below. It is encouraging that **91% of goals were rated 'Green' or 'Amber'** at the end of Q2, which means they are where we expected them to be in relation to their milestone plans or have moderate issues impacting delivery that are being addressed to bring them on track. There has been an increase in amber rated goals vs green between Q1 and Q2, which is a pattern we have seen in previous years and is to be expected as more unpredicted issues impacting the achievement of milestones can emerge as the year progresses.

Strategic aim	Red		Amber		Green	
	Q1	**Q2**	Q1	**Q2**	Q1	**Q2**
Clinical Services (12 goals)	2	3	6	6	4	3
People (11 goals)	1	0	5	7	5	4
Quality (14 goals)	0	0	5	7	9	7
Sustainability (7 goals)	0	1	2	2	5	4
Total	3	**4**	18	**22**	23	**18**
	7%	**9%**	41%	**50%**	52%	**41%**

5. Exceptions at end of Q2

Birmingham and Solihull Mental Health NHS Foundation Trust

⚠ Red goals ⚠

4 goals were rated 'Red' (9%) at the end of quarter 2 which means they are not where we wanted them to be in relation to their milestone plans. These are shown below:

Strategic priority	Goal	vs Q1 rating
Clinical services	*Improve patient flow (older adult services):* P2 beds were cut from 10 to 5 in May 2025 which is having a detrimental impact on length of stay and ability to admit older adults to older adult beds, with a knock-on effect on out of area placements and number of older adults on acute wards. This is being escalated to the system via the Executive Director of Operations.	↓
Clinical services	*Improving access, experience and outcomes in Talking Therapies:* The Mental Health and LDA Provider Collaborative issued a performance notice in September 2025 relating to underperformance in activity and reliable recovery and reliable improvement rates. A detailed action plan is in place and a power BI report has been developed for the service covering key KPIs to support enhanced and robust performance monitoring. A range of further supportive measures are being put in place by commissioners to review the Trust's recovery action plan.	↓
Clinical services	*Transforming and improving children and young people's services:* Solar (Solihull CAMHS) has received a performance notice in October 2025 as a result of concerns around Mental Health Support Teams delivered by our VCFSE partner. A detailed remedial action plan was submitted to commissioners at the end of October with clear and measurable actions which are being robustly managed and monitored by the Trust and Provider Collaborative.	↔
Sustainability	*Maximising opportunities through provider collaboratives:* This overarching goal is red due to delays in the final version of the draft Mental Health and LDA Provider Collaborative strategy, co-production framework and community voice options appraisal as a result of limited team capacity during Q2. This is expected to be resolved in Q3. Also, NHSE operating model changes and ICB mergers are impacting the secure care provider collaborative, Reach Out's progress in strategic pathway planning and commissioner relationships. Whilst red against milestones, neither of these issues are a significant risk to the Trust.	↓

The above pose a risk around the ability to deliver the goal by the end of the year.

Birmingham and Solihull Mental Health NHS Foundation Trust

Part B:
Refreshing our strategy for 2026-31

6. Strategy refresh – 'It's time for another brew'

Building on and learning from the the success of our 'help brew our Trust strategy' campaign five years ago, in July 2025 we launched widespread engagement on the refresh of our strategy through a well-attended online Listen Up Live session hosted by our Chief Executive.

Targeted engagement activities to date have included:

- Visiting nearly every Trust site, having discussions, leaving comment cards and postboxes, with a final few planned for November.
- Engagement with professions – medical, nursing, psychology, OT, social workers, AHPs, admin staff.
- Engagement with Trust Board, senior leaders and divisional senior management teams.
- 'Brew up' sessions held with corporate teams.
- An online survey open to all staff.
- Sessions on the agenda of a wide range of forums and events.
- Our 'brew up' branded AGM, celebrating developments and looking to the future.
- Engagement with service users and carers led by the Participation and Experience Team using patient councils, HOPE action group, brew up sessions and surveys.
- Attendance at four of the five staff networks with the remaining one being planned.
- Engagement with unions ongoing.
- Governor engagement being planned.

110
visits / events to date

1,532
people engaged

7. Strategy refresh – next steps and timeline

- The engagement phase will continue until end of November/early December. Themes are being collated from all of the engagement undertaken.
- A high level 'blueprint' will be produced during December and shared for feedback, during January and February 2026, starting with a Board session in January. This will include:
    - Drivers for the strategy – external and internal context including NHS 10 Year Plan and other local and national strategies and plans.
    - SWOT and PESTLE analysis.
    - What people have told us during the engagement activities, and the resulting key themes
    - Baseline development – where are we now and how will we know we've achieved our strategic aims by 2031?
- Once feedback on the blueprint is collated and incorporated, the final strategy will be produced and taken to Board for approval, ready for launch in April 2026.
- A detailed launch plan will be developed ahead of this.

Clinical Services Strategic Goals 2025/26

Strategic aim	Overarching goal	Progress / achievements in Quarter 2	Q2 RAG rating
Rooted in communities	**Joined up services** Reduce fragmentation, handovers and transitions across teams, making it easier for service users to access joined up health and care services in their local communities	Lifecourse specification: work is focused on the life course specification and how this will impact across divisions, regular working groups have been set up and an intial plan of phase 1 services have been outlined. CYP embedded within daily Bed Management Meeting. However, they continue to manage their own list. Reviewing and aligning policies. Joint 'Get to Green' escalation model in place. Practice Standard on Bed Management escalation due to go to November CGC. CMHT Link Worker process in place In place in acute care but needs review and improvement. Locality working: A number of workshop sessions held with senior clinical and operational leaders. We have agreed aims, key outcomes, high level locality model, leadership principles and each locality has an executive and senior leader lead. Key next steps are to explore alignment with the new life course specification and transformation plan, ensure each locality has robust mental health plans targeted to the population, and engage with teams about locality working and our model.	Amber
Rooted in communities	**Community transformation** Continue to progress the transformation of community services across all geographical areas within the BSOL footprint	Implementation of Participation Oversight Group completed, attended by VCSFE colleagues BiPolar and Psychosis training has now been rolled out in the North and West CMHTs this will be evaluated in November Caseload stratification SOP has been signed off from the ROAD group and ist of Medics in phase 1 finalised. Joint working around transition points to support people where needs change - project Board is in place and govnerance around the project has been established, highlight reporting has commenced. Intial workshop was completed 15th October. Enhance partnerships and pathways with VCFSE organisations, e.g. enhance The Waiting Room, discharge, employment, CGL, Gambling Harms Clinic - now moved to business as usual. Roll out plan for trauma informed care training is being finalised. Planned joint work around a single community health and wellbeing pathway and transition points is part of the work on the lifecourse specification.	Green
Rooted in communities	**24/7 neighbourhood mental health pilot** Improve access, experience and outcomes for local people through delivering a 24/7 neighbourhood mental health service pilot in East Birmingham	Phase two recruitment is nearing completion with a total of 5 roles remaining from this phase. Approval by exec team on 20/10/25, to proceed with phase 3 recruitment via bid monies, rather than solely via internal transfers. Exec agreement obtained to commence the reorganisation of resources in alignment with case migration for BAU delivery – workshop due to take place end November with respective service leads Commencement of capital works began on 8 Sept-25 and continues to progress well and remains on track for November completion and handover. ICT colleagues are liaising with virgin media to scope possibility of earlier installationand two interim solutions are being scoped. The EBE's, Community partners and the 24/7 team continue to work collaboratively on the production of the script and story board for the 24/7 animation video to be completed in line with the official project launch. An expected date for the launch is to be confirmed. The community partners steering group continues to meet monthly and progress well.The Second cohort of the VCFSE projects have been evaluated and successful applicants were informed on 30th Oct. Initial relationship established with Birmingham City Football Club (BCFC) Foundation Charity Matrixing has commenced to support the development of a 24/7 wellbeing offer / menu reflective of clinical and VCFSE led activities.	Amber

Rooted in communities	**Improve patient flow (forensic services)**	Non secure pathways and services out of secure inpatient care - Project Board is in place and govnerance around the project has been established, highlight reporting has commenced. Intial workshop was completed 15th October. Dawn House step down service for women's forensic service users - Agreement of 7 beds has been confirmed by Reach out Mobilisation group is established with increases in members based on project development. Managed to recruit to Band 8A project lead which will mean the whole project will move at an improved rate, and all areas can feed in where required. Interviews for band 7 role happening, and other roles being recruited to. Have managed to sort out CQC status and it's been agreed that it will be a supported accommodation, not a hospital which means medication management will be more straight forward. Additional sites visits have been taking place, SOPs will start to be produced in Q3. High level equitable psychological therapies in forensic services re offending, substance misuse and relapse prevention - Gender specific interventions offered to service users as well as adapted interventions to support neuro diverse service users to undertake and complete psychological therapies. Arts therapies also offered across all services to expand the psychological offer to service users who are unable to access traditional therapies. Focus on increasing the psychological offer in terms of activity levels to all service users. Continue to implement trauma informed care training across the services within the division and across professional groups. Prison referrals to hospital: assessments within 14 days and transfer within 28 days - Continue to meet required targets for 14 day assessments. There remain significant delays in getting patients in prison admitted to a ward in 28-day target period.	Amber
Rooted in communities	**Improve patient flow (older adults services)**	Allocated social worker in place by BCC for P2 beds. We currently have no access to P2 beds for MH step down which impacts length of stay. P2 discharge team remains in place to support with referrals to system wide P2 beds.	Red
Rooted in communities	**Improve inpatient flow (acute and rehabilitation services)** Reduce length of stay and total inpatient bed usage and by ensuring: - Purposeful admission - Therapeutic inpatient stay - Post discharge support	Length of stay and use of non-trust beds are over trajectory. In addition to the LOS productivity plan and established patient flow meeting, a short life working group has been put in place to focus on action to improve the adult inpatients with LOS above 60 days on discharge. Culture of Care QI project launched across acute inpatients More work needed on review the day hospital model and offer. Enhanced Intensive Community Rehabilitation Team (ICRT) - delivery of 10 OOA repatriatins and 5 S117 diverted - on track Plans/design of the Highcroft development are on track. Design meetings have been held with good clinical, expert by experience and wider project representation and will continue, as well as drop-in sessions, mop-up sessions and sign-off sessions up to 18/12/2025.	Amber
Prevention and Early Intervention	**Urgent care** Transform our urgent care pathways and services to eliminate inappropriate attendances and waits in A&E and acute care settings, with a focus on reducing demographic disproportionality	Development of a Psychiatric Assessment Centre at the Urgent Care Centre as an alternative to people attending emergency departments - scoped ready for when opportunities for funding arise. Efforts ongoing to enable 111 to book appointments directly with CMHT Link Workers. MHRV - NHSE and MHPC discussions ongoing - Added to November UCPG Agenda. BTP Triage service starting in November. Recovery House launching on 5th November. HTT Business Case has been developed and currently seeking approval. Gatekeeping model is being reviewed. Advanced Clinical Practitioners now in post. CMHT interface workers now in post to work with known service users presenting at A&E. now looking at options around supporting locality working and linking to to inpatients for those on CPA open to CMHTs	Green

Prevention and Early Intervention	**Children and young people services** Transforming and improving services for children and young people to improve access, experience and outcomes and reduce health inequalities	Adriatic (low secure CAMHS) - Staff and patients informed the ward closure. Expected to be spending 6 months finding placements for YP, however, YP have no moved out of Adriatic and ward is closed. Staff have been distributed to other wards in Ardenleigh. An alternative use/income stream for Adriatic Ward has not yet been agreed following its closure, leading to financial risks of having an empty ward in the building. An options appraisal will be completed in Q3 for new purpose of ward. The anticipated Parkview bid has not gone ahead as planned due to the quality and financial risks with remaining risk around a new provider and impact on current pathways and relationships. We are monitoring the outcome of the tender. Solar (Solihull CAMHS) has received a performance notice in October 2025 as a result of concerns around Mental Health Support Teams delivered by our VCFSE partner. A detailed remedial action plan was submitted to commissioners at the end of October with clear and measurable actions which are being robustly managed and monitored by the Trust and Provider Collaborative.	Red
Prevention and Early Intervention	**Specialist pathways** Make sure we have specialist pathways to better meet the specific needs of a range of groups in our population	Develop EUPD pathway to prevent A&E attendances/ avoidable admissions to inpatient care - High Volume User forum in place at Midlands Met and UHB. Clinical Risk Management of Personality Discharge and Self Harm Guideline has been launched. Dementia diagnosis pathway transformation using Fairer Futures Fund money - ACP recruited, idenitifed PCN in North for new models of working, system wide improvement in dementia diagnosis rate which is currently 63.7% - the most improved ICS in region	Amber
Prevention and Early Intervention	**Talking therapies** Improve access, experience and outcomes for those who use our Birmingham Healthy Minds service	The Mental Health and LDA Provider Collaborative issued a performance notice in September 2025 relating to underperformance in activity and reliable recovery and reliable improvement rates. A detailed action plan is in place and a power BI report has been developed for the service covering key KPIs to support enhanced and robust performance monitoring. A range of further supportive measures are being put in place by commissioners to review the Trust's recovery action plan. The local activity and income trajectory for Birmingham Healthy Minds is just below trajectory and also remains under the ICB activity plan requirements, with a related financial deficit of £415,900 for April - October 2025. Recovery rates for October have improved with the Reliable Improvement rate to 68.47% meeting the 68% target and Reliable Recovery Rate at 45.19% an improvement from last month but remaining below the 50% target.	Red
Clinically Effective	**Dialog+ and care planning** Ensure that our service users' care plans are co-produced and personalised to improve outcomes and quality of life	Full roll-out has been completed for both community and inpatient settings. Regular communication and engagement is ongoing, with additional video's, testimonies and launch material produced and further video's planned. Reporting on the uptake of DIALOG+ is being shared on a weekly basis and discussed within the monthly project meeting. Governance and data meetings have also been implemented on a monthly basis to look at quantitative and qualitative information on DIALOG+ uptake and quality. A safety planning working group has also been set up. Take up within certain areas remains low, further training requirements are being scoped which include train the trainer and other options. Following a meeting with the project lead and operational lead on 28/10/2025 it was agreed to scope an approach to Phase 2 - enhanced implementation of DIALOG+. Project meetings will be refreshed with more targeted stakeholders to focus on DIALOG+ implementation, with wider care planning sitting outside of this within the safety planning working group - which the project board will report into.	Green
Clinically Effective	**Learning Disability and Autism** Better support for service users with learning disability or autism	Discharge targets Quarter 2 trajectory achieved. Enhanced Support Team recruitment progressing although has been slower than hoped due to recruitment/job evaluations processes; 8a manager starts January; service specification finalised and governance strengthened. Continue to aim to get more SCOH patients onto the Dynamic Support Pathway and Register but hampered by limited DSR resource in the LDA team. Autism accreditation paused due to changes in focus for LDA and National Autism Trainer Programme rollout planned for March 2026. ICCR training completed and work temporarily paused due to staffing gaps. All inpatients have received at least one Safe and Well Check; feedback processes established.	Amber

People Strategic Goals 2025/26

Strategic aim	Overarching goal	Progress / achievements in Quarter 2	Q2 RAG rating
Shaping our future workforce	Aim to reduce the vacancy rate from 11% to 10% with a target of 9% turnover current baseline is 10%	The vacancy rate in September was 11.51% which is above our trajectory target 10.64%. In part this was contributed to by the CYP transfer and some teams that has a high level of vacancies. We are still on a downward trajectory and in Q3 tend to have a recruitment peak due to newly qualified recruitment to get back on track. We have more substantive clinical staff than ever before which is having a positive impact. Turnover was 9.61% so we are performing above target. We are still trying to resolve reporting issues with the informatics team, following a change in definition. Workforce plans have continued to be reviewed at Shaping Our Future Workforce. Uptake still low for training. Integrated Planning Group set up in readiness for 26/27 planning round BSOL ICB new offer is well promoted throughout the trust in colleague brief and posters etc- comms have led on this Nursing Vacancies are much reduced and the challenge is to place nursing graduates. Allocated resources to CYP division to support with filling vacancies and bank/ agency reduction. Representative workforce - community mental health workers and peer support roles recruited from the local community are in post	Green
Shaping our future workforce	To ensure that substantive and temporary workforce (total workforce) does not exceed the workforce plan funded establishment.	Bank is on a downward trajectory. There was a spike in July and August which is usual due to the holiday period but this was significantly less than previous years. It remains an area of high focus and opportunity for efficiency. ToRs have been agreed for Q3/4 project to improve quality. Plan still to be created with key stakeholders to ensure maximum effectiveness of both substantive and contingent workforce. Transfer of CYP has led to 3 fold increase in agency - working with the division on an action plan to address. Remaining Trust agency remains low and still reducing.	Amber
Shaping our future workforce	Aim to achieve overall Fundamental Training compliance of 95% by March 2026.	All managers with teams below 75% compliance have been contacted via phone and informed. They have been asked if they require any support. Also, these discussions have been captured in the FPP meetings. There were initially seven teams below 75%, and this has now reduced to six teams.	Amber
Shaping our future workforce	Reduce average time to recruit from 16 to 12 weeks	This work has been picked up through the modernising admin pilot. and the recruitment collaboration that uses RPA in many processes. No Plan in place yet but work is progressing. We are awaiting a Collaborative report however have undertaken a piece of work to remove exclusions from the data which has reduced our time to recruit below the 60 day target. We will work towards a 40 day (NHSE target) in Q3/4.	Amber
Transforming our culture and staff experience	Achieve a reduction in Trust sickness absence to the national average of 5.0% (2024, NHS Digital)	Localised action via People Partnering team continues, supported by HR Clinics to provide operational monitoring/support. Reasonable Adjustments to be stood up as Knowledge Base resources, rather than policy, and Health, Wellbeing and Attendance policy strengthened in review in 2026 to support reasonable adjustment duties. 21% training reach for Managing Health and Wellbeing achievedfor teams with a sickness absence rate above Trust average (6% in January 2025), monthly sessions ongoing with localised delivery on an ad-hoc basis. Health and Wellbeing Plan for teams above 5% sickness rate - Progress has been made in several areas within Secure and Offender Health and in various interventions across Corporate Services. A schedule is being prepared to complete the work in the other divisions. A longer timeline has been allowed due to prioritisation of activities following the BWC TUPE.	Green

Transforming our culture and staff experience	67.5% of staff would recommend BSMHFT as a place to work for staff survey 25/26	Leadership development - Cohort 1 commenced, due to run until December 2025 . Cohort 2 shortlisting complete ready to commence in Jan 2026. Managing Team Discipline sessions continue monthly at HQ, with additional localised delivery on demand - targeting led by managers and people partners. Trajectories in place and updated after each training session. Session delivery handed over to Consultants to reduce continuity risks and support upscaling. Disciplinary Policy now ratified and DMG Terms of Reference stood-up. Create safe reporting cultures through roll out of just culture and PSIRF - Building on the insights gathered in Q1 around staff perceptions of safety culture and psychological safety, we've taken steps to deepen engagement and lay the groundwork for sustainable culture change. EDI/OD have been involved in shaping the final versions of key policies, ensuring they reflect both RJLC principles and the realities of frontline experience. To support implementation, we've begun identifying and equipping OD team to support managers to champion and lead cultural conversations and model best practices within their teams. These champions will play a vital role in embedding PSIRF and promoting a psychologically safe environment for incident reporting and learning. We remain mindful of the ongoing challenge around staff confidence in the process. Targeted communications and peer-led support are being developed to address this, with the aim of increasing transparency and trust in the system. Improvements in workforce inequalities - Tracker document established and leads have been identified for action. Race Code Assessment Reporting is reported quarterly via EDI/OD report to TCSE. Also reports into Audit Committee.	Green
Transforming our culture and staff experience	To reduce the number of employees experiencing harassment, bullying or abuse from colleagues and managers by 1%.	Following the initial divisional FPP conversations in Q1, we've continued to build shared understanding and capability around Restorative Just and Learning Culture (RJLC), with a particular focus on SCOH and ACUC. These discussions have helped surface practical ways RJLC principles can complement existing priorities such as PSIRF, civility, and compassionate leadership. In Q2, we've begun translating these insights into action by: - Developing tailored resources and guidance to support teams in applying RJLC approaches within their local contexts. - Engaging with SCOH and ACUC stakeholders to co-design learning opportunities that reflect the values of accountability, repair, and psychological safety. - Identifying early adopters and champions who can model restorative practices and support cultural change across their areas. This phase has strengthened the foundation for RJLC implementation and created momentum for embedding these principles more widely across the organisation. Active Bystander Training - Following a high level of interest and requests from staff for Active Bystander Training during Phase 1, Phase 2 has now been rolled out. Early feedback suggests strong engagement and a continued appetite for further sessions. The focus for this quarter is to assess the effectiveness of the training, gather feedback to refine delivery, and explore opportunities to embed the approach more widely across teams. Management essentials skills training - As of 7th October 25, a total of 105 managers have been trained from across the Trust. We have worked closely with the Comms team in producing a campaign to provide key information to our managers. Based on current feedback/evaluation data we have actioned; 1) the introduction of webinars from mid-sept 25 to boost learning uptake, alongside face-to-face sessions. 2) Continuing with the dissemination of course information directly to managers and at matron level. 3) Continue to work alongside People and OD colleagues in support of bespoke sessions e.g. recently supported at Ardenleigh (receiving positive feedback from staff). We are currently reviewing delivery plans and trajectories by end of Q3. Divisional workforce inequalities plans - Work is underway to develop specific actions, and a draft plan is in progress. The next step will focus on aligning divisional actions with the overarching organisational EDI priorities and ensuring consistency in approach across all areas. Some divisions are ahead in terms of inequalities plan in particular socialising within their divisions. Anti-racist supervision - George Smalling has now shared the final report with his findings which has been shared at Transforming Culture and Staff Experience Committee. EDI and OD team to adapt the model to support facilitating Anti Racist Supervision	Amber

Transforming our culture and staff experience	Improve staff engagement scores to 57.5% for staff survey 25/26	To support leaders and line managers, we've begun delivering targeted training and resources focused on engaging leadership behaviours. These are designed to equip them with practical tools to foster inclusion, recognition, and psychological safety within their teams. Early feedback has been positive, with participants reporting increased confidence and clarity in their role as engagement enablers. In parallel, we've supported conversations with managers and leaders through the wider Organisational Development and Business Partnering (ODBP) offer to identify gaps and understand what's needed to strengthen engagement. Additionally, listening spaces have been provided across divisions, creating safe environments for staff to share experiences and contribute to shaping local engagement priorities. Trust Employer Value Proposition (EVP) - Scoping of benefits and reward has identified concerns in relation to the sustainability of Job Evaluation practices, prompting an end-to-end review alongside national benchmarking and Nursing role assessments. Work is ongoing to develop the recommendations report for TCSE Committee, which is now pencilled for Q3, to permit further time for scoping within the ICS and Nationally with the Reward and Recognition Network for comparators. Corporate support offer - Following the evaluation of the current Corporate Support Offer (CSO) in Q1, we have begun implementing the key recommendations to strengthen its effectiveness and alignment with organisational needs. This quarter, we've focused on: Enhancing communication about the CSO, including updated guidance and visibility of available resources. Aligning support functions more closely with divisional priorities via ODBPs to improve responsiveness and relevance. These actions are helping to embed the CSO more firmly into operational practice and ensure it delivers consistent value across the organisation. Appraisal compliance - We have met our Q2 target as our overall trust compliance is currently 82.1% (as of 6th Oct), indicating that our interventions/processes in place are positively impacting trust compliance e.g. Acute & Urgent Care services have achieved a 10% increase on their appraisal compliance from April-July 25. Values Based Appraisal training delivery commenced upon completion of the new content co-produced within the QI project all actions are now complete. Hot spot areas are identified on a monthly basis, executives, appraiser and appraisees are informed where compliance falls below 75% and offered appropriate support. Increased uptake has been realised due to improved communication, training and bespoke support for managers and staff.	Amber
Transforming our culture and staff experience	To reduce the disproportionality of racialised groups involved in people processes by 10% with a focused approach in Secure Care and Offender Health	Divisional workforce inequalities plan are currently being worked on with identified lead with a focus on people processes, however some divisions are ahead in socialising the plan and highlighting the link with Health Inequalities. Restorative Justice and Learning Culture (RJLC) - Building on the baseline assessment of understanding and confidence among people managers in Q1, we've focused this quarter on engaging RJLC learning across identified priority areas. Key actions include: Targeted engagement sessions delivered to priority teams, tailored to their operational context and aligned with existing initiatives such as PSIRF and compassionate leadership. Development of practical RJLC learning materials to support consistent understanding and application of restorative, just, and learning principles. Facilitated peer learning spaces where managers can reflect on real scenarios and share approaches to embedding RJLC in their leadership practice. Ongoing collaboration with divisional leads and OD to ensure RJLC learning is integrated into wider development offers and aligned with organisational priorities. These efforts are helping to build momentum and confidence in applying RJLC principles, and a shift away from blame-based responses. Links of civility and respect wtih Culture of Care Programme and PSIRF - Mapping completed and comms plan being developed with Patient Safety colleagues. Reduction of disproportionality of global majority colleagues involved in formal processes in SCOH - A decrease of 6% has been recorded so far through target corporate support offering and proactive work to increase informal resolution. Actions ongoing.	Amber
Modernising our people practice	Work collaboratively with others to ensure our workforce systems are fit for purpose and we are in a state of readiness for the new workforce solution	ESR training uptake has increased significantly following refresh of comms. Capacity on the corporate systems team has led to delays in corrective action on the system. ESR optimisation team will be supporting a data quality project in Q3/4.	Amber

Modernising our people practice	Reduce response times to common employee relation casework by 30 days	Connect Knowledge Base and Resource Hub launched successfully in July 2025 and build continues to add support articles, resources and information. AI tool (Ask Ava) development indefinitely on hold following migration to central tenant. Managing Employee Performance Policy ratification delayed due to capacity within Operations Team, agenda capacity at TCSE Committee and a request to return to JOSC before chairs action to ratify. Development of training resources placed on hold pending final version, draft workshop piloted in Primary Care and Dementia Services. PowerBI People Operations Dashboard launched as a pilot, including casework progression and sickness data, in addition to triangulation metrics. Access granted to People Partners, Head of HR and Associate Director. Uptake of Management Essential training - As of 7th October 2025, a total of 105 managers have been trained in Management Essentials from across the Trust. We have worked closely with the Comms team in producing a campaign to provide key information to our managers. Based on current feedback/evaluation data we have actioned; 1) the introduction of webinars from mid-sept 25 to boost learning uptake, alongside face-to-face sessions. 2) Continuing with the dissemination of course information directly to managers and at matron level. 3) Continue to work alongside People and OD colleagues in support of bespoke sessions e.g. recently supported at Ardenleigh (receiving positive feedback from staff). We are currently reviewing delivery plans and trajectories by end of Q3.	**Green**

Quality Strategic Goals 2025/26

Strategic aim	Overarching goal	Progress / achievements in Quarter 2	Q2 RAG rating
Improving service user experience	Work together with service users to improve experience and participation in line with the principles of the HOPE strategy	Hope and Recovery Box project has now been extended to include other inpatient areas. Program of EBE's delivering recovery chats to service users within inpatient areas has now been established. Setting Recovery College as a service on RiO is in progress. SWOT analysis undertaken, service evaluation drafted, waiting sign off from R&D. Review of EbE recruitment, training and processes is due to be completed by the end of 2025. Attending national co-production leads meeting on a quarterly basis.	Green
Preventing harm	Ensure safe care and staffing by embedding standards, skills and competencies and learning	Scoping of universal JDs and PS for B5 and B6 are being reviewed in November 2025 with Heads of Nursing and HR People Partner as part of wider project which will include accurate following of the recruitment and selection policy. The Clinical Education Packages have been delivered across multiple sites. Reflecting using PDSA cycle 2, we are currently in a review cycle with particular focus on acute care. Matrons are engaged and supporting this piece of work. Following a meeting with Dr Sadira and Sam Munbodh re the Quality Goal learning and improvements from recent national reports, we have agreed to use the safety incident framework to avoid confusion and different processes, documents titled. Safety Incident Learning Framework, ISR template updated July 24 and PSIRF Hot Debrief Template outline the process. Any national reports/enquiries will be flagged and considered under the above named documents.	Green
Preventing harm	Continue to deliver the AHP strategy	77% of job plans complete (60%) or in sign off stage. E-roster active for Tamarind, Ardenleigh OT teams, Reaside in progress.	Amber
Preventing harm	Ensure harm reduction and long-term support for physical health support)	Policy and procedures that were overdue were reviewed. Implemented the Acute Respiratory Infections Procedure. Matressess audit completed. Review of audit tools ogoing. Inclusion of CYP services into audit programme. Physical Health Strategy in now updates with refresh quality outcomes for 2025/6. Approved and agreed at Physical health committee to share with CGC (especially the successes). Working group for Physical Health dashboard (which is co-produced have agreed information and data to be added. Dashboard work now with the informatics team being produced	Green
Preventing harm	Reducing restrictive practice	Communication video has been edited and ready to be shared as part of a de-escalation toolkit. Local plans are being shared at each meetings.	Amber
Preventing harm	Improve safeguarding awareness and practice relating to service users who experience domestic abuse.	Identification of themes and trends to inform practice guidance. This will be for staff and will include guidance on adult (child) to parent carer domestic abuse and any other aspects idenitified through the scoping work. 7-minute Briefing on ACPA and is now available on Safeguarding pages on Connect. Once agreed at SMB we can sign up to PEGS Covenant and use their resources to create further guidance.	Green
Preventing harm	Implement positive risk management approaches that involve the service user in identifying and managing their risk	Version 2 of a personalised safety assessment form is ready to be reviewed by patient safety partners and will be tested with staff with the support of QI facilitators in Q3.	Green
Preventing harm	Embed Suicide Prevention and Safety Planning approaches into routine clinical care across all services	Localised plans to be presented during Q3 to the Learning From Deaths group and a rolling programme of service presentation will commence for oversight and identification of high priority areas.	Amber

A patient safety culture	Continue to foster a culture across all services where service users, carers and staff can flourish	Roll out of Culture of Care commenced as planned in Acute Care with good engagement. Board Development session held in October led by Culture of Care QI Lead. Pre- planning for Specialities and ICCR being drawn up and on track for Q3. Voice of family/carers in care and safety plans - Co-production of the safety assessment continues. V2 of form to be reviewed. Service user voice and how they will be involved in the training is being scoped. AHP PA training underway. Expect to have 3 qualied Professional Advocates by January 2026. Trainee PNAs are due to start at BCU on 22nd October. Lead PNA is already recuiting for February 2026 cohort. Lead Nurse for Non Medical Education and Development is orgnaising train the trainer days and safeguarding supervision awareness for the Matrons. Visible leadership and civility - Culture of Care programme in Acute Services night visits completed with NEDs Leadership and support for staff to speak up - Senior Leadership Team presentation booked for 10th November. Profesional infrastructure for social workers - Lead Social Worker appointed/ Comemnces 6th January 2026. Social workers involved in strategy work whilst wiating for inaugural social worker professional council. Nursing Strategy - Power point re nursing strategy awaiting final approval from Chief Nurse. Professional Standards have been developed as below: Professional Standards (PS) for Nurses PS Guidance-Accurate & Timely Record keeping. PS Guidance-Leaving a shift without authorisation. PS Guidance-Lone working compliance. PS Guidance-S17 Leave. PS Guidance-Staff sleeping on duty. PS Guidance-Therapeutic Observations. A monthly working group to consider further standards required to support practice has been convend and further Practice Standards are in the process of being developed in areas re MDT and expansion of lone working. Practice standards will be added as a link to the relvant policy to ensure access, timely review and ensure staff are clear on expectations. Embedding learning from incidents - Learning event occurred in September next one scheduled to take place in January 2026. Masterclass videos etc being put together as a resource. Service areas scoping where learning is being shared and discussed locally.	Amber
Quality assurance	Ensure robust audit and assurance of policies to ensure they are effective reflect the reality of practice	First policy assurance meeting has been held with policy authors to review and improve the audit and assurance section of their policy to ensure we are measuring the right elements to demonstrate compliance with it. Five policies were reviewed and the next meeting is scheduled for October 29th and will review a further 5. This meeting also covered the CYP and BSMHFT policy alignment.	Green
Quality assurance	Improve quality data and monitoring from a Trust and divisional perspective	Report presented to CGC presenting the first iteration of the Early Warnings Dashboard, covering data for August 2025. Focusing initiall on Acute and Urgen Care Services, with planned rollout to Children and Young People (CYP), Specialties, and Intergrated Community Recovery (ICR) service by year end. The dashboard aligns with the Culture of care programme and incorporates the Nottingham style "Safe Care Today" reporting model, which includes narrative assurance on actions and mitigations. The dashboard brings together a wide range of indicators, including: Patient flow (e.g., bed waits, discharges, readmissions) Safety (e.g., incidents, seclusion, restraint, rapid tranquilisation) Staffing (e.g., supervision, sickness, training compliments) Patient experience (e.g., PALS, complaints, compliments) Regulatory and audit compliance (e.g., infection control, risk assessments, safety plans) Plans to integrate feedback from Freedom to Speak Up, patient councils, and physical health metrics. Further development is required to enchance data capture and reporting for Urgent Care and Home Treatment services. This includes aligning patient contact data with triage tools (e.g., 4/12/14-hour response standards), capturing call logs, missed visits, appointment attendance, referral rates, and long waits for care coordinator allocation. Additionally, the percentage of patients seen within two weeks of discharge from Home Treatment will be monitored, in line with the Trust's Clinical Governance Committee policy on "Waiting Well". The aim is to make data meaningful and actionable for Ward Managers and senior leaders, enabling early identification of areas requiring support and improvement.	Amber

Using our time more effectively	Develop leaders to make effective use of resources and rostering to support quality care	Roster Dashboard is now discussed more widely and has now been introduced to the Safer Staffing. A positive is we have now introduced spot checks into our HTT service on WTD breaches and additioanl training has been provided to those services. The MHOST has now been completed with a focus on our Acute Care division to receive an uplift. It is anticipated that papers will initially go to Safer Staffing Committee in November 2025. We have now estabished the Bank Gold Meetings to review our bank with important workstreams to aid the success of the project.	Amber
Using our time more effectively	Ensure fit for the future clinical governance and foster effective and supportive relationships between the nursing and quality division and clinical services	Quality partners model introduced. Chairs training commissioned with 25 places all now filled. Adoption of new AAA report.	Amber
Using our time more effectively	Quality Improvement and Quality Management System Methodology	QMS workshop with CGC membership facilated and delievered in Q1 by Deputy Medical Director for Quality and Safety and Head of QI. Planned QMS session with QI Team looking at strategic alignment of projects and QMS Planning on 9th September 2025. National survey returned to NHS Impact in progress in May by Head of QI. Re-score planned in Q3 with Board input.	Green

Sustainability Strategic Goals 2025/26

Strategic aim	Overarching goal	Progress / achievements in Quarter 2	Q2 RAG rating
Transforming with digital	Use of technology to improve productivity	We have Microsoft Co-Pilot built into the trust's MS Teams for all of our staff to access. We have circa 300 licences in use for Copilot enhanced and have agreed on the onboarding of smart notes into our instance of RIO, allowing ambient voice for clinical teams. Better use of Office 265 applications is technically enabled, but we acknowledge this is more than technical enablement. The informatics team is doing some great work with BI and RPA, including Power Automate, We have onboarded to the national tenancy, and this set us back with the BOTS and RPA we had in flow. We have some work to do to establish the use of agentic bots in the national tenancy, but we have a clear road map to get us there over the next two quarters.	Green
Transforming with digital	Develop our business intelligence capability to improve the information and performance insights available for Trust service areas	Published initial 24-7 programme monitoring dashboard as planned, including operational and evaluation tracking elements, and have continued adding extra screens and functinality iteratively. Detailed demand and capacity management project with Solar was initiated as planned, and a model developed collaboratively with the service to reflect their detailed pathway and processes. Next step is to validate the model using historic data and start applying to future predictins and planning tasks. Development of the wider future performance reporting plan has had to be pushed back while detailed integration work is underway on bringing CYP Division data into the Trust's data warehouse and reporting infrastructure. However, that work has progressed very well through the quarter and combined MHSDS reporting started seamlessly from July	Green
Caring for the environment	Implement a refreshed Estates and Facilities Strategy to ensure our estates and facilities are fit for the future	Final draft version of the Estates and Facilities Strategy is at consultation having already been discussed at the MAC, the PEAR meeting, OMT and Trust Executive Team, all positive to date. Consultation due to finish in November 2025. Improving space utilisation: Trust approval of ubook has been given for SSL to now scope resources necessary to implement and manage, SSL to review use of room booking software system including reference to other Trust, BSol and Primary Care systems. The refurbishment of Main House for the FIRST team programme of works being underway. In addition positive that the Trust have approved the additional funding to support Yewcroft CMHT team and other ICCR functions allowing for all of Main House to be refurbished ready for use. Vacant or underutilised property shared as standing agenda item on Trust Strategic Property Group for awareness, prioritisation and decision.	Amber
Caring for the environment	Work towards the achievement of the new sustainability targets	New Green Plan has been to full Trustwide consultation including for example Trade Unions. Final ratification to be via Trust FPP due 23rd October 2025 which has been given delegated authority on behalf of Trust Board. The Plan will then be shared with NHSE to meet 31 Oct 2025 National mandated target. Heat Decarbonisation Plan commenced development. Quarterly meeting of Trust Sustainability / Green Group reporting to Director of Finance.	Green

Changing through partnerships	Maximising opportunities through provider collaboratives to improve access, experience and outcomes and address inequalities for our diverse population and staff	BSOL MHLDA Provider Collaborative: The final version of the draft Provider Collaborative Strategy has been paused due to capacity. Launch planned for the New Year. Co-production of the local place delivery plans has commenced. This has included a session with the Snr Black Leaders Group in Birmingham and the VCFSE. Co-production framework development paused till quarter 3 Options appraisal for embedding community voice into commissioning was delayed due to long term staff sickness. Member of staff has returned and session arranged with the team in November 2025. Reach Out: Refreshing the clinical strategy - Commencing the procurement process for local beds has been delayed and currently waiting for the Cabinet Office approval. Dawn House provision business case fully approved, resources are currently being secured by the provider Technical solution for the single point of access has been identified by the Trust The initial provider recovery plans are developed and the discussions will continue to ensure productivity and efficiency. 'Health Inequalities Strategy' has been finalised for further discussions with Partner organisations. Funding has been agreed to support the recruitment of two social workers to reduce the clincially ready for discharge patients numbers. Further delays in completing the women's services bed modelling and the LDA male bed modelling due to engagement from provider trusts. Embedding new commissioning and contracting arrangements with the ICB - Changes in the NHS England operating model and the local ICB mergers impact on building relationships with commissioners. This is further impacted by the progress made on how ICBs will develop their strategic commissioning functions, and how they engage with the Host ICB. Discussions are ongoing with NHSE about how the LPC could support discussions to support the system design. Developing non-forensic community interfaces - Each ICB/MHPC project are now underway, albeit mobilised at different stages. Specialist Community Forensic Team (FIRST) specification fully signed off which will align with the newly developed ICB services.	Red
Balancing the books	Improve underlying financial position, ambition and timescale for achieving recurrent balance, with identified proposals for generating cash releasing cost savings	Use productivity and benchmarking information as a driver for identifying opportunities - Corporate benchmarking return submitted on time. Report received during September and shared with relevant corporate leads. Mechanisms for reviewing services and fitness for the future - Suggested services lines discussed. Savings submissions from operational portfolios includes some area for further consideration. Commissioner issued life course spec has allowed divisional leads the opportunity to consider pathway rationalisation. Review financial reporting to ensure visibility of position, decisions and priorities - Ongoing. Additional information contained within reports around underlying position and implications of NOF metrics.	Green
Good governance	Ensure the safe transfer of services, staff and infrastructure from Forward Thinking Birmingham	Phase 1 transfer completed on 1 July 2025. Post transition plan - The ICT feasibility study has taken place and an options appraisal has been developed, all systems that will form part of ICT systems integration are now known. Work is now starting to understand how the integration will be funded. There continues to be difficulties in gathering required level of detail around estates. A number of workstreams have been stood down as there are no deliverables as part of Phase II. The other workstreams are clear what needs to be delivered and are working towards this.	Amber

Report to Board of Directors							
Agenda item:	**23**						
Date	3 December 2025						
Title	Annual Review of the Terms of Reference (ToR) of Board Committees						
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 *(executive summary, key risks)*

Alert		**Advise**		**Assure**	✓

1. Purpose:

It is best practice to regularly review the terms of reference of Board Committees to ensure relevance and alignment with organisational strategy and once reviewed, their Terms of Reference must be presented to the Board of Directors for ratification. Robust Terms of Reference should set out the committee`s role, objectives, scope, authority, responsibilities and membership. This paper presents the Terms of reference of QPES, People Committee, and the FPP which had been approved at their meetings to the Board for ratification (recognising it had ratified the ToR of the Audit Committee at its October meeting).

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 delegated responsibilities from the Board while ensuring its effectiveness and added value in contributing to the organisation's success. It is best practice for Board Committees including their sub-committees to review their terms of reference annually against external best practices, model ToR and standards, with the aim of continuously strengthening their governance arrangements and fostering a culture of learning and improvement.

Key changes that have been made to the ToR of QPES, the People Committee and FPP include: -

- Clarification of the committees` strategic oversight functions in regularly reviewing and scrutinising the CRR and BAF while seeking assurance on the effectiveness of the mitigations/controls and actions in place.
- Clarification of QPES` and the People Committee`s responsibilities in seeking assurance from the Freedom To Speak Up Guardian that the recommendations on quality and clinical services-related issues as well as those relating to people respectively cited in their reports (Quarterly, Bi-annual and Annual Reports) have been appropriately

implemented as a way of closing the loop.

- Strengthening the memberships by clearly identifying designated deputies with the expectation that they could count towards quoracy, however, there is a caveat that this shouldn`t be the norm but the exception.
- Other amendments are highlighted in orange.

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 different Board Committees while ensuring they are effectively implemented. This will be mitigated through sufficient publicity and sharing of the final version with all members of the Committee for their records.

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*** *the content of this report and* ***RATIFY*** *the Terms of Reference set out in appendixes 1, 2, & 3.*
2. ***GAIN ASSURANCE*** *that the Terms of Reference of QPES, the People Committee and the FPP have been appropriately updated in line with their delegated functions and best practice.*

Enclosures

Appendix 1: Updated Terms of Reference of the QPES Committee.
Appendix 2: Updated Terms of Reference of the People Committee.
Appendix 3: Updated Terms of Reference of the FPP Committee.

Appendix 1: Updated Terms of Reference of the QPES Committee.

Quality, Patient Experience and Safety Committee (QPES)

Terms of Reference

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1. VALUES

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 Quality, Patient Experience and Safety Committee ("**QPES**") is constituted as a Standing Assurance Committee of the Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. The Terms of Reference can only be amended with the approval of the Board of Directors.

2.2 QPES is authorised by the Board of Directors to govern any activity which falls within its purpose, duties, and responsibilities. It 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 QPES.

2.3 QPES can request external and internal individuals and/or authorities to attend its meetings to help it make decisions and can escalate any issues within its remit to the Board of Directors for consideration. QPES is an assurance committee of the Board of Directors only, i.e., it is part of the governance of the Trust's provider arm.

2.4 The overall aim of QPES is to seek and obtain evidence-based assurance on all aspects of quality and safety of care across the Trust and also to provide scrutiny and oversight of the effectiveness of the Trust`s quality and patient safety arrangements, systems and processes. It shall ensure that both strategic and operational risks aligned to the delivery of the Trust`s Quality and Clinical Services strategic priorities are effectively mitigated and managed.

2.5 The Committee has strategic oversight function for related risks on the Trust`s Corporate Risk Register (CRR) and BAF and will seek and provide assurance to the Board that all risks on the Trust`s CRR and BAF which could inhibit the achievement

of the Trust`s operational and strategic objectives linked to the `Quality` and `Clinical Services` priorities, are effectively and robustly mitigated and managed.

3. PURPOSE

3.1 QPES is responsible for assuring on behalf of the Board of Directors that the Clinical Services and Quality streams of the Trust's Strategy (2024/25) are being delivered:

- Leader in mental health
- Recovery focussed
- Rooted in communities
- Prevention and early intervention
- Clinically effective
- Changing how we work
- Improving service user experience
- Preventing harm
- A Patient Safety culture
- Quality assurance
- Using our time more effectively.

3.2 A key purpose of the Committee is to monitor and receive assurance on the delivery of the Quality Strategy for the Trust.

3.3 The Committee will lead on monitoring of controls and assurances related to the 'Clinical Services' and 'Quality' sections of the Board Assurance Framework and to assure itself that any strategic and operational risks aligned to the delivery of the `Quality` and `Clinical Services` priority are effectively mitigated and managed.

3.4 The Committee will ensure and assure, on behalf of the Board of Directors, all matters relating to the administration within the Trust of statutory requirements relating to mental health legislation. These include the Mental Health Act (1983 and 2007 amended) and the Mental Capacity Act (2005).

3.5 The Committee will promote an open and transparent reporting and learning culture across the Trust to support quality, safety and clinical effectiveness.

3.6 The Committee will also provide the Board with an independent and objective view and assurance on the appropriateness of the quality and safety of care provided to patients and the robustness of the Trust`s clinical governance arrangements while also focusing on clinical effectiveness and patient experience.

4. DUTIES

4.1 Monitor the implementation and progress of the Trust's Quality Strategy against the five strategic aims to focus on:

- Improving service user experience
- Preventing Harm
- A Patient safety culture
- Quality Assurance
- Using our time more effectively.
- PEAR

4.2 Receive the Trust's Quality Account endorse and recommend for approval by the Board of Directors.

4.3 Oversee and receive assurance of statutory and mandatory requirements relating to quality of care.

4.4 Receive assurance on the development and effective governance of the safety culture within the Trust.

4.5 Oversee effective systems for safety within the Trust, with a focus on patient safety, staff safety, and wider health and safety requirements. Undertake detailed scrutiny of the Trust`s Quality and Clinical Services performance information in the Integrated Performance Report (IPR) while linking to any emerging intelligence from the Financial and People strategic priorities.

4.6 Oversee the delivery of a high-quality experience for all service users, with a particular focus on:
a) assessing impact on quality due to financial decision-making involvement
b) engagement for the purposes of learning and making improvement.

4.7 Oversee an effective system for monitoring quality outcomes and effectiveness with focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities.

4.8 Assure the Trust's maintenance of compliance with the CQC registration through assurance of the systems of control with emphasis on the areas of quality and safety.

4.9 Oversee and assure on external assessments and regulatory bodies' requirements.

4.10 Oversee and assure the Board of Directors on statutory and mandatory requirements relating to quality of care.

4.11 Approve the annual Clinical Audit Plan for the Trust.

4.12 Support and hold to account the committee reporting to QPES in achieving its purpose, responsibilities, and duties.

4.13 Identify its annual objectives, produce an annual work plan in the agreed Trust format, measure performance at the end of the year, and produce an annual report. This will also include an assessment of compliance with its terms of reference.

4.14 Consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to QPES and to identify and act upon any areas of significant concern to the Board of Directors.

4.15 Undertake any other responsibilities as delegated by the Board of Directors.

4.16 The Committee shall receive bi-annual reports from the Freedom To Speak Up Guardian on `Quality` and `Clinical Services` related issues and seek assurance that where applicable, all learning, improvement and recommendations identified in their reports have been effectively implemented, disseminated at scale and embedded.

4.17 Discharge the duties that previously rested with the Mental Health Legislation Committee:

- Monitor and scrutinise the Trust's implementation and compliance with current mental health legislation and guidance and consider any proposed changes for the Trust.
- Seek assurance that arrangements for the compulsory detention of service users within the Trust are lawfully managed.
- Monitor and scrutinise trends in the application of the Mental Health Act within the Trust and make recommendations to the Board of Directors for change where necessary.
- Maintain an appropriate number of suitably skilled and experienced Lay Managers in place in the Trust, ensure that they are appropriately supported and trained, and monitor and scrutinise their activities.
- Approve MHL specific policies and procedures for use within the Trust and monitor and scrutinise their application.
- Assess and review risks that may impact on the Trust's ability to meet the requirements of the MHA, review controls and assurance that risks are appropriately managed, and identify and escalate to the Board of Directors as required.

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director (Member)
- Executive Director of Quality and Safety (Chief Nurse)
- Executive Medical Director
- Executive Director of Operations

In Attendance

5.2 The following will be standing attendees of the Committee:

- ~~Associate Director of Clinical Governance~~
- Head of Mental Health Legislation
- Medical Lead for MHA and MCA

- ~~Deputy Director of Nursing~~
- ~~1 x Associate Director of Nursing~~
- Head of Health and Safety and Regulatory Compliance
- ~~Director of Quality and Improvement~~
- ~~Director of Urgent Care Transformation.~~ Deputy Director of Operations
- Associate Chief Nurse for Policy and Practice
- Chief AHP/Deputy Director for Quality & Safety/Patient Experience
- Interim Associate Director of Nursing: Patient Safety
- Lead Nurse for Safer Staffing
- Head of Quality Improvement & Clinical Effectiveness
- Associate Director of Safeguarding
- Company Secretary
- Chairs of the sub-committees which report into QPES.
- Associate Director of Corporate Governance

5.3 Designated Deputies

No	Exec Membership	Designated Deputy
1	Executive Director of Quality and Safety (Chief Nurse)	Chief AHP/Deputy Director for Quality & Safety/Patient Experience
2	Executive Medical Director	Deputy Medical Director – Quality & Safety
3	Executive Director of Operations	Deputy Director of Operations

5.4 Other Directors will attend if they have an agenda item but only for that item. Other officers will attend but only for specific agenda items, e.g., Trust Solicitor, Lay Managers, Associate Director of Corporate Governance etc.

5.5 All members have one vote. In the event of votes being equal the Chair of the Committee has a casting vote.

5.6 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.7 Other members of the Board can attend meetings if they indicate to the Chair of QPES, in advance, of their intention to do so.

5.8 Where members are unable to be present, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.9 Members are expected to make every effort to be present at all meetings of the Committee. There will be 10 meetings in a financial year, however, members will be expected to attend at least 70% of the total number of meetings for the year.

5.10 The Company Secretary shall keep a register of attendance of all members as per this ToR.

5.11 Meeting attendance will be reviewed by the QPES Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with 4 Committee members, including two Non-Executive Directors and one Executive Director. These ~~cannot~~ could be designated deputies attending on behalf of substantive members. Designated deputies can only represent substantive members twice in any rolling year with any departures due to exceptional circumstances subjected to rigorous scrutiny and agreement by the Committee.

7. DECLARATION OF INTERESTS

7.1 All members must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes.
However, if a member is conflicted with an item on the agenda, 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 will be held 10 times per year.

8.2 Meeting dates will be agreed annually in advance by the members of the Committee.

8.3 The agenda of every Committee meeting will include as a standing item a review of 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 Prior to each meeting, the Company Secretary will organise an agenda setting meeting as per the QPES annual calendar of meetings, this will bring together the Chair and Executive Director of Quality and Safety (Chief Nurse) to establish and agree the draft agenda which will be timely circulated for papers to be crafted.

9.4 Any issues with the agenda must be raised with the Committee Chair for advice prior to the final papers and bundle being circulated.

9.5 All reports, papers and the bundle including the agenda, action log and minutes must be circulated at least 5 working days before the meeting.

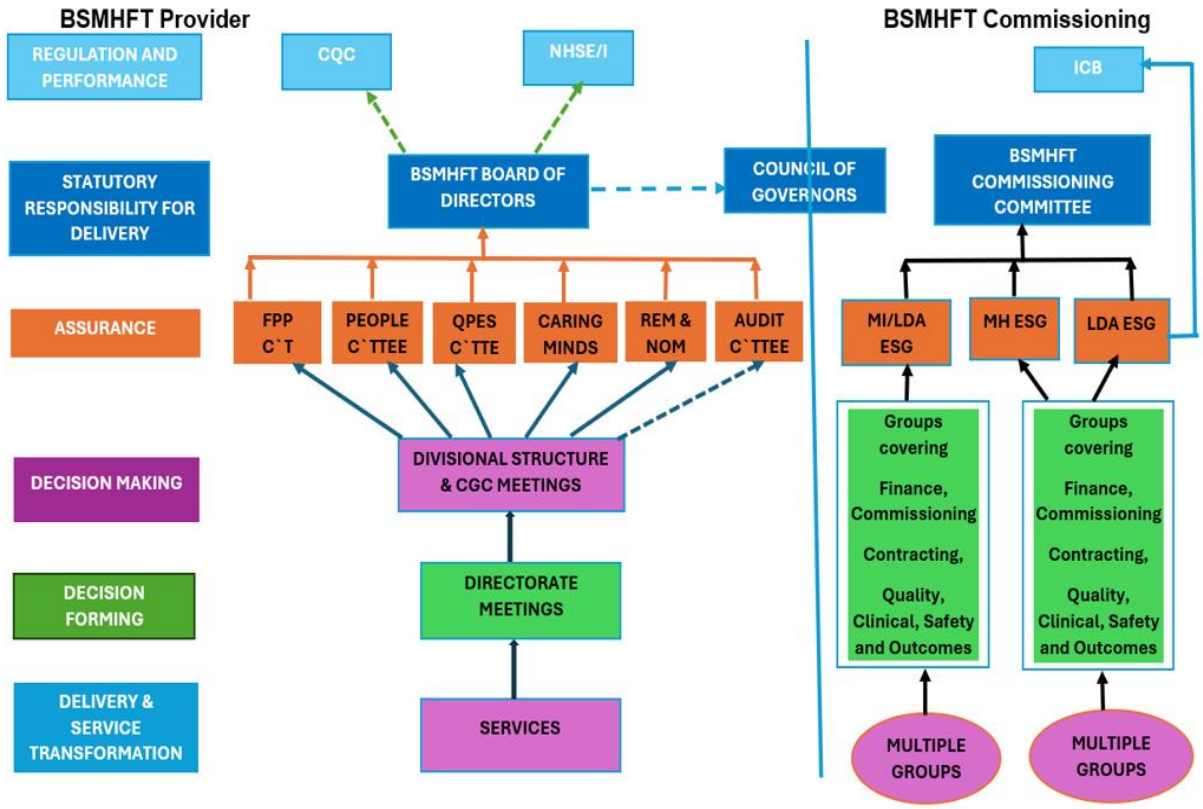
9.6 An action log and minutes will be compiled during the meeting and circulated within 5 working days of the end of the meeting.

9.7 Any issues about the action ~~list~~ log or minutes must be raised within 5 working days of issue.

9.8 The Company Secretary will be responsible for updating the forward plan with input from the Director of Quality and Safety (Chief Nurse) and Associate Director of Clinical Governance, for agreement with the QPES Chair.

10. Governance Structure

10.1 BSMHFT Provider and Commissioning Governance structure



11. REPORTING AND LINKS TO OTHER COMMITTEES

11.1 The Committee Chair will provide a `Triple A` Assurance Report at every Board meeting which will reflect the things the Committee is Alerting, Assuring and Advising the Board on.

11.2 The Committee will receive regular reports from the sub-committees and groups reporting into it – the formal timing of these will be outlined on the QPES forward plan and in addition to this exception reports will be provided as required. The Committee

will receive regular Chair`s Assurance Reports from the Trust Clinical Governance Sub-committee (TCGC) at each of its meetings.

11.3 The Committee will provide exception reports to the Audit Committee.

11.4 Any service changes will require sign off in terms of impact on quality by the Medical Director and the Director of Quality and Safety (Chief Nurse).

11.5 Members and Attendees at both QPES and FPP will be expected to have an integrated approach so that impact issues are not lost, and papers to both committees will need to indicate where there is a potential impact on quality. Where necessary, exception reports will be provided between the two committees.

11.6 The Committee will review their effectiveness on an annual basis, through an annual self-assessment, reporting the outcome of the review to the Board of Directors.

11.7 The Committee Chair will present to the Council of Governors (CoG) annually a report on the work of the Committee. QPES Chair`s Assurance Report(s) will be presented by the Chair to the CoG as per its Forward Plan.

REVIEW

12.1 These terms of reference are to be reviewed at least annually.

Date Reviewed: November 2025

Date Approved by QPES: 19th November 2025

Date Ratified by the Board: -- December 2025

Date of Next Review: November 2026

Version: 1.8

Appendix 2: Updated Terms of Reference of the People Committee.

People Committee (PC)

Terms of Reference

1. Values

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 People Committee is constituted as a Standing Assurance Committee of the Board and is authorised by the Board to investigate any activity within its Term of Reference. It is authorised to seek any information it requires from any employee and contractors as directed to co-operate with any request made by the Committee or the Board of Directors. Any amendments to its constitution and terms of reference as set out below, must be subject to approval by the Board of Directors.

2.2 The Committee is authorised by the Board of Directors to instruct professional advisors and require the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions.

2.3 The Committee has strategic oversight function for related risks on the Trust`s Corporate Risk Register (CRR) and BAF and to seek and provide assurance to the Board that all risks on the Trust`s CRR and BAF which could inhibit the achievement of the Trust`s operational and strategic objectives linked to the `People` priority, are effectively and robustly mitigated and managed.

2.4 The Committee is authorised to obtain internal information as is necessary and expedient to the fulfilment of its functions.

People is an assurance committee of the Board of Directors only, i.e., it is part of the governance of the Trust's provider arm.

3. PURPOSE

3.1 To ensure and provide assurance on behalf of the Board of Directors that the People Strategic Priority of the Trust's Strategy (2024/25) and people related issues of the Strategic Priorities of the Trust strategy (2024/25) are being delivered to all staff groups in line with the Trust values.

3.2 The Committee will take responsibility and delivery of aims set out within the People Strategic Priority as below:

- Shaping Our Future Workforce including
  - Attract and Retain Diverse Talent
  - High-Performing Workforce
  - Flexible &Transformative Workforce Models
- Transforming Our Culture including
  - Inclusion, Equality, and diversity
  - Safety to Speak Up and Share Learning
  - Compassion and Wellbeing
- Modernising Our People Practice including
  - Integrated People Practice
  - Evidence-Based People Practice
  - Digitally Enabled Workforce.

3.3 The following sub-committees will be chaired by professional leads outside of the People function:

- Shaping the Future Workforce Sub Committee.
- Transforming Our Culture and Staff Experience Sub Committee.
- Safer Staffing Report from Safer Staffing Sub Committee to include updates on (Recruitment & Retention).

3.4 To assure focus and delivery of wellbeing and inclusion where staff are the top priority to support a happy workforce.

3.5 The People Strategy, structures, systems, and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care.

3.6 Processes are, and the right culture is, in place to support optimum employee performance to enable the delivery of the People Strategy and business plans aligned with the Trust's values.

3.7 To assure The Trust is meeting its legal and regulatory duties in relation to staff, volunteers, and peers by experience.

3.8 To review and advise any human resource risks and issues that may jeopardise the Trust's ability to deliver its objectives, that these are being managed in a controlled way.

3.9 To lead on monitoring of controls and assurance related to the 'People' sections of the Board Assurance Framework and to assure itself that any strategic and operational risks aligned to the delivery of the `People` priority are effectively mitigated and managed.

4. RESPONSIBILITIES AND DUTIES

4.1 Developing and advising the Board of Directors on the People Strategic Priorities including any leadership and organisational development interventions, actions to improve inclusion, equality, and diversity necessary to deliver the Trust's strategy, incorporating external best practice and professional advice.

4.2 Overseeing delivery of the People Strategic Priorities on behalf of the Board of Directors against agreed plans, a range of workforce metrics, indicators, and targets.

4.3 Undertake detailed scrutiny of the Trust`s People performance information in the Integrated Performance Report (IPR) while linking to any emerging intelligence from Sustainability, Quality and Clinical Services strategic priorities.

4.4 Providing appropriate reports to the Board of Directors on the above indicating assurances received, decisions made, and matters escalated that require consideration by the Board of Directors.

4.5 Monitoring the development of the future workforce, through an effective workforce plan that includes workforce supply, new roles, learning and organisational development.

4.6 Ensure that there is sufficient leadership and management capacity and capability within the Trust to deliver the Trust's strategy.

4.7 Ensuring that the voice of staff and volunteers is heard, via staff networks, staff surveys and other appropriate mechanisms, and that this is acted upon in line with the strategic vision and values and to ensure compliance with requirements relating to Freedom to Speak Up and Whistleblowing.

4.8 Maintain oversight and assure the Trust's equality, diversity, and inclusion agenda is being delivered.

4.9 Ensure the Trust has a suitable policy framework and leadership development framework to deliver the People Strategic Priorities, ensuring alignment with the NHS People Plan and relevant regulatory requirements such as NHS Improvement workforce standards and CQC.

4.10 Oversee the development and implementation of initiatives to maintain the organisation as an undergraduate and postgraduate learning provider.

4.11 Oversee and influence key relationships with educational partners to maximise benefit of these relationships to the Trust.

4.12 Review national and local strategies and reports from external bodies such as CQC, NHSE HEE & NHS Employers, identifying the implications for, and actions required by the Trust.

4.13 Ensure there are ongoing arrangements for reviewing the regulatory requirements relating to staff, such as NHSE and CQC standards such as Well-Led. Ensure that appropriate strategies and plans are developed, implemented, and sustained to meet these requirements.

4.14 Maintain oversight of its associated sub-groups through receipt of regular update reports and metrics.

4.15 The Committee will receive, for information, the minutes from the Joint Negotiation and Consultative Committee and the Joint Local Negotiation and Consultative Committee.

4.16 Receive the People Risk Register and relevant risks from the BAF to review assurance on risk mitigation and controls including any gaps in control.

4.17 Assess any risks within the workforce portfolio brought to the attention of the Committee and identify those that are significant for escalating to the Board of Directors as appropriate.

4.18 Maintain oversight of Remuneration and Reward, ensuring and assuring alignment to relevant Employee and Worker legislation.

4.19 The Committee shall receive bi-annual reports from the Freedom To Speak Up Guardian on People related issues raised in their reports and will seek assurance where applicable, that all learning, improvement and recommendations identified have been effectively implemented, disseminated at scale and embedded.

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director
- Executive Director of Quality & Safety (Chief Nurse)
- Executive Medical Director
- Deputy CEO & Executive Director of Strategy, People & Partnerships
- Executive Director of Operations.

In Attendance

5.2 The following will be standing attendees of the Committee:

- ~~Deputy Director of Nursing~~
- Deputy Director of Finance
- Deputy Medical Director – Quality and Safety
- ~~Associate Director for Allied Health Professions and Recovery.~~ Chief AHP/Deputy Director for Quality & Safety/Patient Experience
- Chief Psychological Professions Officer.
- Associate Director of People, Learning and Development.
- Chair of the Shaping the Future Workforce Sub Committee.
- Chair of the Transforming Our Culture and Staff Experience Sub Committee.
- Chair of Safer Staffing sub-committee.
- Chair of Multi-Professional Education and Training sub-committee.
- Company Secretariat/Company Secretary.

- Associate Director of Corporate Governance
- Associate Director of Comms and Marketing

5.3 Designated Deputies:

No	Exec Membership	Designated Deputy
1	Deputy CEO & Executive Director of Strategy, People & Partnerships	Associate Director of OD & EDI or Associate Director of People, L&D
2	Executive Director of Operations	Deputy Director of Operations
3	Executive Medical Director	Deputy Medical Director – Quality & Safety
4	Executive Director of Quality & Safety (Chief Nurse)	Associate Chief Nurse for Policy and Practice

5.4 Other members of the Board of Directors can attend meetings if they indicate to the Chair of the People Committee, in advance, of their intention to do so.

5.5 Other members of staff may attend to present papers or to contribute to the staff story.

5.6 Other parties may be invited to present papers from time to time.

5.7 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.8 Where members are unable to make the meeting, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.9 Members should make every effort to be present at all Committee meetings. There will be 10 meetings in a financial year, however, members will be expected to attend at least 70% of the total number of meetings.

5.10 The Company Secretary shall keep a register of attendance of all members as per this ToR.

5.11 Meeting attendance will be reviewed by the People Committee Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with 4 Committee members, two of which must be ~~a~~ Non-Executive Directors and two must be Executive Directors. These ~~cannot~~ could be designated deputies attending on behalf of substantive members. Designated deputies can only represent substantive members twice in any rolling year with any departures due to exceptional circumstances subjected to rigorous scrutiny and agreement by the Committee.

7. DECLARATION OF INTERESTS

7.1 All attendees must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes.
However, if a member is conflicted with an item on the agenda, 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 The meeting will be closed and not open to the public.

8.2 Meetings will be held 10 times per year. Members will agree the meeting dates annually in advance.

8.3 The agenda of every Committee meeting will include as standing items a review of how effectively it has discharged its business and how effective the Committee has role modelled the values of the Trust through its decision making.

9. ADMINISTRATION

9.1 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.

9.2 The Committee shall report to the Board of Directors on its proceedings after each meeting to provide assurance and to escalate issues as appropriate.

9.3 The Committee will provide an annual report to the Board of Directors setting out how it has discharged its responsibilities as set out in these terms of reference.

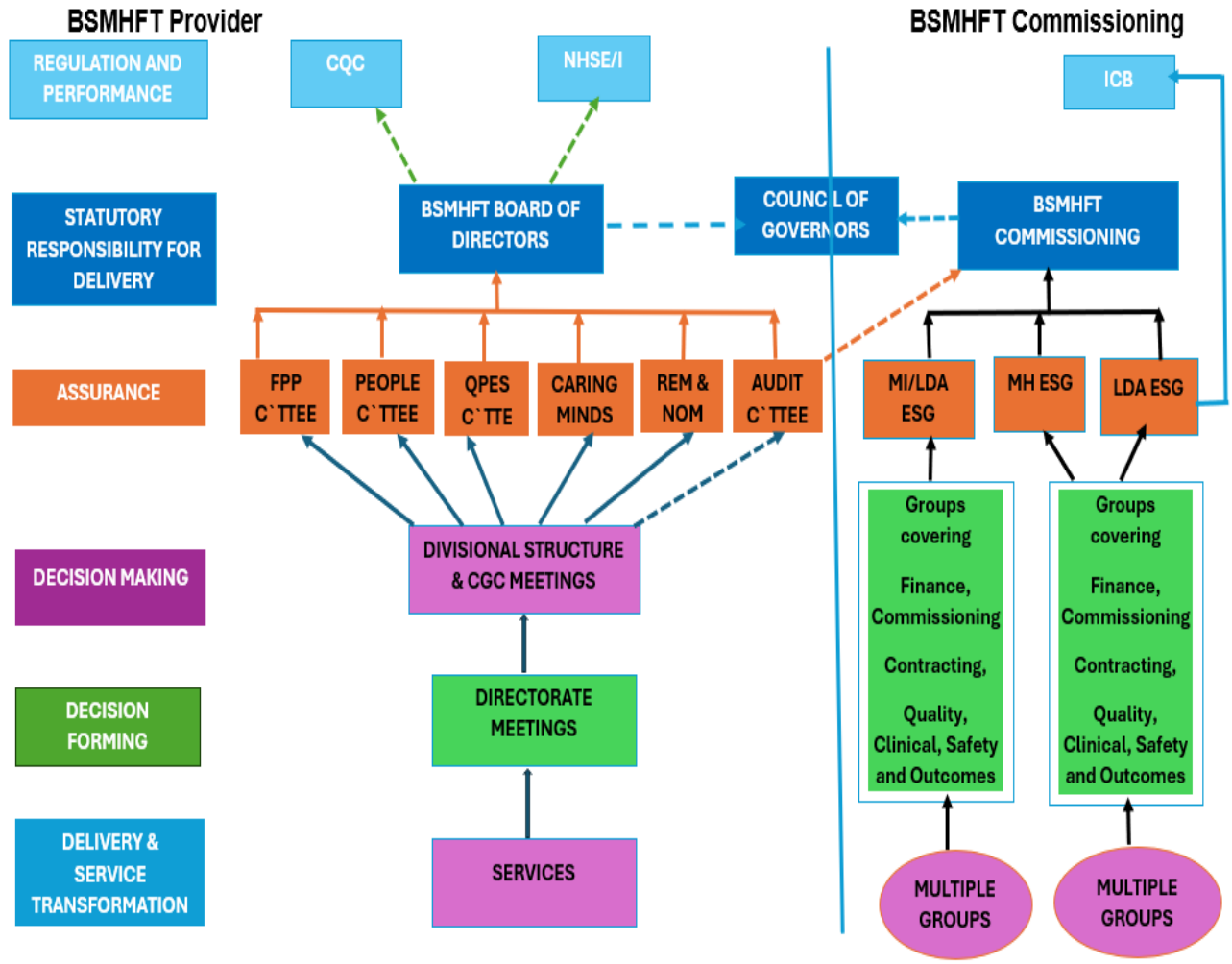
9.4 Prior to each meeting, the Company Secretary will organise an agenda setting meeting as per the People Committee annual calendar of meetings, this will bring together the Chair and Deputy CEO & Executive Director of Strategy, People & Partnerships to establish and agree the draft agenda which will be timely circulated for papers to be crafted. The agenda, minutes and papers will be circulated 5 working days before the meetings and any issues with the agenda must be raised with the People Committee Chair within 4 working days.

9.5 An action list log and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

9.6 Any issues with the action list or minutes will be raised within 5 working days of issue.

10. Governance Structure

10.1. BSMHFT Provider and Commissioning Governance structure



11. REPORTING AND LINKS TO OTHER COMMITTEES

11.1 The Committee Chair will provide a Committee Assurance Report (Triple `A` Report) for the next meeting of the Board of Directors. This will seek to amongst others `Alert`, `Assure` and `Advise` the Board as well as describe any major issues that were discussed by the Committee, and the level of assurance was received through papers and oral testimony.

11.2 The Committee will report to QPES on matters that are likely to affect workforce resourcing, education, and learning to enable triangulation with clinical outcome and patient care indicators.

11.3 The Committee will bring to the attention of the Finance Productivity and Performance Committee ("**FPP**") any matters that are likely to affect expenditure on the Workforce and quarterly on the work of the Workforce Intelligence and Systems as they relate to pay.

11.4 The Committee will provide exception reports to the Audit Committee.

11.5 The Committee will provide reports as requested to the remaining committees.

11.6 Operational delivery of the Committee's work plan will be overseen by the Director of Strategy, People & Partnerships via day-to-day oversight of the HR, OD, and Learning and Development functions.

11.7 The Committee will review its effectiveness on an annual basis, through an annual self-assessment, reporting the outcome of the review to the Board of Directors.

11.8 The Committee Assurance Report(s) will be presented by the Committee Chair to the Council of Governors as per its schedule of meetings.

11.9 The Committee will foster dialogue and relationships with Trade Union colleagues via biannual conversations and updates from them on their activities, challenges, and suggestions on promoting and enhancing the working conditions of our staff.

12. REVIEW

12.1 Terms of Reference are to be reviewed at least annually.

Date Reviewed: November 2025

Date Approved by the People Committee: 18th November 2025.

Date Ratified by the Board: --- December 2025

Date of Next Review: November 2026

Version: 3.2

Appendix 3: Updated Terms of Reference of the FPP Committee.

Finance, Performance, and Productivity Committee (FPP)

Terms of Reference

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1. VALUES

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 Finance, Performance and Productivity Committee ("**FPP**") is constituted as a Standing Assurance Committee of the Board. Any amendments to its constitution and terms of reference as set out below, must be subject to approval by the Board of Directors.

2.2 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from within and outside the Trust with relevant experience and expertise as it considers necessary.

2.3 The Committee is authorised to carry out any function within its terms of reference. FPP is an assurance committee of the Board of Directors only, i.e., it is part of the governance of the Trust's provider arm.

2.4 The Committee has strategic oversight function for related risks on the Trust`s Corporate Risk Register (CRR) and BAF and will seek and provide assurance to the Board that all risks on the Trust`s CRR and BAF which could inhibit the achievement of the Trust`s operational and strategic objectives linked to the `Sustainability` priority, are effectively and robustly mitigated and managed.

3. PURPOSE

3.1 The primary purpose of the Committee is to provide assurance on finance, performance and productivity systems and processes and to approve any business cases in line with the SFI's and scheme of delegation.

3.2 To seek any and all explanations and information it requires from any employee or contractor of the Trust to achieve the Committee's purpose.

3.3 To ensure and assure on behalf of the Board that the Sustainability stream of the Trust's Strategy (2024/25) is being delivered:

- Balancing the books
- Transforming with digital
- Caring for the environment
- Good governance
- Changing through partnerships.

3.4 To lead on monitoring of controls and assurance related to the "Sustainability" sections of the Board Assurance Framework and to assure itself that any strategic and operational risks aligned to the delivery of the `Sustainability` priority are effectively mitigated and managed.

4. DUTIES

4.1 To receive assurance regarding the Trust's medium- and long-term financial strategy and financial health, including consideration and endorsement of financial plans and budgets for approval by the Board.

4.2 To approve business cases in line with authority limits defined by the scheme of delegation or to make a recommendation to the Board for matters reserved to Board. The Committee will expect assurance that there has been full and proper consideration of the quality implications of any business case coming to the Committee for approval or review.

4.3 To consider savings targets and plans and endorse them for approval by the Board, including assurance of progress against the cost improvement programme.

4.4 To consider the Trust's approach to tax and promote financial sustainability, innovation and transformation while ensuring that the Trust`s purpose and strategy are being pursued in a cost-effective manner and achieving value for money.

4.5 Undertake detailed scrutiny of Trust`s financial and performance information, including performance against the cost improvement programme and the capital investment programme and through detailed review of the Integrated Performance Report (IPR).

4.6 To approve and keep under review the Trust's investment strategy and policy.

4.7 To receive regular reports and insights regarding organisational performance in a form determined by the Committee, including external benchmark information as an aid to improving overall performance and productivity of the Trust.

4.8 To review and approve `Significant Transactions` within its delegated limits from the Board and review, scrutinise, advise on and recommend `Significant Transactions` above its delegated limits to the Board.

4.9 To scrutinise and challenge financial information and service redesign plans and ensure that any potential impact on quality is fed back to QPES.

4.10 To seek assurance regarding the strategic direction and operational delivery of the digital agenda, its impact on users and plans for sustaining it.

4.11 Where there are any concerns regarding finance, planning, performance and productivity, the committee is authorised to seek assurance that the concerns have been investigated, corrective action taken, and lessons learnt.

4.12 To review and advise on the Trust's strategic business development and planning approach, including strategic intentions. This includes consideration of any relevant, significant business development proposals.

4.13 To approve policies appropriate to the work of the Committee, as defined by the Policy for Management of Policies.

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director
- Executive Director of Finance
- Deputy CEO & Executive Director of Strategy, People & Partnerships
- Executive Director of Operations

In Attendance

5.2 The following will be standing attendees of the Committee:

- Deputy Director of Finance
- Company Secretariat/Company Secretary
- Associate Director of Corporate Governance
- Associate Director of Comms and Marketing
- Chairs of the sub-committees which report into the FPP (i.e. (P&DSC), and the Capital Review Sub-Committee)

5.3 **Designated Deputies**

No	Exec Membership	Designated Deputy

1	Executive Director of Finance	Deputy Director of Finance
2	Deputy CEO & Executive Director of Strategy, People & Partnerships	Head of Strategy, Planning and Business Development
3	Executive Director of Operations	Deputy Director of Operations

5.4 All members have one vote. In the event of votes being equal the Chair of the Committee has a casting vote.

5.5 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.6 Other members of the Board can attend meetings if they indicate to the Chair of FPP, in advance, of their intention to do so.

5.7 Where members are unable to be present, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.8 Members are expected to make every effort to be present at all Committee Meetings. There will be 10 meetings in a financial year, however, members will be expected to attend at least 70% of the total number of meetings.

5.9 The Company Secretary shall keep a register of attendance of all members as per this ToR.

5.10 Meeting attendance will be reviewed by the Committee Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with 4 Committee members, including two non-executive director and ~~one~~ two executive directors. These ~~cannot~~ could be designated deputies attending on behalf of substantive members. Designated deputies can only represent substantive members twice in any rolling year with any departures due to exceptional circumstances subjected to rigorous scrutiny and agreement by the Committee.

7. DECLARATION OF INTERESTS

7.1 All attendees must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. However, if a member is conflicted with an item on the agenda, the Chair ~~will~~ 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 will be held ~~8~~ 10 times per year.

8.2 Meeting dates will be agreed annually in advance by the members of the Committee.

8.3 The agenda of every Committee meeting will include as a standing item a review of 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 The Associate Director of Corporate Governance/Company Secretary will be responsible for updating the Committee's cycle of business, with input from the Executive Director of Finance and Executive Director of Operations, for agreement with the Chair of the Committee.

9.4 Prior to each meeting, the Company Secretary will organise an agenda setting meeting as per the FPP annual calendar of meetings, this will bring together the Chair and Executive Director of Finance to establish and agree the draft agenda which will be timely circulated for papers to be crafted.

9.5 Any issues with the agenda must be raised with the Committee chair for advice prior to the final papers and bundle being circulated.

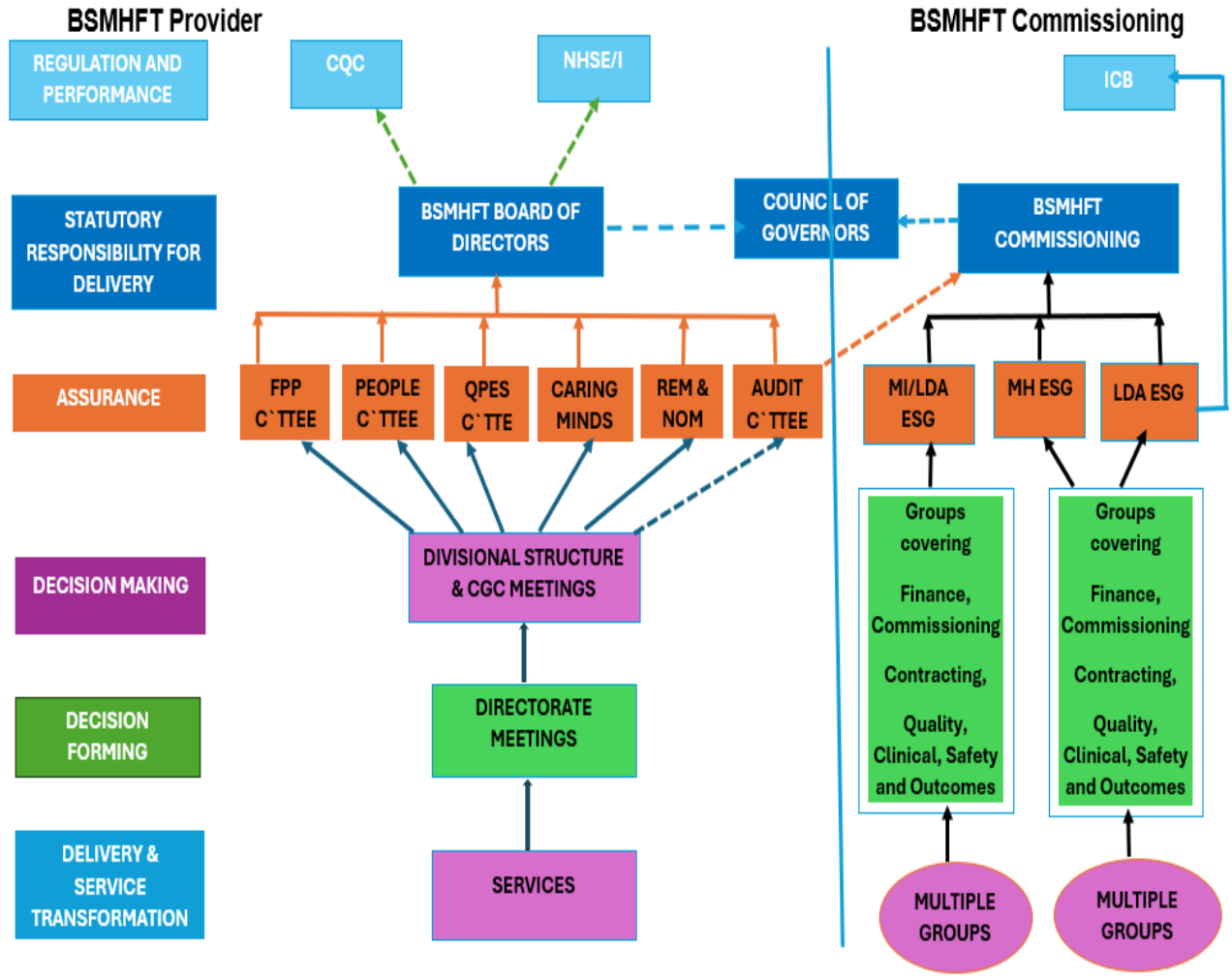
9.6 All reports, papers and the bundle including the agenda, action log and minutes must be circulated at least 5 working days before the meeting.

9.7 An action ~~list~~ log and minutes will be compiled during the meeting and circulated within 5 working days of the end of the meeting.

9.8 Any issues with the action log or minutes will be raised within 5 working days of issue.

10. Governance Structure

a. BSMHFT Provider and Commissioning Governance structure



11. REPORTING AND RELATIONSHIP WITH OTHER COMMITTEES

11.1 The Committee Chair will provide a Committee Assurance Report (Triple `A` Report) for the next meeting of the Board. This will seek to amongst others `Alert`, `Assure` and `Advise` the Board as well as describe any 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 provide exception reports to the Audit Committee as the lead committee for governance and risk.

11.3 The Committee where applicable, will receive exception reports from QPES on concerns which have been raised about potential impact on quality of financial plans. Conversely, and where applicable, exception reports will be reported to QPES on issues the committee needs to draw to its attention about the impact on quality from issues emerging from discussions.

11.4 Overlap between QPES, PC and FPP business will be provided through an attendee at QPES meetings providing a verbal update to FPP. Attendees at QPES, PC and FPP will ensure the need for an integrated approach so that

impact issues are not lost, and papers to committees will need to indicate

11.5 The Committee will review their effectiveness on an annual basis, through an annual self-assessment, reporting the outcome of the review to the Board of Directors.

11.6 The Committee Chair will present to the Council of Governors (CoG) annually a report on the work of the Committee. FPP Chair`s Assurance Report(s) will be presented by the Chair to the CoG as per its Forward Plan.

11.7 The Committee will have two sub-committees i.e. Planning & Delivery Sub-Committee (P&DSC), and the Capital Review Sub-Committee which shall regularly report into it via Chair`s Assurance (Triple A) Reports.

12. REVIEW

12.1 These terms of reference are to be reviewed at least annually.

Date Reviewed: November 2025

Date Approved by the FPP: 20th November 2025

Date Ratified by the Board: -- December 2025

Date of Next Review: November 2026

Version: 3.1