# Public Board of Directors

**Schedule** Wednesday 4 February 2026, 9:00 AM — 12:30 PM GMT
**Venue** Plymouth Room, Uffculme Centre
**Organiser** Kat Cleverley

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# Agenda

**BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST**
**Board of Directors Public Meeting**
**09.00, Wednesday 4 February 2026, Uffculme Centre**
**AGENDA**

| Ref | Item | Purpose | Report type | Time |
|---|---|---|---|---|
| | **Staff Talk 09.00-09.30** | | | |
| 1 | **Chair's Welcome and Introduction** | | | 09.30 |
| 2 | **Apologies for absence** | | | |
| 3 | **Declarations of interest** | | | |
| 4 | **Minutes of meeting held on 3 December 2025** | Approval | Enc | 09.35 |
| 5 | **Matters arising from meeting held on 3 December 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** *Nick Moor, Non-Executive Director* | Assurance | Enc | 10.20 |
| 12 | **Quality and Safety Report** *Lisa Stalley-Green, Chief Nurse* | Assurance | Enc | 10.30 |
| 13 | **Safeguarding Annual Report 2024/25** *Lisa Stalley-Green, Chief Nurse* | Approval | Enc | 10.40 |
| | **People** | | | |
| 14 | **People Committee Report** *Sue Bedward, Non-Executive Director* | Assurance | Enc | 10.50 |
| 15 | **Guardian of Safe Working Hours Quarterly Report** *Hari Shanmugaratnam, Guardian of Safe Working Hours* | Assurance | Enc | 11.00 |
| | **Sustainability** | | | |
| 16 | **Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director* | Assurance | Enc | 11.10 |
| 17 | **Finance Report** *Dave Tomlinson, Executive Director of Finance* | Assurance | Enc | 11.20 |
| 18 | **Summerhill Services Ltd (SSL) Overview Report** *Shane Bray, SSL Managing Director* | Assurance | Enc | 11.30 |
| 19 | **Audit Committee Report** *Winston Weir, Non-Executive Director* | Assurance | Enc | 11.45 |
| | **Reflections** | | | |
| 20 | **Living the Trust Values** *Lisa Stalley-Green, Chief Nurse* | | Verbal | 11.55 |
| 21 | **Board Assurance Framework reflections** | | Verbal | 12.00 |
| 22 | **Any other business** | | Verbal | 12.05 |
| 23 | **Questions from Governors and members of the public** | | | |
| | **Close by 12.30** | | | |
| | **Date and Time of Next Meeting: Wednesday 1 April 2026, 09.00-12.30** | | | |

# 1. Chair's Welcome and Introduction

# 2. Apologies for absence

# 3. Declarations of interest

# 4. Minutes of meeting held on 3 December 2025

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

**BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST**
**Minutes of the Public Board of Directors Meeting**
**Wednesday 3 December 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 |
| | 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** | Katherine Allen | KA | Lead for Recovery, Service User Carer and Family Experience (item 0 only) |
| | Kat Cleverley | KC | Company Secretary (minutes) |
| | Ella McGowan | EMc | Higher Specialty Trainee in Psychiatry (item 15 only) |
| | Hari Shanmugaratnam | HS | Guardian of Safe Working Hours (item 17 only) |
| | David Tita | DTi | Associate Director of Corporate Governance |
| **Observers** | Three governors and three members of staff/the public observed the meeting in person. | | |

| Ref | Item |
|---|---|
| 0 | **Service User Talk**<br><br>KA and Barry, a service user, attended the meeting to talk about his experiences at Reservoir Court and Juniper. Barry described his preference for Reservoir Court due to psychological knowledge available. Barry was passionate about ensuring that patients were involved in multi-disciplinary team meetings to be involved in their own care.<br><br>Barry described his experience as a service user at Juniper, noting some privacy and dignity issues, and highlighting how scared patients were when first going into a ward and being searched. Barry also suggested a jargon buster for service users to explain language and acronyms used.<br><br>Barry had experienced some excellent staff working within the Trust, and one in particular who worked at Reservoir Court, he would nominate for a Mustak Mirza Award<br><br>Barry also had experienced some poor practice, describing how some staff members were on their phones or talking across patients, and Barry reminded the Board that people felt overpowered by the system, particularly when a new patient.<br><br>NM asked Barry if he felt safe overall. Barry confirmed that he did in the early stages of his illness as it felt safer, however once he started to improve it felt restrictive and petty.<br><br>KA highlighted that Barry was interested in becoming an Expert by Experience and would begin his training in January.<br><br>LSG asked about Barry's experience of leaving hospital and the care and support he received. Barry felt that Reservoir Court aftercare had been excellent, but Juniper was not as good.<br><br>BC reflected on the performance management of staff, and the variation that Barry had experienced. LSG also reflected on what the Trust was measuring and monitoring in relation to culture and behaviours, regular |

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| | management supervision and the culture of care programme rollout. PN noted that this also highlighted how important it was to talk to service users as part of Board site visits.<br>VD commented that carer feedback and involvement also needed to be considered and more work was needed to address how the Trust adjusted to the different skill mix required at mutli-disciplinary meetings.<br>The Board thanked Barry for attending and sharing his journey, noting his descriptions of his care were powerful and would lead to change. The Board was also encouraging of Barry becoming an Expert by Experience to help shape future changes. |
| 1 | **Chair's Welcome and Introduction**<br>PG welcomed everyone to the meeting. |
| 2 | **Apologies for absence**<br>Roisin Fallon-Williams, Chief Executive Officer |
| 3 | **Declarations of interest**<br>None. |
| 4 | **Minutes of meeting held on 1 October 2025**<br>The minutes were approved as a true and accurate record. |
| 5 | **Matters arising from meeting held on 1 October 2025**<br>All matters arising were updated. |
| 6 | **Chair's Report**<br>The Board received the report. PG highlighted the following key points:<br>• PG had visited the 24/7 Neighbourhood Centre with the Chair of Black Country, Birmingham and Solihull ICB Cluster and had been very impressed and excited about the work that was going on.<br>• PG had also visited HMP Birmingham and though staff were working in a challenging environment, the recent CQC inspection had highlighted some positive comments and feedback.<br>PA commented on the changing Freedom to Speak Up Guardian arrangements at national level, and asked that the Trust continued its support and commitment to the office. PG advised that BSMHFT acknowledged the importance of the Guardians and that this would continue at the Trust.SB noted that recent Courage to Speak Up workshops had taken place to reinforce this message.<br>SB asked if there was a date for the formal 24/7 Neighbourhood Centre launch. PN noted that a formal launch would be planned for February, and details would be announced once confirmed. |
| 7 | **Chief Executive and Director of Operations Report**<br>The Board received the report. RFW and VD highlighted the following key points:<br>• Staff were thanked for completing the Staff Survey. A significant improvement in the level of engagement in the survey had been seen and the Trust looked forward to receiving the results in the new year.<br>• The team continued to drive the flu campaign.<br>• There had been sustained reductions in bank and agency use.<br>• RFW thanked clinical and management colleagues who had supported the recent resident doctor's industrial action. Further industrial action was planned for December.<br>• The Board acknowledged the significant financial pressures across the NHS, noting that plans were being developed in line with the Ten Year Plan.<br>• RFW commented on the recent CQC inspection that had taken place at HMP Birmingham. Initial high-level feedback had been positive, but there were still actions that the Trust needed to undertake. |

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| | • The Trust had been shortlisted for a HSJ Award for Race Equality.<br>• There was a continued focus on productivity and how the Trust utilised key performance indicator metrics and performance measures to make improvements.<br>• Services were exploring how to be more service user-led, co-producing with Experts by Experience and learning from patients, carers and families.<br>• A contract performance notice had been issued to Solar, and the team was being given support to develop improvement plans.<br>• There was a focus on workforce key performance indicators within Acute and Urgent Care, with improvements being seen in completed appraisals and regular management supervision. The division was reporting 94.4% fundamental training compliance.<br>• Children and Young People were performing well on access, and the BSOL system was now ranked the eleventh best system in England. The team was looking to share and support learning for others.<br>• A Culture of Care programme was beginning in primary care dementia and specialty services.<br><br>LC commented on the number of good news stories within the report, and noted particularly the increased community work which provided some real opportunities to work closely with services users and local communities.<br><br>BC was pleased to hear about the focused work to become more service user-led, noting that this ambition would need to be linked to the significant financial situation. BC asked about the temporary support that was in place in CYP services. LSG confirmed that this was a focused support offer at Parkview to provide expertise, due to end in March 2026 once procurement had been determined.<br><br>PA commented on the over-diagnosis mentioned within the report and the risk that this was prevalent and costly. LSG advised that this aligned to the reducing length of stay work, and ongoing cultural work with medical colleagues.<br><br>PG asked about demand and flow and case complexity, querying how the Trust would ensure that clinical and quality staff wellbeing was maintained whilst keeping services safe. VD explained the work of the prevention of admissions team so that service users in units were more complex cases. Constant reviews were ongoing to make sure service users were in the best place for their needs. Teams were currently well staffed, clinical supervisions were ongoing, and reviews were underway to ensure caseloads were fair. Teams across the organisation were also very supportive of each other.<br><br>NM reinforced comments and concerns around complex caseloads and not transferring risk to community teams, noting that this had been discussed at Quality, Patient Experience and Safety Committee. |
| 8 | **Board Assurance Framework**<br><br>The Board received the Board Assurance Framework for assurance. DTi highlighted two key areas including the refreshed linked risks to the Corporate Risk Register and the external risk factors report that had been discussed at Audit Committee and would be reflected.<br><br>The Board discussed financial risk scores on the Corporate Risk Register and how they correlated to the Board Assurance Framework. DT explained the process of categorisation and scoring in relation to the Risk Management Policy, and the Risk Management Group responsibility for reviewing and moderating risk scores.<br><br>The Board was satisfied with the overall process. |
| 9 | **Corporate Risk Register**<br><br>The Board received the Corporate Risk Register for information and assurance on the risk management process within the organisation, and assurance that high-scoring risks were linked to the Board Assurance Framework. |
| 10 | **Integrated Performance Report**<br><br>The Board received the report for information, noting particularly that the Trust remained in National Oversight Framework segment four, with monthly review meetings taking place with NHSE. |

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| | SB raised a query in relation to the increase in safety incidents. LSG commented on the ongoing monitoring and planning and increased safety measures being put in place across the Trust. PA noted that he had seen a continued improvement during his three months as a non-executive director at the Trust. |
| 11 | **Quality, Patient Experience and Safety Report**<br>The Board received the report for information. LC and NM highlighted the following key points from the October and November meetings:<br>• Drug use remained a significant issue in secure services.<br>• Staffing capacity concerns were highlighted in North and South Home Treatment Teams.<br>• There were a high number of Clinically Ready for Discharge patients in older adults' services.<br>• The Committee had received the Mental Health Legislation Committee escalation report, which was appended for information. WW commented that he regularly attended the Committee meetings and was satisfied that the report reflected the discussions held. PG noted high levels of black males subjected to community treatment orders and acknowledged the continued close monitoring of this. PG wished to thank the team for the work they do on compliance with the Mental Health Act.<br>LC felt that risk was more visible now, which was supporting the escalation and resolution of issues. PG asked if there were any predictive measures on wards in relation to safety so that the Trust could mitigate before there were escalations. LSG commented on the patient derived incident trends, which related to small numbers of high-risk patients. The acute North and PICU wards were being closely monitored for this reason. LSG also highlighted that the implementation of the smokefree policy and Trust-approved vapes had resulted in some issue, and staff de-escalation training was ongoing as a key factor in managing complexities. |
| 12 | **Quality and Safety Report**<br>The Board received the report for information and assurance.<br>LSG advised that the recent CQC inspection at HMP Birmingham had resulted in some positive feedback, notably that it was the best prison mental health care that inspectors had reviewed. LSG confirmed that there were no areas within the Trust that were rated Inadequate, and all Section 29a notices had been removed.<br>PN commented on the good progress around reduction in patient harm and increased safety, and the need to publicise and celebrate the work that was taking place to continually improve.<br>PG commented on individuals within the community who required close monitoring to ensure their health was maintained, and how the Trust looked after staff who managed heavy and complex caseloads. PG also queried the kind of behavioural or environmental factors that were driving divergence, and was the Trust confident that the Culture of Care Programme was focusing on the root of the problem. LSG commented on the positive outcomes of the Culture of Care work that was being rolled out across the Trust and how it was tangibly changing culture and making positive differences to both staff and service users. LSG also noted that the environment was constantly being reviewed to make improvements and consider the range of activities available.<br>FA noted that the Reducing Restrictive Practice Group also discussed this regularly. |
| 13 | **Safer Staffing Report**<br>The Board received the report for assurance. LSG highlighted the combination of a number of priority workstreams over the last six months to evidence improvement at the Trust. Improvements in the increased number of substantive staff and clearer controls and monitoring processes were particular achievements during the year. Training and development would be priorities for 2026/27. |
| 14 | **Assertive and Intensive Action Plan Highlight Report**<br>The Board received the report for assurance, with no further discussion. |
| 15 | **Resident Doctor Peer Representative Report** |

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| | EMc attended the meeting. FA described the NHS Ten Point Plan and its aim to improve the working lives of resident doctors and the requirement for trusts to appoint a representative to report directly to the Board at relevant points.<br><br>EMc described that she was an ST5 doctor working in the eating disorders service. She had attended national meetings with other resident doctors to share concerns, barriers to improvement and good practice. EMc noted that BSMHFT was unique in that it was formed of multiple sites across Birmingham and Solihull, rather than a large hospital.<br><br>EMc fed back some concerns raised by resident doctors, including the need for easy and clear documentation when first joining the organisation in relation to annual leave processes and payroll, ensuring that Switchboard was cohesive and consistent across the Trust, and food availability out of hours.<br><br>The Board thanked EMc for attending and highlighted the value of resident doctors and their work.<br><br>**Action:** quarterly updates would be scheduled into the Board's forward plan. |
| 16 | **People Committee Report**<br><br>The Board received the report for information. SB highlighted the following key points from the October and November meetings:<br><br>• The October meeting had been a strategy session, focusing on the launch of the Sexual Safety Charter.<br>• The Committee raised concern about the ongoing challenges in relation to ESR data quality which was impacting on training, registration and workforce reporting. The Committee had been advised that a data cleanse was underway to support improvements.<br>• There were legacy issues relating to HR and casework issues following the CYP service transfer which was impacting on capacity. The People team was focusing on timely resolution and consistent values modelling.<br>• 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.<br>• Attendance and engagement at some subcommittees required improvement to ensure robust governance and representation. |
| 17 | **Guardian of Safe Working Hours Quarterly Report**<br><br>The Board received the report for assurance. HS highlighted the following key points:<br><br>• No immediate safety concerns had been reported during the quarter.<br>• Three fines had been levied against the Trust for breaches in safe working hours.<br>• There had been 421 locum bookings made to cover vacant shifts during the quarter. This was driven by core and higher trainee rotas for Children and Young People's services.<br>• Nationally, the Guardian of Safe Working Hours process was due to be changed. HS advised that educational supervisors would be removed from the process from next year, and reports received directly by HR and recruitment teams. HS noted that there were concerns about how these would be assessed through the changed process.<br><br>PN highlighted capacity issues with the People team and emphasised concern about how this would be managed. HS noted that he was hoping to work closely with colleagues in the People team once changes had been implemented. HS commented that the NHS Ten Point Plan reflected concerns that doctors may be under-reporting concerns due to fear of adverse consequences, and the decision to report directly to HR aimed to address this. FA noted that there needed to be a greater focus on how supervisors supported the process. |
| 18 | **Finance, Performance and Productivity Committee Report**<br><br>The Board received the report for information. BC highlighted the following key points from the October and November meetings: |

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| | • 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. The Committee had been assured by the controls in place to achieve the year-end position.<br>• Although national planning guidance for 2026/27 had not yet been received, the Committee was assured that internal planning had been progressing for some time.<br>• The Committee continued to discuss the risk of non-recurrent savings and the impact on long-term financial sustainability. The Committee acknowledged that the refreshed strategy would reflect the overall cost-reduction programme for the coming year.<br>• 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.<br><br>PA reiterated the importance of establishing an internal escalation framework to ensure issues were managed at an earlier point. |
| 19 | **Finance Report**<br><br>The Board received the report for information.<br><br>DT highlighted the potential financial risk of the £3.5m related to Children and Young People's Services, which was currently being discussed with partner organisations and was not yet resolved. PG queried the timeline for this, and it was noted that a system decision was required in order to conclude. |
| 20 | **Audit Committee Report**<br><br>The Board received the report. WW highlighted the key points from the meeting held in November:<br><br>• The Committee raised concern that the Single Tender Waivers and Losses and Special Payments reports had not been received for some time, and noted that these had been requested as part of an extraordinary meeting.<br>• The Committee had been assured by scrutiny of the Board Assurance Frameworks for the Trust and the Mental Health Provider Collaborative.<br>• A robust discussion had been held on the Corporate Risk Register, and the External Factors Risk Report which had been appended to the Audit Committee Report for information.<br><br>WW noted that the Committee had suggested a board strategy session to focus on Children and Young People's Services. This would be included in the schedule. **Action** |
| 21 | **Caring Minds Committee Report**<br><br>MS verbally updated the Board on the meeting held on 1 December:<br><br>• Funding was currently stable, however the Committee needed to be aware of the longer-term sustainability of the Charity and requirement for increased focused fundraising work.<br>• A funding limit of £20k had been agreed to support applications until the end of March 2026.<br>• The Committee approved the Annual Report and Accounts 2024/25.<br>• The funding application process was being finalised and would be launched in the new year.<br>• Governance arrangements for the Committee and establishment of a Board of Trustees would be reviewed in the new year. |
| 22 | **Trust Strategy Report**<br><br>The Board received the report for information.<br><br>PA highlighted the need to consider potential commercial ambitions for 2026/27 and beyond. |
| 23 | **Committee Terms of Reference**<br><br>The Board ratified the terms of reference for its committees.<br><br>The Board approved the arrangements for formal Deputy Chairs of each Committee. |

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| 22 | **Living the Trust Values**<br><br>PA described his experiences of the Trust during his first three months as a Non-Executive Director. He felt that there was a key focus on safety and quality, demonstrated through meeting papers and conversations, which linked to the three Trust values. PA noted that he had been on two site visits and described staff as very focused on their jobs, very approachable and happy to speak about what they did.<br><br>Although it was clear that there was pressure at both sites that he had visited, PA felt there were proactive approaches to understanding pressures within the teams and attempts to resolve them. |
| 23 | **Board Assurance Framework reflections**<br><br>No further reflections. |
| 24 | **Any other business**<br><br>PG and the Board thanked LC for her years as a Non-Executive Director, Chair of Quality, Patient Experience and Safety Committee and the work she had done for the Trust. |
| 25 | **Questions from Governors and members of the public**<br><br>The following questions were asked:<br><br>• There were general comments made about the positivity of the meeting.<br>• Some challenging estates and environments had been highlighted through recent CQC reports.<br>• A comment was raised about ensuring confidentiality of Freedom to Speak Up Guardian processes, and the Board highlighted the number of Champions across the organisation in different teams who support this.<br>• A question was asked in relation to the Mentally Healthy City plan and whether the Trust was involved. The Board responded that BSMHFT was closely involved in partnerships with local authorities. |
| **Close** | |

| **Actions/Decisions** | | | |
|---|---|---|---|
| **Item** | **Action** | **Lead/ Due Date** | **Update** |
| **Resident Doctor Peer Representative Report** | Quarterly updates would be scheduled into the Board's forward plan. | KC<br>Feb 26 | Completed |
| **Audit Committee Report** | A board strategy session on Children and Young People's Services would be scheduled. | KC<br>Feb 26 | Completed |
| **Committee Terms of Reference** | The Board ratified the terms of reference for its committees. | | |
| | The Board approved the arrangements for formal Deputy Chairs of each Committee. | | |

# 5. Matters arising

# 6. Chair's Report

# Report to the Board of Directors

| Agenda item: | 6 | | | | | |
|---|---|---|---|---|---|---|
| **Date** | 4 February 2025 | | | | | |
| **Title** | Chair's Report | | | | | |
| **Author/Presenter** | Phil Gayle, Trust Chair | | | | | |
| **Executive Director** | Phil Gayle, Trust Chair | **Approved** | **Y** | ✓ | **N** | |

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

## Summary of Report

| **Alert** | | **Advise** | | **Assure** | |
|---|---|---|---|---|---|

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

## Recommendation

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

## Enclosures

**BOARD OF DIRECTORS CHAIR'S REPORT**

## *1. Introduction*

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

Following recent system changes, Birmingham and Solihull ICB has established a formal cluster agreement with the Black Country ICB. I am engaging regularly with the Chair of the ICB cluster to ensure clear strategic alignment, support effective system leadership, and strengthen collaborative partnership working. These discussions are focused on identifying and progressing opportunities to enhance mental health service provision across the wider system and geographical footprint, improving population outcomes, maximising value for money, and delivering agreed transformation priorities. This includes identifying areas where collective impact can be maximised and enabling the systematic sharing and adoption of best practice.

Building on this system-wide alignment, the emerging Trust strategy has been developed to both reflect and actively support the broader ambitions of collaborative system working, while setting out a clear, ambitious and transformative direction for the organisation. The Trust remains focused on maintaining strategic clarity and organisational grip as the system landscape continues to evolve. The strategy will enter a structured testing and assurance phase during February and March, ahead of a full launch in April, to ensure it is robust, deliverable and aligned with system priorities.

The strategy is explicitly aligned to the NHS 10 Year Plan and incorporates its three key shifts: moving care from hospital to community settings, strengthening prevention, and making better use of digital and data to improve care. This phase will be supported by comprehensive engagement with colleagues, Governors, partners and service users, providing assurance that the Trust's priorities are evidence-led, informed by lived experience, aligned with national expectations and system transformation objectives, and focused on improving population outcomes and value for money. I am confident that the strength of our governance arrangements, alongside the professionalism, innovation and commitment of our teams, will ensure effective delivery of the strategy and sustained improvement in the quality of care for the communities we serve.

## *2. Governance Matters*

The Trust held its first facilitated Board Well-Led session, which was both timely and highly productive. The session enabled focused reflection, constructive challenge and open discussion, strengthening collective understanding of effective governance, leadership behaviours and Board dynamics. It also supported clear alignment with the Care Quality Commission's Well-Led framework and enhanced Board preparedness, both in terms of regulatory expectations and the Board's ability to provide robust strategic oversight and effective system leadership. The session was well-received and reinforced the value of continued Board development to support confident decision-making and sustained organisational improvement.

***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.

Visits to Trust services are continuing, with Non-Executive Directors and Governors actively participating over the coming months. These visits form an integral part of the Board's assurance role, providing direct insight into the experiences of staff, patients and service users. Engagement at service level supports a deeper understanding of the quality and impact of care being delivered, including areas of strength and opportunities for improvement, and directly informs Board oversight and decision making. This approach ensures that the voices of those delivering and receiving care remain central to governance and strategic leadership.

Additionally, I am reaching out to local and newly elected Members of Parliament to encourage greater interest in, and understanding of, our service provision across Birmingham and Solihull. This engagement is intended to strengthen relationships, increase awareness of the Trust's contribution to population health, and support shared priorities in improving outcomes for the communities we serve.

***3. Partner and System Development / Stakeholders***

As Chair, I continue to maintain an active and visible presence within key strategic and system forums, providing leadership, influence and constructive challenge on behalf of the Trust. This engagement supports strong relationships with partners and stakeholders and ensures the Trust's priorities remain aligned with wider system objectives.

These activities provide assurance to the Board that the Trust is well positioned within the regional landscape, actively contributing to the development of integrated mental health services, promoting innovation and inclusion, and maintaining a clear focus on improving outcomes for the communities we serve.

***4. Stakeholder Engagement***

As part of ongoing stakeholder engagement, I met with the West Midlands Police and Crime Commissioner, Simon Foster, to discuss shared priorities relating to community safety, increasing mental health demand and opportunities to strengthen joint working across the region. The discussion was constructive and focused on how closer collaboration can improve support for individuals who interact with both mental health

services and the criminal justice system, while contributing to more effective and joined up system responses.

In addition, I continue to Chair the Council of Governors meetings, which provide an important forum for engagement, assurance and development. These meetings include focused assurance from Non-Executive Directors on key areas of Trust performance and governance, alongside constructive discussion that supports effective oversight and ongoing organisational development.

***5. People / Quality***

I continue to Chair the Board Strategy sessions, which provide a critical forum for strategic alignment, collective leadership and challenge, and continuous improvement. These sessions play a central role in shaping the Trust's strategic direction and provide assurance that quality, safety and workforce considerations are integral to decision making.

I also maintain regular one to one meetings with our Chief Executive and Non-Executive Directors to ensure strong leadership cohesion, clarity of roles and effective oversight across the Board.

In addition, I meet monthly with the Freedom to Speak Up Guardians as a key source of assurance on staff experience and organisational culture. These discussions provide valuable insight into themes relating to wellbeing, workload, inclusion and psychological safety, and support the Board in maintaining a clear line of sight to workforce risks and actions, reinforcing our commitment to a respectful, supportive and open working environment.

**PHIL GAYLE**
**CHAIR**

# 7. CEO and Director of Operations Report

| Report to Board of Directors | | | | | | |
|---|---|---|---|---|---|---|
| Agenda item: | 7 | | | | | |
| **Date** | 4 February 2026 | | | | | |
| **Title** | Chief Executive Officer and Director of Operations Report | | | | | |
| **Author/Presenter** | Vanessa Devlin, Executive Director of Operations<br>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

**Performance Overview**

- Performance across our People key performance indicators continues to improve with the following being of note:
  - Fundamental Training (FT): Trust compliance at 94%, 1% below the 95% target.
  - Appraisals: In addition to compliance improving c.80% of individuals who have had an appraisal report this as linked to improvement in how they perform their role.
  - Sickness Absence: Continued improvement with an average 5.69% (Apr–Oct 2025), down from 5.89%.
  - Employee Relations: Active cases down 34%, with fewer formal cases due to improved early resolution.
  - Agency Spend: 32% reduction in non-medical agency usage since July 2025.

**Strategic Developments**

- *Targeted Interventions:* Q1 2026 triangulated interventions to focus on areas with high sickness, incidents, or negative survey indicators, supported by HR Clinics and People Partners.
- *Wellbeing:* Continued emphasis on preventative approaches, Wellbeing Champion recruitment in high-absence areas, improved RTW processes, and ongoing OH campaigns.
- *Workforce Planning:* Draft submission completed; refinement underway with finance, informatics, and ADs to ensure alignment with service and CIP plans.
- *ESR Replacement:* National replacement procured; governance group established with initial focus on data quality ahead of expected implementation timelines.

**Industrial Action**

- *Resident Doctors' strike (17–21 Dec 2025):* Participation increased vs previous periods (53% overall; 79% of weekend-rostered doctors). We are grateful to colleagues who ensured we continued to provide safe, responsive services during the period.

## CLINICAL SERVICES

### Primary Care, Dementia Services & Specialties

**Older Adults**

The older adult Wards continue to face the challenges to discharge service users who are clinically ready for discharge, this is primarily due to the availability of appropriate placements to support the complexity and behaviour challenges resulting in health and social care elongated processes for placement allocation and funding. Escalation processes with Birmingham City Council are being reviewed and strengthened in relation to this.

Enhanced observations have reduced across all four wards, supported by daily reviews and weekly meetings involving the Consultant, Clinical Nurse Manager, Matrons and Ward Managers. This has led

to a reduction in the usage of bank staffing alongside improved patient care. Face-to-face multi-disciplinary team meetings have been relaunched to ensure patient participation, while enhanced therapeutic observations and care work (ETOC) continue on Rosemary Suite and a culture of care work is ongoing on Sage Suite, both supported by the full multi-disciplinary team. Additionally, a working group is reviewing the Moseley Hall Hospital pathway for Juniper patients to reduce transfers to the Queen Elizabeth hospital.

**Older Adults Community Mental Health Teams**

Dementia and Frailty Community Services are continuing work on the Health and Equalities Plan, with a strong focus on improving how data is recorded. Over the past month, the business intelligence team has delivered data improvement and awareness sessions for all team managers. Managers have now put action plans in place to strengthen data quality and drive through improvements. This has helped raise awareness of data accuracy issues and created a clear foundation for ongoing improvement

The Fairer Futures funded programme regarding dementia diagnosis is progressing well. Engagement activities are happening across the North and West localities and with a range of Voluntary, Community, Faith and Social Enterprise partners. A communications plan is being developed and will be rolled out next month to ensure consistent messaging and wider visibility. The Sutton Primary Care Network in the North locality is fully involved in co-producing a Primary Care Dementia Pathway, supporting the mobilisation plan and ambitions.

**Birmingham Healthy Minds**

There remains a focus on delivery against key performance indicators as described in the remedial action plan, as underperformance persists across some of the recovery and activity indicators. Training requests and workforce upskilling submissions have been completed, and the service is awaiting confirmation of training places for 2026/27. Birmingham Healthy Minds has also secured innovative funding from the Integrated Care Board following a successful Dragon’s Den-style presentation in December 2025. The funded project, Improving Access for Black Men (IABM), aims to enhance engagement and access for Black men through a phased, sustainable approach that connects community, compassion, and culture.
Feedback via friends and family test from a patient following her intervention with a psychological wellbeing practitioner within the service:

*“I felt cared for, considered, and listened to. The next steps after discharge helped me feel like I was still considered. The best for me was thought about.”*

**Perinatal**

The Community Perinatal Service saw 2,131 patients between January and December 2025, exceeding the 12-month target of 1,953. Referrals continue to rise (2,864), driven by successful community engagement and improved referral routes for vulnerable women. However, the service faces a projected £1.2m overspend against its £5.8m budget. A cost-saving plan has been implemented, including ending fixed-term roles and reviewing leadership structures, aiming to reduce spend by £500k in 2026/27 without affecting productivity or patient experience. Further discussion is underway to review staffing and delivery models to bring costs within budget over the next two years.

Leadership changes are also taking place, with the Clinical Development Lead leaving in January and the Service Manager in February. Additionally, the East Team Manager has commenced a secondment

to support development of a system-wide Perinatal and Infant Mental Health strategy. The senior leadership team is working closely with staff to maintain stability during this period of transition.

**Clinical Health Psychology**
The Transfer of Undertakings (Protection of Employment) (TUPE) of the Clinical Health Psychology and Clinical Neuropsychology service from BSMHFT into University Hospitals Birmingham NHS Foundation Trust (UHB) is planned to take place on 1st April 2026. Service leads, People and Culture, Contracts, and Finance colleagues from BSMHFT and University Hospitals Birmingham NHS Foundation Trust are meeting regularly to ensure the appropriate processes are followed, and 1-1 consultations with staff have commenced. All clinical services continue to operate well during this process.

## Acute and Urgent Care

**Service Development and System Working**

A new Urgent Care service has launched in partnership with British Transport Police at Birmingham New Street Station, providing timely mental health assessment and intervention for individuals in crisis within the transport hub. Early partner feedback indicates improved joint working and a reduction in unnecessary Emergency Department conveyances. Activity and outcomes will continue to be monitored and reported through the well-established Urgent Care Pathway Group.

**Patient Flow and Length of Stay**

Length of Stay remains a key operational priority. Red2Green methodology is being introduced across inpatient pathways to strengthen multidisciplinary discharge planning, reduce non-value-added days, and improve system visibility of delays.

A Learning Improvement Network (LIN) bid has been submitted, focused on improving gatekeeping and pre-admission preparation to support purposeful admissions and therapeutic engagement from day one. This work aligns directly with the NHSE MH system's Big Hairy Audacious Goal, promoting timely, appropriate, person-centred care and more effective use of inpatient capacity.

**Workforce and Culture**

The Urgent Care Staff Survey has closed with strong engagement across teams. Results are currently being reviewed, with themed analysis underway. Findings and agreed priority actions will be shared with teams and aligned with Culture of Care and People Strategy initiatives to support staff wellbeing and retention.

**System Collaboration and Strategic Development**

The Urgent Care Pathways Group, working with VCFSE partners, is developing a system-wide Mental Health Emergency Department bid. This partnership approach aims to improve crisis pathways, patient experience in Emergency Departments, and integration of voluntary and community sector expertise within urgent care models.

**Quality, Experience and Co-Production**

A new Ward Induction Booklet, co-produced with Experts by Experience, is due to be introduced across inpatient wards. Led by Katy Willmont, the booklet will support patient orientation on admission, clarify ward routines and therapeutic activity, and enhance person-centred inpatient experiences. Implementation will be supported by ward teams, with feedback used to inform ongoing refinement.

**Our Key Messages**

- Strengthened partnership working across blue light services, VCSE and system partners
- Clear and coordinated focus on Length of Stay and patient flow improvement
- Staff voice actively informing service and culture improvement
- Continued commitment to co-production and patient experience

## Integrated Community Care and Recovery (ICCR)

Leads across the division have focussed this period on the staff survey, supporting teams to partake and encourage them to share their feedback. Working alongside John Travers and with support from our communications lead this year we saw an increase to 657 completed this year 58.7%.

Work continues to progress across the division reviewing complexity across the caseloads and improving flow through the pathway.

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

**Neighbourhood Teams:**

- Work is taking place across our NMHTs to consider how NMHT consultants can further enhance links with Primary Care Network (PCN) colleagues. We are looking to enhance our provision around consultation to GP colleagues for queries such as medication reviews. This also links to the work being undertaken around the Assertive and Intensive action plan and increasing our oversight of medication concordance. This is being support by Trust and Integrated Care Board (ICB) colleagues.
- Integrated Neighbourhood Teams (INTs) continue to be rolled out, and staff are being onboarded to move the Mental Health support element to these, this is being led by Birmingham Community Health Care, Phase 1 is due to go live fully by the end of March 26.

**CMHTs**

- The two CMHT link workers are now in place, these roles focus on reducing the number of service users that are known to CMHTs presenting to A&E. Initial data is showing positive impact and a decrease in known service users presenting. Working with Acute and Urgent Care colleagues' formal data collection to reflect impact is in the process of being finalised to support ongoing reporting. We have also been approached by the Psychiatric Liaison Team at Good Hope to collaborate on a pilot to address frequent A&E attenders who are under North CMHT.
- CMHTs continue to see a rise in demand, with an increasing number of new and complex referrals. Staff capacity is being monitored and sickness if being monitored with plans being established to ensure clinical rigor.
- Vacancy management remains a priority, supported by strengthened vacancy panels and proactive reviews. In April 2026, an additional ICCR Panel will be established to oversee recruitment plans across the division.  Recruitment activity is aligned at team level, reflecting specific role requirements such as Matron posts.

- A revised caseload review process is being tested in Solihull and the East to support an MDT approach to caseload decisions. Within the East this links to a wider project which is seeking to consolidate all the learning from transformation and apply to a CMHT to measure impact. This will be overseen by the Associate Director and Clinical Directors and take place over the next 12 months.

**Adult ADHD services:**
The service continues to see a high number of referrals, which has resulted in waits for triaging, remedial plans are in place. Accurx project has commenced incorporating digital solutions. Work is also taking place across the system with partners to consider waits and immediate remedial plans to tackle waiting lists.

**Assertive Outreach Teams (AOTs):**
Fortnightly interface meeting with CMHT Hub managers and Clinical Leads are in place and working well, allowing a space to discuss pathway issues for referrals in/out of the teams, improving pathway flow and building relationships between services. AOT acute bed management is going well with patient flow manager and locality meeting regularly, AOT have consistently been under bed allocation for the past month.

**Intensive Community Rehabilitation Team:**
Phase 1 is progressing well and ICRT have achieved their objectives of increasing caseload capacity to 50 and diverted 5 high-cost packages of care to ICRT in line with expectations. The next phase of the service improvement will commence this month with a view to present to provider collaborative colleagues in April.

**Homeless Mental Health Services and Rough Sleepers:**
Tender process for Primary Care Homeless Services has now been completed and awarded to SmartCare. The new contract will commence January 9th, 2026.

**Addiction Services:**
Across Recovery Near You (Wolverhampton), SIAS (Solihull), and Compass Dual Diagnosis services, demand continues to increase, particularly linked to dual diagnosis and mental health crisis presentations, placing pressure on capacity and workforce. Wolverhampton services are operating without vacancies or agency usage. Work is underway to improve training compliance, supervision, and caseload equity.

SIAS is approaching the end of its local authority contract and discussions are taking place re next steps. Focused working taking place on improvement on KPIs, service models, pathways, and workforce development, with positive performance seen in its alternative to residential rehabilitation.

Compass Dual Diagnosis has experienced significant sickness absence over winter 2025, impacting training delivery; recovery plans are in place for Spring 2026, alongside skill-mix reviews and targeted engagement to improve awareness and uptake of dual diagnosis training across inpatient services.

**Solar:**
Support continues to partner Barnardo's to provide additional assurance around the service provision especially the Mental Health in Schools Teams. Secondary Care waits remain an area of

focus. Improvement plans are in place for both elements of the service and joint working with partners and commissioners in underway.

Job plans have been reviewed and updated to ensure that staff are working effectively. A Capacity and Demand model has been built to support service planning with managing and reducing waits.

As part of the improvement plan, a key area of focus has been Co-Production. This work in Solar is being led by ICCR Co-Production Lead providing strategic leadership and support to develop a robust co-production offer for Solar, inclusive of all children and young people. This work is also being supported by dedicated workforce to drive progress. Together, this team will work with Solar colleagues, VCFSE organisations, and crucially CYP and families/carers to co-design and co-produce a meaningful co-production offer across the service.

**Steps to Recovery:**
Steps to Recovery are undertaking final stage discussions with a local provider for High Dependence Unit beds in Birmingham with MH Provider Collaborative commissioners, to reduce need for Out of Area placement and have closer relational governance with providers to support improved system flow and Length of Stay.

## Secure Care and Offender Health (SCOH)

**FIRST:** Renovation work at Main House continues, with furniture orders planned this financial year. Move date remains April 2026, subject to contractor updates. Recruitment is progressing well, with several Band 6 community psychiatric nurses and Band 7 Approved Mental Health Professional's due to start in January and February, and an 8b Psychologist expected in April. Experts by Experience (EbEs) remain integral, chairing meetings and co-facilitating transition groups.

**Tamarind:** Service remains well staffed with focused ongoing recruitment for psychology. Newly qualified nurses are on standby for future vacancies. Clinical skills gap training continues. Positive feedback received on Culture of Care work, with further share-and-learn sessions scheduled. Compliance with fundamental training, regular management supervision, clinical supervision, and annual development reviews is above expectations. High sickness rates are being managed with wellbeing support. Patient Reported Outcome Measures report completed, with plans to enhance patient choice and involvement.

**Reaside & Hillis Lodge:** No registered mental health nurse vacancies and occupational therapy team fully recruited. Psychology vacancies still require focused recruitment. Culture of Care celebrated its 12-month milestone, and Expert by Experience involvement has increased. Alarm system replacement is near completion. Positive patient reported experience outcome measure data reported.

Environmental challenges and fire risk improvements remain priorities. Clinical activity and enhanced observations continue to be high.

**Ardenleigh:**

High clinical activity remains across the wards with complex dynamics and enhanced observations, continued input from the senior leadership team supporting. Close monitoring of vacancies and sickness continue, which is impacting adversely on for key performance indicators seeing an elevated sickness rates.

**Youth First:** Progress on in-reach project despite delays in information technology access and heating issues. Some sickness managed effectively. Awaiting quality review feedback.

**Dawn House:** A new service soon up and running with service user transitions due to start over the forthcoming weeks.

## Children and Young People's (CYP) Services

**Summary update**

Children and Young People's services have remained operationally stable over the reporting period, with continued focus on performance, flow, and system assurance.

There are no new or emerging unmitigated patient safety concerns. However, the Division is managing a challenging position within the Child and Adolescent Crisis and Home Treatment Team, where the temporary loss of key capacity impacted responsiveness during December. A recovery plan is in place and is being actively managed, with full recovery anticipated over the next two to three months.

Children and Young People's access performance continues to be strong, with the Birmingham and Solihull Integrated Care System maintaining delivery above the national target. The Trust remains the largest contributing provider to this performance. As the system remains well positioned, discussions are underway with commissioners regarding the formal step-down of the Recovery Action Plan, reflecting sustained improvement.

Crisis demand across the 18–25 pathway remains stable. Enhanced oversight arrangements are now embedded and have resulted in sustained reductions in caseload size and adult inpatient bed usage, supporting patient flow, quality, and financial stability. Caseloads are now consistently within agreed thresholds, enabling increased focus on service transformation and improvement against national standards, including urgent access measures within the National Oversight Framework. The sustained reduction in adult inpatient bed usage has also supported the development of a more robust and sustainable financial position, informing a clearer and more deliverable set of plans for 2026/27.

Early Intervention in Psychosis services continue to meet the national referral-to-treatment standard, despite increased referral volumes and ongoing workforce pressures. Clinical outcome recording remains strong, providing assurance on quality and effectiveness.

Specialist Eating Disorder services continue to deliver timely urgent care, with all urgent referrals seen within one week and no inpatient admissions during the reporting period. Overall access performance has been impacted by a small cohort of highly complex cases; this is being actively managed and monitored.

Preparatory work for the continued transfer of the Division's services into the Trust continues, with mobilisation progressing across workforce, digital, and estates workstreams. Key transition risks remain consistent with previous reporting and are being actively managed through established programme governance.

## SUSTAINABILITY

## Birmingham and Solihull (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:

- On the 17 December 2025 the provider collaborative along with SOLAR colleagues attended a Solihull Scrutiny Engagement Session to discuss CYP mental health provision in Solihull. This was a positive session whereby members received a presentation on activity and performance of the service and key areas of development.
- The BSOL Mental Health Strategy has now been finalised and currently going through both internal and external governance for sign off. Parallel work is underway to develop the underpinning Place Delivery Plans which will articulate the key areas of action to drive forward the transformation set out in the strategy and improve access, experience and outcomes across BSOL.
- The collaborative has also been working with the new Birmingham, Black Country and Solihull Cluster to inform the development of a new 5 Year Commissioning Strategy for the Cluster and outcomes aligning into the BSOL Mental Health Strategy.
- The Provider Collaborative (PC) and BSMHFT attended the Birmingham Health & Adults Overview & Scrutiny Committee to present on the actions from the Children and Young Peoples (CYP) Mental Health Inquiry led by Scrutiny members and to update alongside Public Health on the development of our two policies, Birmingham Creating a Mentally Healthy City Strategy and the Birmingham & Solihull Mental Health Strategy.
- The tender opportunity for Emergency accommodation and wrap around provision has now closed and is currently in the evaluation phase. An outcome is expected by the end of February 2026.
- During December there were two market engagement events held, one for the Individual Patient Support Service and one for Recovery Centres in order to inform commissioning decisions during 2026.

## Funding and Finances

The Trust continues to work towards achieving our financial plan for this year – while we continue to be little behind where we need to be at this time, we remain confident that our plans will deliver, especially given improvements in our spend on beds.

Teams across the Trust are also working hard on preparing plans for the new financial year – we submitted draft plans before Christmas and are finalising our workforce, activity and financial plans for a final submission in mid-February. Our plan includes new investment across Birmingham and Solihull in Talking Therapies, Mental Health Support for Schools and Individual Placement and Support schemes.

# QUALITY

**Regulatory Activity**

Following receipt of the Care Quality Commission (CQC) inspection report for the North Acute Wards and Zinnia Centre Wards in October 2025, the factual accuracy check was submitted and accepted by the CQC. The final report reflected a number of areas that have improved with Responsive and Well led being rated as Good and remaining domains requiring more improvement. The Section 29a notices were removed for the Zinnia Centre Wards and the Trust is no longer subject to any formal regulatory concerns. The Trust has provided the CQC with an action plan in response to three remaining areas of concern and this is being delivered through the Acute Wards Culture of Care Programme.

**Fire Safety**

To provide greater assurance on current fire safety arrangements and in response to the findings of external surveys and audits by the Fire Service and fire safety specialists, a new Fire Safety Group was launched in November 2025. This group will report into the Trust Health and Safety Group, and the Terms of Reference includes representatives from corporate services and each operational area. The focus of the group will be to ensure that findings from fire risk assessments, passive fire protection surveys and incident investigations are adequately addressed.

**Culture of Care Programme**

All inpatient units/ and wards in Acute Care and Secure Care directorates are inducted into the programme. In December 2025 Reaside Clinic and Hillis Lodge were the first area to complete the year long programme and have celebrated a number of innovations that will be adopted Trust wide, these include; Patient Reported Outcome & Experience Measures, Nighttime Care Handbook, staff 'daily exit polls' and the Ward Manager's 'Plan for the Day'.

The next phase of rollout includes soft launches planned for Dementia, Frailty and Specialities inpatient areas in Jan/Feb 2026, and ICCR Steps to Recovery units coming onboard in Feb/Mar 2026.

The Culture of Care Quality Improvement programme in Children and Young People's (CYP) services and Community Teams across Birmingham and Solihull started with a 'senior leads shaping meeting' in mid-January, and the adaptation of standards for a community setting, in line with Neighbourhood working has started with the Divisional team.

# LOCAL TRUST, BIRMINGHAM AND SOLIHULL SYSTEM AND MIDLANDS REGIONAL NEWS

**All Our Voices - Early Reflections on a Growing Conversation**

Following a successful pilot, we have now officially launched All Our Voices, our new Trust-wide initiative designed to build stronger connections with teams and shine a light on what matters most to our colleagues across services.

Over our first two conversations, it's already clear just how powerful these sessions can be. Most recently, we spent time with the West Hub Older Adult CMHT at Ashcroft, where colleagues shared thoughtful, honest reflections about how we can continue improving the way we engage.

The discussion ranged from practical tools—such as making the most of Connect, navigating the Trust's wellbeing offer, and celebrating achievements through our Values Awards—to broader themes about visibility, communication, and ensuring everyone feels heard. Importantly, we learned that we have more to do to amplify the voices of our professional support colleagues, and this insight directly aligns with what we're hearing through the ongoing administration review.

Our thanks go to the whole team for their openness, energy, and willingness to help shape a better experience for all. These early conversations are already helping us understand where we're getting it right, where we need to go further, and how we can build a culture where every voice has the space to be heard.

All Our Voices has begun exactly as intended: grounded in real experiences, shaped by genuine insight, and driven by our shared ambition to improve. There's much more to come, and we're excited for the journey ahead.

**Independent Governance Review**

The ICB recently commissioned an independent clinical governance review for BSMHFT. We have carefully considered the findings and in January developed a comprehensive action plan in response to the report's recommendations. This will be taken through our appropriate Committees during February.

We are fully committed to delivering these improvements and will work hard to ensure meaningful and sustained progress across the organisation.

**Children and Young People's Services Transfer – Phase 2 Update**

Phase 2 of the CYP services transfer is progressing well. We recently held an executive-to-executive meeting with Birmingham Women's and Children's (BWC) to agree our approach for the final areas of the transfer. This joint work is helping ensure a smooth, safe and well-coordinated transition for children, young people and their families as we move into the final stages.

**Our new Strategy – Update**

The 'Brew Up' strategy development phase is now complete, and the blueprint has been finalised. We are moving into a live testing period through February and March, working with teams to refine and validate the approach.

A full launch is planned for April, once testing feedback has been incorporated to ensure the strategy is practical, meaningful, and ready for organisation-wide adoption.

**New Integrated Care Board (ICB) Cluster Arrangements Announced**

New ICB cluster arrangements have now been announced for **Birmingham, Solihull and the Black Country**. Birmingham and Solihull ICB will formally cluster with the Black Country ICB as part of NHS England's programme to streamline running costs and strengthen strategic commissioning. These clusters will share leadership and support functions while remaining separate legal entities.

*What's changing?*

- **Shared leadership:** Both ICBs now operate under a single Chair and single Chief Executive, providing one strategic direction across the cluster. [birmingham...icb.nhs.uk], [england.nhs.uk]

- **Shared senior management and support functions:** Some corporate, governance and commissioning functions will be delivered jointly to reduce duplication and strengthen consistency. [democracy....ull.gov.uk]
- **Focus on strategic commissioning:** The cluster supports the national Model ICB Blueprint, enabling stronger planning across a larger population and supporting shifts such as prevention, community-based care and digital transformation.

*What's staying the same?*

- Both ICBs remain separate legal entities with local accountability and no disruption to services or place-based working.

## NATIONAL NEWS

**Major Legislative Reform – Mental Health Act Update**

The **Mental Health Act 2025** gained **Royal Assent on 18 December 2025**, marking the most significant overhaul of mental health legislation in decades. The new Act modernises the 1983 framework, strengthens patient rights, reduces unnecessary detention, and aims to address longstanding inequalities in the system. [gov.uk], [commonslib...liament.uk]

Mills & Reeve have published helpful briefings outlining the key changes, timelines, and what the phased 10-year implementation will mean for services. Their guidance highlights strengthened patient autonomy, updated detention criteria, and forthcoming consultation on the revised Code of Practice due in early 2026. [beta-mr.mi...-reeve.com]

We will continue to review these briefings and prepare for the changes as national implementation plans develop.

**National Review of Mental Health Demand and Diagnosis**

A new national review of mental health demand and diagnosis was launched by the Government in December 2025. The independent review, announced on 4 December 2025, will examine the sharp rise in demand for mental health, autism and ADHD services, what is driving this growth, and the role diagnosis plays in accessing support. [gov.uk]

Led by Professor Peter Fonagy, the review forms part of the Government's 10-Year Health Plan and aims to build an evidence base to improve access, reduce waiting times and ensure people receive the right care at the right time. [nationalhe...cutive.com]

**Key Highlights – Mental Health UK National Strategy 2026–2031**

- Major new five-year strategy launched on 13 January 2026, responding to growing and more complex pressures on mental health across the UK. [birmingham...icb.nhs.uk]
- Focus on building a mentally healthier and thriving UK, tackling rising stress linked to living costs, work pressures, and difficulties accessing support.
- Grounded in lived experience – shaped by real stories from people, families and communities facing mental health challenges.

- Strategy built around key life areas affecting mental health, including money worries, school pressures, and workplace stress, ensuring support reaches people earlier and in everyday settings. [solihullob...rver.co.uk]
- Commitment to expand and deepen support, helping people access practical tools and guidance to stay well before reaching crisis point.
- Strengthened community partnerships – working with schools, employers, and frontline services to embed mental health support where it's most needed.
- Focus on prevention and early intervention, aiming to reduce inequalities and improve resilience across communities.
- Long-term, sustainable approach, designed to meet rising demand and support the nation through rapid social, economic and wellbeing pressures.

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

# 8. Board Assurance Framework

# Report to Board of Directors

| Agenda item: | 8 | | | | | |
|---|---|---|---|---|---|---|
| **Date** | 4 February 2026 | | | | | |
| **Title** | Board Assurance Framework | | | | | |
| **Author/Presenter** | David Tita – AD Corporate Governance<br>Kat Cleverley, Company Secretary | | | | | |
| **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 | ✓ |
|---|---|---|---|---|---|

The Board Assurance Framework (BAF) is a structured governance tool that enables the Board of Directors and its Committees to effectively monitor and gain assurance that principal risks to the Trust's strategic objectives and priorities are effectively and robustly mitigated and managed. An effective BAF serves as a dynamic driver for providing evidence-based assurance, strengthening decision-making, and grounding Board and Committee discussions. It also enables clear focus on what matters most while remaining strategic, fosters strategic oversight and foresight, organisational alignment to strategy and improves the overall effectiveness of the Board and its Committee.

Each of the Board’s Committees has reviewed and scrutinised their respective risks, and Audit Committee recommended the current BAF to the Board of Directors for assurance.

The BAF will need to be realigned, as appropriate, to reflect any changes arising from the refresh of the Trust’s Strategy for 2026 – 2031, with any resulting updates communicated across the Trust through established meetings and networks.

## Strategic Priorities

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

## Recommendation

**The Board of Directors is *requested to:***

1. ***NOTE*** *the content of this report.*

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

## Enclosures

*Table 1: Summary of the Board Assurance Framework.*
*Table 2: Heat Map of the BAF.*
*Appendix 1: Details of the People Committee Board Assurance Framework.*
*Appendix 2: Details of the QPESC 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.*

# BOARD ASSURANCE FRAMEWORK

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

| Ref | Strategic Risk | Date of Entry | Last Update | Lead | Target Risk Score | Previous Risk Score | Current Risk Score |
|---|---|---|---|---|---|---|---|
| **1.** | **People: Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users.** | | | | | | |
| **SR1** | Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care. | June 2024 | Dec 2025 | DSPP | **3x3 = 9** | N/A | **5x3=12** |
| **SR2** | Inability to attract, retain or transform a resilient workforce in response to the needs of our communities. | June 2024 | Dec 2025 | DSPP | **3x3= 9** | N/A | **4x3=12** |
| 2. | **Quality: Delivering the highest quality services in a safe inclusive environment where our services users, their families, carers and staff have positive experiences, working together to continually improve.** | | | | | | |
| **SR3** | Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery. | Sept 2024 | April 2025 | CN | **4 x 2 = 8** | N/A | **4 x 4 = 16** |
| **SR4** | Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services. | Sept 2024 | April 2025 | CN | **4 x 2 = 8** | N/A | **4x 3 = 12** |
| **3.** | **Sustainability: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population** | | | | | | |
| **SR5** | Failure to maintain a sustainable financial position. | Sept 2024 | October 2024 | DOF | **5 x 2 = 10** | N/A | **5 x 5= 25** |
| **4.** | **Shared Risks:**<br>**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.**<br>**&**<br>**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 | **3x 3 = 9** | N/A | **4 x 3 = 12** |

| 5. Clinical Services: Transforming how we work to provide the best care in the right way in the right place at the right time, with joined up care across health and social care. | | | | | | | |
|---|---|---|---|---|---|---|---|
| **SR8** | Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities. | Sept 2024 | April 2025 | MD | **3 x 3 = 9** | N/A | **4 x 3 = 12** |
| **SR9** | Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs. | Sept 2024 | April 2025 | COO | **3x 3 = 9** | N/A | **4 x 3 = 12** |

**Table 2: Trust Board Assurance Framework - Heat Map**

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



compassionate

***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**<br>• **Transforming our culture and staff experience**<br>• **Modernising our people practice** | • Increased FTSU contacts.<br>• Lack of early local resolution<br>• Staff survey results<br>• Colleague feedback | • Sickness and recruitment challenges.<br>• Lack of engagement.<br>• Loss of trust and confidence with communities.<br>• Services that do not reflect the needs of service users and carers.<br>• Inequality across patient population.<br>• 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.<br>***Target risk score range 9-10.*** | | 5 | 5 | 20 |
| | | **DATE RISK WAS ADDED** | June 2024 | | |

| CURRENT RISK SCORE | RATIONALE | TARGET RISK SCORE | RATIONALE | RISK HISTORY |
|---|---|---|---|---|
| **Impact 4 x Likelihood 3 = 12** | Due to the consistent improvements in colleague engagement and improvements experienced across people processes although events are | **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. | |

| | | | | |
|---|---|---|---|---|
| | 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 care and the engagement seen through the authentic leader programme | **DATE OF LAST REVIEW** | 17 December 2025 | |

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

| | |
|---|---|
| ▪ Culture of Care-Incorporates Anti Racism<br>▪ Authentic Leadership programme<br>▪ Masterclass series on policies and management practices. | |

**ACTIONS PLANNED**

| Action | Lead | Due date | Update |
|---|---|---|---|
| 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.<br>Policy awaiting final confirmation at TCSE in March 2025.<br>Anti Racist practitioner and leader remaining to be rolled out.<br>Anti Racist Framework Roadshows scheduled from September onwards.<br>Anti Racist Policy Ratified and currently being socialised.<br>Comms shared in relation to current surgency in hate crime and violence against racialised communities.<br>QI project commenced in Acute and Urgent Care to co-produce ways in addressing racism from Service users.<br>First cohort of Authentic Leader has concluded and evaluated well.<br>521 colleagues trained as Active Bystanders across the Trust.<br>159 colleagues trained in Cultural Humility and Safety to improve culturally informed Patient Care. |
| 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.<br>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 | On track<br><br>17/12/25 - A Learning and Development Strategy has been drafted and is in process of undergoing stakeholder review and feedback. The strategy is designed to support the delivery of high-quality patient care by fostering a culture of continuous improvement and professional excellence. By increasing the accessibility to learning and equipping managers, staff and clinical and non-clinical professionals with the skills and capabilities they need, the strategy will enhance decision-making, strengthen leadership, and ensure that teams are competent and confident in delivering safe, effective, and compassionate care. This approach underpins improvements in service quality, patient safety, and overall clinical outcomes, aligning workforce development with the Trust's commitment to patient care. This is linked to CRR042/2119 (Persistent DNA's of staff in face-face trainings).` |
|---|---|---|---|

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

| | | | |
|---|---|---|---|
| • Values In Practice feedback process.<br>• Behavioral framework<br>• Inclusive health & wellbeing offer.<br>• Management essential and people related training.<br>• Improved experience scores on staff survey<br>Improved retention rates.<br>• EDI Improvement plan.<br>• Increase in staff survey engagement<br>▪ Reducing time to recruit<br>▪ Exec and system vacancy controls in place<br>▪ Temporary Staffing reduction plans<br>▪ NHSP and Direct Engagement being utilised<br>• Divisional Workforce plans in place<br>• Culture of Care roll out<br>• 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. |
| **CRR041/2100** | Risk that BSMHFT may be unable to workforce plan effectively. |
| **Update since last review:** | |
| **30 Jan 2025**<br>Risk newly assessed with inputs from the team and presented for Exec sign-off. | |
| **31/01/2025**<br>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**<br>Gaps in assurance have been added. |
| **13th May 2025**<br>Increased assurance and reduced gaps in assurance with a proposed reduction in score |
| **23rd June 2025**<br>• 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**<br>• Actions updated<br>○ Suggested to move HI plans in BAU |
| **17th December 2025**<br><br>Due to the current political climate, it is suggested that the risk level remains. Actions have been updated and awareness across the Trust continues. |

# BOARD ASSURANCE FRAMEWORK

| 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.**<br>• **Transforming our culture and staff experience.**<br>• **Modernising our people practice.** | • Increased demand.<br>• Reduced pipeline locally and nationally to fill workforce gaps.<br>• Reduced training commissions.<br>• Hard to fill specialty posts across multiple professions on a national scale.<br>• Poor management of people related matters.<br>• Insufficient HWB offer. | • Reduced capacity to deliver key strategies, operational plan and high-quality services.<br>• Increased staff pressure.<br>• Continued reliance on temporary staffing.<br>• Reduced ability to recruit the best people due to deterioration in reputation.<br>• High turnover<br>• 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.<br>***Target risk score range 9-10.*** | | 5 | 5 | 25 |
| | | **DATE RISK WAS ADDED** | June 2024 | | |

| CURRENT RISK SCORE | RATIONALE | TARGET RISK SCORE | RATIONALE | RISK HISTORY |
|---|---|---|---|---|
| **Impact 4 x Likelihood 3 = 12** | Despite continuing demand and acuity pressures, workforce is in a healthier position with the vacancy factor reduced, turnover improved and pipelines have been strengthened. The staff survey results show improvements in staff experience particularly against the | **Impact 3 x Likelihood 3 = 9** | A number of workforce plans focused on recruitment, retention and improved culture would have positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce. | SR2 (chart: Initial, Current, Target; Jan-25 to Dec-25; 0–30) |
| | | **DATE OF LAST REVIEW** | 9th December 2025 | |

<table>
<tr><td></td><td>People Promise.<br>Challenges remain in hotspot areas which are now being addressed through a more targeted approach.</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">CONTROLS/MITIGATIONS</td><td colspan="2">GAPS IN CONTROL</td></tr>
<tr><td colspan="3">▪ International recruitment pipeline.<br>▪ Safer Staffing model<br>▪ MHOST<br>▪ E-Rostering compliance.<br>▪ Training Needs analysis.<br>▪ Leaver’s questionnaires.<br>▪ Stay conversations<br>▪ Staff Survey<br>▪ Pulse survey<br>▪ Values and Behavioural framework.<br>▪ Robust People processes.<br>▪ Robust temporary staffing processes.<br>▪ Retention plan<br>▪ Health & wellbeing offer.<br>▪ Flexible retirement options<br>▪ To support and implement system priorities such as 4 Rs (Reconnect, Recruit, train and Retain, Resilience and reform).<br>▪ Focussing on hotspots<br>▪ Reducing time to recruit<br>▪ Exec and system vacancy controls in place<br>▪ Temporary Staffing reduction plans<br>▪ NHSP and Direct Engagement being utilised<br>▪ Divisional Workforce plans in place</td><td colspan="2">▪ Delays in time to hire (albeit reducing).<br>▪ No formalised marketing and attraction strategy / plan for some hard to fill clinical roles<br>▪ High dependency on temporary staffing.<br>▪ Not using E-Rostering to full ability.<br>▪ Not following values and behaviours framework.<br>▪ People processes not being adhered to.<br>▪ Not enough vacancies at band 5 nursing levels for the pipeline<br>▪ No talent management strategy</td></tr>
<tr><td colspan="5">ACTIONS PLANNED</td></tr>
<tr><td>Action</td><td>Lead</td><td>Due date</td><td colspan="2">Update</td></tr>
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| | | | |
|---|---|---|---|
| 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. The plan will be iterated as needed. This is linked to CRR041/2100 (Risk to workforce plan effectively) |
| 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.<br>Staff engagement through Staff Survey at a high of 60%. |
| Collaborate with comms to create a marketing and candidate attraction plan. | Associate Director of People, Learning and Development | 31st March 2026 | A plan is being developed and will be reviewed through Shaping our Future Workforce. This is also linked to CRR043/2121 (risk that we may lose out on future workforce). |
| Develop a talent management framework and toolkit | Associate Director of EDI and OD and Head of workforce transformation | 31st March 2026 | Framework agreed in principle at TCSE. Currently developing a toolkit. |

| POSITIVE ASSURANCES | NEGATIVE ASSURANCES | PLANNED ASSURANCE | GAPS IN ASSURANCE |
|---|---|---|---|
| • Ability to offer flexible working arrangements.<br>• Values based recruitment<br>• Flexibility with the targeted use of Bank | • Diversity gaps in senior positions.<br>• Gender pay ga | Internal audit reviews 2025-6:<br>• Race Equality Code<br>• Recruitment and Retention.<br>• Complaints<br>• Bank and agency<br>• Disciplinary Process<br>• Sickness Absence Management. | • Data quality concerns for all demographics.<br>• Changes not translating into change of experience at the pace and levels of sustainability we would require. |

| | | | |
|---|---|---|---|
| incentives and Trust-wide reward.<br>• Improving vacancy and turnover performance.<br>• Customer satisfaction survey positively improving.<br>• Values based recruitment<br>• Stay conversation data<br>• Comprehensive health & wellbeing offer.<br>• Increased % of staff recommending BSMHFT as a place to work.<br>• Improved staff engagement scores.<br>• Reduction of the vacancy gap from 10.4 to 7.1% in 24/25<br>• Improved recruitment timeline.<br>• HR KPI reports<br>• Increased use of social media to attract. | • Cost of living increases with AfC pay-scales not as competitive as some private sector roles.<br>• WRES and WDES indicator 2 (likelihood of appointment from shortlisting).<br>• Colleagues not adhering to flexible working initiatives in some areas.<br>• Non-adherence to values-based recruitment principles. | • Bank Gold oversight | |

| 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. |
| **CRR043/2121** | Risk that we may lose out on future workforce because we cannot afford financially to over establish at a band 5 level. |

| Update since last review: |
|---|
| **9 October 2025**<br>• 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. |
| **17 December 2025**<br>• Linked risks to the risks on the Corporate Risk Register. Included some narrative on potential impact on patient care, quality and clinical services. |

### Appendix 2: Details of the QPESC Board Assurance Framework

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **SR3** | **Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.** | • **Quality**<br>❖ Preventing harm<br>❖ Patient safety culture<br>❖ Quality improvement and assurance<br>❖ Improving service user experience<br>❖ Using our time more effectively | • Lack of implementation & embedding of QI processes.<br>• Unwarranted variation of quality of care.<br>• Lack of data to enable harm prevention<br>• Insufficient focus on prevention and early intervention.<br>• Poor management of the therapeutic environment.<br>• Limited co-production with services users and their families. | • Failure to meet population needs and improve safety.<br>• Variations in care standards and outcomes.<br>• Unwarranted incidents<br>• Failure to reduce harm.<br>• Poor patient experience. | QPES | Executive Director for Quality & Safety/ Chief Nurse | SR4<br>SR8<br>SR9 |

| RISK APPETITE | | INHERENT RISK SCORE | Impact | Likelihood | Risk score |
|---|---|---|---|---|---|
| | **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.*** | | 4 | 5 | 20 |
| | | **DATE RISK WAS ADDED** | 18th October 2024 | | |

| CURRENT RISK SCORE | RATIONALE | TARGET RISK SCORE | RATIONALE | RISK HISTORY |
|---|---|---|---|---|
| **Impact 4 x Likelihood 4 = 16** | Current score demonstrates the controls in place and level of assurance evidenced. | **Impact 4 x Likelihood 2 = 8** | Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded. | SR3 |
| | | **DATE OF LAST REVIEW** | 29th December 2025 | |

| CONTROLS/MITIGATIONS | GAPS IN CONTROLS |
|---|---|

<table>
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- 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%

</td>
<td>

- 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 assurance audit/clinical service and Trust level
- Full implementation of Dialogue+
- Requirement to strengthen nursing assurance 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

</td>
</tr>
<tr><th colspan="4">ACTIONS PLANNED</th></tr>
<tr><th>Action</th><th>Lead</th><th>Due date</th><th>Update</th></tr>
</table>

| | | | |
|---|---|---|---|
| Roll out of Culture of Care Programme across all in-patient areas during 2025/26 | Executive Director Quality & Safety | 31st March 2026 | 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.<br><br>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.<br><br>The Acute Wards will undertake the new self-assessment framework developed by the Trust for Culture of Care and CQC I and we Statements.<br><br>*December 2025 update:*<br><br>Acute care now live with Culture of Care over Q2, monthly Strategic Divisional group in place.<br><br>Acute Wards now live with Programme, monthly programme board in place, additional resources aligned with Division for Delivery<br><br>Specialities to soft launch in Q3 and relevant IP Community bases.<br><br>National events attended by colleagues on the Culture of Care programme.<br><br>Future mapping and initial scoping exercise underway with CNO and QI team for 2026 rollout for Culture of Care. |
| 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<br>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 | *December 2025 update:*<br>It was agreed at SMB in October 2025 to sign the PEGs covenant. This has now been signed and the pledge made and BSMHFT will receive HR and managerial training in PEGs in 2026. Following this access to resources will become available which can be used for training and supervision etc.<br>Funding is still yet to be secured for the ACPA training video. It is hoped that this will be progressed during Q4.<br>Trust Safeguarding team have been working with BSMHFT communications team on the 16 days of activism which runs between 25 November – 10th December 2025. This is a national domestic abuse campaign to raise awareness on domestic abuse. Daily posts have been going out on Connect and social media. There has been a partnership approach to this year's campaign to ensure consistent messaging. |
| Embed suicide prevention and safety planning approaches into routine clinical care across all services. | ED Q&S | 31st March 2026 | Implement Dialogue+<br>Training on safety planning<br>*December 2025 update:*<br>Written AAA Updates from Service areas to CEAG with a target date of 11th December 2025.<br>Dialog+ Care and Safety Planning Phase 2 Project Starting December 2025 with target completion date September 2026.<br>Insight Reporting Care Plan Status to support monitoring of Dialog+ and Safety Planning completion, starting November/December 2025 with ongoing monthly reporting. |

| | | | |
|---|---|---|---|
| | | | There has been ongoing and incremental increased uptake of Dialog+ Training and completion with positive feedback being received. Starting November/December 2025 with ongoing monthly reporting. |
| Ensure robust audit & assurance policies to ensure they are effective and reflect practice. | ED Q&S | 26th March 2026 | *December 2025 update:*<br>Training session planned in October commenced to start this process that is ahead of trajectory as a need requirement over the previously planned NICE portfolio.<br>The CYP division are currently entering their quality and assurance audits into the AMAT system with an agreed completion date of the 31st December 2025<br>The specialties division have the mandated audits on AMAT however they are required to input the service specific audits by the end of January 2026 one the audit alignment workstream has been completed.<br>To date an additional PDMG meeting has been convened to review the Audit and assurance of all clinical policies. A paper with an up-to-date position will be presented to January 2026 Trust CGC |
| Improve Quality data and monitoring from a Trust and Divisional perspective (quality metrics and deep dives). | ED Q&S | 27th February 2026 | *December 2025 update:*<br>Culture of Care National Programme progressing well with online sessions available for all staff and the launch of the Culture of Care Dashboard.<br>The first Quality Assurance meeting was held on the 8th December 2025 and the data from the SafeCare dashboard was utilised. Physical health metrics are to be agreed through the physical health committee prior to submission. In January 2026 the CYP division will have the first iteration of the SafeCare dashboard. |

| POSITIVE ASSURANCES | NEGATIVE ASSURANCES | PLANNED ASSURANCE | GAPS IN ASSURANCE |
|---|---|---|---|
| Learning for improvement:<br>• Structured Judgment Reviews reviewed at local safety panels.<br>• Corporate led learning from deaths meeting.<br>• Executive Director's Assurance Reports to QPES Committee and Board.<br>• NHS Digital Quarterly Data<br>• Commissioner and NED quality visits.<br>• CGC Local review has been completed and actions implemented.<br>• Action in place in respect of the learning from Greater Manchester and Nottingham.<br>• Physical Health Strategy<br>• System Quality improvement Group in place for in response to CQC inspection and reviews. | • Reaside regulatory notice environment and governance.<br>• Reaside FTSUG Regional escalation.<br>• Reaside CQC Report<br>• External Audit Clinical Governance Review (18 recommendations).<br>• Zinnia Section 29A warning notices – training, sharing learning, supervision, governance, observation.<br>• Zinnia CQC report<br>• PFD on learning identification through internal investigations<br>• CQC Inspection 'North' Acute Wards<br>• Serious incident Larimar Ward | • CQC planned and unannounced inspection reports.<br>• Reaside commissioned support programme and Culture of Care Programme.<br>• Door alarm implementation programme.<br>• Internal and External Audit reports.<br>• Triple A reporting to QPES from CGC.<br>• Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting.<br>• QMS update reporting to QPES<br>• 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.<br>• Incident reporting and learning is included in the Patient Safety Report to Trust CGC, QPES, and Board.<br>• Independent annual assessment against the 68 NHS Core Standards for EPRR.<br>• Safety Huddles review staffing on a daily basis<br>• DIPC/IPC/Estates monthly escalation Meeting.<br>• 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.<br>• Safer staffing assurance report for QPESC<br>• Safety Alert process | • The availability of real time safety data to triangulate information.<br>• Analysis and triangulation of data across different sources needs is weak and inconsistent.<br>• 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.<br>• Staff training via e-learning and lack of assurance on competence<br>• Searching policy update, staff training and audit required<br>• Assurance process with data on physical health checks and admission assessments to be added to dashboard<br>• Safety Notice on completion of physical health observations and reviews to MDTs<br>• Staff attendance at planned Culture of Care events from clinical teams outside of programmes control. |

| 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 |
| **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. |

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|---|---|
| **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. |
| **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. |
| **Update since last review:** | |
| **29th December 2025**<br>Physical Health management reviews underway in all divisions. Final report due 22nd January 2026 highlighting assurance and learning. | |

| 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**<br>❖ Patient safety culture<br>❖ Quality improvement and assurance<br>❖ Improving service user experience<br>❖ Using our time more effectively. | • Inability to effectively collate, share and understand intelligence from incident data in improving patient experience.<br>• A workforce that requires greater knowledge about recovery and personalised care.<br>• Increased turnover<br>• Overreliance on bank and agency staff.<br>• Difficulties with sharing good practice and duplicating it.<br>• The lack of a central hub to capture all engagement activities which could be accessed by services once they`re designing services.<br>• Increased waiting list time affecting care and support for patients and their families and carers.<br>• Families and carers not always engaged in care planning.<br>• Estate /environment not fit for purpose in some areas.<br>• Poor food choices and opportunities in some settings.<br>• Lack of understanding of sphere of influence for clinical facing teams. | • A reduction in quality care.<br>• Service users not being empowered<br>• Services that do not reflect the needs of service users and carers.<br>• Service provision that is not recovery focused.<br>• Increased regulatory scrutiny, intervention, and enforcement action.<br>• Failure to think family<br>• Inequality across patient population.<br>• Workforce that is not equipped or culturally competent to support populations and colleagues.<br>• Failure to provide resources that support health, wellbeing, and growth.<br>• Lack of engagement from staff and patients, families and carers.<br>• Reactive rather than proactive service model<br>• Increased service demand. | QPES | Executive Director for Quality & Safety/ Chief Nurse | SR3<br>SR8<br>SR9 |

<table>
<tr><td rowspan="3">RISK APPETITE</td><td rowspan="3">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.</td><td rowspan="2">INHERENT RISK SCORE</td><td>Impact</td><td>Likelihood</td><td>Risk score</td></tr>
<tr><td>4</td><td>4</td><td>16</td></tr>
<tr><td>DATE RISK WAS ADDED</td><td colspan="3">18th October 2024</td></tr>
</table>

<table>
<tr><td>CURRENT RISK SCORE</td><td>RATIONALE</td><td>TARGET RISK SCORE</td><td>RATIONALE</td><td>RISK HISTORY</td></tr>
<tr><td rowspan="2">Impact 4 x<br>Likelihood 3 = 12</td><td rowspan="2">Current score demonstrates the controls in place and level of assurance evidenced.</td><td>Impact 4 x<br>Likelihood 2 = 8</td><td>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.</td><td rowspan="2">SR4</td></tr>
<tr><td>DATE OF LAST REVIEW</td><td>29th December 2025</td></tr>
</table>

| CONTROLS/MITIGATIONS | GAPS IN CONTROL |
|---|---|
| • Community transformation<br>• The design of a Community Engagement Framework being led by the ICBQI Programmes with our EBE`s/ HOPE Strategy.<br>• IPEAR representation<br>• Recovery for all team<br>• Trust induction sessions<br>• EBE educator programme<br>• Recovery College<br>• Participation & Experience team members in each division.<br>• HOPE (Health, Opportunities, Participation, Experience) action groups.<br>• LEAR action groups<br>• EBE recruitment panel programme.<br>• Carer strategy<br>• QPESC Visits<br>• Chair and Non-Executive and Executive Director Visits.<br>• Board and QPESC Stories | • Challenges around workforce as genuine engagement requires sufficient and consistent staff.<br>• Turning off part of CPA where family and carers were being recorded and offered family engagement tool – risk that Dialog + won't always capture family and carers needs / support Ongoing work around preventative needs and stigma A stretched workforce that hasn`t always got the capacity to make these relationships. Difficulties with sharing good practice and duplicating it. The lack of a central hub to capture all engagement activities which could be accessed by services once they`re designing services The diversity of our communities means Communities can find us hard to reach Lack of consistency and burnt-out workforce in some of the services use of bank and agency staff can impact on our capacity to build relationships with families.<br>• Lack of audit compliance monitoring on MDT standards, risk assessments and safety plans |

| | |
|---|---|
| • Healthwatch reports<br>• PALS and Complaints access, resolution and learning.<br>• Culture of Care patient and staff surveys reporting through PEAR<br>• PLACE reports to come to PEAR<br>• Nutrition and Food group to report through PEAR<br>• National CQC Community MH Survey to be delivered and assured on through PEAR | • Implementation of 'In Mustak's Steps' 15 steps for BSMHFT.<br>• Framework for aligning reporting to QPESC using 'I statements'.<br>• Addition of subgroups to PEAR to bring in more feedback from patients and their families<br>• Uptake of national community MH survey to be supported through PEAR<br>• Development of ward dashboards<br>• 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<br>Patient councils underway in all divisions<br>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<br>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<br>New report to come to QPESC each month from November 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<br>• Healthwatch<br>• EbE Observer project<br>• Patient councils in Secure Care. Urgent care, CMHT and D&F. | • Community Mental Health survey 2024 | • Monthly reports on participation and engagement presented QPES<br>• QI Reports<br>• Participation and Experience team provide quarterly reports to divisional teams. ICCR have requested bi-monthly | • Lack of regular and frequent governance reporting and oversight – divisional teams to provide assurance through PEAR.<br>• Inability to integrate and effectively use data in reporting – Inability to integrate and triangulate data from patient experience and PALS/Complainants effectively. |

| | | | |
|---|---|---|---|
| | | reporting to support with actions related to negative comments in Community Mental Health survey.<br>• Executive oversight of the engagement activities.<br>• Participation worker visits to clinical areas reported via Participation & Experience Team monthly meetings and escalated through PEAR.<br>• TOR to come to QPESC | • 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.<br>• Backlog of complaints and gaps in complaints team capacity.<br>• Increase in PALS activity due to ADHD pathway and CYP additional work.<br>• 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. |
| **CRR039/2072** | Complex patients who struggle to engage with mental health services and treatments may cause significant harm to themselves or the public. |
| **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. |

**Update since last review:**

**29 December 2025**

- Continued engagement work with service users to ensure PEAR terms of reference and subgroups can ensure a strong and representative patient, family an carer voice. Final changes to be agreed by PEAR in December meeting with ToR refresh available for QPESC in January 2026. AMHP provision to be included in workstream for Lead Social Worker role which will commence in January 2026. Service evaluation work in progress for Recovery College and Participation and Experience team.

## Appendix 3: Details of the FPP Board Assurance Framework

| REF | STRATEGIC RISK | GOAL/ENABLER | CAUSES | CONSEQUENCES | LEAD COMMITTEE | LEAD | LINKED RISKS |
|---|---|---|---|---|---|---|---|
| **SR5** | **Failure to maintain a sustainable financial position**<br><br>**NB In this context, a sustainable financial position means an in year AND underlying breakeven over next 2 years and sufficient cash headroom.** | • **Sustainability**<br>❖ **Balancing the books** | • *Poor financial management by budget holders.*<br>• *Inadequate financial controls.*<br>• *Cost pressures are not managed effectively.*<br>• *Savings plans are not implemented.* | • Trust not meeting its financial targets limiting available funds for investment in patient pathways.<br>• Ranking in lower segments for financial metrics in Oversight Framework. | FPP | Executive Director of Finance | SR6<br>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.<br>**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. | SR5 (chart: Jan-25 to Dec-25; Initial, Current, Target) |
| | | **DATE OF LAST REVIEW** | 3rd December 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.<br>• Development of new Performance Assurance Panel to provide greater oversight on areas of poor performance.<br>• Continued review and utilisation of balance sheet flexibility. | • Consequences of poor financial performance do not attract any further review.<br>• Requests for cost pressure often made without following agreed process.<br>• Attendance at Sustainability Board variable. |

| | |
|---|---|
| • Savings Policy<br>• Sustainability Board review.<br>• ICS expectations and reporting requirements.<br>• Development of Financial Recovery Plan | • Trust has not been able to develop a pipeline for delivery of savings.<br>• Recovery Action Plans not having required financial impacts |

**ACTIONS PLANNED**

| Action | Lead | Due date | Update |
|---|---|---|---|
| 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.<br>• Financial recovery plan focused attention on trajectory and mitigations.<br>• Recovery plans in key areas on beds and bank spend demonstrating run rate reductions. | • | • Ability to deliver planned financial position dependent on sufficient controls<br>• Internal and External Audit review.<br>• Audit Committee and FPP oversee financial framework and monthly reporting of financial position and any deviation from plans.<br>• Ongoing monthly oversight from NHSE around delivery of financial recovery plan. | • Trust continues to be given assurance through audit reports.<br>• HFMA sustainability audit has identified a number of development areas that would improve controls and performance.<br>• 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. |
| **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. |
| **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. |
| **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. |

| Update since last review: |
| --- |
| **3 December 2025**<br>• Risk reviewed and score maintained at 5x5=25, owing to the scope of the risk spanning beyond one financial year. |

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

| REF | STRATEGIC RISK | GOAL/ENABLER | CAUSES | CONSEQUENCES | LEAD COMMITTEE | LEAD | LINKED RISKS |
|---|---|---|---|---|---|---|---|
| **SR6** | **Failure to maintain acceptable governance and national standards.**<br><br>• **Progress in delivering national standards including:**<br>• **Reducing Inappropriate Out of Area Placements in line with agreed reduction targets (0 for acute and 10 for PICU) and maintenance.**<br>• **Service users followed up within 3 days of discharge.**<br>• **Reducing long waits for accessing CMH and CYP services.**<br>• **Achieving and maintaining national waiting time standards for accessing Talking Therapies services.**<br>• **Achieving and maintaining** | • **Operational Strategies and Transforming Care Programmes covering Acute & Urgent Care, ICCR, Specialties and Secure Services.**<br>• **Ensure the Trust is compliant with its Licence & the Code of Governance.**<br>• **Ensure the Trust is well-led and ready for the CQC Well-led Inspection.** | • Low number of adult and older adult beds per weighted population, below national average<br>• High levels of admissions under the mental health act<br>• Acuity of patients impacting on having longer lengths of stay<br>• 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.<br>• 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.<br><br>Agreed national reduction targets for inappropriate OOA placements not being met and impacting on patient experience.<br><br>Patients not being admitted to a local bed in a timely way, service users waiting for admission and being managed in the community.<br><br>Patients who are CRFD remaining in inpatient care longer than is required impacting on increasing length of stay.<br><br>Long waits for ADHD | FPP / QPES | Executive Director of Finance<br><br>&<br><br>Chief Operating Officer | SR5<br>SR7 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Reliable Improvement and Recovery rates for service users accessing Talking Therapies services.**<br>• **Reducing our length of stay and clinical ready for discharge.**<br>• **Compliance with the new NHS Provider Licence & Code of Governance.**<br>• **CQC Well-led readiness.** | | of social worker availability, funding of placements, availability of appropriate placements.<br>• High bed occupancy levels reducing bed availability.<br>• High CMHT caseload numbers – maintain contact and engagement with service users.<br>• Non-compliance could undermine the quality of care and lead to poor leadership. | assessments affecting CYP waiting times<br><br>Financial impact on Trust if Talking therapies activity levels not met<br><br>Increased risk to service users not followed up with 3 days of discharge.<br>High DNA rates in CMH services.<br><br>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.<br>Attract regulatory actions and greater scrutiny. | | | |
| **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.<br>***Target risk score range 6-8.*** | | **INHERENT RISK SCORE** | Impact | Likelihood | Risk score |
| | | | | | 5 | 5 | 25 |
| | | | | **DATE RISK WAS ADDED** | September 2024 | | |

# BOARD ASSURANCE FRAMEWORK

| CURRENT RISK SCORE | RATIONALE | TARGET RISK SCORE | RATIONALE | RISK HISTORY |
|---|---|---|---|---|
| **Impact 5 x Likelihood 4 = 20** | Current score demonstrates the controls in place and level of assurance evidenced. | **Impact 4 x Likelihood 3 = 12** | Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded. | SR6 |
| | | **DATE OF LAST REVIEW** | 8th January 2026 | |

| 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.<br>• Trust Sustainability and Net Zero Group established.<br>• Heat De-carbonisation reviews across sites.<br>• Trust prioritisation of Risk Assessments, Statutory Standards and Backlog Maintenance Programme.<br>• Delivery of the Trust Green Plan and the built in Action Plan.<br>• Regular audits on compliance.<br>• Staff training and awareness sessions to tackle poor behaviour around compliance.<br>• Strengthen the internal control systems and processes.<br>• Regular horizon scanning for cases of non-compliance.<br>• Inappropriate Out of Area numbers/ 3 day Follow up reported via Trust FPPC and local Service FPPCs and included in IPD<br>• Daily 3 day follow up notifications in place for clinical teams<br>• Community waiting times reported via FPPC against trajectory and granular reports available to clinical teams to manage and progress at patient level.<br>• 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.<br>• Service level Deep dive meetings cover national indicators, waiting times and benchmarking.<br>• Talking Therapies remedial action plan in place. | • Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews.<br>• All properties reviewed by professional Estates and Facilities Managers.<br>• Named Non-Executive Lead for Sustainability, Net Zero Carbon and Green Plan.<br>• Condition Surveys, review of premises statutory standards and compliance assessments / independent AE audits ensure standards are met and maintained.<br>• Operational pressures negatively impacting on staff capacity to fully implement these controls.<br>• Self-assessments, accreditation and self- certification processes aren`t strong.<br>• Governance around compliance is weak. |

| • Performance Assurance Meetings in place (Performance Assurance Panel) | | | |
|---|---|---|---|
| **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'.<br>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.<br>Replacement of current Reaside facility to address poor functionality, Service user accommodation and environmental system life cycle impacts is a Trust led major project.<br>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.<br>Regular reporting and scrutiny and the Performance Delivery Group and service deep dives.<br>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 |

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|---|---|---|---|
| | | | the meeting to support flow and focus on patient who are clinically ready for discharge (CRFD).<br><br>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.<br><br>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. |
| Ensure the Trust is ready for the Well-led CQC Inspection. | Head of Health and Safety and Regulatory Compliance & AD of Corporate Governance | 31 March 2026 | On track as well-led workshops are currently taking place across the Trust to widen engagement and enhance readiness. |
| Ensure the Trust is compliant with its Licence and the Code of Governance. | AD of Corporate Governance & Company Secretary | 31 March 2027 | On track |
| Length of stay improvement and clinically ready for discharge action plan. (Part of the Learning & Improvement Network) | AD Acute and Urgent Care/Specialties.<br>AD CYP Division | April 2026 | On track |

| **POSITIVE ASSURANCES** | **NEGATIVE ASSURANCES** | **PLANNED ASSURANCE** | **GAPS IN ASSURANCE** |
|---|---|---|---|
| • Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews.<br>• All properties reviewed by professional Estates and Facilities Managers.<br>• Multi-disciplinary Trust | • | • Inspection reports.<br>• Compliance audits.<br>• Self-assessment, accreditation and self-certification reports.<br>• External visit | • Lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply.<br>• Lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply.<br>• Poor learning from previous regulatory inspections.<br>• Self-assessment, accreditation and self-certification culture |

| | | | |
|---|---|---|---|
| Sustainability Group including SSL, Finance, Procurement, Clinical/ Nursing Teams, etc.<br>• Performance reported to FPPC.<br>• Governance arrangements for monitoring the quality of care provided to patients in non-BSMHFT beds in place. | | reports.<br>• Peer Reviews<br>• Board Assurance Framework Report. | not strong enough to be relied upon for assurance.<br>• Peer review not very regular.<br>• 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. |
| **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) |
| **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. |
| **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). |
| **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. |

**Update since last review:**

**8 January 2026**

- BAF reviewed and CYP elements incorporated – recognising plans are in place to strengthen the CYP risk management arrangements.

| REF | STRATEGIC RISK | GOAL/ENABLER | CAUSES | CONSEQUENCES | LEAD COMMITTEE | LEAD | LINKED RISKS |
|---|---|---|---|---|---|---|---|
| **SR7** | **Failure to deliver optimal outcomes with available resources** | • Achieving and maintaining delivery of 'Culture of Care Standards for Mental Health Services', comprising:<br>❖ Lived Experience — We value lived experience.<br>❖ Safety — People feel safe and cared for.<br>❖ Relationships — High-quality and trusting.<br>❖ Staff support — Present alongside distress.<br>❖ Equality — We are inclusive, value difference and promote equity.<br>❖ Avoiding Harm — Actively avoid harm and traumatisation.<br>❖ Needs Led — We respect people's own understandings.<br>❖ Choice - Nothing about me without me.<br>❖ Environment — Spaces reflect the value we place on our people<br>❖ Things To Do — Requested activities every day.<br>❖ Therapeutic Support — We offer a range of therapy.<br>❖ Transparency — We have open and honest conversations | • Inadequate resources<br>• Staff do not understand or commit to the standards<br>• Competing priorities<br>• Variation in performance between teams<br>• Shortage of suitably qualified and experienced staff and leaders<br>• Lack of meaningful data and evidence.<br>• Unwarranted variation of quality of care. | • Patient outcomes and satisfaction are less than optimal<br>• Staff assaults and Patient harm<br>• psychological harm<br>• Services are not responsive or consistent<br>• Regulatory oversight<br>• High bank utilisation<br>• Gaps in ward to board governance<br>• Complaints and concerns<br>• Financial claims<br>• Regulatory costs | FPP / QPES | Executive Director of Finance<br><br>&<br><br>Executive Director for Quality & Safety/ Chief Nurse. | SR3<br>SR4<br>SR5<br>SR6<br>SR8 |
| **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.<br>***Target risk score range 9-10.*** | | **INHERENT RISK SCORE** | Impact<br>4 | Likelihood<br>5 | Risk Score<br>20 |
| | | | | **DATE RISK WAS ADDED** | September 2024 | | |
| **CURRENT RISK SCORE** | | **RATIONALE** | **TARGET RISK SCORE** | **RATIONALE** | | **RISK HISTORY** | |

| | | | | |
|---|---|---|---|---|
| **Impact 4 X Likelihood 3 = 12** | 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 | SR7 |
| | | **DATE OF LAST REVIEW** | **29th December 2025** | |

| CONTROLS/MITIGATIONS | GAPS IN CONTROL |
|---|---|
| ▪ Culture of Care Programme<br>▪ Process in place to review and learn from deaths.<br>▪ Clinical Effectiveness process including Clinical Audit, NICE.<br>▪ Implementation of PSIRF<br>▪ Safer Staffing Committee and Bank Gold<br>▪ Implement a culture of continuous learning and improvements.<br>▪ Mental Health Improvement Programme work as defined in the Patient Safety Strategy.<br>▪ Development and application of RRP Dashboard<br>▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems.<br>▪ Internal adoption of a transparent Quality/assurance process AMaT implementation.<br>▪ CQC Insight Data and regular joint meetings<br>▪ Healthcare Quality Improvement – NCAPOP (National Clinical Audit and Patients Outcome Programme).<br>▪ Use of workforce resources; e-roster compliance, reduction in temporary staffing.<br>▪ Coroner's Reports<br>▪ Capital prioritisation process<br>▪ Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation.<br>▪ E-roster compliance metrics | ▪ Lack of aligned comprehensive assessment of delivery against culture of core standards.<br>▪ Lack of process that explicitly prioritises process against culture of care standards.<br>▪ Discharge for patients under section who are clinically ready for discharge requiring social care assessment and placement<br>▪ Not all wards covered by programme<br>▪ All ward self-assessment under new trust framework combining culture of care standards and CQC I and We Statements<br>▪ Use of Bank staff<br>▪ Training compliance for Bank staff<br>▪ Formal review of Temporary Staffing Services.<br>▪ MHOST review Acute Wards September/October 2025.<br>▪ E-roster compliance metrics business as usual in Divisional Performance Reviews.<br>▪ Assurance on levels of therapeutic activity on all wards. |

**ACTIONS PLANNED**

| Action | Lead | Due date | Update |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Culture of Care<br>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.<br><br>Roll out across wards to complete self-assessments as part of Well Led preparation and report into CGC/QPESC. |
| Implementing NHSE/CQC Community Standards<br>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.<br>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.<br>Night visits completed across all Acute Wards October<br>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 | 10.12.2025<br>To support the ongoing roster work, there will need to be robust rules in place for the authorisation of bank, this will initially start in Acute Care and have been agreed and supported at Bank Gold and with Staff side.<br>AHP Rostering is now in place from a corporate perspective and additional support is being provided until they confident using the system. |
| 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.<br><br>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.<br><br>Implementation of self-assessment process and metrics started |

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

**Update since last review:**

**29 December 2025**

- Risk reviewed and a reduction in score recommended.

***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**<br>❖ Preventing harm<br>❖ Patient safety culture<br>❖ Quality improvement and assurance<br>❖ Improving service user experience.<br>❖ Using our time more effectively | • Inability to effectively use time resource in driving learning and transforming services.<br>• Inability to develop and embed an organizational learning and safety culture.<br>• Failure to identify, harness, develop and embed learnings from deaths processes.<br>• Lack of support for and involvement of families and careers.<br>• Lack of effective understanding by staff of what the Recovery Model is about and its expectations.<br>• 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.<br>• Failure to learn from incidents and improve care.<br>• A failure to develop pathways of care within the Integrated Care System.<br>• Lack of equity for service users across our diverse communities.<br>• Ineffective relationships with key partners.<br>• Lack of continuity of care and accountability between services.<br>• Negative impact on service user access, experience and outcomes.<br>• Negative impact on service user recovery and length of stay/time in services.<br>• Some communities being disengaged and mistrustful of the Trust.<br>• Negative impact on | QPES | Executive Medical Director | **SR3**<br>**SR4**<br>**SR9** |

compassionate inclusive committed

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | or aligned to local services.<br>• Lack of understanding of our population, communities and health inequalities data.<br>• Not working together to tackle inequalities across the BSOL system. | service user recovery and length of stay.<br>• Increased local and national scrutiny.<br>• Increased risk of incidents due to inappropriate physical environments.<br>• Poor reputation with partners.<br>• Negative impact on service user access, experience and outcomes. | | | |

| 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.<br>***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 3 = 12** | Current score demonstrates the controls in place and level of assurance evidenced. | **Impact 3x Likelihood 3 = 9** | Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded. | SR8 |
| | | **DATE OF LAST REVIEW** | 9th January 2026 | |

| CONTROLS/MITIGATIONS | GAPS IN CONTROL |
|---|---|

| | |
|---|---|
| • Patient Safety Advisory Group (PSAG).<br>• Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity.<br>• Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels.<br>• Culture of Care national QI and other pieces of QI projects that address health inequalities. Culture of Care now rolled out across 2 Divisions<br>• Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems.<br>• Implementation of Learning from Excellence (LFE).<br>• PSIRF Implementation Strategy including PSIRF Implementation Group and PMO support.<br>• Freedom to speak up processes.<br>• Cultural change workstreams including Just Culture.<br>• BSOL Provider Collaborative Development Plan.<br>• Experience of Care campaign.<br>• Health, Opportunity, Participation, Experience (HOPE) strategy.<br>• Family and carer strategy.<br>• Implementation of Family and carer pathway.<br>• BSOL peer support approaches.<br>• Expert by Experience Reward and Recognition Policy.<br>• EbE educator programme.<br>• EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc.<br>• Divisional inequalities plans.<br>• PCREF framework<br>• Synergy Pledge.<br>• Provider Collaborative inequalities plans.<br>• System approaches to improving and developing services.<br>• Community Transformation Programme – now in year 3 of implementation.<br>• Community caseload review and transition.<br>• Out of Area programme. | • Limited assurance from current approach to review of quality and governance metrics at Divisional level.<br>• Limited reporting of Divisional quality reviews to QPES and Board.<br>• No organisational wide reporting of LFE metrics.<br>• Family and carers pathway not consistently applied or suitable for all services.<br>• Performance in these areas is not effectively measured.<br>• Divisional inequalities plans not fully finalised for all areas.<br>• Availability of sufficient capital funding for developments.<br>• Capacity within teams to deliver transformation and service developments alongside day job.<br>• Inability to identify milestones that reduce health inequalities and improve patient experience.<br>• Inability to identify clear data metrics to demonstrate impact (Cause and effect) in reducing health inequalities. |

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

**ACTIONS PLANNED**

| Action | Lead | Due date | Update |
|---|---|---|---|
| To audit health inequalities footprint within the Trust`s governance and reporting arrangements from `Ward to Board`. | AD Corporate Governance | 27th February 2026 | 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.<br>• Serious Incident Reports. Increased scrutiny and oversight through SI Oversight Panel.<br>• Executive Chief Nurse's Assurance Reports to CGC, QPES Committee and Board.<br>• New processes have been devised to improve learning from deaths including improved oversight of Structured Judgement Reviews (SJR's) and associated learning/actions.<br>• Participation Experience and Recovery (PEAR) Group.<br>• Community collaboration with system partners.<br>• Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme.<br>• PREOMS data from Secure and Offender Health showing a move towards parity for Black and white groups | • Highlight and escalation reporting to Strategy and Transformatio n Board.<br>• Reports to QPES Committee. | • Updates on PSIRF Implementation to QPES and Board.<br>• Integrated performance dashboard.<br>• BSOL MH performance dashboard.<br>• Outcomes measures, including Dialog+<br>• BSOL MHPC Executive Steering Group.<br>• Health Inequalities Project Board.<br>• Community Transformation governance structures.<br>• Out of Area Steering<br>• Performance Delivery Group "deep dives".<br>• Highlight and escalation reporting into BSOL MHPC Executive Steering Group.<br>• 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.<br>• 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.<br>• The Safety Summits are in their early conception and may not be adopted well by Divisions/services.<br>• Work to be undertaken to embed human factors/just culture.<br>• 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. |
| **CRR035/2058** | Risk of harm to service users and the general public due to the lack of AMHP provision in Birmingham. |

**Update since last review:**

**9 January 2026**

- Risk remains at a 12 until we have the data across access, experience and outcomes that showcases a more equitable experience across all services.

# BOARD ASSURANCE FRAMEWORK

| REF | STRATEGIC RISK | GOAL/ENABLER | CAUSES | CONSEQUENCES | LEAD COMMITTEE | LEAD | LINKED RISKS |
|---|---|---|---|---|---|---|---|
| **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.** | **Clinical Services**<br>• Community transformation including Life Course Specification approach and 24/7 & evaluation and roll out.<br>• Inpatient transformation<br>• Improving access<br>• Patient flow improvement programme<br>• Partnership working<br>• Urgent care transformation<br>• Children and Young People new model of care. | • Demand for services exceeding our capacity including increase in demand for inpatient services.<br>• Increased demand in the community.<br>• Limited capacity in social service provisions.<br>• Lack of partnership and effective system working.<br>• Organisation delivering transformation but not joined-up.<br>• Long waiting times to access services.<br>• Inadequate support for our service users with mental health co-morbidities.<br>• Not thinking as a system in developing priorities and pathways. | • Service users being cared for in inappropriate environments when in crisis.<br>• Increased OOA and the financial consequences.<br>• Increased pressure on A&E in acute hospitals.<br>• Increased waiting times/waiting list and backlog.<br>• Negative impact on recovery and length of stay/time in service.<br>• Negative impact on service user access, experience and outcomes.<br>• Lack of joined up pathways and care.<br>• Service users falling between gaps.<br>• Inferior and poor care.<br>• Increased risk of incidents. | QPES | Executive Director of Operations. | SR3<br>SR4<br>SR8 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | • Fragmented pathways and interfaces.<br>• Lack of service user voice in informing service transformation.<br>• Lack of support for and involvement of families and careers.<br>• The difficult financial landscape. | • Provision in the 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.<br>**Target risk score range 9-10.** | | **INHERENT RISK SCORE** | Impact | Likelihood | Total score |
| | | | | 4 | 5 | 20 |
| | | | **DATE RISK WAS ADDED** | September 2024 | | |

| **CURRENT RISK SCORE** | **RATIONALE** | **TARGET RISK SCORE** | **RATIONALE** | **RISK HISTORY** |
|---|---|---|---|---|
| **Impact 4 x Likelihood 3 = 12** | Current score demonstrates the controls in place and level of assurance evidenced. | **Impact 3 x Likelihood 3 = 9** | Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded. | |
| | | **DATE OF LAST REVIEW** | 8th January 2026 | |

| **CONTROLS/MITIGATIONS** | **GAPS IN CONTROL** |
|---|---|
| • Inpatient Bed Strategy and Inpatient quality transformation programme.<br>• Digital transformation programme.<br>• Partnership working with the Voluntary Sector.<br>• Inpatient flow improvement programme.<br>• Patient initiative follow-up work. | • Not enough beds for population when compared nationally.<br>• Lack of the right model of care that is suitable for our patients.<br>• Capacity within teams to deliver transformation and service developments alongside day job.<br>• Family and carers pathway not consistently applied or suitable for all |

| | |
|---|---|
| • Urgent care and Community transformation.<br>• Better prioritisation and triaging of patients of waiting lists.<br>• System approaches to improving and developing services.<br>• Solihull Children and Young People Transformation.<br>• System approaches to improving and developing services.<br>• Solihull Children and Young People Transformation.<br>• EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc.<br>• Partnership working re dual diagnosis processes and pathways.<br>• Plans in place around transformation and implementation of Community transformation.<br>• Use of multi-disciplinary triage hubs in the South in delivering patient benefits through joint working with Talking Therapies colleagues.<br>• 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.<br>• Implementation of work around Patient Initiated Follow Up (PIFU).<br>• Implementation of locality working model.<br>• Implementation of clinical activities for 24/7 NMHC team.<br>• 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.<br>• Life Course Delivery Group in place to ensure good governance and delivery. | services.<br>• Partnerships strategy is currently being refreshed – containing gap/opportunity analysis of current pathways.<br>• Needs assessment for BSOL is not up to date, which weakens our intelligence about our population and needs. |

**ACTIONS PLANNED**

| Action | Lead | Due date | Update |
|---|---|---|---|
| Transformation of the Urgent Care Pathway | Associate Director of Operations- Acute and Urgent Care 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.<br><br>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.<br><br>Winter plan development along with Board 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.<br>Updates – Jan 2026<br>Submitted capital bits moving towards a MH ED approach which will be integrated with existing services in Community and within the Acute Trust. |
| Implementation of the Talking Therapies Action Plan to address performance issues. | AD for Specialties | 31st Dec 2025 | On track<br>Recovery action plan in place with good oversight from the divisions leadership team.<br>Regular reporting and scrutiny and the Performance Delivery Group and service deep dives.<br>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<br>Regular monthly steering group meetings in place to monitor delivery along with assurance meeting and visits from NHSE.<br>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 |
| Setting up of a Transformation and Improvement Board | Deputy Ops | 28th February | Plan in place to launch in Feb 2026. On track |

| POSITIVE ASSURANCES | NEGATIVE ASSURANCES | PLANNED ASSURANCE | GAPS IN ASSURANCE |
|---|---|---|---|

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

**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. |
| **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. |
| **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. |

**Update since last review:**

**8 January 2026**

- BAF risk reviewed and updated, including launch of the Transformation Board to strengthen governance, delivery and assurance.

## 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<br>No time off work required | Minor injury or illness requiring minor intervention.<br>Requiring time off work <3days.<br>Increase in length of hospital stay by 1-2days. | Moderate injury requiring professional intervention.<br>Requiring time off work 4-14 days<br>RIDDOR/agency reportable incident<br>An event that impacts on a small number of patients | Major injury leading to long-term incapacity / disability<br>Requiring time off work >14days.<br>Increase in length of hospital stay by >15days.<br>Mismanagement of patient care with long term effects. | Incident leading to death<br>Multiple permanent injuries or irreversible health effects<br>An event which impacts on a large number of patients. |
| **Quality Complaints Audit** | Peripheral elements of treatment or service sub-optimal<br>Informal complaint or inquiry | Overall treatment or service sub-optimal<br>Formal complaint (stage 1)<br>Local resolution<br>Single failure to meet internal standards. | Treatment or service has significantly reduced effectiveness<br>Formal complaint (stage 2)<br>Local resolution (with potential to | Non-compliance with national standards with significant risk to patients if not resolved.<br>Multiple complaints / independent review | Incident leading to totally unacceptable level or quality of treatment or service.<br>Gross failure of patient safety if findings not acted on |

| | Consequence Score (severity levels) and examples of descriptors | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| | | Minor implications for patient safety if unresolved<br>Reduced performance rating if unresolved. | go to independent review).<br>Repeated failure to meet internal standards.<br>Major patient safety implications if findings are not acted on | Low performance rating<br>Critical report | Inquest / Ombudsman inquiry<br>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.<br>Unsafe staffing level or competence (>1day).<br>Low staff morale<br>Poor staff attendance for mandatory / key training. | Uncertain delivery of key objectives / service due to lack of staff.<br>Unsafe staffing levels or competence. | Non-delivery of key objectives due to lack of staff<br>On-going unsafe staffing levels or competence.<br>Loss of several key staff.<br>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<br>Reduced performance rating if unresolved. | Single breech in statutory duty<br>Challenging external recommendations / improvement notice. | Enforcement action<br>Multiple breeches in statutory duty<br>Improvement notices.<br>Low performance rating<br>Critical report. | Multiple breeches in statutory duty<br>Prosecution<br>Complete systems change required.<br>Zero performance rating.<br>Severely critical report. |
| **Adverse publicity / Reputation** | Rumours<br>Potential for public concern | Local media coverage – short term reduction in public confidence<br>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)<br>Total loss of public confidence |
| **Business objectives / projects** | Insignificant cost increase / schedule slippage | <5% over project budget.<br>Schedule slippage. | <5-10% over project budget<br>Schedule slippage | Non-compliance with national 10-25% over budget project.<br>Schedule slippage. | Incident leading >25% over project budget<br>Schedule slippage.<br>Key objectives not met. |

| | Consequence Score (severity levels) and examples of descriptors | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| | | | | 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**<br>**Environmental impact** | Loss / interruption of >1hour<br>Minimal or no impact on environment | Loss / interruption of >8hours<br>Minot impact on environment | Loss / interruption of >1day<br>Moderate impact on environment | Loss / interruption of >1week<br>Major impact on environment | Permanent loss of service or facility<br>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<br>Incident resulting in a bruise or graze<br>Delay in routine transport for patient | Wrong drug or dosage administered, with no adverse side effects<br>Physical attach such as pushing, shoving or pinching causing minor injury<br>Self-harm resulting in minor injuries<br>Grade 1 pressure ulcer<br>Laceration, sprain, anxiety requiring occupational health counselling – no time off work required | Wrong drug or dosage administered with potential adverse side effects<br>Physical attack causing moderate injury<br>Self-harm requiring medical attention<br>Grade 2-3 pressure ulcer<br>Healthcare-acquired infection (HCAI)<br>Incorrect or inadequate information / communication on transfer of care<br>Vehicle carrying patient involved in road traffic accident<br>Slip / fall resulting in injury such as sprain | Wrong drug or dosage administered with adverse side effects<br>Physical attack causing serious injury<br>Grade 4 pressure ulcer<br>Long-term HCAI<br>Slip / fall resulting in injury such as dislocation, fracture, blow to the head<br>Loss of limb<br>Post-traumatic stress disorder | Unexpected death<br>Suicide of a patient known to the services within last 12 months<br>Homicide committed by a mental health patient<br>Large-scale cervical screening errors<br>Incident leading to paralysis<br>Incident leading to long-term mental health problem<br>Rape / serious sexual assault |

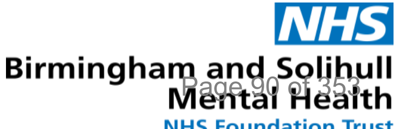
**5 x 5 Risk Scoring Matrix (AS/NZS 4360:1999)**

| | 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 | | | | |



compassionate

# 9. Corporate Risk Register






| Report to Board of Directors | | | | | | |
|---|---|---|---|---|---|---|
| **Agenda item:** | 9 | | | | | |
| **Date** | 28th January 2026 | | | | | |
| **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 18th December 2025; and was updated to reflect any changes made on the Eclipse system up until 22nd December 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- 18 risks
Finance Risks- 5 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.

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

- A new Operations Directorate has been set up for Trustwide Operational risks.
- Although not on the CRR, the high scoring risk around cold adverse weather has been reduced in score. This was discussed at the West Midlands Health Risk Management Group to see how other organisations across the system score the risk, it was concluded that-
  - We are used to managing this as it is an annual event
  - Good contingency plans are in place
  - We have good capabilities should action plans need to be put in place

  Comments to take on board for community teams were about the gritting capabilities of the Local Authorities. Score has reduced to 9.

- The Risk Management Group meeting ToR has been updated to reflect that all Directorates should have representation at every meeting, even if they are not presenting. Core members include every CD/ AMD and/or the HoN. Associate Directors are also invited to attend as additional members.
- 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-

- CRR045/2137- Finance: 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. Risk entered 29/09/2025, was previously merged with the Reaside capital risk, however each project has different elements presenting different levels of risk.
- CRR044/2144- Corporate Nursing: Potential harm caused by inconsistent searches by staff and contraband on wards. New risk entered 17/10/2025.

Risks De-escalated from CRR since last review-

- CRR037/2047- ICT: Potential Cyber security incident due to support ending for Windows 10. Risk closed as all trust computers have been either upgraded or replaced.

**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 |
|---|---|---|---|---|
| 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 |
| 2154 | Potential harm caused by commissioning issues with dementia drugs | 12/11/2025 | Dementia & Frailty | 15 |

| | | | | |
|---|---|---|---|---|
| 2172 | Risk that service users may take illicit substances whilst at Reaside clinic through various ways including mail, service users coming back from leave despite searches or observations. | 06/01/2026 | Secure Care | 15 |
| 2174 | Risk of harm to service users and staff alongside risk of essential care needs being missed caused by significant staffing shortages across the Ardenleigh site. | 08/01/2026 | Secure Care | 20 |

**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 |
|---|---|---|---|---|
| 2164 | Risk of medicines omission (including critical medicines), duplication and reliance on paper-based systems if the EMIS/Optum EPMA system may not work as intended for all wards/units and dispensaries across the Trust in the event of an EPMA outage. | 09/12/2025 | Pharmacy | 16 |
| 2171 | There are significant breaches in compartmentation at Reaside, therefore a fire could spread a lot quicker than in other sites where this isn't the case | 19/12/2025 | Secure Care | 15 |
| 2173 | Risk of the Trust not being able to provide Certificate of Sponsorships (required for visa applications) caused by the Trust nearly using its full allocation before the new financial year. | 07/01/2026 | HR Management Team | 16 |
| 2177 | Potential loss of income for the trust, and a review of service provisions as there is an underperformance against KPI's within BHM therefore the service is not on track to meet activity target for the rest of financial year Y25/26. | 16/01/2026 | Birmingham Healthy Minds | 16 |

**Risks awaiting de-escalation at next RMG meeting**

Risk owners are to present assurance to the group regarding reduction in risk scores before de-escalating from the CRR.

| Risk ID | Title of Risk | Date Entered | Team/ Department | New Risk Score |
|---|---|---|---|---|
| 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 | Urgent Care | 6- risk closed as met target |
| 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 | Corporate Nursing- IPC | 12 |
| 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 | HR Management Team | 9 |

**Key Issues and Risks**

- CYP will be bringing their highest scoring risks to the February RMG meeting for inclusion onto the CRR, discussion, and for understanding.
- 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 22nd December 2025 (to be reviewed 24th February 2026)

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 22nd December 2025. Updates to risks correct as of 22nd December 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***

**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 | 17/11/2025 | Kreshan Nirsimloo, CNM Urgent Care | 2x3=6 | 4x4=16 | 2x3=6 |
| 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 | 03/11/2025 | 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 | 14/11/2025 | 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 | 28/10/2025 | 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 | 20/10/2025 | 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 |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| CRR020/950 | High risk of clinical incidents and staff burnout as OA CMHT caseloads continue to be above 35 | 29/10/2018 | 04/11/2025 | 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 | 19/11/2025 | 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 | 26/11/2025 | 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 | 20/10/2025 | 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 | 29/10/2025 | 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 | 06/11/2025 | Danni Juttla, CSM Oleaster & Natassia James, Head of Health & | 4x2=8 | 5x3=15 | 5x3=15 |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 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 | 22/10/2025 | Liz Thurling, Clinical Director of ICCR | 5x2=10 | 5x3=15 | 5x3=15 |
| CRR044/2144 | Risk that patients may bring in or have delivered to wards harmful products leading to a risk of serious harm to themselves, other patients, or staff. | 17/10/2025 | new | Sophia Fletcher, Associate Chief Nurse for Policy and Practice | 4x2=8 | 3x5=15 | 3x5=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 | 02/12/2025 | Richard Sollars, Deputy Director of Finance | 4x3=12 | 5x5=25 | 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 | 12/12/2025 | 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 | 01/12/2025 | Richard Sollars, Deputy Director of Finance | 3x3=9 | 5x5=25 | 5x5=25 |
| CRR045/2137 | Risk that there may be a lack of capital availability to fund major capital works at Highcroft caused by lack of cash availability | 29/09/2025 | 12/12/2025 | Richard Sollars, Deputy Director of Finance | 3x3=9 | 4x5=20 | 4x4=16 |
| **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 | 4x2=8 | 4x4=16 | 4x4=16 |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | People, Learning & Development | | | |
| 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 | 15/12/2025 | Ngozi Anya, Associate Director of People, Learning & Development | 3x3=9 | 4x4=16 | 3x3=9 |
| 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<br>CRR033/2049<br>CRR038/1875<br>CRR039/2072<br>CRR044/2144 | | CRR010/108<br>CRR022/2004<br>CRR032/1989 |
| 4 Major | | | | CRR018/1901<br>CRR020/950<br>CRR030/2010<br>CRR031/2016<br>CRR034/2055<br>CRR035/2058<br>CRR040/2099<br>CRR041/2100<br>CRR043/2121<br>CRR045/2137 | CRR029/1225 |
| 3 Moderate | | | CRR042/2119 | | CRR005/1929<br>CRR006/1930<br>CRR012/1622<br>CRR017/1803<br>CRR021/1545<br>CRR024/1922<br>CRR033/2049 |
| 2 Minor | | | CRR004/1933 | | |
| 1 Insignificant | | | | | |

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# *Details of QPES Corporate Risk Register (CRR)*

| Executive Lead | Executive Director of Nursing |
|---|---|
| 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. |
| CRR ID | **CRR004/1933** |

| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 5 Catastrophic | 4 Likely | 20 |
| Current Risk Rating | 2 Minor | 3 Possible | 6 |
| Target Risk Score | 2 Minor | 3 Possible | 6 |
| 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.** | | |

| Oversight Committee | |
|---|---|
| QPES | |
| Date opened | 01/03/2016 |
| Last updated on Eclipse | 17/11/2025 |

| 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.<br><br>This is caused by the lack of bed availability.<br><br>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.<br>• Daily report which details ward round compliance to enhance flow.<br>• CNM's are contacted on a daily basis to see if patient under home treatment still requires an inpatient admission.<br>• Bed Management Policy are reviewed, and a multi-agency capacity meeting is held daily.<br>• 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.<br>• 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.<br>• Due to the demobilisation of under 25 services there is a need to close inpatient wards which impacts on resources.<br>• Timeliness of social and CCG panels/assessments to agree needs of patients - often delays out of our control.<br>• 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.<br>• Control over external factors - such as reliance on progress from partners such as social care and CCG.<br>• National shortage of beds means that there are occasions when out of area beds are not readily available.<br>• Patients declining out of area when informal/ out of area placements not accepting patient who are informal due to risk profile.<br>• 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** |

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| | | | | | | |
|---|---|---|---|---|---|---|
| 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 | Completed |
| | 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 |
| 17/11/2025 | Will look to close risk due to the locality it's leading to be able to create own beds. |

| 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 | 03/11/2025 |
| 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.<br><br>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.<br><br>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.<br>• 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.<br>• Incident reporting should be captured after a 4 hour delay.<br>• Bi-monthly meeting with Joanne Lowe- Head of Social Care for BCC to look at AMHP provision.<br>• Shortage of AMHP provision in Birmingham is reflected on the Social Care risk register. | • Eclipse reporting and feedback into CGC.<br>• BCC collate reports with the length of time between request and assessment.<br>• Discussed at Bed Management meetings. |

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|---|---|
| • Work actively with the bed management team to ensure that beds available when needed. | |

| 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.<br>• 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** |

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| 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 | |
| | **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 | |
| | **CRR006/1929/ 005** | Explore section 75 agreement with local authority, continue to record via eclipse, and attend interface meetings with LA colleagues | Tariro Nyarumbu | 31/03/26 | Gain support and understanding from the LA | |

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| 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 |
| 03/11/2025 | Risk reviewed by Tariro Nyarumbu- The risk remains and has been reported through the relevant committees so that consideration can be given to enter in to a Section 75 agreement. in the interim incidents are recorded via eclipse, interface meetings with senior colleagues are also in place to support more effective ways of working. |

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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 | 14/11/2025 |
| 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.<br><br>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.<br><br>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.<br>• A phone number has been provided to give support for mental health queries.<br>• Ongoing work around AMHP availability<br>• Ongoing work around bed availability by Acute Care | • Monitoring of impact on teams.<br>• Data is being collected and reviewed.<br>• Eclipse reporting and feedback into UC CGC. |

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|---|---|
| • 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 | 02/02/26 | 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 | 02/02/26 | 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 |
| 14/11/2025 | Risk reviewed by Kreshan Nirsimloo- 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 | 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 | 28/10/2025 |
| 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.<br>• Environmental risk assessment is updated regularly.<br>• Agile working is promoted where possible.<br>• Robust room booking is in place for shared rooms.<br>• Over 80% of staff have had both Covid vaccinations. | • Discussed and fed back into Secure Care CGC |

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|---|---|
| • Regular RMS/ Supervision for staff taking place.<br>• Staff are considerate of individuals space wherever possible.<br>• Service users requiring rooms are prioritised. | |

| Gaps/weaknesses in Controls/mitigations |
|---|
| • The delays to discharge are not something we can measure easily.<br>• Clinical need that requires staff to be in the building above and beyond the numbers recommended.<br>• 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** |
| | **CRR012/1622/** | Awaiting approval of capital money and board approval. Head of capital planning and projects has | Dianna Dass-Farrell | 31/03/26 | Funds required to better house the team | |

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|---|---|---|---|---|---|---|
| Actions being implemented to achieve target risk score | 002 | been in liaison with the FIRST service regarding the requirements for the team's long term accommodation needs. | | | | |
| | 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. |
| 28/10/2025 | Risk reviewed by Diana Dass-Farrell- action updated on Eclipse. Expected date for completion of main house building is March 2026. |

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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 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. | 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).<br><br>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.<br><br>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.<br>• Training is provided via e-learning.<br>• There is a Fire Safety Management Policy in place.<br>• 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.<br>• Incidents reported on Eclipse are reviewed by the current Fire Safety Advisor.<br>• The post holder completes risk assessments, training, investigations, committee reports, drills and provides advice and guidance to the Trust.<br>• The training is a statutory requirement, so monitored via traffic light system. |

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| | • 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.<br>• 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<br><br>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 |

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| | 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. |

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<table>
<tr><td>Executive Lead</td><td>Executive Director of Nursing</td><td></td><td>Impact</td><td>Likelihood</td><td>Score</td><td colspan="2">Oversight Committee</td></tr>
<tr><td rowspan="3">Title of risk</td><td rowspan="3">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.</td><td>Inherent Risk Rating</td><td>3 Moderate</td><td>5 Almost Certain</td><td>15</td><td colspan="2" rowspan="2">QPES</td></tr>
<tr><td>Current Risk Rating</td><td>3 Moderate</td><td>5 Almost Certain</td><td>15</td></tr>
<tr><td>Target Risk Score</td><td>2 Minor</td><td>3 Possible</td><td>6</td><td>Date opened</td><td>14/07/2023</td></tr>
<tr><td>CRR ID</td><td>CRR017/1803</td><td>Risk Appetite</td><td colspan="3">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.</td><td>Last updated on Eclipse</td><td>20/10/2025</td></tr>
</table>

| 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.<br><br>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.<br><br>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.<br><br>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. |

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|---|---|
| • The team produced a self-assessment tool action plan that identifies where our trust shortfalls are, and what actions are to be taken.<br>• 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.<br>• 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.<br>• 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.<br>• There is currently no admin support.<br>• Risk of burnout as staff are covering more aspects.<br>• 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. |

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| Actions to mitigate risk and attain target score: | | | | | | |
|---|---|---|---|---|---|---|
| **Risk Response Plan**<br><br>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 | 23/01/26 | 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. |
| 20/10/2025 | Risk reviewed with Zalika Geohaghon- there are a number of new staff who are still settling into their roles- 2 starting in June/ July 2025 and one who has returned from mat leave. As these staff become comfortable in post and understand what is needed we will see work progress. |

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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 | 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.<br><br>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.<br><br>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. | • HoN&AHPs are monitoring the issue at directorate level. |

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|---|---|
| • Medical Devices group has been set up. | • This has been escalated to the exec team to discuss concerns. |

| **Gaps/weaknesses in Controls/mitigations** |
|---|
| • Current system is out of date<br>• No oversight<br>• 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 | **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 |

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|---|---|---|---|---|---|---|
| achieve target risk score | **CRR018/1901/ 002** | Baseline Assessment to be completed and sent to UHB for system support and Dave Tomlinson as Exec Support | 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 Amanda stating that she will review the documents and respond accordingly | Completed |
| | **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. |

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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 | 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 | 04/11/2025 |

| 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.<br><br>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.<br><br>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<br>- 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.<br>- 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.<br>- Incident reporting via Eclipse.<br>- Monitoring of number of complaints and SI, fortnightly. Issues/ concerns escalated to AD.<br>- Team managers meeting undertaken monthly with CNM and staffing reports reviewed. |

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| discussions with appropriate senior managers about being reviewing practices so services are in line with NICE standards.<br>- Bank Assistant Psychologists are being utilised to help with waiting lists and caseloads.<br>- Agency and bank nurses have been sourced to be able to help cover.<br>- 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.<br>- Bank and agency staff only provide a short term fix and cannot be relied upon.<br>- 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.<br>- Discussion still to had regarding review of KPI, however this will need to be formally agreed by the Trust to take forward<br>- There are new referrals received to the CMHT's on a daily basis, increasing the pressure on resources and impacting on staff morale.<br>- 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. |

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|---|---|---|---|
| | | 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 |

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|---|---|---|---|---|---|---|
| | **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.<br><br>- Currently there is a requirement to see a medic yearly- this has been highlighted to the medical director for discussion and review.<br><br>- 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 | |

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| | **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. |
| 04/11/2025 | Risk reviewed by Lou Pickering (CSM)- Detailed caseload monitoring review is being undertaken, a full capacity and demand workstream has been identified to review resource allocation across cmht teams, fairer futures fund bid aims to review system ways of working for dementia cohort commences January 26, engagement with GP's re: discharge pathways underway to help understand how to optimise flow.  Workstream looking at service criteria to ensure referrals are appropriate and relevant to service to help with flow management |

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| Executive Lead | Executive Director of Nursing | | Impact | Likelihood | Score | Oversight Committee | |
|---|---|---|---|---|---|---|---|
| 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. | Inherent Risk Rating | 4 Major | 5 Almost Certain | 20 | QPES | |
| | | Current Risk Rating | 3 Moderate | 5 Almost Certain | 15 | | |
| | | Target Risk Score | 2 Minor | 3 Possible | 6 | Date opened | 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 | 19/11/2025 |
| 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<br><br>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.<br><br>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.<br>- Patients with higher level of need or who present a greater risk will be on CPA and therefore have a care coordinator allocated.<br>- Reviewing waiting lists to identify where there are priorities, specific issues and patients where risk indicated appointment may need to be expedited.<br>- Remote consultations are being offered in the interim period to try to identify those who may need a sooner intervention.<br>- Booking clinics for the earliest opportunity. | - Reporting and updates through D&F CGC.<br>- Incident reporting via Eclipse.<br>- Monitoring of number of complaints and SI, fortnightly. Issues/ concerns escalated to AD.<br>- RMS<br>- Discussion in MDT.<br>- Waiting list<br>- Risk assessments |

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|---|---|
| - Routine reviews will not be prioritised, however the team will be responsive to changes in service user need.<br>- Agency and bank have been sourced to be able to help cover.<br>- Medic who was providing cover to the Juniper Admission Suite has agreed to support North Hub and provide clinical cover.<br>- 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)<br>- Bank and agency staff only provide a short term fix and cannot be relied upon.<br>- Lack of Senior Medic presence in MDTs in Solihull Hub (see risk number 1543) and in North Hub (see risk 1544)<br>- There are new referrals received to the CMHT's on a daily basis, increasing the pressure on resources and impacting on staff morale.<br>- 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: |
|---|

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| 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 | 01/02/2026 | Reduction in caseload numbers | |
| | **CRR021/1545/ 005** | Reviewing impact of transformation work and funding | Lou Pickering | 01/02/2026 | 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 | 01/02/2026 | 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. |

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|---|---|
| 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 |
| 19/11/2026 | Risk reviewed with Lou Pickering (CSM)- actions updated, risk still remains |

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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 | 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.<br><br>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.<br><br>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<br>- Discuss at central bed management to identify wider resources<br>- Regular contact with other members of the provider collaborative | - Eclipsing of incidents for monitoring at PCG<br>- 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. Dawn House proposal has been accepted and agreed, work commencing on implementation |

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| 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.<br><br>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.<br><br>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.<br>- 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. |

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|---|---|
| - 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.<br>- Active Recruitment Strategy: The trust maintains a proactive approach to recruiting experienced Band 6 nurses, with efforts to attract qualified candidates.<br>- 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<br>- Roster clinics - confirm and challenge |

| Gaps/weaknesses in Controls/mitigations |
|---|
| - Individual Competency Support Programs are new and remain untested for effectiveness.<br>- This is a relatively new reporting arrangement into Safer Staffing Committee and so will need embedding<br>- 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. |

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| 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 | | |

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|---|---|---|---|---|---|---|
| | **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 | | |

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|---|---|---|---|---|---|---|
| | | 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. |

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| 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.** | | | | |
| CRR ID | **CRR031/2016** | | | | | Last updated on Eclipse | 26/11/2025 |

| 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.<br><br>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.<br><br>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.<br>- 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 | 31/07/26 | 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 | 31/07/26 | 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. |
| 26/11/2025 | Update at Solar EIS CGC by Steve Scrimshaw: Mpower funding has not been confirmed post March 2026. Which adds potential financial and service delivery risk. Ongoing discussions by Head of service with Directors, Finance and Commissioners. |

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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 | 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 |
| | | 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 |
| CRR ID | CRR033/2049 | | | | | | |

| 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).<br><br>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.<br><br>Training on the Eclipse system would need to be provided. |

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| 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 | 20/10/2025 |
| 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.<br><br>-Basic outbreak and escalation procedures in place<br><br>-IPC team provides reactive advice when infection risks are identified. | -Regular IPC audits are conducted and reported through governance channels.<br><br>-Staff compliance with standard infection prevention procedures is monitored via routine observation.<br><br>-Incident reporting system in place for suspected infection control breaches<br><br>-EPRR annual review and tabletop exercise for HCID. |

| Gaps/weaknesses in Controls/mitigations |
|---|

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| -No specific HCID-focused training for frontline staff.<br><br>-Lack of clear local protocols for HCID response.<br><br>-No formal liaison with HCID designated units or UKHSA<br><br>-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.<br><br>-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 | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| | | -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. |
| 20/10/2025 | Risk reviewed with Zalika Geohaghon (Specialist Lead Nurse IPC)- remains the same, however we have managed to get 2 of our staff booked onto a train the trainer course in November. After this we will be able to create plans for the rollout of training across the trust. |

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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 | 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 | 29/10/2025 |
| 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.<br><br>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.<br><br>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.<br><br>BSMHFT have participated in the Birmingham Pathways Review and completed all actions.<br><br>Discussed and reviewed in Safety Huddles. | Incidents raised on Eclipse and reviewed.<br><br>Oversight at Trust CGC.<br><br>Monitored by HTT teams and fed into Acute Care CGC and Bed management meetings. |

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|---|---|
| Shortage of AMHP provision in Birmingham is reflected on the Social Care risk register.<br><br>Daily escalation meeting with AMHPs in place<br><br>HTT continue to escalate issues, delays and eclipse related incidents to Head of Social Care (JL).<br><br>Work actively with the bed management team to ensure that beds available when needed.<br><br>Urgent Care continually review 72 hour breaches and feedback to BCC.<br><br>AMHPs recruited to FIRST service<br><br>Two additional Nurse AMHPs have been employed through the trust to support in the Place Of Safety<br><br>Escalation to Chief Nurse | Monitored via incident reporting and feedback into Urgent Care CGC.<br><br>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.<br><br>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.<br><br>BCC have not participated in the Birmingham Pathways Review.<br><br>Limited to actions we can take due to lack of engagement by BCC.<br><br>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. |

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| 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 | | | |

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|---|---|---|---|---|---|---|
| | **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. |
| 29/10/2025 | Update provided by Sophia Fletcher- see attached report. A review of incident data (Nov 2024 - June 2025) identified 81 incidents, of which 74 were relevant, affecting at least 54 patients. |

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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 | 06/11/2025 |
| 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.<br><br>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.<br><br>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.<br><br>Considerable uptake in car park scheme<br><br>Regular comms and signage on safe parking<br><br>Dedicated on-call spaces | Eclipsing of incidents- reviewed at Acute Care CGC<br><br>Discussed at Health and Safety committee |

| Gaps/weaknesses in Controls/mitigations |
|---|

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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** |

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| Actions being implemented to achieve target risk score | CRR038/1875/001 | Actions to be completed by newly established Parking Group- See attachments for updates<br><br>- Develop a clear policy for car parking management at different sites.<br><br>- Create and communicate a detailed eligibility criteria for car parking spaces to staff, ensuring it is signed off and implemented and integrated into policy.<br><br>- 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.<br><br>- 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.<br><br>- Identify a single person responsible for the overall management of the Barberry and Oleaster buildings to ensure governance and control. | Natassia James | 31/03/2026 | | |
|---|---|---|---|---|---|---|

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|---|---|---|---|---|---|---|
| | | - 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. |
| 09/10/2025 | Trust Health & Safety Committee approved the introduction of a parking policy as well the other proposals agreed around increasing the fine and introducing a criteria for parking. Further steering group meeting set up for November |
| 06/11/2025 | Parking group met 3/11/25 and sent out a draft parking policy- attached. Also discussed was- Car parking controls (aligned to policy and enforcement / penalties), Funding for barriers & bollards capital and revenue, Management of barriers, Installation of access system / barriers, Car parking enforcement, Pre-existing fines for Trust Payment, Instructions to Q Park based on Trust Policy approved criterions to enforce parking measures. Policy to support penalties (UHB / BWC £50 penalty), Disciplinary, Communication, Trust Sustainable Travel Plan and alternate parking options off campus, Staff awareness across BSMHFT and partners. Informed re process, options, timeline and penalties, Signage, Future controls measures, New Departments, Expanding Teams, Impact on facilities, Job adverts/ Contracts, Future appointments, A clearly defined operational lead for each building. |

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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 |
| | | 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 | 22/10/2025 |
| CRR ID | **CRR039/2072** | | | | | | |

| 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.<br><br>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.<br><br>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<br><br>Gap analysis completed and fed back to NHSE, with feedback received.<br><br>Ongoing support from NHSE<br><br>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<br><br>Reviewed monthly at QPES, Trust CGC, MHPC Executive Steering Group<br><br>Support and oversight from NHS England |

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|---|---|
| Crisis Line<br><br>Work completed around enhancing duty standards with senior leads having oversight and clear escalation guidelines<br><br>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. |

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| 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:<br>- Identification of individuals who may need more intensive support<br>- Workforce needs, including recruitment of Advanced Clinical Practitioners (ACPs) to provide oversight for complex cohort.<br>- Systems in place to respond when they disengage<br>- Clear pathways in place to 'step up' care, and to ensure transition and flow to make sure that there is capacity when needed<br>- Response to crisis<br>- Care planning<br>- Our relationship with other services<br>- Appropriate governance in place, including monitoring people who are discontinuing medication against advice and risk management processes<br>- Involvement of Experts By Experience, families, and carers | AD and CDs for ICCR plus other actions for other teams within the trust | 31/03/25 | Address the gaps established following the review to ensure that complex patients who disengage are looked after | |

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|---|---|---|---|---|---|---|
| | | | | | | |

| Date | Risk Reviews and Progress made since last Committee review/scrutiny of risk: |
|---|---|
| 21/08/2025 | Risk newly added to CRR |
| 22/10/2025 | Risk reviewed by Elizabeth Thurling, action plan updated and new version attached to risk |

compassionate inclusive committed

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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 patients may bring in or have delivered to wards harmful products leading to a risk of serious harm to themselves, other patients, or staff. | Current Risk Rating | 5 Catastrophic | 3 Possible | 15 | | |
| | | Target Risk Score | 4 Major | 2 Unlikely | 8 | Date opened | 17/10/2025 |
| | | 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 | |
| CRR ID | **CRR044/2144** | | | | | | |

| Risk description |
|---|
| There is a risk that patients may bring in or have delivered to wards harmful products leading to a risk of serious harm to themselves, other patients, or staff.<br><br>This risk was identified following a serious incident where a patient was able to have a poisonous substance delivered in a parcel and ingest it leading to their death. When the parcel was delivered to the ward, it was not checked by staff. This highlighted that staff across all wards are not routinely checking parcels when they are delivered to patients on wards. There have also been incidents of knives being found in patient rooms during searches, identifying that there are inconsistencies in the use of wands when searching patients returning from leave. Concerns also surround contraband being passed into wards via courtyards.<br><br>This may result in death, serious injury, or harm to patients, staff or damage to buildings. This may also bring reputational and financial damage. |

| Controls in place | Assurances |
|---|---|
| - Searching parcels before it gets to a patient in all wards<br>- Training for bank staff so all staff aware and follow the same rules<br>- Reporting of incidents<br>- Searching of Service Users policy is in place and has been updated following this incident with an audit process attached<br>- Courtyard management process in place | - Being reviewed by the RRP group<br>- Search audits in place on AMaT reviewed in deep dive metrics<br>- Incidents monitored and reviewed at Acute Care CGC |

| Gaps/weaknesses in Controls/mitigations |
|---|

- Searches can be challenging as we are a healthcare facility, so searches need to be as unrestrictive as possible. Even if policies are followed there will always be a risk
- Use of drones
- Service users may use many techniques to smuggle in contraband, including using takeaway providers, putting alcohol in soft drink bottles etc
- Many resources online that service users can use to find ways to smuggle in contraband- we can't restrict internet access

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

| Actions to mitigate risk and attain target score: | | | | | | |
|---|---|---|---|---|---|---|
| **Risk Response Plan** | **Action ID** | **Action** | **Action Lead/ Owner** | **Due date** | **State how action will support risk mitigation and reduce score** | **RAG Status** |
| Actions being implemented to achieve target risk score | **CRR044/2144/ 001** | To implement a process of the check of parcels when they are delivered to the ward and ensure that this process is consistent across sites by the use of audit | Sophia Fletcher | 31/03/2026 | Ensure consistency and therefore reduce the likelihood of dangerous items being brought onto premises | |
| | **CRR044/2144/ 002** | Search audits in place on AMaT to be reviewed in deep dive metrics | Sophia Fletcher | 31/03/2026 | Ensure consistency and therefore reduce the | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | likelihood of dangerous items being brought onto premises | |
| | | | | | | |

| Date | Risk Reviews and Progress made since last Committee review/scrutiny of risk: |
|---|---|
| 18/12/2025 | Risk newly added onto the 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** | |
|---|---|---|---|---|---|---|---|
| **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 | **Inherent Risk Rating** | 5 | 5 | 25 | FPP | |
| | | **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** | 02/12/2025 |
| **CRR ID** | **CRR010/108** | | | | | | |

| **Risk description** |
|---|
| There is a risk that savings schemes may not be delivered in full by the Trust.<br><br>This may be caused by the Trust failing to meet its financial plans.<br><br>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.<br>• Internal Audit includes performance against CIP, and associated process in their annual plan.<br>• 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.<br>• Planning for 24/25 financial plans already includes expectations around 1% recurrent plans. |

| **Gaps/weaknesses in Controls/mitigations** |
|---|

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- 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 |

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| | |
|---|---|
| 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 |

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| | |
|---|---|
| 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 |
| 02/11/2025 | Risk reviewed by Richard Sollars- in year savings shortfall offset by other mitigations identified in the financial recovery plan, including significantly improved beds position |
| 02/12/2025 | Risk reviewed by Richard Sollars- in year recurrent savings shortfall offset by mitigations identified in financial recovery plan. Element in plan linked to additional income from Toucan provider collaborative at risk pending system discussions - other proposals being developed to fill the gap |

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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.*** | | | Last updated on Eclipse | 12/12/2025 |
| CRR ID | **CRR022/2004** | | | | | | |

| Risk description |
|---|
| There is a risk that the Trust is unable to deliver its financial plan.<br><br>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.<br><br>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<br>▪ Sustainability Board, FPP and Board receive monthly updates on financial position<br>▪ Targeted actions on areas of key financial risk – OOA, Bank and Agency spend<br>▪ System wide requirement for medium term financial planning (Submit in August 24)<br>▪ System wide requirement for financial recovery plans for providers off target (Submit in August 24)<br>▪ Request already issued for 2% transformational savings ideas for 25/26 | Reports into Trust FPP through Integrated Performance Report<br><br>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 | |

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|---|---|---|---|---|---|---|
| | **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 |

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| | |
|---|---|
| 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 |
| 06/11/2025 | Risk reviewed by Richard Sollars- risk continues although financial performance in months 3,4,5,6 and now month 7 all been at or better than trajectory. Risks remain, especially around securing planned reductions in bank spend but mitigations identified |
| 12/12/2025 | Risk reviewed by Richard Sollars- significant risk continues - while ahead of financial recovery plan at month 8, element of funding from Toucan assumed in plan at risk - discussions at system and regional level to explore alternatives. Mitigations developed to cover |

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| **Executive Lead** | Executive Director of Finance | | **Impact** | **Likelihood** | **Score** | **Oversight Committee** | |
|---|---|---|---|---|---|---|---|
| **Title of risk** | Lack of available capital funding and investment requirements | **Inherent Risk Rating** | 4 Major | 5 Almost Certain | 20 | FPP | |
| | | **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).<br><br>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.<br><br>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.<br>• Senior management continue to link in with system colleagues to identify any additional capital funding that may become available.<br>• Senior management to monitor any national funding available for specific programmes such as ICT and carbon neutralisation grants.<br>• A list of capital schemes is circulated to operational and corporate leads regularly to maintain visibility of requirements<br>• 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: |
| --- |

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| 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 |

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| | |
|---|---|
| 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 | 01/12/2025 |

| Risk description |
|---|
| There is a risk that there may be a lack of capital availability to fund major capital works at Reaside.<br><br>This may be caused by lack of cash availibility or lack of capital availability within the system.<br><br>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.<br>• Senior management to monitor any national funding available for specific programmes such as ICT and carbon neutralisation grants.<br>• 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 |
|---|

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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** |

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| 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 |
| 31/10/2025 | Risk reviewed by Louise Merrison- Discussed at CRG and risk rating to remain the same |
| 01/12/2025 | Risk reviewed by Louise Merrison- Discussed at CRG 01/12/25 risk rating to remain the same |

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| Executive Lead | Director of Finance | | Impact | Likelihood | Score | Oversight Committee | |
|---|---|---|---|---|---|---|---|
| Title of risk | Risk that there may be a lack of capital availability to fund major capital works at Highcroft caused by lack of cash availability | Inherent Risk Rating | 4 Major | 5 Almost Certain | 20 | FPP | |
| | | Current Risk Rating | 4 Major | 4 Likely | 16 | | |
| | | Target Risk Score | 3 Moderate | 3 Possible | 9 | Date opened | 29/09/2025 |
| | | 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 | **CRR045/2137** | | | | | Last Update on Eclipse | 12/12/2025 |

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

| Controls in place | Assurances |
|---|---|
| -Senior management to monitor any national funding available for specific programmes such as ICT and carbon neutralisation grants.<br><br>-A list of capital schemes is circulated to operational and corporate leads regularly to maintain visibility of requirements | Monitored at FPP & CRG |

| Gaps/weaknesses in Controls/mitigations |
|---|
| |

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| 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 | **CRR045/2137/ 001** | | | | | |

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| achieve target risk score | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |

| Date | Risk Reviews and Progress made since last Committee review/scrutiny of risk: |
|---|---|
| 18/12/2025 | Risk newly added onto the CRR. |

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## Details of People Committee Corporate Risk Register (CRR)

| Executive Lead | Director of Strategy, People & Partnerships | | Impact | Likelihood | Score | Oversight Committee | |
|---|---|---|---|---|---|---|---|
| Title of risk | Efficiency and accuracy risks associated with the administration workforce not utilising new technology and modernising admin practices | Inherent Risk Rating | 4 Major | 5 Almost Certain | 20 | People Committee | |
| | | Current Risk Rating | 4 Major | 4 Likely | 16 | | |
| | | Target Risk Score | 4 Major | 2 Unlikely | 8 | Date opened | 07/08/2025 |
| CRR ID | CRR040/2099 | 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. | | | 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.<br><br>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.<br><br>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<br>Clear terms of reference<br>Newly established Modernising Admin Practices Steering group | Steering Group in place<br>Progress to be monitored through Shaping our Future Workforce into People Committee<br>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 | | |
| | | | | | | |

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| 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 | |
|---|---|---|---|---|---|---|---|
| Title of risk | Risk that BSMHFT are unable to workforce plan effectively. | Inherent Risk Rating | 4 Major | 5 Almost Certain | 20 | People Committee | |
| | | 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<br>System Workforce Planning group<br>Workforce planning specialist in post<br>Data available from local universities on graduate numbers.<br>Annual Multi-disciplinary Training Education Programme exercise Training demand template) | Workforce planning specialist in post<br>Oversight by Shaping Our Future Workforce sub committee up to People Committee<br>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.<br><br>Data quality in ESR poor<br><br>Annual planning too short-term to plan for longer term i.e. 3 years |

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| 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:**

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| 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 | |
|---|---|---|---|---|---|---|---|
| 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. | Inherent Risk Rating | 4 Major | 5 Almost Certain | 20 | People Committee | |
| | | Current Risk Rating | 3 Moderate | 3 Possible | 9 | | |
| | | 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 | 15/12/2025 |

| 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.<br><br>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<br><br>Develop incentives or recognition schemes for teams or individuals who demonstrate high attendance and engagement in training, encouraging greater participation.<br><br>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.<br><br>L&D Offer includes a variety of training delivery formats, such as eLearning modules, recorded sessions, and multiple time slots, to accommodate |

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| | |
|---|---|
| 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.<br><br>Provide regular assurance reports to senior leadership and governance committees, detailing mitigation activities, trends, and outcomes.<br><br>Regularly reinforce the value of training for professional development, patient safety, and service quality through internal communications, ensuring all staff understand its significance.<br><br>Integrate mandatory training completion into performance appraisals and compliance audits, making it a core requirement for progression or ongoing employment where appropriate.<br><br>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<br><br>Understanding amongst staff and managers of the appropriate notice period to cancel training in order to release the slot to another member of staff<br><br>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 |
|---|---|

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| 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.<br><br>Quarterly DNA data will be made available to ADs and senior managers through FPP meetings from November onwards | Diane Phipps | 31/12/2025 | | |
| | | | | | | |

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

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

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| | |
|---|---|
| 16/10/2025 | Risk accepted onto CRR at RMG |
| 15/12/2025 | Risk reviewed by Diane Phipps- FT DNAs have decreased by 22% in Q2 and a further 55% in Q3, demonstrating that mitigation actions are effective. management skills modules 1&2- The data shows the number of DNAs total 44 Q2-Q3. If current progress with FT continues- risk will be stood down at next report. The management skills training will also be reviewed and continued comms to promote the modules will be available. |

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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.<br><br>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.<br><br>This may result in<br>-Inability to fulfil the NHSE graduate offer<br>-Poor experience of recruitment for newly qualified nurses as those who have offers have delayed start dates as unable to place in a vacancy.<br>- Promoting too quickly into higher bands before staff have the appropriate clinical and/ or managerial skills.<br>- Continued bank / agency usage at band 6 and above |

| Controls in place | Assurances |
|---|---|
| Regular reviewing of vacancy information<br>Holding band 5 vacancies for newly qualified staff<br>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.<br><br>MHOST data not robust enough to increase establishments<br><br>Reasons for booking bank staff not always clear<br><br>Vacancies not always entered in a timely manner<br><br>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 | | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| | **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 |

# 10. Integrated Performance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

# Report to All Committees and Board

| Agenda item: | |
|---|---|
| **Date** | 22nd January 2026 |
| **Title** | Integrated Performance Report |
| **Author/Presenter** | Richard Sollars, Deputy Director of Finance<br>Sam Munbodh, Clinical Governance Team<br>Hayley Brown, Workforce Business Partner<br>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)**
  Q2 national data was published on the Model Hospital and the NHSE Public facing website on the 11th December 2025. BSMHFT remains in segment 4 (Low performing) but Trust rank has moved to 51of 61 Trusts from 55th in Q1 publication. The only in-year metric that showed improvement was the financial YTD variance from plan which moved from red to amber in Q2 publication.

  To note that the national NOF data for the CYP access measure was suppressed as significant variances in performance are viewed to be data quality issues. This was due to the large % increase in BSMHFT performance due to the inclusion of the CYP division data following FTB transfer to BSMFT. NHSE leads acknowledged that the increase is accurate but the Q2 NOF position was not amended. Going forwards this metric is expected to achieve quartile 1 performance rating.

  To note six non scoring 'contextual measures' have been published for the first time on the Model Hospital website, see Appendix I, slides 12 and 13. An internal review is being undertaken to check and compare national data with local Trust data to ensure alignment of methodology going forwards where possible.

  To note that as a result of the Trust being classified in NOF segment 4, (low performing), monthly joint improvement meetings with NHSE and the Executive team have commenced. It should be noted that the agenda for these meetings to date has been wider than the NOF metrics.

  To note that as a subset of the Trust's Adult Acute Services 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.

- **New:** To note that as a result of a national issue with ESR, reporting outputs have been impacted resulting in accurate data not being available for sickness and appraisals. Actions to address are being overseen via the People Team and People Committee.

- **New:** The current placements within the new contract bed framework with Cygnet Hospitals for adult acute inpatients are currently being classified as 'inappropriate' as the Standard Operating Protocol

demonstrating that local clinical care and qualitative criteria are in place has yet to be approved by NHSE. Once agreed, it is anticipated these beds will be classified as 'appropriate'

- **New:** Talking Therapies - The MH Provider Collaborative issued a performance notice in September 2025 relating to the Talking Therapies underperformance in activity and outcome measures for reliable recovery and reliable improvement rates. As at Month 9 there is an income deficit of £537,912 related to underperformance on activity. 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. December 2025 data for inappropriate out of area placements at 6 acute (target of 0) and 11 PICU patients (target of 10). Patient are placed in Cygnet Hospitals. Improving trend being achieved in reducing all out of area placements impacting on improving the Trust's financial recovery plan.
- Recovery House opened in November 2025 providing 24/7 residential service delivered in partnership with Birmingham Mind, offering intensive support for adults experiencing acute mental health needs.
- Clinically Ready for Discharges – increased in November to 14% from 9% in October and the latest Trust position showing a small reduction to 13.31%. and continues to impact on available Trust capacity to repatriate out of area placements for adult inpatients. System level escalations continue to be taken.
- Performance on the 2025/26 national planning trajectories for Length of Stay (LOS) for adult and older adult inpatient shows the Adult and Older adult LOS is above trajectory for the last 3 months but a reducing trend is observed. LOS for non-trust beds is also on a reducing trend. - detail is outlined in Appendix III. To note that as the LOS methodology is based on discharge, long stay discharges will increase overall LOS.
- Formal review of service users within last 12 months has fallen slightly now in mid-90% level.
- Referrals over 3 months with no contact remains high, but mitigations are in place to manage risks, with continued focus on reducing long waits.
- Sickness absence – data not yet available – national ESR issue impacting.
- Bank and agency reduction – December above trajectory with bank at 637.9 and Agency at 35.8 WTE
- Appraisals – data not yet available – national ESR issue impacting.
- Vacancies – Vacancy rate remains at 7.3% for December.
- Fundamental Training increased in last month from 93.8% to 94.2% in December but below 95% target.
- Incidents of Self Harm have decreased from 164 to 156 in December.
- Psychological harm (staff/third party) has increased to 3 this month.
- Physical restraints have decreased from 261 to 208 this month.
- Prone restraints have reduced from 40 to 30 in December
- Reported incidents have decreased to 2619 from 2189 in December.

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 in Table 1. The detailed summary of progress against action plans is included in 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 | | | Improvement in last month above the national trajectory | 3, 12-14 |
| **People** | | | | |
| Vacancies | | | Sustained at 7.3% in December below trajectory | 6 |
| Sickness | | | Data not yet available | 6 |
| Appraisals | | | Data not yet available | 6 |
| **Sustainability** | | | | |
| Monthly Agency costs | | | | |

**Table 2: Performance**

| | On Track | Plan in Place | Progress | Page |
|---|---|---|---|---|
| Talking Therapies - Service users moving to recovery | | | Improving trend in last 3 months (50.5%) and above national 50% target | |
| Talking Therapies Reliable Recovery Rate | | | Deteriorating trend in last month (46.2%) and below national target of 50% | 4, 19-20 |
| Talking Therapies Reliable improvement rate | | | Improving trend in last 3 months (68.34%) above the national target of 68% | 4, 17-18 |
| Clinically Ready for Discharge: percentage of bed days | | | Improvement in last month. December 2025 at 13.3%. | 5, |
| Clinically Ready for Discharge: Number of delayed days | | | Improving trend in last month. December 2025 at 2163 bed days. | 5, 15-16 |
| Eating Disorders waiting times- Routine | | | Reduction in last month to 90% below the 95% target (small numbers) | |

**Table 3: People**

| | On Track | Plan in Place | Progress | Page |
|---|---|---|---|---|
| Fundamental Training | | | Improving trend in last month (94.2%) below Trust target of 95%. | 6, 21-22 |

| | On Track | Plan in Place | Progress | Page |
|---|---|---|---|---|
| Incidents resulting in self-harm | | | Decreasing trend in last month | 5, 23 |
| Psychological Harm – staff/third party | | | Increased to 3% last month. Reviewed at QPES. | 6, 24 |
| Physical Restraints | | | Decreased from 261 to 208 in last month | 6, 25 |
| Prone Restraints | | | Decreased from 40 to 30 in last month | 6, 26 |
| Reported incidents | | | Decreased from 2619 to 2476 in last month | 6, 27 |

**Table 4: Quality**

**Table 5: CYP**

| CYP Division | On Track | Plan in Place | Progress | Page |
|---|---|---|---|---|
| Eliminate Out of Area Placements | | | Deterioration in last month at 5 above target of 0 | |
| Increase CYP Accessing Services (MHSDS figures, month behind) | | | CYP access rate based on 12-month rolling remains below target for December (awaiting final update) | 6 |
| National <18 eating disorders waiting times (Routine inc ARFID) | | | Deterioration in last month (53%) below 95% target. Small numbers | 6 |
| National <18 eating disorders waiting times (Urgent inc ARFID) | | | Sustained performance at 100% for last nine months | 6 |
| Local Adult >18 eating disorders (routine) | | | Improvement last month (100%) | 6 |
| EIP – Suspected First episode of Psychosis seen in 2 weeks | | | Improved performance in last month above 60% target | |
| Talking Therapies 6 weeks | | | Sustained performance in last nine months above target | |
| Talking Therapies 18 weeks | | | Sustained Performance in last nine months above target | |
| Talking Therapies Moving to recovery | | | Sustained performance in last 6 months (54%) above target | |
| Non-Contract > 18 beds charged of (ave weekly Snapshot) | | | Reduction in last 3 months (4) above target of 0 | 6 |
| All > 18 beds charged for (ave weekly Snapshot) | | | Total number of beds used (70) below target of 92 | |

## Strategic Priorities

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

## Recommendation

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

## Enclosures

FPPC January 2026 Performance Report and Integrated Performance Dashboard

Appendix I FPPC January 2026 National Oversight Framework Update

Appendix II FPPC January 2026 CYP Division Performance Report
Appendix III FPPC January 2026 FPPC Performance Improvement Metrics
Appendix IIIa FPPC January 2026 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 planned to be addressed via the Performance Assurance Panels going forwards to assess progress and delivery of recovery action plans where relevant. Appendix III outlines an update on improvement plans as 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: Update on the National Oversight Framework (NOF) Metrics (Appendix I)

Appendix 1 provides an update on the national Q2 publication issued by NHSE in December 2025 as well as providing a local Trust update on NOF metrics that can be tracked in-year.

Q2 NOF national data was published on the Model Hospital website and on NHSE's Public facing website on the 11th December 2025. Summary position outlined below:

- BSMHFT Q2 NOF score remains in segment 4 (Low performing). Trust ranked position has moved to 51 out of 61 Trusts compared to 55 of 61 Trusts in Q1.
- Financial YTD variance from plan measure has improved from red to amber in their Q2 publication.
- CYP access measure data was suppressed nationally due to the large increase in performance observed, over 30% which was viewed as being a data quality issue. Following Trust feedback that this increase was an accurate reflection as the performance included the CYP activity following FTB transfer to BSMHFT. Whilst NHSE leads confirmed accuracy, the NOF position was suppressed for Q2.
- To note that six additional non-scoring 'contextual measures' were also published for the first time on the Model hospital website only – see Appendix I, slides 12 and 13. An internal review is being undertaken to check and compare national data with local Trust data to ensure alignment of methodology going forwards where possible.

Local Trust in-year position: For existing NOF measures which are not based on annual data, reports using local and up to date data have been developed and shared with service leads to aid action plans to achieve in-year performance improvement. As there is a lag to the national NOF data that is used, improvements achieved in year are likely to positively impact on future NOF ratings subject to levels of improvement achieved by other Trusts. The NOF metrics which can be influenced by in-year action are outlined below:

- Percentage of adult inpatients with > 60-day length of stay (on discharge)
- Percentage of patients in crisis receiving face-to-face contact within 24 hours
- 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. For more detail, please refer to Appendix 1.

FPPC is also asked to note that due to the Trust being in segment 4, Low Performing, NHSE monthly Joint Improvement, Oversight and Assurance meetings with the Executive Team are in place. It should be noted that the agenda for these meetings is wider than just NOF performance.

# Trust Performance in December 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.

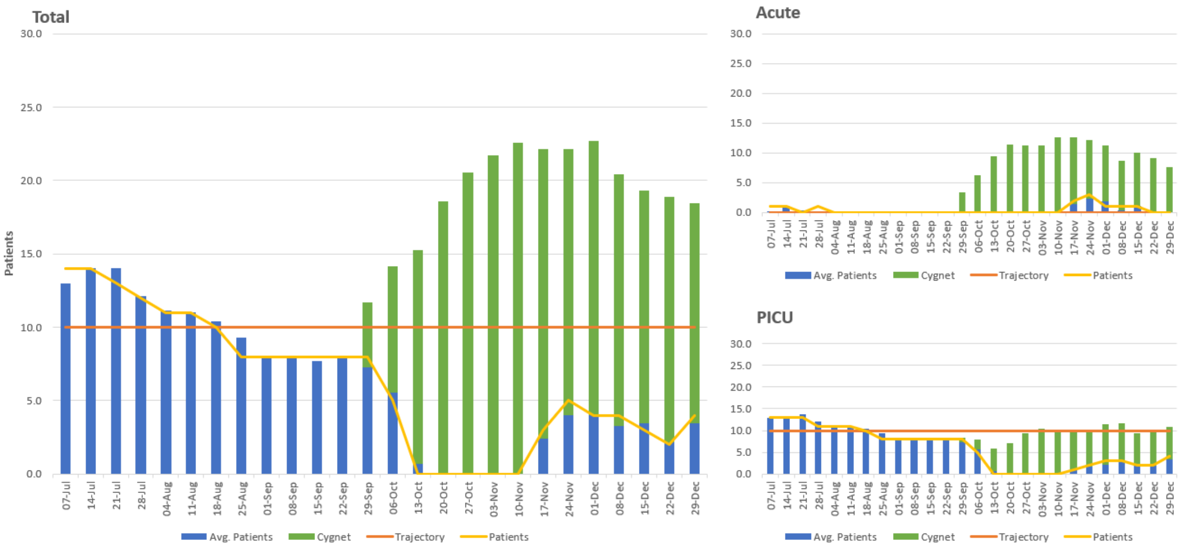
From 29th September as part of the move to a new framework arrangement with private providers, out of area patients are being placed in Cygnet hospitals. During the transition phase we are classifying this bed use as 'inappropriate' but it is anticipated these beds will be classified as 'appropriate' following review and approval of the Trust's Standard Operating Protocol (SOP) for these beds by NHSE. Sign off/approval of the SOP is expected in January 2026 via the Mental Health Provider Collaborative. It should be noted that if the SOP was in place now there would have been 4 inappropriate PICU out of area placements in December 2025 and within the target of 10 agreed by NHSE.

As the SOP is not yet in place, at the end of December 2025, there were 6 acute (target 0) and 11 PICU (target 10) inappropriate out of area placements. 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.

November saw a large rise to 14% in Clinically Ready for Discharge patients which has shown a small decrease in December to 13.3%, and pressure remains, impacting our ability to maintain patient flow and reduce out of area placements.

Q3 productivity plan actions are outlined in Slide 8 of Appendix III and 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 Productivity plan 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 above trajectory for the last 3 months but a reducing trend is observed. LOS for Non-trust beds is also on a reducing trend. The trajectories are based on patients 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.

Length of stay is actively reviewed via the weekly Patient Flow Group, which is operationally led and includes ward level deep dives and reviews of long stay patients to identify escalated action to support and facilitate discharge. This also includes CRFD patients.

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 being achieved. This can be found in Appendix III, slide 4; Adults/ Older Adult LOS Trajectory 2025/26.

## Talking Therapies – 2025/26 Recovery action plan

The MH Provider Collaborative issued a performance notice in September 2025 relating to underperformance in activity levels and reliable recovery and reliable improvement rates. A summary of the Trust's action plan is attached as Appendix IIIa.

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 outcomes rates
- Reducing DNA rates
- Reducing 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. The Provider Collaborative have confirmed a 0.68% uplift in the cost per case back dated to 1st April 2025 and these revised figures are reflected in the activity table with a financial activity performance deficit of £537,912 for April – December 2025. The service in agreement with the Provider Collaborative have also revised downwards their internal activity targets from November 2025.

Recovery rates for December have improved with the Reliable Improvement rate at 68.39% meeting the 68% target for 3 months in a row and Reliable Recovery Rate at 46.2% a deterioration from last month at 47.6% and remaining below the 50% target.

**Clinically Ready For Discharge (CRFD)** - bed days lost to CRFD increased in November to 14% from 9% in October and the latest Trust position is showing a small reduction to 13.31%. The main drivers for this are reduced delays in adult acute services. CRFD in December 2025 in Adult Acute & Urgent Care was at 13.7% - a 0.5% decrease (38 patients) and in Older Adult Services at 50.2% - a 1.4% increase (47 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.

### 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 areas for improvement.

Following FTB transfer, the BSMHFT informatics team have been undertaking a full review of FTB's reporting methodologies and data quality issues to establish and ensure consistency and alignment of reporting across CYP and Solar services. This work is being done in conjunction with the CYP service leads.

Board members are also 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. This has also been formally acknowledged in further discussion with NHSE and the MH Provider Collaborative Leads. It was therefore agreed that local Trust data would be used for contract monitoring until the national MHSDS reporting becomes reliable.

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 position 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 reduced and remains below the national target this month (December) the number of patients is small so a small change in the numerator will impact adversely. This has been impacted by DNA and patient cancelations.

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% (December) 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 December, there were two patients in spot purchase beds.

5. **Eliminate Out of Area admissions** – the number of out of area placements has increased to 5 from 0 for December.

**Quality -** The detailed position on these metric areas is discussed at QPES Committee. Data below based on December 2025 data.

- Incidents of Self Harm – Small decrease from 164 to 156 in December

- Psychological harm (staff/third party) has increased to 3% from 2.6% this month
- Physical restraints have decreased from 261 to 208 this month.
- Prone restraints have reduced from 40 to 30 in December
- Reported incidents in December have decreased to 2476 from 2619

**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.

Due to a national issue with ESR the sickness absence and appraisal data for December are not yet available.

- Bank and Agency WTE reduction – The figures for December show that bank WTE is above trajectory at 637.9 WTE and agency is above trajectory at 35.8 WTE

- Staff vacancy levels Vacancy rate at 7.3% in December- 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)

# Integrated Performance Dashboard

December 2025

HOME PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

Children & Young People | Specialties | Secure Services & Offender Health | Corporate

## Performance

| Measure | Value | Trend |
|---|---|---|
| Bed Occupancy (%) | 91 | |
| Clinically Ready for Discharge: Bed Days | 2163 | |
| Clinically Ready for Discharge: Bed Days (%) | 13 | |
| CPA 3 Day Follow Up (%) | 86 | |
| CPA 7 Day Follow Up (%) | 95 | |
| Eating Disorders: Waiting Time - Routine (%) | 90 | ↓ |
| Eating Disorders: Waiting Time - Urgent (%) | 100 | ↑ |
| First Episode Psychosis: Waiting Time (%) | 100 | |
| Out of Area: Inappropriate Placement Bed Days | 625 | |
| Out of Area: Inappropriate Placements Active | 17 | |
| People on CPA with a Formal Review in last 12 Months (%) | 94 | ↓ |
| Referrals over 3 Months with no Contact | 4036 | ↓ |
| Talking Therapies: Reliable Improvement Rate (%) | 68 | ↑ |
| Talking Therapies: Moving to Recovery (%) | 51 | |
| Talking Therapies: Reliable Recovery Rate (%) | 46 | |
| Talking Therapies: Seen in 18 Weeks (%) | 100 | ↑ |
| Talking Therapies: Seen in 6 weeks (%) | 96 | ↑ |

## People

| Measure | Value | Trend |
|---|---|---|
| Bank & Agency Fill Rate (%) | 91 | |
| Fundamental Training (%) | 94 | |
| Staff Turnover: Rolling 12m (%) | 5 | ↑ |
| Staff Vacancies (%) | 7 | ↑ |

## Quality

| Measure | Value | Trend |
|---|---|---|
| Absconsions from Inpatient Units | 0 | |
| Commissioner Reportable Incidents | 0 | |
| Community Confirmed Suicides | 0 | |
| Community Suspected Suicides | 0 | |
| Failure to Return | 15 | ↑ |
| Harm (physical) – patients (%) | 19 | |
| Harm (physical) – staff/third party (%) | 7 | |
| Harm (psychological) – patients (%) | 17 | |
| Harm (psychological) – staff/third party (%) | 3 | ↘ |
| Incidents of Self Harm | 156 | ↑ |
| Inpatient Confirmed Suicides | 0 | |
| Inpatient Suspected Suicides | 0 | |
| Ligature no Anchor Point | 12 | |
| Ligature with Anchor Point | 0 | |
| Patient Assaults | 45 | ↘ |
| Patient Assaults / 1000 OBDs | 2.3 | |
| Physical Restraints | 208 | |
| Physical Restraints / 1000 OBDs | 10.8 | |
| Prone restraints | 30 | ↗ |
| Prone restraints / 1000 OBDs | 1.6 | ↗ |
| Reported Incidents | 2476 | |
| Staff Assaults | 110 | |
| Staff Assaults / 1000 OBDs | 5.7 | |

## Sustainability

| Measure | Value | Trend |
|---|---|---|
| Agency as % of Pay Spend | 1 | ↑ |
| Agency Staff Spend | £330k | |
| Bank as % of Pay Spend | 9 | |
| Capital Expenditure | £2,220k | |
| Cost Improvement Programmes | £2,957k | ↑ |
| Group Cash Balance | £94,619k | |
| Info Governance (%) | 92 | |
| Operating Surplus | -£345k | ↓ |

| Key | Meaning |
|---|---|
| (pink) | Not meeting target |
| ↑ | Significant IMPROVEMENT |
| ↓ | Significant CONCERN |
| ↗ | Possible improvement |
| ↘ | Possible concern |

Last refreshed 14th Jan 2026

# Integrated Performance Dashboard

December 2025

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Secure Services & Offender Health

Corporate

| Measure | Latest Target | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 |
|---|---|---|---|---|---|---|---|
| Clinically Ready for Discharge: Bed Days | | 2339 | 2055 | 1614 | 1513 | 2211 | 2163 |
| Clinically Ready for Discharge: Bed Days (%) | | 14 | 13 | 10 | 9 | 14 | 13 |
| CPA 3 Day Follow Up (%) | 80 | 80 | 87 | 82 | 87 | 84 | 86 |
| CPA 7 Day Follow Up (%) | 95 | 90 | 95 | 90 | 95 | 90 | 95 |
| Eating Disorders: Waiting Time - Routine (%) | 95 | 80 | 100 | 100 | 100 | 100 | 90 ↓ |
| Eating Disorders: Waiting Time - Urgent (%) | 95 | | | | | 100 | 100 ↑ |
| First Episode Psychosis: Waiting Time (%) | 60 | 100 | 100 | 50 | 100 | 100 | 100 |
| Out of Area: Inappropriate Placement Bed Days | 328 | 435 | 346 | 370 | 515 | 662 | 625 |
| Out of Area: Inappropriate Placements Active | 10 | 12 | 8 | 11 | 21 | 24 | 17 |
| People on CPA with a Formal Review in last 12 Months (%) | 95 | 96 | 95 | 95 | 94 | 94 | 94 ↓ |
| Referrals over 3 Months with no Contact | | 3906 | 4054 | 3988 | 3998 | 3905 | 4036 ↓ |
| Talking Therapies: Reliable Improvement Rate (%) | 68 | 68 | 69 | 66 | 68 | 68 | 68 ↑ |
| Talking Therapies: Moving to Recovery (%) | 50 | 46 | 49 | 47 | 48 | 49 | 51 |
| Talking Therapies: Reliable Recovery Rate (%) | 50 | 44 | 47 | 45 | 45 | 48 | 46 |
| Talking Therapies: Seen in 18 Weeks (%) | 95 | 99 | 100 | 100 | 100 | 100 | 100 ↑ |
| Talking Therapies: Seen in 6 weeks (%) | 75 | 94 | 94 | 93 | 96 | 95 | 96 ↑ |

| Key | Meaning |
|---|---|
| (pink) | Not meeting target |
| ↑ | Significant IMPROVEMENT |
| ↓ | Significant CONCERN |
| ↗ | Possible improvement |
| ↘ | Possible concern |

# Integrated Performance Dashboard

December 2025

Birmingham and Solihull Mental Health
NHS Foundation Trust

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Trust

Acute & Urgent Care

ICCR

Children & Young People

Specialties

Secure Services & Offender Health

Corporate

| Measure | Latest Target | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 |
|---|---|---|---|---|---|---|---|
| Bank & Agency Fill Rate (%) | | 93 | 93 | 94 | 94 | 94 | 91 |
| Fundamental Training (%) | 95 | 92 | 93 | 94 | 94 | 94 | 94 |
| Staff Turnover: Rolling 12m (%) | | 5 | 5 | 5 | 5 | 5 | 5 ↑ |
| Staff Vacancies (%) | | 9 | 9 | 8 | 8 | 7 | 7 ↑ |

| Key | |
|---|---|
| (pink) | Not meeting target |
| ↑ | Significant IMPROVEMENT |
| ↓ | Significant CONCERN |
| ↗ | Possible improvement |
| ↘ | Possible concern |

# Integrated Performance Dashboard

ecember 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Specialties | Secure Services & Offender Health | Corporate

| Measure | Latest Target | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | |
|---|---|---|---|---|---|---|---|---|
| Absconsions from Inpatient Units | | 5 | 3 | 1 | 2 | 1 | 0 | |
| Commissioner Reportable Incidents | | 0 | 0 | 0 | 0 | 0 | 0 | |
| Community Confirmed Suicides | | 0 | 1 | 0 | 0 | 0 | 0 | |
| Community Suspected Suicides | | 3 | 2 | 2 | 1 | 0 | 0 | |
| Failure to Return | | 15 | 12 | 18 | 20 | 27 | 15 | ↑ |
| Harm (physical) – patients (%) | | 18 | 19 | 17 | 18 | 20 | 19 | |
| Harm (physical) – staff/third party (%) | | 5 | 5 | 5 | 6 | 7 | 7 | |
| Harm (psychological) – patients (%) | | 15 | 17 | 14 | 17 | 17 | 17 | |
| Harm (psychological) – staff/third party (%) | | 2 | 3 | 2 | 2 | 3 | 3 | ↘ |
| Incidents of Self Harm | | 163 | 159 | 84 | 108 | 164 | 156 | ↑ |
| Inpatient Confirmed Suicides | | 0 | 0 | 0 | 0 | 0 | 0 | |
| Inpatient Suspected Suicides | | 0 | 0 | 0 | 0 | 0 | 0 | |
| Ligature no Anchor Point | | 22 | 16 | 5 | 14 | 16 | 12 | |
| Ligature with Anchor Point | | 0 | 1 | 2 | 1 | 1 | 0 | |
| Patient Assaults | | 45 | 38 | 27 | 40 | 43 | 45 | ↘ |
| Patient Assaults / 1000 OBDs | | 2.3 | 2.0 | 1.5 | 2.1 | 2.3 | 2.3 | |
| Physical Restraints | | 246 | 283 | 211 | 256 | 261 | 208 | |
| Physical Restraints / 1000 OBDs | | 12.7 | 14.8 | 11.3 | 13.3 | 13.9 | 10.8 | |
| Prone restraints | | 40 | 48 | 51 | 48 | 40 | 30 | ↗ |
| Prone restraints / 1000 OBDs | | 2.1 | 2.5 | 2.7 | 2.5 | 2.1 | 1.6 | ↗ |
| Reported Incidents | | 2925 | 2735 | 2248 | 2699 | 2619 | 2476 | |
| Staff Assaults | | 96 | 86 | 79 | 126 | 108 | 110 | |
| Staff Assaults / 1000 OBDs | | 5.0 | 4.5 | 4.2 | 6.6 | 5.7 | 5.7 | |

| Key | |
|---|---|
| (pink) | Not meeting target |
| ↑ | Significant IMPROVEMENT |
| ↓ | Significant CONCERN |
| ↗ | Possible improvement |
| ↘ | Possible concern |

# Integrated Performance Dashboard

December 2025

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Children & Young People

Specialties

Secure Services & Offender Health

Corporate

| Measure | Latest Target | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | |
|---|---|---|---|---|---|---|---|---|
| Agency as % of Pay Spend | | 0 | 1 | 1 | 1 | 1 | 1 | ↑ |
| Agency Staff Spend | | £431k | £468k | £374k | £395k | £319k | £330k | |
| Bank as % of Pay Spend | | 9 | 11 | 8 | 8 | 10 | 9 | |
| Capital Expenditure | | £297k | £299k | £1,050k | £734k | £1,046k | £2,220k | |
| Cost Improvement Programmes | | £2,764k | £2,623k | £5,050k | £2,557k | £2,990k | £2,957k | ↑ |
| Group Cash Balance | | £83,825k | £97,920k | £89,383k | £101,115k | £101,385k | £94,619k | |
| Info Governance (%) | | 100 | 100 | 100 | 100 | 100 | 92 | |
| Operating Surplus | | -£528k | -£739k | -£1,389k | -£970k | -£487k | -£345k | ↓ |

| | |
|---|---|
| (pink) | Not meeting target |
| ↑ | Significant IMPROVEMENT |
| ↓ | Significant CONCERN |
| ↗ | Possible improvement |
| ↘ | Possible concern |

# Out of Area: Inappropriate Placements Active

December 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

Trust

Divisions

Services

Commentary

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

| Month | Value |
|---|---|
| Dec-23 | 13.0 |
| Jan-24 | 23.0 |
| Feb-24 | 15.0 |
| Mar-24 | 23.0 |
| Apr-24 | 23.0 |
| May-24 | 12.0 |
| Jun-24 | 17.0 |
| Jul-24 | 27.0 |
| Aug-24 | 23.0 |
| Sep-24 | 14.0 |
| Oct-24 | 17.0 |
| Nov-24 | 27.0 |
| Dec-24 | 21.0 |
| Jan-25 | 20.0 |
| Feb-25 | 25.0 |
| Mar-25 | 20.0 |
| Apr-25 | 12.0 |
| May-25 | 10.0 |
| Jun-25 | 12.0 |
| Jul-25 | 12.0 |
| Aug-25 | 8.0 |
| Sep-25 | 11.0 |
| Oct-25 | 21.0 |
| Nov-25 | 24.0 |
| Dec-25 | 17.0 |

Mean UCL LCL Value Concern Improvement Plan

| 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.<br>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.<br>Inappropriate out of area placements has fluctuated since January 2024 with large peaks and troughs. December has decreased to 17 placements with 6 in acute beds and 11 in PICU beds above the trajectory of 10 for December 2025. There were 8 inappropriate admissions during December, a reduction of 9 from last month with 3 acute and 8 PICU.<br>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 was due for sign off in November 2025, but following some queries will be resubmitted for sign off in January. If this was in place now we would have 9 'inappropriate' out of area placements at the end of December.<br>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 reduced from April - October 2025, after which an increase was observed with delay reasons attributed to community which is not in the Trust's immediate control. CRFD at 2163 overall in December with adults at 914 lost bed days which equates to 13.7%, a decrease of 0.5%. Adult bed occupancy has seen a decreased to 94.2% and length of stay has remained at an average of 107 days in December.<br>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. |
| 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 was due for sign off in November 2025, but following some questisons from the collaborative it will be resubmitted in January 2025 for sign off.<br><br>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:<br><br>Admission avoidance<br>• launch Recovery House as an alternative care setting, supporting admission avoidance<br>• Undertake Home treatment Staffing review<br>• To refresh Length of stay action plan in partnership with ICCR and other collegues as part of the work on the national Oversight Framework<br>Actions include: Recovery House has now opened, HTT business case developed to increase HTT capacity is being taken forward as assurance is built on financial improvments due to reductions in spot purchasing of beds<br><br>Inpatient Care & Reducing Length of Stay<br>• launch new framework contract for beds<br>• continued integration of CYP to ensure clinical prioritisatoipn of 18+ admissions<br>Actions include: Transition to new framework has comenced and monitoring in place to ensure that number of beds aligns to financial recovery trajectory. Monitored through patient flow group<br><br>Discharge Planning and Support<br>• Introduce tighter structure and mechanism for accountability, monitoring and reporting. Impact: Clear goals and processes in place for LOS and Discharge<br>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. Deep dive reviews of patients with long lengths of stay taking place with wards, to identify any issues which need escalating |
| 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

Birmingham and Solihull Mental Health NHS Foundation Trust

December 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

| Month | Bed Days |
|---|---|
| Dec-23 | 1329.0 |
| Jan-24 | 1415.0 |
| Feb-24 | 1375.0 |
| Mar-24 | 1461.0 |
| Apr-24 | 1334.0 |
| May-24 | 1559.0 |
| Jun-24 | 1546.0 |
| Jul-24 | 1689.0 |
| Aug-24 | 1603.0 |
| Sep-24 | 1933.0 |
| Oct-24 | 1909.0 |
| Nov-24 | 2117.0 |
| Dec-24 | 2300.0 |
| Jan-25 | 2140.0 |
| Feb-25 | 1968.0 |
| Mar-25 | 2716.0 |
| Apr-25 | 2405.0 |
| May-25 | 2543.0 |
| Jun-25 | 2242.0 |
| Jul-25 | 2339.0 |
| Aug-25 | 2055.0 |
| Sep-25 | 1614.0 |
| Oct-25 | 1513.0 |
| Nov-25 | 2211.0 |
| Dec-25 | 2163.0 |

Mean UCL LCL Value Concern Improvement Plan

| 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.<br>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. Between August 2025 - October there has been an overall decrease, but this was reversed in November with an increase to 2211 days. December has seen a decrease to 2163 with Adults moved from 932 days in November to 914 days in December, which related to 38 patients, with a main delay reason of Social Worker allocation and supported accommodation and older adults moved from 998 days inNovember to 1069 in December and related to 47 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 in place with 1 Social Worker allocated to Older Adults 3.5WTE for adults and 1 Homeless social worker have been recruited to.<br>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.<br>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 (%)

December 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

| Month | Value |
|---|---|
| Dec-23 | 62.4 |
| Jan-24 | 68.3 |
| Feb-24 | 63.7 |
| Mar-24 | 61.3 |
| Apr-24 | 61.1 |
| May-24 | 62.7 |
| Jun-24 | 60.3 |
| Jul-24 | 59.1 |
| Aug-24 | 61.1 |
| Sep-24 | 58.9 |
| Oct-24 | 58.6 |
| Nov-24 | 62.5 |
| Dec-24 | 61.1 |
| Jan-25 | 61.4 |
| Feb-25 | 59.3 |
| Mar-25 | 65.4 |
| Apr-25 | 66.8 |
| May-25 | 62.8 |
| Jun-25 | 66.3 |
| Jul-25 | 68.1 |
| Aug-25 | 68.6 |
| Sep-25 | 66.1 |
| Oct-25 | 68.5 |
| Nov-25 | 68.0 |
| Dec-25 | 68.4 |

Y-axis: 56, 58, 60, 62, 64, 66, 68, 70

Legend: Mean, UCL, LCL, Value, Concern, Improvement, Plan

| 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. December 2025 at 68.34% above the 68% target for the third month in a row. 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.<br><br>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.<br>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. Face to face groups including Step 3 Anxiety group and Compassion Focussed Therapy have commenced across areas in September and October 2025 to increase capacity. The DNA rate has started to fall and has been maintained at 11% in December 2025 for the third month in a row. |
| 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 (%)

December 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Trust

Divisions

Services

Commentary

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

| Month | Value |
|---|---|
| Dec-23 | 47.1 |
| Jan-24 | 44.3 |
| Feb-24 | 44.8 |
| Mar-24 | 40.8 |
| Apr-24 | 43.4 |
| May-24 | 45.3 |
| Jun-24 | 42.1 |
| Jul-24 | 43.7 |
| Aug-24 | 44.5 |
| Sep-24 | 40.3 |
| Oct-24 | 40.3 |
| Nov-24 | 44.0 |
| Dec-24 | 45.5 |
| Jan-25 | 44.6 |
| Feb-25 | 46.0 |
| Mar-25 | 44.4 |
| Apr-25 | 45.0 |
| May-25 | 42.9 |
| Jun-25 | 43.6 |
| Jul-25 | 43.9 |
| Aug-25 | 46.5 |
| Sep-25 | 44.9 |
| Oct-25 | 45.2 |
| Nov-25 | 47.6 |
| Dec-25 | 46.2 |

Mean · UCL · LCL · Value · Concern · Improvement · Plan

| 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. December 2025 position has seen an decrease to 46.18%, 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.<br>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.<br>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. Face to face groups including Step 3 Anxiety group and Compassion Focussed Therapy have commenced across areas in September and October 2025 to increase capacity. The DNA rate has started to fall and has been maintained at 11% in December 2025 for the third month in a row. |
| 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. |

# Fundamental Training (%)

December 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

| Month | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Value | 92.8 | 92.5 | 92.4 | 92.8 | 93.4 | 94.1 | 91.5 | 92.8 | 93.3 | 93.1 | 93.6 | 94.3 | 94.3 | 94.8 | 95.4 | 95.6 | 95.6 | 93.8 | 92.7 | 91.9 | 92.7 | 93.7 | 94.3 | 93.8 | 94.2 |

Mean UCL LCL Value Concern Improvement Plan

| Question | Answers |
|---|---|
| A: What has happened? | Fundamental Training compliance increased from 93.8% in November to 94.2% in December, falling below the Trust's 95% target for substantive staff, though remaining above the Commissioners' target.<br><br>Areas currently below 95% compliance include:<br>- Chief Exec - 76.6%,<br>- CYP - 84%<br>-ICCR- 94.3%<br>- Medical - 94.7%<br>-Acute and Urgent Care - 94.4%<br>- New Care Models - 91%,<br>- Strat and People - 94.6%<br>-Trustwide- 74.6%<br><br>Temporary staffing compliance has increased from 87.8% to 90%, 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, Moving and handling level 2 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 (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 - 86.7%, M&H Level 2-82.3% PS L2 - 87.7%, ELS - 76.5%, ILS - 72.6%, SRS 72.4%, Care Certificate 86.6% |
| 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.<br><br>• 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.<br><br>• The Trust is adding more FT training on the traffic light and this can impact on the overall Trust compliance.<br><br>• 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.<br><br>• 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.<br><br>• Business as usual activities are in place such as<br>o emailing employees and managers to inform them of DNAs and requesting they re-book<br>o reminder emails to both employees and managers regarding training that is booked.<br>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<br>o Monthly chase up emails to those who have expired or approaching expiry to book onto training<br><br>• 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 , M&H level 2 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

December 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

| Month | Value |
|---|---|
| Dec-23 | 150.0 |
| Jan-24 | 160.0 |
| Feb-24 | 161.0 |
| Mar-24 | 199.0 |
| Apr-24 | 162.0 |
| May-24 | 166.0 |
| Jun-24 | 230.0 |
| Jul-24 | 227.0 |
| Aug-24 | 208.0 |
| Sep-24 | 218.0 |
| Oct-24 | 234.0 |
| Nov-24 | 192.0 |
| Dec-24 | 114.0 |
| Jan-25 | 224.0 |
| Feb-25 | 205.0 |
| Mar-25 | 223.0 |
| Apr-25 | 213.0 |
| May-25 | 156.0 |
| Jun-25 | 111.0 |
| Jul-25 | 163.0 |
| Aug-25 | 159.0 |
| Sep-25 | 84.0 |
| Oct-25 | 108.0 |
| Nov-25 | 164.0 |
| Dec-25 | 156.0 |

Mean UCL LCL Value Concern Improvement Plan

# Harm (psychological) – staff/third party (%)

December 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Trust

Divisions

Services

Commentary

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

| Month | Value |
|---|---|
| Dec-23 | 1.7 |
| Jan-24 | 2.1 |
| Feb-24 | 3.2 |
| Mar-24 | 2.8 |
| Apr-24 | 2.8 |
| May-24 | 2.1 |
| Jun-24 | 2.1 |
| Jul-24 | 1.7 |
| Aug-24 | 1.9 |
| Sep-24 | 1.5 |
| Oct-24 | 1.5 |
| Nov-24 | 1.9 |
| Dec-24 | 1.7 |
| Jan-25 | 1.2 |
| Feb-25 | 1.5 |
| Mar-25 | 1.5 |
| Apr-25 | 2.1 |
| May-25 | 1.6 |
| Jun-25 | 2.1 |
| Jul-25 | 1.6 |
| Aug-25 | 2.6 |
| Sep-25 | 1.8 |
| Oct-25 | 1.9 |
| Nov-25 | 2.6 |
| Dec-25 | 3.0 |

Mean · UCL · LCL · Value · Concern · Improvement · Plan

# Physical Restraints

December 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

| Month | Value |
|---|---|
| Dec-23 | 224.0 |
| Jan-24 | 213.0 |
| Feb-24 | 217.0 |
| Mar-24 | 277.0 |
| Apr-24 | 183.0 |
| May-24 | 200.0 |
| Jun-24 | 315.0 |
| Jul-24 | 312.0 |
| Aug-24 | 364.0 |
| Sep-24 | 285.0 |
| Oct-24 | 343.0 |
| Nov-24 | 266.0 |
| Dec-24 | 232.0 |
| Jan-25 | 227.0 |
| Feb-25 | 293.0 |
| Mar-25 | 347.0 |
| Apr-25 | 277.0 |
| May-25 | 259.0 |
| Jun-25 | 246.0 |
| Jul-25 | 246.0 |
| Aug-25 | 283.0 |
| Sep-25 | 211.0 |
| Oct-25 | 256.0 |
| Nov-25 | 261.0 |
| Dec-25 | 208.0 |

Mean UCL LCL Value Concern Improvement Plan

# Prone restraints

December 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

| Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 56.0 | 50.0 | 44.0 | 47.0 | 35.0 | 49.0 | 41.0 | 67.0 | 35.0 | 43.0 | 74.0 | 49.0 | 42.0 |

| Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 56.0 | 67.0 | 77.0 | 57.0 | 56.0 | 38.0 | 40.0 | 48.0 | 51.0 | 48.0 | 40.0 | 30.0 |

Y-axis: 20, 40, 60, 80

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

# Reported Incidents

December 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

| Month | Value |
|---|---|
| Dec-23 | 2276.0 |
| Jan-24 | 2413.0 |
| Feb-24 | 2180.0 |
| Mar-24 | 2377.0 |
| Apr-24 | 2205.0 |
| May-24 | 2233.0 |
| Jun-24 | 2555.0 |
| Jul-24 | 2738.0 |
| Aug-24 | 2548.0 |
| Sep-24 | 2350.0 |
| Oct-24 | 2728.0 |
| Nov-24 | 2715.0 |
| Dec-24 | 2418.0 |
| Jan-25 | 2654.0 |
| Feb-25 | 2432.0 |
| Mar-25 | 2631.0 |
| Apr-25 | 2540.0 |
| May-25 | 2617.0 |
| Jun-25 | 2799.0 |
| Jul-25 | 2925.0 |
| Aug-25 | 2735.0 |
| Sep-25 | 2248.0 |
| Oct-25 | 2699.0 |
| Nov-25 | 2619.0 |
| Dec-25 | 2476.0 |

Y-axis: 1800, 2000, 2200, 2400, 2600, 2800, 3000, 3200

Legend: Mean, UCL, LCL, Value, Concern, Improvement, Plan

Appendix I FPPC 22nd January 2025

# NHSE 2025/26
# Quarter 2
# National Oversight Framework

compassionate

# Latest Position as at December 2025

- Nationally Q2 data published on 11th December on the public facing dashboard – see Slide 3 below.
- BSMHFT Q2 NOF score remains in **Segment 4**: Low performing.
- BSMHFT's Q2 rank position has improved from 55/61 at Q1 to **51/61.**
- The **average metric score** has reduced by 0.14 from the previous quarter to 2.76% (positive improvement)
- Trust focus on following 5 NOF metrics as these can be influenced by in year action:
  - ➢ Annual change in number of CYP accessing NHS-funded MH services
  - ➢ Percentage of inpatients with >60-day length of stay (Adults – 18-64 years)
  - ➢ Percentage of patients in crisis to receive face-to-face contact within 24 hours
  - ➢ Sickness absence rate - Quarterly aggregated monthly figures
  - ➢ Variance year-to-date to financial plan - YTD
- New contextual measures published in Q2 for first time on Model Hospital only (see slides 12 &13)
- NHSE monthly Performance Review meetings with Executive Team in place.
  *Note - Agenda is wider than NOF metrics.*

# NOF 'Overall Score' Metrics – 2025 Q2 Public Data



Birmingham and Solihull Mental Health NHS Foundation Trust

| Domain | Metric | Q1 Value | Q1 Rating (Public) | Rank Q1 | Period | Q2 Value | Q2 Rating (Public) | Rank Q2 | Portfolio | Definition |
|---|---|---|---|---|---|---|---|---|---|---|
| Access | Annual change in number of CYP accessing NHS-funded MH services | 2.65% | Below Average | 28/46 | Jun 25 | No data | No data | N/A | Director of Operations | % change of people <18 with 1+ contact vs previous year. Unique patient count |
| Effectiveness & experience of care | Percentage of inpatients with >60-day length of stay | 35.34 % | Low Performing | 47/47 | Sept 25 | 38.52 % | Low Performing | 46/47 | Medical Director & Director of Operations | Adult acute inpatients (18-65) with LOS over 60 days at discharge |
| | Community mental health survey satisfaction rate | 6.4 | Better than expected | | 2024 | 6.4 | | | Director of Operations | Banded score for section 12 - overall experience |
| Patient Safety | CQC safe inspection score (if awarded within the preceding 2 years) | No data | | | | | | | | |
| | Percentage of patients in crisis to receive face-to-face contact within 24 hours | 49% | Below Average | 32/45 | Sept 25 | 49.63 % | Below average | 38/48 | Director of Operations | % of new urgent referrals to crisis services with first F:F contact within 24 hours |
| | NHS Staff Survey – Raising concerns sub score | 6.41 | Low Performing | 53/61 | 2024 | 6.41 | Low Performing | 53/61 | Director of People and Partnerships | Staff Survey sub score using questions: 20a/b/25e/25f |
| People & Workforce | Sickness absence rate | 5.63% | Below Average | 30/61 | Jun 25 | 5.12% | Below Average | 32/61 | All Executive Directors | FTE No of days sick/FTE no of days available excludes bank/honorary |
| | NHS staff survey engagement theme score | 7.07 | Below Average | 34/61 | 2024 | 7.07 | Below Average | 34/61 | Director of People and Partnerships | Aggregation for sub scores covering motivation, involvement and advocacy |
| Finance & productivity | Planned surplus/deficit | 0.58% | On Plan | 9/61 | Apr 25 | 0.58% | On plan or better | 10/61 | Director of Finance | Base on annual financial plan returns |
| | Variance year-to-date to financial plan | -1.97% | Greater then 1% | 60/61 | Sept 25 | -0.78% | Between 0.5% and 1% variance | 58/61 | Director of Finance | The variance between planned surplus/deficit at the current month and the actual surplus/deficit figure |
| | Relative difference in costs | | Above Average | 21/60 | Mar 25 | 94.57 % | Above Average | 13/61 | Director of Finance | National Cost Collection Index (interim measure) |

# National Oversight Framework – Trust Action Plans



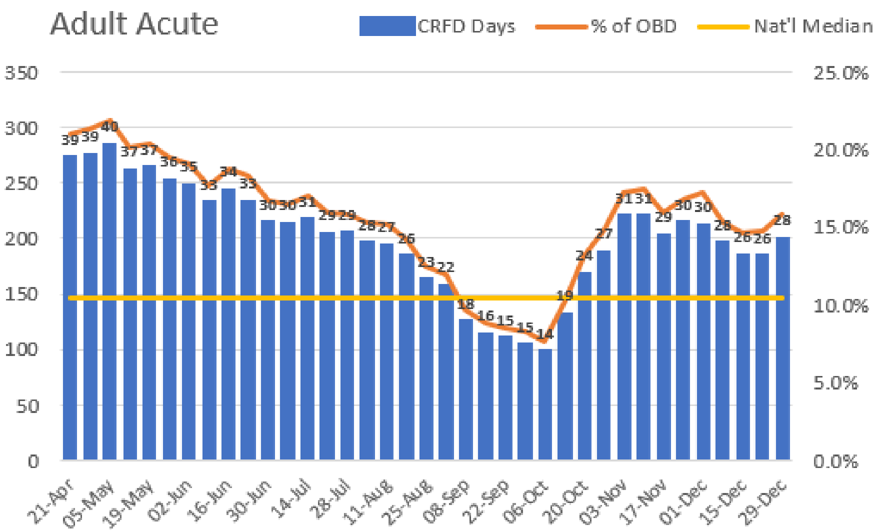
NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

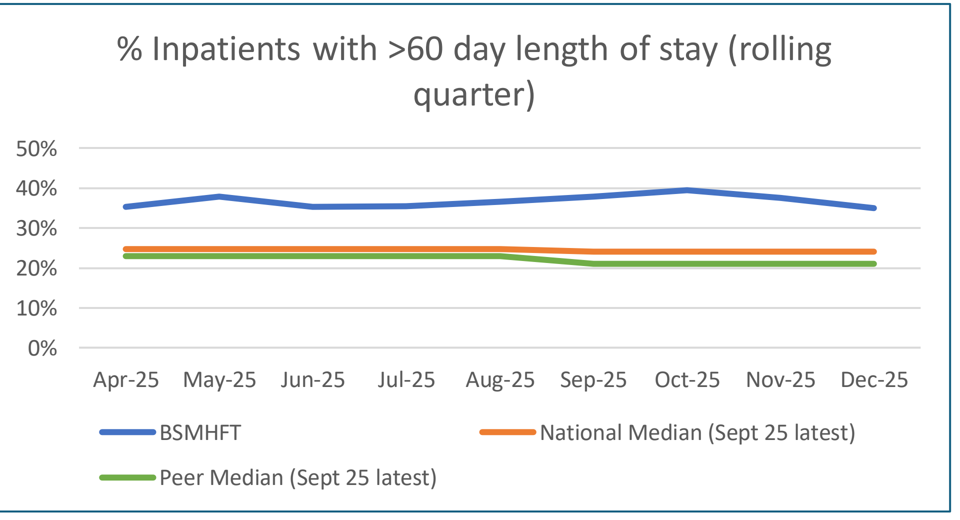
- **Targeted operational action plans developed for**:
  - % Adult Acute discharges with LoS >60 days
  - % Crisis Referrals seen F-F in 24 hours
- **Annual change in CYP numbers seen** – national MHSDS includes new CYP division data from 1st July. HOWEVER, as there was a significant improvement observed in NOF data due TO CYP achieving improved year on year access rates, this was viewed as being a data quality issue and unfortunately Q2 data for the Trust was not published. NHSE leads have acknowledged that the increase represents an accurate position, but the NOF publication was not changed for Q2. It is expected that we will see this reflected in the Q3 publication and an improved quartile position being achieved as a result.
- **Sickness Absence rate** – Good alignment between national data (used for NOF) and local Trust data. As Trust sickness absence rate is showing upward trend, this is likely to have a negative impact on future BSMHFTs NOF score. Trust action plans reviewed via the People Committee.
- **Financial metrics** – Q2 saw improvement, see finance report for detail.

# % Adult (18-64 yrs) Acute discharges with LoS >60 days

- Q1 & Q2 NOF segmentation score: **4** – Lowest performing
- Note accelerated discharge of long stay patients will initially impact negatively on this measure.
- Impact of CRFD on LOS – continuing challenge, - see chart.
- Regular tracking of progress of actions being managed by the Patient Flow LOS Steering Group chaired by AD for Acute & Urgent Care.

  Includes ward level deep dives on individual patient LOS to enable escalation where appropriate.
- Granular level data provided to support operational and clinical oversight.
- Q3 Trust trend is showing a small reduction.

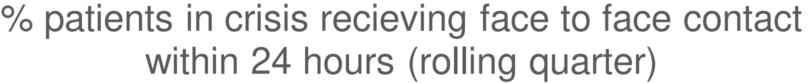


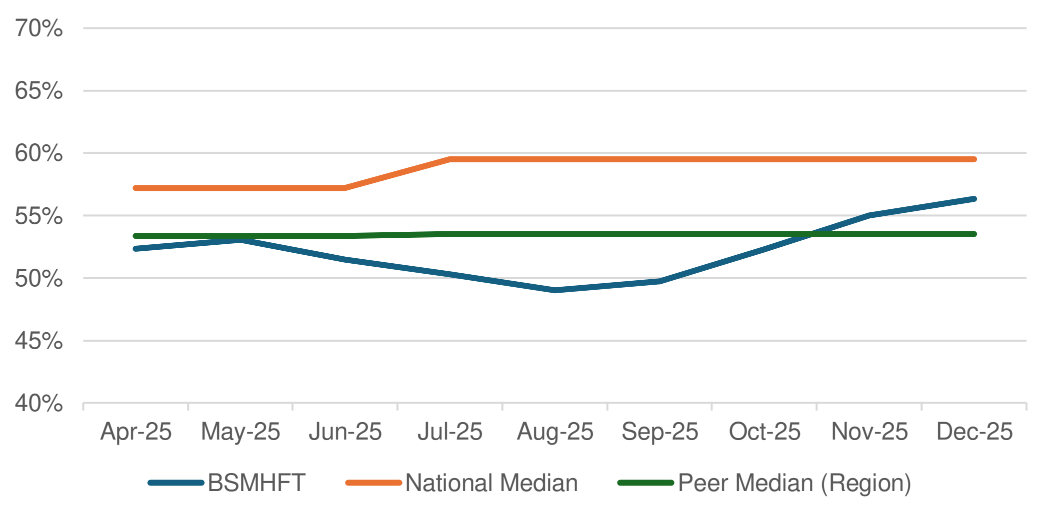



Birmingham and Solihull Mental Health NHS Foundation Trust

# % Crisis Referrals seen Face to Face in 24 hours

- Q2 NOF Trust position at 49.63%, national median at 59.5%.
- Targeted initial action plan developed and implemented jointly by the Information Team with Acute & Urgent Care Operational Lead.
- Definitions of ‘urgent’ referrals were reviewed and implemented from 1st November 2025.
- Local granular level data report available to teams and clinicians to enable proactive action.
- Significant data quality work undertaken by the service to address recording requirements.
- Internal Q3 Trust data shows improved performance to 56.3%, largely driven by Adult Home Treatment Teams.
- Based on our current Q3 score we expect to move from 3rd to 2nd quartile in the next national publication subject to no change in other Trust performance.

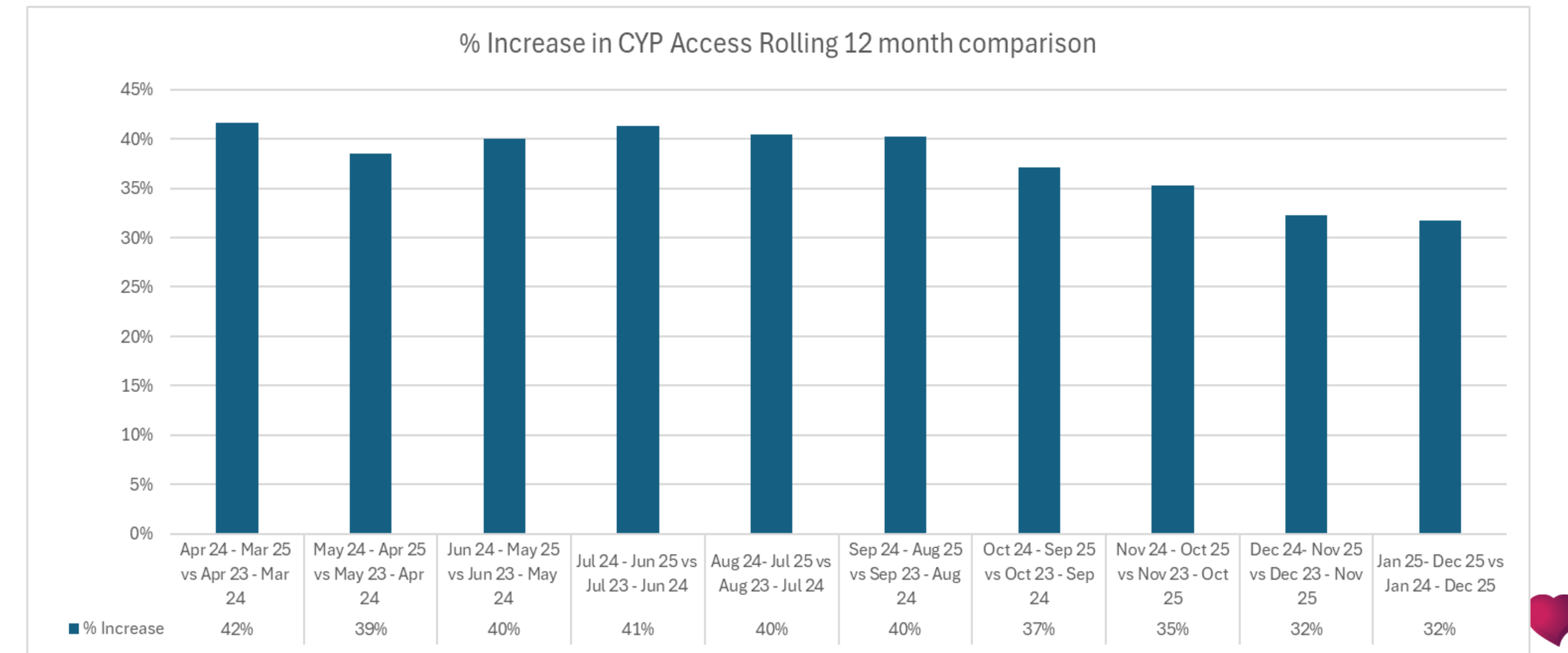


# Annual change in CYP numbers seen

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

- 12 month rolling year on year comparison – measure based on annual % change/improvement on previous year.
- Q1 NOF score based on BSMHFT data only (excluded FTB CYP) – performance below average.
- Q2 data included CYP but was suppressed for NOF as NHSE presumed any improvement of over 30% would be a data quality issue. To be amended going forwards. NHSE leads have acknowledged that the increase represents an accurate position. It is expected that we will see this reflected in the Q3 publication and an improved quartile position being achieved as a result.
- Inclusion of CYP division data has impacted positively on Trust performance (see chart below). This is due to the CYP division substantially increasing contacts and access rates in the last year. Expect to be in 'high performing' quartile for this metric from Q3 onwards.

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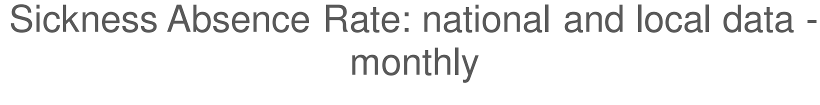
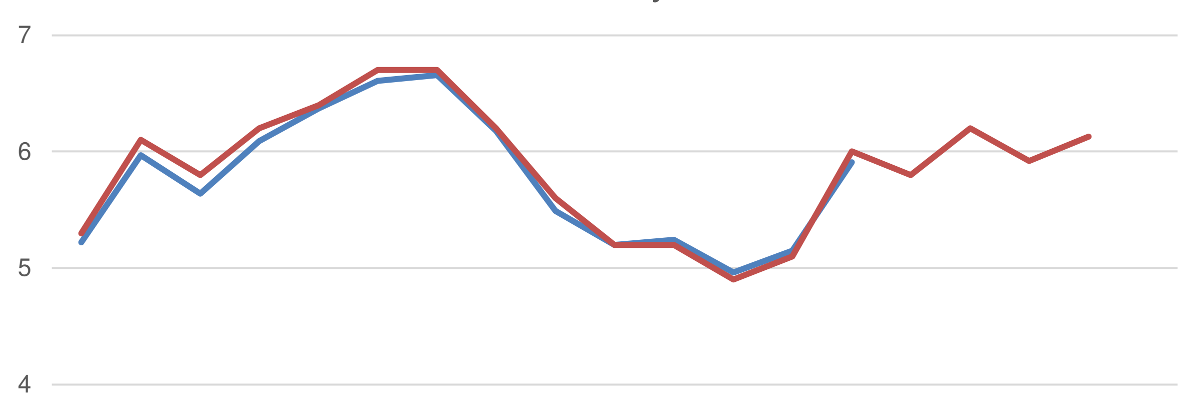
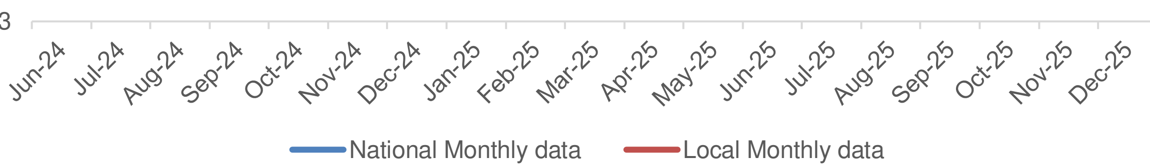
# Sickness Absence rate




Sickness Absence rate – NOF data source is ESR. All Trust's data published monthly on NHSE Digital website.
Good alignment between this data and local Trust data.
The NOF indicator is based on quarterly, figures. **Q2 based on Apr-June 2025.**

Note: – Latest available national data is as at July 2025.
The graph above shows good alignment between national and local Trust data but continued increase in Trust sickness absence levels as shown above is likely to impact negatively in future NOF publications subject to how other Trusts perform.

**Apr-June 2025 – Q2 NOF position:**

Trust metric value: 5.12%
National Average: 5.10%
NOF segmentation score: **2.88** – Below Average.

# Finance

## Planned Surplus/Deficit:

- Trust metric value: 0.58%
- National Average: 0.00%
- NOF segmentation score: **1** – no planned deficit - unchanged

## Variance YTD to financial plan:

- Trust metric value: -0.78 to month 6 (from1.97%)
- National Average: 0.00%
- NOF segmentation score: **3** – between 0.5% and 1% negative variance
- Improvement from Q1 score of 4

## **Combined finance Score** (combining planned and actual)

- NOF segmentation score: Improved to 2 (from 3) – above average
- ***Trust Plan*** that combined score achieves quartile **2** in Q2 (achieved) and forecasting quartile **1** in Quarters 3-4

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# Finance: Relative difference in costs

- Trust metric value: 94.57%
- National Average: 104.85%
- NOF segmentation score: 1.60 – **Above average**
- Q2 decrease of 3.12%

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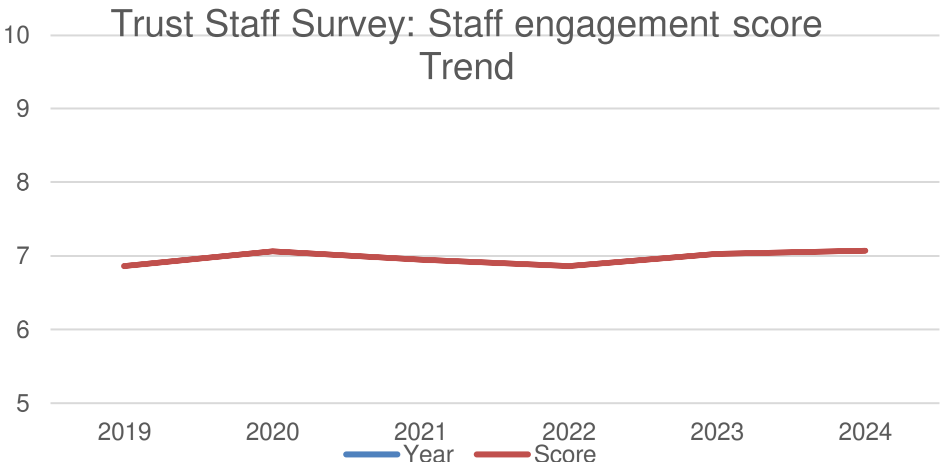
# Annual NOF measures – BSMHFT position including Year on Year Trends

Birmingham and Solihull Mental Health NHS Foundation Trust

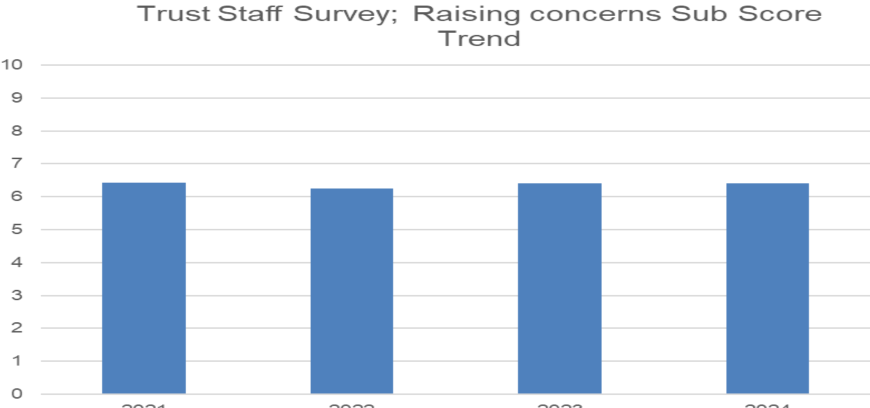
## Staff Survey Engagement Score

**NOF score – Below average**

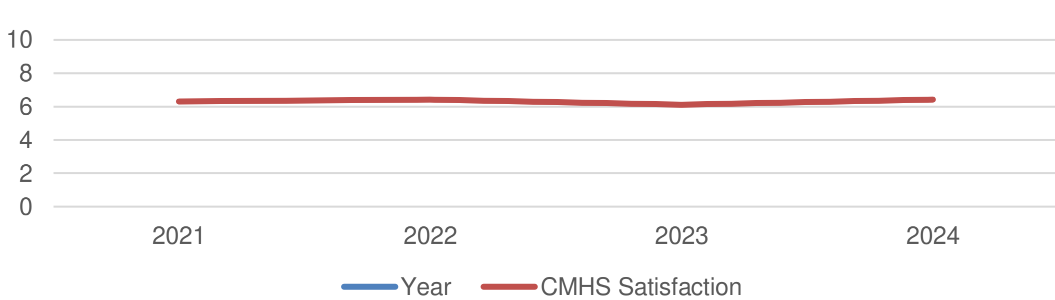



## Staff Survey Raising Concerns

**NOF score – below average**

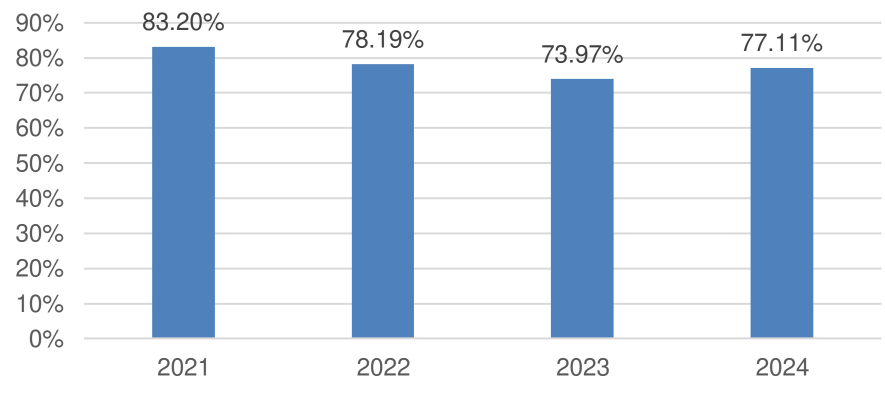



## Community Mental Heath Survey Satisfaction rate




## National Education and Training 'overall experience' score

**BSMHFT position Quartile 3 (Mid-High) (non-Scoring)**




**Year on Year no material change in trends to date on the 3 scoring measures**

# NEW - Additional Non scoring contextual measures – data published on Model Hospital site as at 2/12/25

Additional non scoring contextual measures have been published on the Model hospital for the first time.

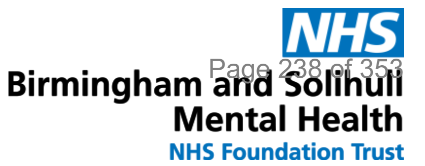
*The Access measures are not RAG rated.

**Local trust data to be shared and Trust actions plans to be raised and discussed with Service Leads.**

| Domain | Metric | Period | Q2 Value | Rating | BSMHFT national position | Definition |
|---|---|---|---|---|---|---|
| Access * | Percentage increase in Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses | Jun 25 | 0.90% | | Quartile 2 (mid – Low) | Percentage increase of people who received 2 or more contacts from NHS community MH services for Adults and Older Adults with Severe Mental Illnesses in rolling 12-month period |
| | Proportion of patients with an open suspected autism referral in the month open for at least 13 weeks with no care contact recorded | Mar 24 | 36% | | Quartile 1 (lowest) | Proportion of patients with an open suspected autism referral in the month that has been open for at least 13 weeks that have not had a care contact recorded. |
| Patient Safety | Rate of restrictive intervention use | June 25 | 20 | G | Quartile 2- (Mid– Low) | Rate of restrictive interventions per 1,000 inpatient mental health, learning disability and autism ward bed days. |
| People | National education and training Survey “overall experience” score | 2024 | 77.11 | G | Quartile 3 – (Mid-High) | Annual survey |

# Improving health and reducing inequality (contextual measures and non scoring)






| Domain | Metric | Period | Q2 Value | Rating | National BSMHFT position | Definition |
|---|---|---|---|---|---|---|
| Improving Population health | NHS Talking Therapies reliable recovery rate | Jun 25 | 43% | R | Quartile 1 - lowest 25% | Proportion of referrals to NHS Talking Therapies with a discharge date in the period that finished a course of treatment and showed reliable recovery. |
| Reducing Inequality | Older Adults Percentage of inpatients aged over 65 with >90-day length of stay | June 25 | 51.11% | R | Quartile 4 - highest 25% | Proportion of people discharged in the period from older adult acute beds aged 65 years and over with a length of stay of 90+ days. |

Appendix II - FPPC 23rd October 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 | Nov-25 | Dec-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 | 5 | 5 | ⇧ | 15 | 0 | | | |
| Increase CYP accessing services (MHSDS figures, month behind) | 18163 | 18163 | 12865 | 13590 | 14270 | 13828 | 13875 | 14013 | 14226 | 14868 | 14051 | | | 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% | 81% | 53% | -28% | ⇩ | 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% | 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% | 73.0% | 80.0% | 100.0% | 66.7% | 100.0% | 57.1% | 100.0% | 43% | ⇧ | 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% | 54.5% | 66.7% | -7% | ⇩ | 50% | 60% | | | |
| IAPT Six Weeks** | 75% | 75% | 81.0% | 84.0% | 80.0% | 80.6% | 75.2% | 83.3% | 81.7% | 81.5% | 77.9% | -4% | ⇩ | 65% | 75% | | | |
| IAPT 18 Weeks** | 95% | 95% | 98.0% | 97.0% | 96.0% | 98.3% | 98.1% | 98.6% | 98.1% | 97.3% | 99.0% | 2% | ⇧ | 85% | 95% | | | |
| IAPT Moving to Recovery Rate** | 50% | 50% | 48.0% | 49.0% | 45.0% | 55.2% | 53.4% | 59.0% | 51.2% | 50.8% | 54.2% | 3% | ⇧ | 40% | 50% | | | |
| Non Contract >18 beds charged for (avge of wkly snapshot)* | zero | | 19 | 16 | 14 | 12 | 7 | 6 | 4 | 5 | 2 | -3 | ⇩ | 10 | 0 | n/a | n/a | |
| All >18 beds charged for (avge of weekly snapshot)* | 92 | | 74 | 72 | 68 | 65 | 71 | 66 | 70 | 67 | 53 | -14 | ⇩ | 105 | 92 | n/a | n/a | |

CYP access figure is draft as provider activity awaited. Final figure will show an increase

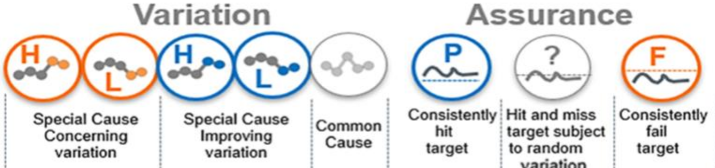
inclusive

# Statistical Process Control - Key

| | SPC Variation/Performance Icons | |
|---|---|---|
| **Icon** | ***Technical Description*** | ***What does this mean?*** |
| | Common cause variation, NO SIGNIFICANT CHANGE. | This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself. |
| | Special cause variation of an CONCERNING nature where the measure is significantly HIGHER. | **Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers. |
| | Special cause variation of an CONCERNING nature where the measure is significantly LOWER. | **Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers. |
| | Special cause variation of an IMPROVING nature where the measure is significantly HIGHER. | **Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done! |
| | Special cause variation of an IMPROVING nature where the measure is significantly LOWER. | **Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done! |
| | Special cause variation of an increasing nature where UP is not necessarily improving nor concerning. | **Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers. |
| | Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning. | **Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers. |

| | SPC Assurance Icons | |
|---|---|---|
| **Icon** | ***Technical Description*** | ***What does this mean?*** |
| | This process will not consistently HIT OR MISS the target as the target lies between the process limits. | The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random. |
| | This process is not capable and will consistently FAIL to meet the target. | The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved. |
| | This process is capable and will consistently PASS the target if nothing changes. | The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved. |

Summary icons key





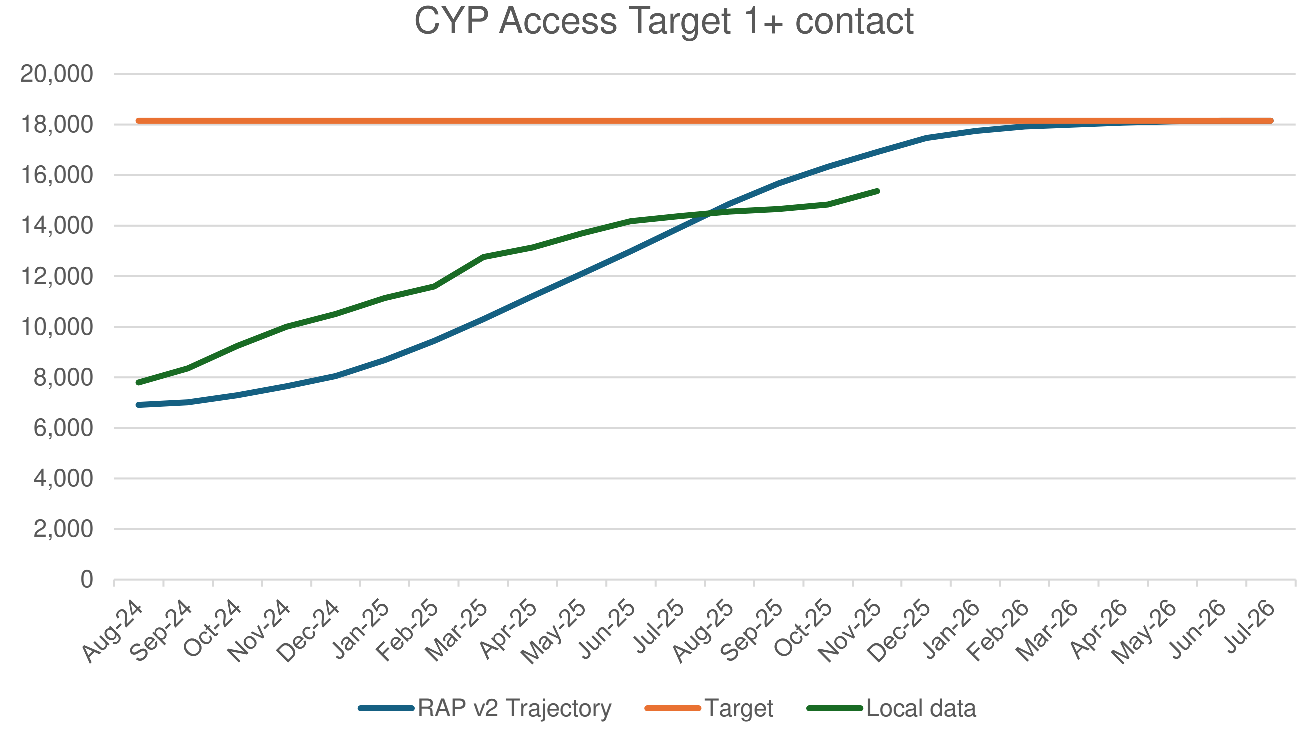
An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation. It includes a mean and two process limits which are both used in the statistical interpretation of the data.
The following generate alerts regarding variation in the chart

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

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

# CYP Access target update

# CYP Access target 1+ contact Recovery Action Plan




- Actual performance has been below improvement trajectory but is now on an upward trend. December’s final figure not yet available
- A contributing factor relates to the identification of double counting across providers which has now been removed

Appendix III - FPPC 22nd January 2026

# 2025/26 Performance metrics Improvement Trajectory updates

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

Birmingham and Solihull Mental Health NHS Foundation Trust

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.

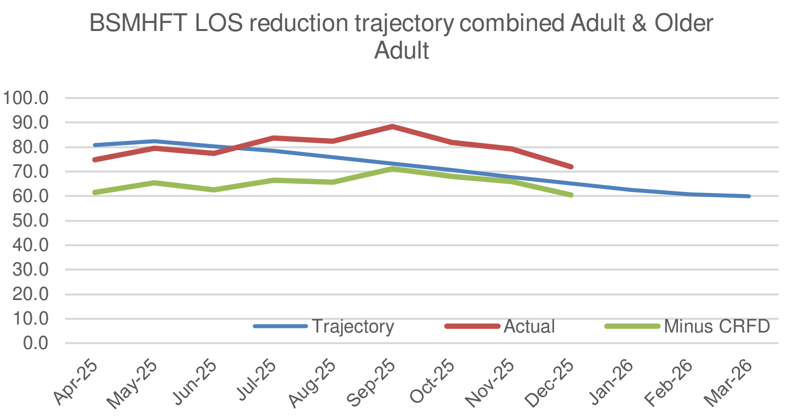
NHSE methodology – Factors to note:

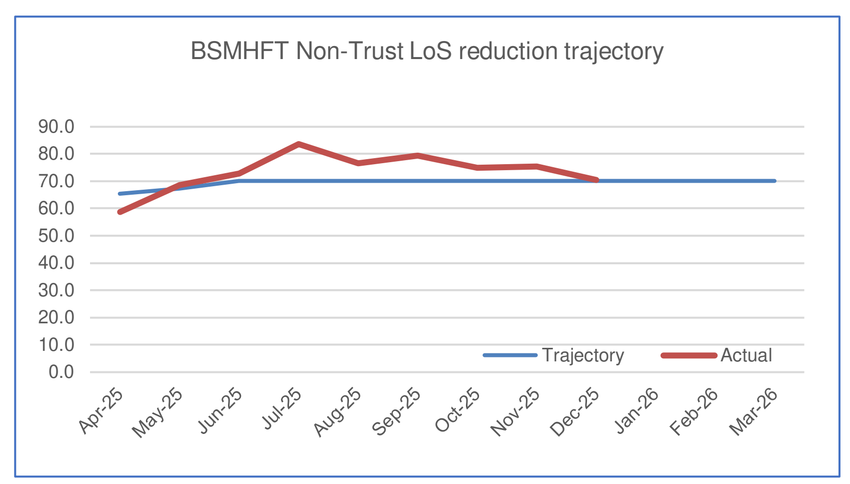
- As the methodology is based on discharge, discharging service users with long lengths of stay will have a negative impact on performance against trajectory.
- Achieving significant length of stay reductions on this methodology will require more discharges of people with longer lengths of stay during 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



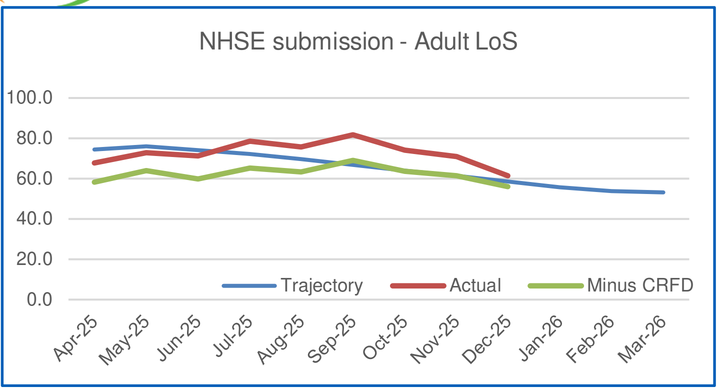




A downward trend is observed for the Trust’s 3-month rolling length of stay non Trust LOS with a recent reduction being observed.

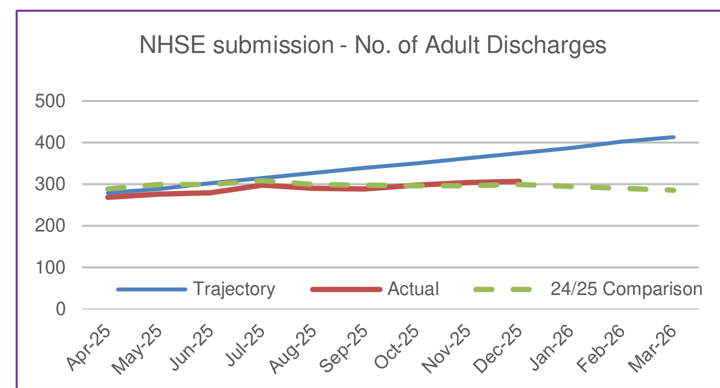
NHSE Methodology: Based on:
- Discharged patients
- Rolling 3 month view
- Entire inpatient spell
- Trust, FTB and BSMHFT non-Trust spells are separate
- Includes leave

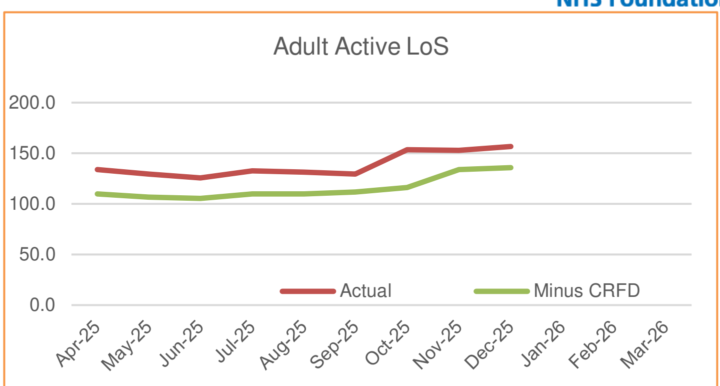
**NEW – As requested at June 2025 FPPC meeting, additional data has been added (see next slide 4) which includes the NHSE LOS measures based on ‘active’ current length of stay position as well as showing the impact of CRFDs on LOS.**

# Adults/ Older Adult LOS Trajectory 2025/26

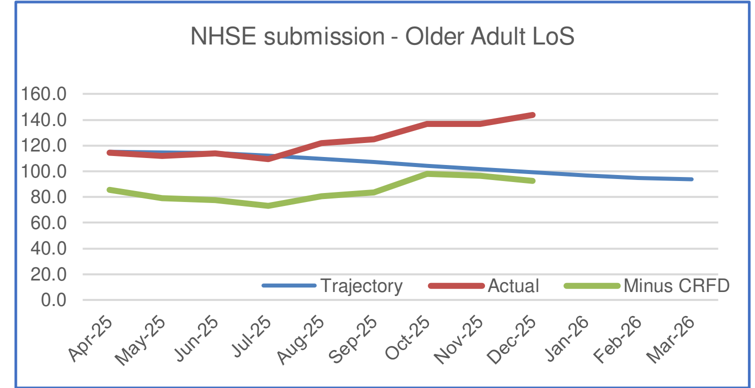



*length of Stay- 3 month rolling based on discharge*

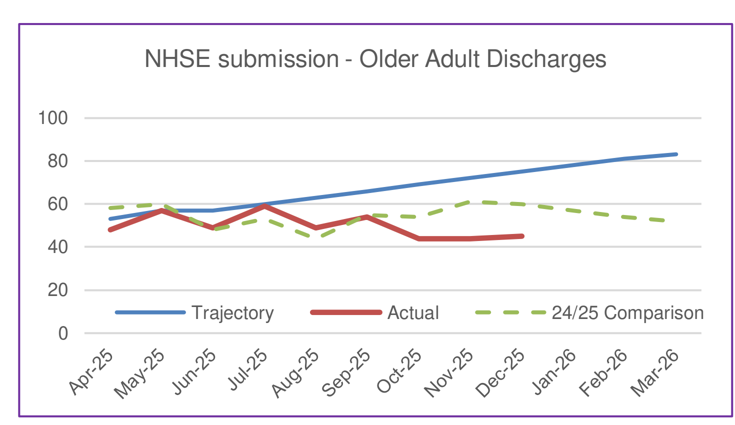


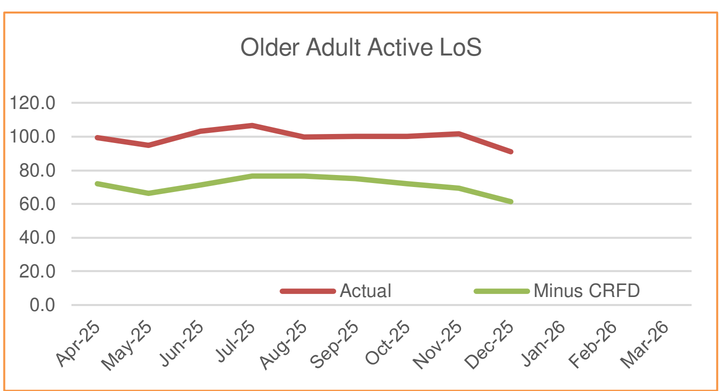




*Current length of Stay- month end figures*




*length of Stay- 3 month rolling based on discharge*




*Current length of Stay- month end figures*

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

**'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. .

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**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.**

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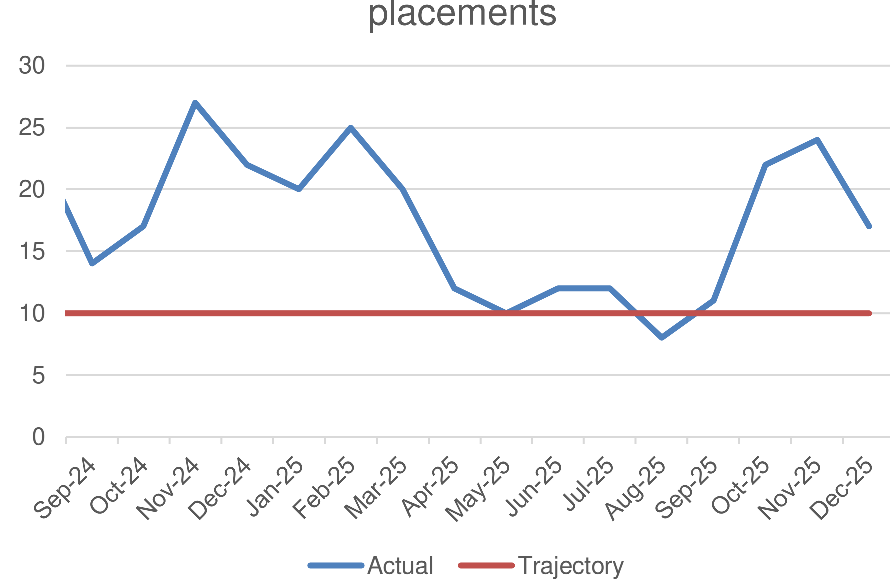
# Active Inappropriate Out of Area Placements



Birmingham and Solihull Mental Health NHS Foundation Trust




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 January 2026. If approved, these placements will be categorized as being appropriate.

December 2025 position – Total inappropriate number of placements at 17 (target 10), 6 acute (target 0) and 11 PICU (target 10).

However, if the patients in Cygnet beds were classed as 'appropriate', there would be 4 'inappropriate' PICU out of area placements at the end of December, meeting the NHSE target.

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.

Clinically Ready for Discharge (CRFD) patients not within Trust control, particularly social care and housing remain a challenge, however overall CRFDs have reduced and this is supporting patient flow/capacity and reduction in the number of all out of area placements.

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# Inappropriate Out of Area Placements - BSMHFT

Total

Acute

PICU

Admissions to Cygnet hospitals, highlighted in green. These are 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. 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. Deep dives are taking place for patients with long lengths of stay to identify any issues for escalation.

# Workforce trajectories – 2025/26 update.

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

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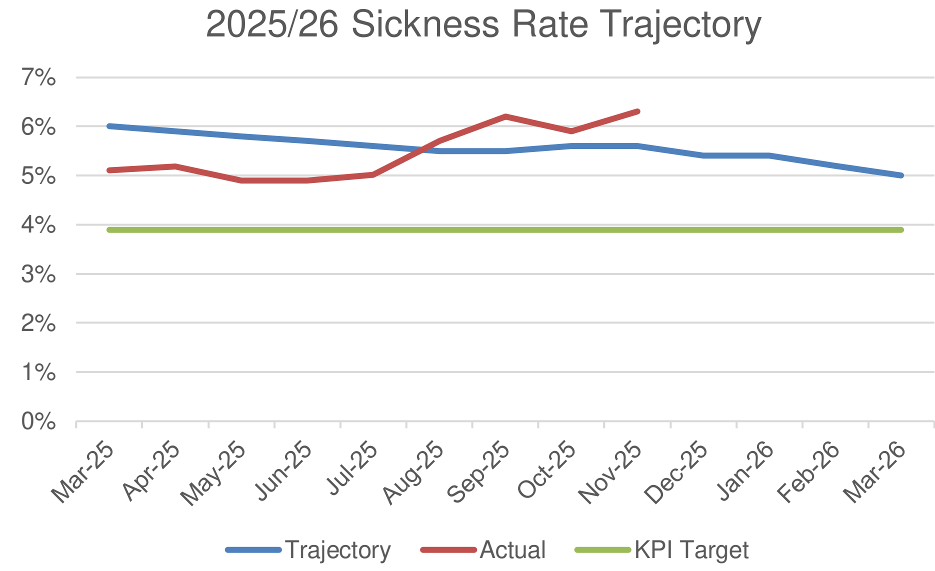
# Sickness Absence

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



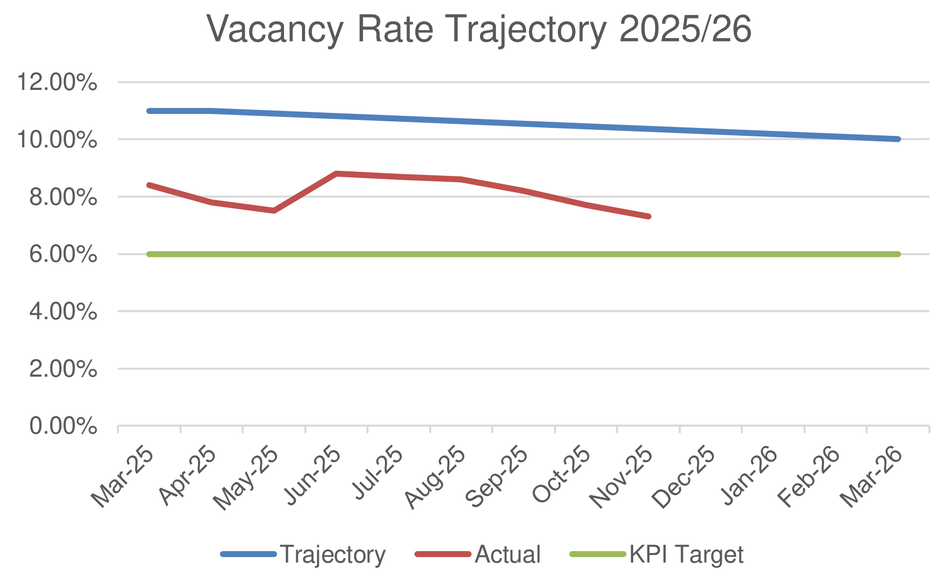

A revised trajectory has been provided for 2025/26 to reduce sickness levels by 1% reaching 5% by March 2026.
December 2025 data not yet available due to national issue with ESR. November at 6.3% and above the monthly improvement trajectory of 6%.

**Action Plan:**
**Occupational Health:** The new provider is now active and work is ongoing to support managers and employees to understand how to access these new services, alongside close contract management.
**Training Reach:** Masterclass delivery on Managing Health and Wellbeing continues, with a focus on reaching  divisions with higher levels of absences. Tailored sessions are also being offered to divisions to support group upskilling.
**Return to Work Focus:** Key activities are ongoing to measure Return to Work and sickness support compliance, including divisionally targeted support.

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

# Vacancies

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




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%. December data not yet available. November at 7.37% 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.

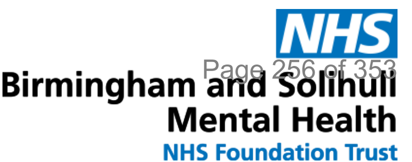
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- 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.

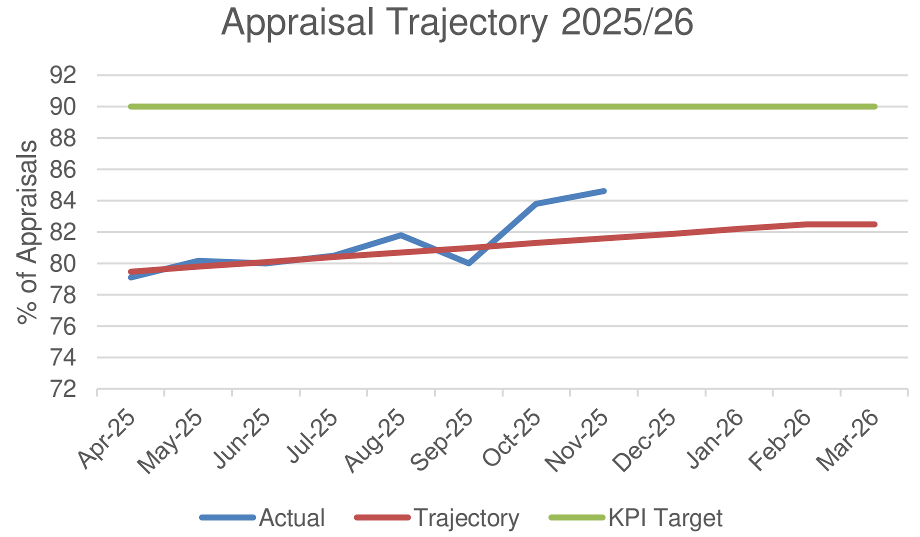
A Recruitment Initiatives and Strategy meeting will be held at the end of October to ensure the department is maximising every opportunity to continuously improve processes and initiatives such as trac procedures, interview techniques training, flexible working, attraction strategy, social media, DBS 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.

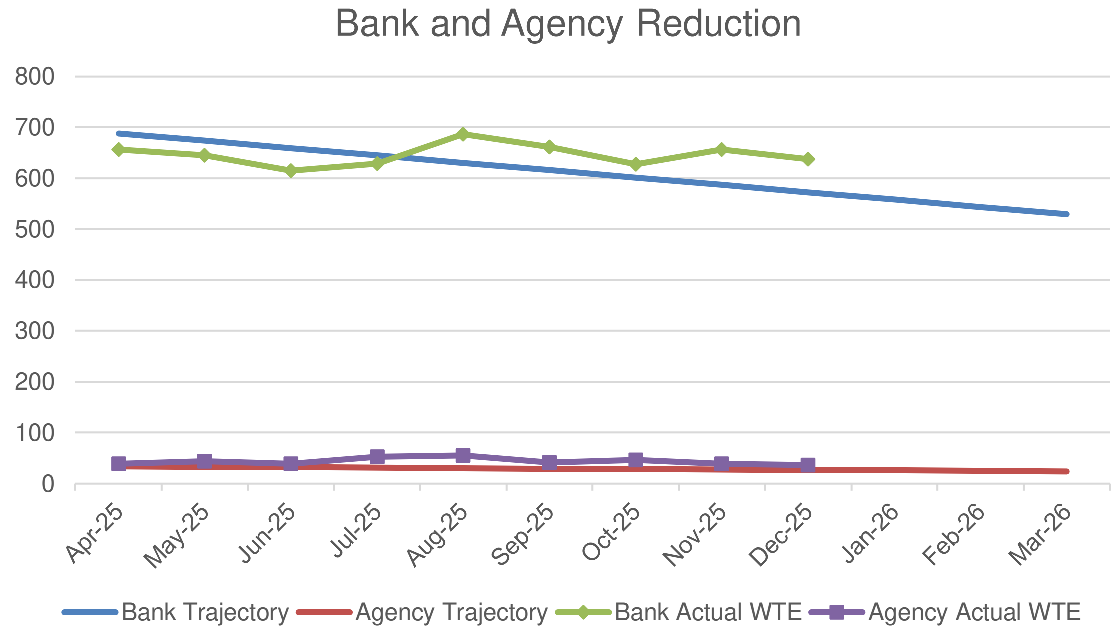
December 2025 appraisal performance is not yet available due to a national issue with ESR. November at 84.6% and above trajectory.

Summary of actions planned to support improvement:

- Continuing current practice to raise compliance and Monitoring.
- Continue to review system and process to improve user experience, including refreshed resources on connect
- 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 six months with December at 637.9 WTE
Agency remains above trajectory with December at 35.8 WTE

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

# Sustainability

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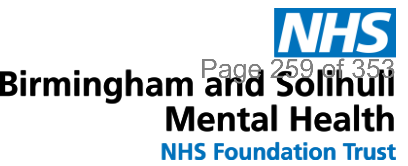
# Monthly Agency costs






- 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.

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## Appendix IIIa - FPPC 22nd January 2025

# 2025/26 Talking Therapies Recovery Action Plan Summary

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Birmingham and Solihull Mental Health NHS Foundation Trust

# 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.
- The Collaborative confirmed in November an 0.68% uplift in the cost per case back dated to 1st April 2025. This moves from £637.89 to £642.13
- The overall activity target has been reduced by the Provider collaborative to 9,162 for 2025/26 reflecting lower performance in Q1 and Q2. No changes have been made to Q3 or Q4 trajectories. These figures are reflected in the ICB reporting
- 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.

# Introduction

At the March 2025 FPPC meeting the Talking Therapies Recovery Plan and future updates were requested.

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

A revised recovery plan was summitted to the ICB in October 2025 to achieve recovery rate targets and monthly activity targets

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# Activity and Performance update

**Update as at December 2025:**

**Ontrack/completed**

- The Reliable Improvement rate performance reached the 68% target for the last 3 months.
- National waiting time standards of 6 (75% standard) and 18 weeks (95% standard) continue to be maintained.
- 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
- The DNA rate has reduced from 13% in September to 11% in December 2025
- In treatment pathway waits have reduced in the last 3 months to 17% in December, but remain above the 10% target

# Activity and Performance update

## Not on track/ In progress

- Reliable Recovery Rate has improved in last 2 months to 47.6% but remains below trajectory of 50%.
- December completed cases at 737 below the target of 811.
- Income and activity remains under the ICB trajectory requirements, with a related financial deficit of £537,412 for April - December 2025.

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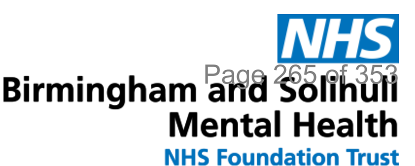
# Workforce Action Plan






## Update as at December 2025:

## Completed

- Skill Mix review completed
- Funding stream has been identified for band 8A post for each team
- Employment advice groups now commenced

## In Progress

- Recruit to locality clinical lead posts for each team- currently awaiting job matching panel
- Staff wellbeing focus groups (work with OD) - awaiting OD's themed analysis following target focus groups across the teams

## Planned

- Establish Action Learning Sets for Managers

# Activity and Income Trajectory

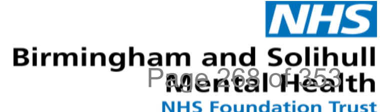
**2025/2026 Activity and Income Trajectory (based on £642.13per case)**

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 Revised Activity (Nov 25-Mar 26) | BHM Actual activity | Estimated income (in line with activity trajectory) | Actual Income received | Income received if total activity is achieved | Total deficit or overachieved income |
|---|---|---|---|---|---|---|---|---|
| Apr | 811.3 | 670 | 670 | 743 | £430,227 | £477,103 | £520,960 | -£43,857 |
| May | 811.3 | 710 | 710 | 721 | £455,912 | £462,976 | £520,960 | -£57,984 |
| Jun | 811.3 | 710 | 710 | 669 | £455,912 | £429,585 | £520,960 | -£91,375 |
| Jul | 811.3 | 750 | 750 | 776 | £481,598 | £498,293 | £520,960 | -£22,667 |
| Aug | 811.3 | 670 | 670 | 638 | £430,227 | £409,679 | £520,960 | -£111,281 |
| Sep | 811.3 | 760 | 760 | 731 | £488,018 | £469,397 | £520,960 | -£51,563 |
| Oct | 811.3 | 800 | 800 | 776 | £513,704 | £498,293 | £520,960 | -£22,667 |
| Nov | 811.3 | 800 | 620 | 673 | £398,120 | £432,153 | £520,960 | -£88,807 |
| Dec | 811.3 | 800 | 740 | 737 | £475,176 | £473,250 | £520,960 | -£47,710 |
| Jan | 811.3 | 812 | 740 | | £475,176 | | £520,960 | |
| Feb | 811.3 | 812 | 740 | | £475,176 | | £520,960 | |
| Mar | 811.3 | 812 | 740 | | £475,176 | | £520,960 | |
| Total | **9,736** | **9,106** | **8,650** | **6,465** | **£5,554,422** | **£4,150,728** | **£6,251,520** | -£537,912 |

Cost per case has increased to £642.13 from £637.89 and has been backdated to April 2025 following notification from Provider Collaborative

# 11. Quality, Patient Experience and Safety Committee Report

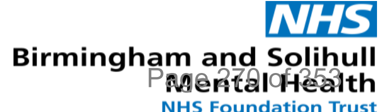




# Committee Escalation and Assurance Report

| Name of Committee | Quality, Patient Experience and Safety Committee |
|---|---|
| Report presented at | Board of Directors |
| Date of meeting | 4 February 2026 |
| Date(s) of Committee Meeting(s) reported | 21 January 2026 |
| Quoracy | Membership quorate: Y |
| Agenda | The Committee considered an agenda which included the following items:<br>• Board Assurance Framework Risks<br>• Patient Safety Report<br>• Safe Care Today Dashboard and Bronze, Silver, Gold Updates<br>• Psychological Harm Report<br>• Regulatory Compliance Report<br>• Clinical Governance Committee Assurance Report<br>• Patient Experience and Recovery (PEAR) Group Assurance Report<br>• Customer Relations Report<br>• Safer Staffing Report<br>• Psychological Professions and Psychological Therapies Report<br>• Assertive and Intensive Action Plan Progress Report<br>• Culture of Care QI Collaborative Programme<br>• Integrated Performance Report<br>• Clinical Effectiveness Advisory Group Assurance Report<br>• Reducing Restrictive Practice Report<br>• Forward Planner 2026/27<br>• QPES Sub-Committee Terms of Reference |
| Alert: | The Committee wished to alert the Board of Directors to the following:<br>• Acuity remains high across services, this is causing ongoing pressures and challenges. Weekly huddles are supporting escalations.<br>• Children and Young People's crisis teams entered the Bronze, Silver, Gold framework due to high caseloads, workforce issues, and lack of systems and audit assurance. The Committee noted immediate action plans have been developed to include training, audit implementation, and safeguarding supervision, with longer-term model reviews underway |
| Assure: | The Committee was assured by the following:<br>• Regulation 29a notices have been formally removed<br>• The Trust has been recognised nationally for being rated highest for cleanliness in both inpatient and community areas<br>• Positive progress has been made mitigating Board Assurance Risks with the Committee endorsing reductions for Board Assurance Risks SR3, SR4 and SR7<br>• Culture of Care programme has been rolled out across divisions and positive progress has been made |

| | | |
|---|---|---|
| | • Development of the Safe Care Dashboard data was noted as positive with the dashboard highlighting improvements in clinical safety and quality metrics | |
| **Advise:** | The Committee noted the improved reporting for patient complaints and acknowledged work is progressing positively overall. Work is ongoing to onboard the data from the transition of Children and Young People although incident reporting in CYP remains on a separate (i.e. not Eclipse) system.<br><br>The Committee noted concerns in relation to colour printing from the Patient Experience and Recovery (PEAR) Group assurance report. This reported colour printing had been substantially restricted due to cost pressures. Committee heard this was an inclusion issue as some services users with cognitive impairment relied on colour cues to help understand written information. Discussions led to a recommendation for a standard operating procedure allowing exceptions based on evidence and speech and language therapist input, with concerns about digital literacy and access also addressed.<br><br>The Committee approved the forward plan for 2026/27 in line with the Board Assurance Framework.<br><br>The Committee approved the sub- committee terms of reference. | |
| **Board Assurance Framework** | The Committee scrutinised the following risks:<br>• SR3- Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery<br>• SR4- Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services<br>• SR7- Failure to deliver optimal outcomes with available resources | |
| | **New risks identified:** no additional risks were identified. | |
| **Report compiled by:** | Nick Moor<br>Non-Executive Director | **Minutes available from:**<br>Hannah Sullivan<br>Corporate Governance and Membership Manager |






# Committee Escalation and Assurance Report

| Name of Committee | Extraordinary Quality, Patient Experience and Safety Committee |
|---|---|
| Report presented at | Board of Directors |
| Date of meeting | 4 February 2026 |
| Date(s) of Committee Meeting(s) reported | 11 December 2025 |
| Quoracy | Membership quorate: Y |
| **Agenda** | The Committee considered an agenda which included the following items:<br>• Patient Safety Report<br>• Homicides Deep Dive Report<br>• Assertive and Intensive Action Plan |
| **Alert:** | The Committee wished to alert the Board of Directors to the following key alerts:<br>• There had been an increase in self-harm incidents reported, from 80 to 184.<br>• Physical restraint use had increased to 255, whilst prone restraints had decreased to 48.<br>• Staff assaults had increased from 79 to 126, and patient assaults from 27 to 39, mainly in Acute Care, Specialties and Secure Services. |
| **Assure:** | • The Committee was assured that weekly safety huddles continued to be held, to monitor incidents and share learning.<br>• The Committee took assurance from incident monitoring through local safety panels.<br>• There had been no Prevention of Future Deaths reports received during the month. |
| **Advise:** | • Progress continued in suicide and self-harm prevention, with safety partners reviewing newly revised risk assessment forms in January.<br>• A seclusion audit review was underway.<br>• Targeted support was in place and enhanced monitoring was in place to monitor and manage staff and patient assaults.<br>• The Committee took some assurance on the actions in relation to the Assertive and Intensive Action Plan, particularly noting the Assertive Outreach Team which managed high-complexity cases, and the development of the Early Warning Signs dashboard.<br>• Some improvements from previous learning into homicide cases were visible, including stronger supervision, better documentation and new multi-agency processes. However, the Committee noted that these were not yet consistent across pathways, and the focus now was to embed them into routine practice. |
| **Board Assurance Framework** | The BAF was not considered during this extraordinary meeting.<br>**New risks identified:** no additional risks were identified. |

| Report compiled by: | Nick Moor<br>Non-Executive Director | Minutes available from:<br>Kat Cleverley, Company Secretary |
|---|---|---|

# 12. Quality and Safety Report

| Report to Board of Directors | | | | | | |
|---|---|---|---|---|---|---|
| Agenda item: | 12 | | | | | |
| **Date** | 4 February 2026 | | | | | |
| **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 Incident Response Framework**

**Incident reporting**

The Patient Safety Incident Investigation following the death of a patient on Larimar Ward is due for completion at the end of January. Family members were involved in agreeing the terms of reference and the report will be shared with them once completed. Family members are being provided with external psychological support arranged through the Trust family liaison officer.

Early learning identified included a strengthening of the post and package searching policy and procedures for Acute Wards, compliance with the process is monitored through a monthly audit presented at Quality Assurance Group. Improvement has been made with compliance achieving over 81% at the end of December with an expectation of consistently reaching 100% by the end of February.

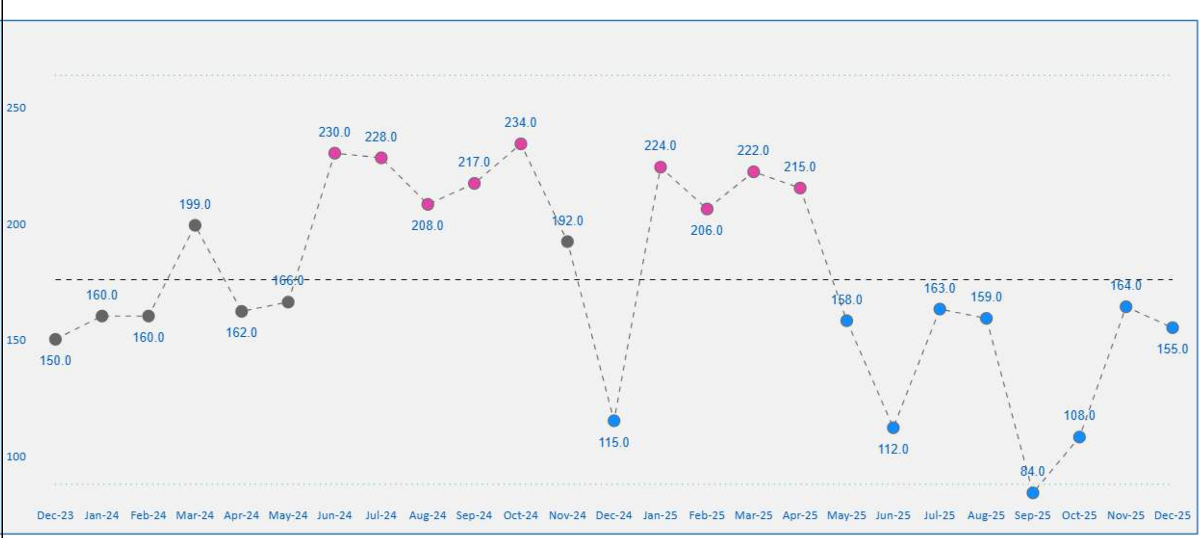
In month we continued to commission proportionate learning responses to incidents. A self-assessment update of our PSIRF progress will be shared with Clinical Governance Committee in March.

A round table was chaired by the Integrated Care Board following a Homicide in Birmingham City Centre towards the end of 2025. The service user had been seen in many services across the country and more recently at a local Acute Trust in their Emergency Department.

**Suspected Suicides**

Four deaths by suspected suicide were reported during December. The service users were at different stages of their care pathways, including referral, active community follow up and recent discharge from PLT. Early learning identified relates to understanding timeliness of access, continuity of handover between teams and maintaining contact. Full reviews are underway and themes for exploration and any required improvement actions will be confirmed through the Learning from Deaths process. There have been two incidents involving patients with a learning disability and or autism which will be reviewed thematically, the Trust has committed to undertaking the work to achieve Learning Disability and Autism accreditation, Mellissa Ward (Female Acute) has been identified as the pilot site and a visit to Wast Hills who are recently accredited is planned.

**Self-Harm**




Self-harm incidents in December remain below the Trust's typical monthly level, making it the eighth consecutive month below the long term average. While some monthly variation continues, the sustained position suggests a positive and meaningful improvement. Where higher monthly figures occur, these are typically driven by repeat incidents involving a small number of service users. The majority of incidents occur in our service areas where we care for women and young people, these include Ardenleigh, Eden PICU, and Acute Wards providing care for women.

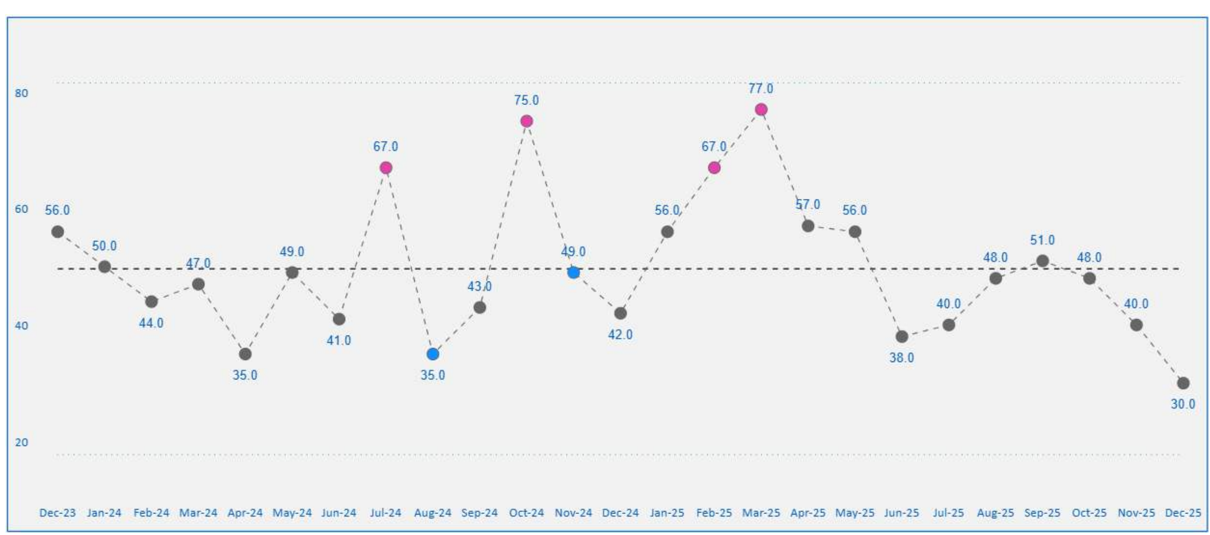
The significant incidents have impacted on staff availability at Ardenleigh and Eden PICU, the Trust has supported operational leaders with a short, medium and long term plan for sustainable staffing for these areas. The Trust has a waiting list of graduates wishing to join the Trust and a 'Rotation and Development Pathway in Care for Women' is being planned.

**Prone Restraint**

Prone restraint incidents show an overall reduction in recent months, following a period of fluctutaion. Whilst there were isolated higher months earlier in the period, these were not sustained and more recent months represents some of the lowest level seen. This downward trend is encouraging and suggests progress in reducing prone restraint, utlising Averts practice effectively and using alternative sites for injection.

Birmingham and Solihull Mental Health NHS Foundation Trust

## Prone Restraint




## Learning from Excellence

During November 2025, the Trust received over 300 Learning from Excellence nominations, demonstrating sustained engagement with positive reporting and recognition of good practice across services.

Nominations were received from all divisions, with the highest volume originating from Secure Care services, reflecting service scale and acuity. Submissions were made by a wide range of staff groups, including registered professionals, support staff, students, managers and partner organisations, indicating organisation-wide participation.

Five consistent themes were identified across Learning from Excellence nominations:

1. Compassionate, person-centred care, particularly during periods of distress, crisis or complexity
2. Teamwork and mutual support, including staff stepping across roles or teams to maintain safe care
3. Visible, values-based leadership that promotes calm and psychologically safe environments
4. Proactive risk management, with staff anticipating and mitigating harm in real time
5. Learning, supervision and development, particularly in support of students and newly qualified staff

## Regulatory Activity

Following receipt of the Care Quality Commission inspection report for the North Acute Wards and Zinnia Centre in October 2025, the factual accuracy check was submitted to and accepted by the CQC. The final report identified three key areas of concern for the Trust to provide an action plan:

Ensure the care and treatment of patients was appropriate, met their needs and reflected their preferences (Regulation 9) improvement required in completing patient risk assessments, care and safety plans

Ensure care and treatment was provided in a safe way to patients (Regulation 12) effective provision of enhanced therapeutic observations of care and autism informed care

Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care (Regulation 17(1)) requiring strengthened ward to board governance at ward and divisional level

A comprehensive plan was developed by the service with support from corporate colleagues and submitted ahead of the CQC's deadline in December. The report also confirmed removal of the Section 29As that were in place at the Zinnia Centre so the Trust is now without any warning notices.

An announced inspection of Home Treatment Teams, Psychiatric Liaison Teams and the Places of Safety and Psychiatric Decision Units took place on 27th and 28th February. Data was provided to the CQC in advance of the inspection and staff focus groups enabled. Service Leaders were interviewed on 2nd February and we await written feedback.

**Fire Safety**

To provide greater assurance around the current fire safety arrangements and also in response to the findings of external surveys and audits by the Fire Service and fire safety specialists in October, a new Fire Safety Group was launched in November 2025. This group will report into the Trust Health and Safety Group, and the Terms of Reference includes representatives from corporate services as well as each operational area. The focus of the group will be to ensure that findings from fire risk assessments, passive fire protection surveys and incident investigations are adequately addressed.

**Preventing Future Deaths**

The Trust received a Preventing Future Deaths Notice from the Coroner in Worcester. This followed the death of a service user who had been transferred to care services in Worcester on discharge from care in our services under Section 117. The finding of the Coroner was that there was insufficient clear information in the handover between our team and the local General Practitioner in respect of after care arrangements from the Trust and Local Authority. In response the Trust has approved a more details handover form and agreed that our policy will be to provide a verbal handover for any patients that is then followed up in writing on the agreed template. An audit will be added to the Clinical Audit Framework for assurance through the Quality Assurance Group.

**Homicide Review**

An After-Action Review for the alleged homicide which took place in Birmingham last year has been chaired by the Integrated Care Board. It highlighted system-level challenges in coordinating care for individuals with complex mental health needs who live transient lives and move between prisons, acute hospitals and community services, limiting continuity and longitudinal assessment.
Key vulnerabilities relate to transition points, particularly prison release, and to inconsistent application of acute hospital "missing patient" protocols when individuals leave prior to assessment. Non-integrated health and justice records further reduced shared situational awareness. The learning therefore relates to strengthening system coordination, information sharing and consistency of safety processes.

The ICB will be submitting a cluster review to NHSE at the end of the month which includes this learning there was nothing specific for our Trust at this point.

**Review Report following the Patient Death on Larimar Ward**

The Independent Review commissioned by the Trust Medical Director has now been completed in draft and will be shared with the family for feedback. The review will then be presented at QPESC in February where learning will be discussed and assured on. The review has included an expert advisor on care for people with Autism which will provide learning for the Trust on Autism Informed Practice.

**System Quality Improvement Group**

The Trust continues to participate in the System level escalation meeting to provide assurance on learning from the patient death on Larimar Ward and the improvements required following the CQC Inspection of North Acute Wards and Zinnia Centre. In January the Trust shared the progress on development of the Safe Care Dashboard and the implementation of the new Quality Assurance Group. In addition, a comprehensive report was provided on care for patients with a Learning Disability and/or Autism. The ICB and NHSE have asked for triangulation with workforce data at the next meeting and a trajectory for the completion on Oliver McGowan Training.

**Safeguarding external assurance**

**Section 11 and Care Act Compliance:**

2025 Section 11 submission, BSMHFT were rated 'Good' across all domains.

Associate Director of Safeguarding attended Solihull Assurance and Review Group (sub-group of Local Solihull Safeguarding Children's Partnership, January 2026) where it was noted that BSMHFT have made "notable improvements over the last two years".
The next step now is to move some of the domains from "Good" to "Excellent". The domains with potential to be Excellent in 2026 are:

- Complaints, whistleblowing and managing allegations
- Quality assurance
- Policies and procedures

**Assertive and Intensive Action Plan**

The Trust has completed the third quarter review of the Assertive and Intensive action plan with the Mental Health Provider Collaborative. The assurance included; operational processes for individuals with Psychosis and/or Severe Mental Illness (SMI) requiring enhanced (assertive and intensive) support, system visibility, strengthened governance, clinical leadership and oversight.

The Trust has implemented an Assertive and Intensive Dashboard with reporting aligned to national benchmarking, local standards and governance committees. Workforce, operational, safety, quality, and patient-experience metrics are monitored, with further enhancements planned for quarter four. Key risk areas are monitored, these include; case loads, medication concordance, clinical supervision compliance, sickness and absence levels, and any gaps in risk assessment and care planning, all areas of variation have associated actions.

The focus of the quarter three assurance was to set out the clear processes for identifying and confirming the Serious Mental Illness patient cohort, managing diagnostic uncertainty, and monitoring interface pathways between Community Mental Health Teams and Assertive Outreach Teams. Data on caseloads, step-up/step-down requirements, and monitoring tools demonstrate strengthened system oversight. Assurance has also been provided on the frequency of service user contact, Multi-disciplinary Team structures, clinical engagement expectations, and audit programmes aligned to national recommendations and the Independent Mental Health Homicide Review.

Family and carer involvement is identified as an area requiring improvement, with a new Culture of Care programme driving future involvement in line with the approach in Secure and Offender Health. The Trust has confirmed the commitment to delivering a safe, consistent, and needs-led model with effective clinical governance and collaborative working across the system.

Feedback from the assurance meeting was that the Trust has a structured, time-bound programme of work to improve, refine and operationalise the Assertive and Intensive Model and Action Plan. Clear actions have been assigned to ensure the plan/model is simplified, clinically coherent, and aligned to relevant priorities.

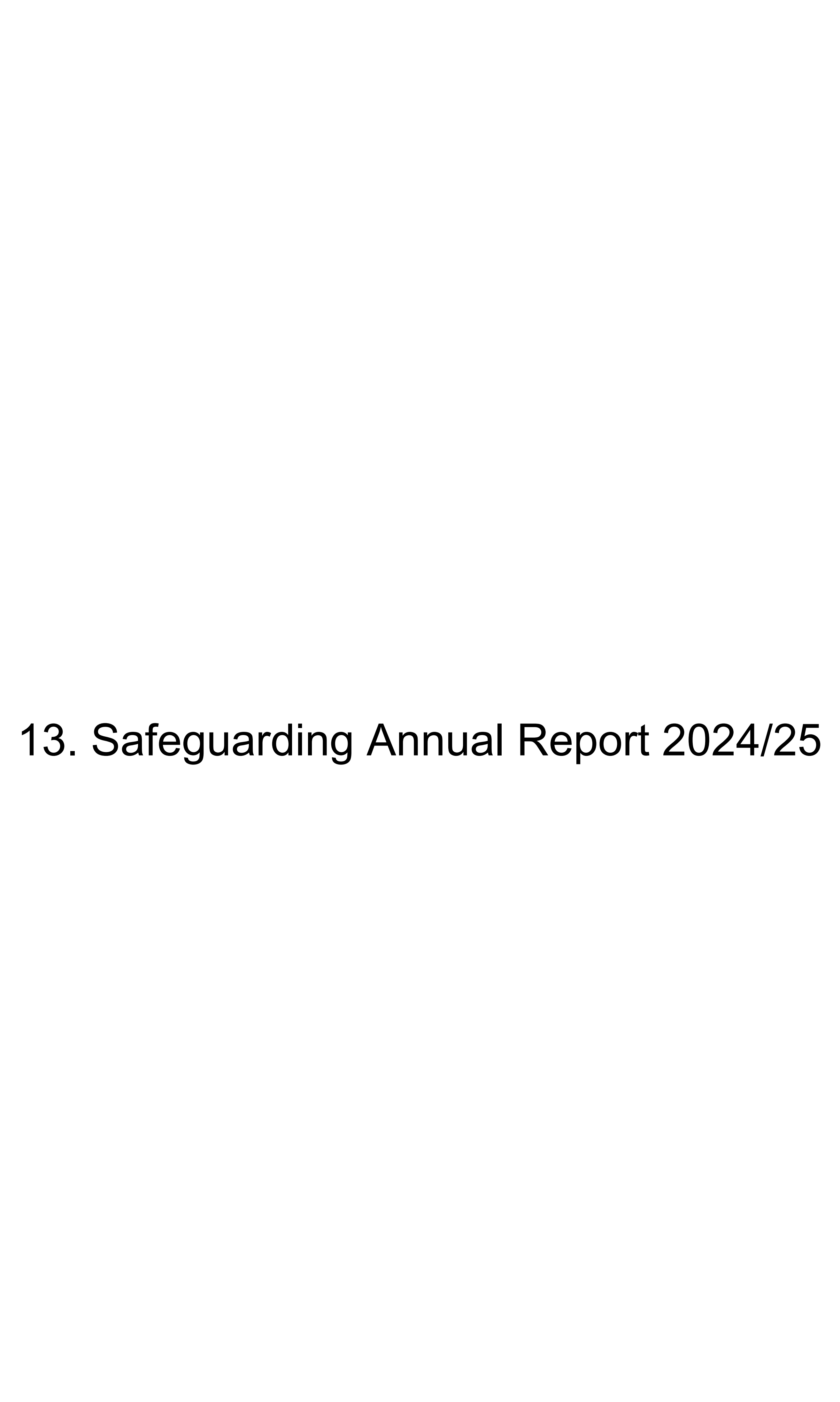
Key assurances include:

- **Cohort clarity:** A shared understanding of AOT, Reach Out, CMHT and the "more complex" group is being established.
- **Revised plan to include services for Children and young people in Birmingham:** A simplified, clearer plan will be produced incorporating CMHT, HTT, inpatient and CYP/FTB interfaces.
- **Data and dashboards:** A comprehensive dashboard is being iterated to provide visibility of caseloads, contact levels, MDT activity and red-flag indicators required for commissioner and Trust assurance.
- **Cohort validation:** Patient lists across CMHT and AOT will continue to be reviewed and clinically validated to ensure accurate identification and pathway alignment.
- **MDT processes:** Expectations for MDT frequency and quality are being reviewed against personalised care standards.
- **Family and carer processes:** Strengthened arrangements are being developed with the Carer Programme to improve documentation, escalation pathways and cultural alignment.
- **Governance and engagement:** Links with NHSE/ICB support teams will ensure oversight, access to information, and consistent system involvement.

The Assertive and Intensive Plan will continue to be overseen through the Clinical Effectiveness Assurance Group, the Trust Quality Patient Experience Safety Committee and periodically Trust Board.

## Recommendation

The Board is asked to review the report and discuss any areas of concern.



13. Safeguarding Annual Report 2024/25

| Report to Trust Board | | | | | | |
|---|---|---|---|---|---|---|
| Agenda item: | 13 | | | | | |
| **Date** | 4 February 2026 | | | | | |
| **Title** | Safeguarding Adults and Children Annual Report 2024/25 | | | | | |
| **Author/Presenter** | Author – Melanie Homer, Associate Director of Safeguarding | | | | | |
| **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**
It is a statutory requirement as per the Children's Act 2004 for NHS organisations to produce a yearly Safeguarding Annual Report. The enclosed Safeguarding Annual report for 2024/25 provides an oversight of the work and activity undertaken by the Trust from April 2024 to end of March 2025 in order to meet regulatory obligations and this includes Safeguarding Children and Young People, Safeguarding Adults, Domestic Abuse and Sexual Safety and Prevent. The report highlights key achievements and areas of focus for the forthcoming year.

**Introduction**
Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) continues to deliver comprehensive and responsive safeguarding practice, rooted in our Trust Values and aligned with national legislation, including Section 11 of the Children Act 2004 and the Care Act 2014. This report demonstrates how safeguarding duties are met across services and systems.

**Key Achievements:**

**Training compliance:**
BSMHFT continues to maintain high standards in safeguarding training across all levels. Level 1 and Level 2 training for both safeguarding adults and children is delivered via an accessible online package and remains fully compliant with national standards. Level 3 training covers adults, children, prevent and domestic abuse. Training is delivered through a flexible and accessible model: including face-to-face sessions, webinars, e-learning modules, and external partnership opportunities provided by Safeguarding Adults Boards and Children's Safeguarding Partnerships.

In 2024–25, the Trust consistently achieved compliance with its commissioner target of 85% for all levels of safeguarding training across adult and children-facing services, with compliancy sitting between 87-91% across the year.

The safeguarding team delivered bespoke training sessions to teams across the Trust, tailored to teams' specific needs, on topics such as routine enquiry, financial abuse, learning from statutory reviews, self-neglect and Think Family. This proactive and sustained focus reflects BSMHFT's commitment to safeguarding excellence, workforce development, and continuous quality improvement.

**Safeguarding supervision:**

Safeguarding supervision remains a priority to support safe, reflective and accountable clinical practice across the Trust. In line with our commitment to trauma-informed care and defensible decision-making, the Safeguarding Team has continued to develop a robust supervision offer for both children's and adult-facing services.

The safeguarding team provide consistent supervision to all children-facing services including SOLAR, forensic, and perinatal pathways. Compliance data is now included in quarterly returns to BSOL ICB.

While not mandated for adult-facing roles, safeguarding supervision is seen as best practice under the Care Act (2014) and NHS safeguarding frameworks. In 2024–25, the Safeguarding Team expanded regular supervision to acute and urgent care, forensics, and high-risk areas—with plans to scale up provision across all inpatient wards by 2025–26.

A standalone Safeguarding Supervision Policy was launched in 2025, reinforcing safeguarding as a key component of good clinical supervision. To support this delivery, every member of the Safeguarding Team has completed dedicated safeguarding supervision training, including NSPCC accredited modules, Bond Solon Restorative Safeguarding Supervision, Talking Life safeguarding supervision or the Richard Swann safeguarding supervision programme. This equips the team with the advanced skills and reflective practice frameworks required to lead supervision confidently across diverse care settings. In an increasingly high-acuity environment, our safeguarding supervision model fosters system-wide learning, emotional resilience, and evidence-informed practice.

**Domestic abuse and sexual safety – key achievements:**

Introduced bespoke, mandatory domestic abuse training as a standalone module in Adult Safeguarding, incorporating the link between domestic abuse and suicide, and BSMHFT's commitment to sexual safety.
Supported the rollout and integration of NHS England's Sexual Safety Charter (2023), with development underway for a dedicated sexual safety training programme for Trust staff. Delivered co-facilitated domestic abuse awareness training based on the IRIS model, in partnership with BSWAID's IDVA, embedding clinical insight with specialist advocacy.
Promoted routine enquiry and Think Family principles across all mental health services through training, safeguarding supervision, and staff consultation.
Conducted assurance visits (e.g. Sutton HTT, Feb 2025), leading to targeted learning and joint teaching sessions focused on domestic abuse.
Raised awareness of "adult/child to parent/carer abuse" as a key theme emerging from incident reviews, supervision, and duty consultations—now designated as a Quality Goal for 2025–26.

**Safeguarding adults – key achievements:**

Developed bespoke sessions on Safeguarding Basics, Financial Abuse, and Organisational Abuse, delivered to priority teams including North Acute Inpatients and Urgent Care.
Published new 7-minute briefings on topics such as Making Safeguarding Personal, Professional Curiosity, and Prevent, supporting just-in-time learning.

Rolled out self-neglect guidance Trust-wide, aligned with Safeguarding Adults Board priorities and supported by targeted teaching.
Delivered targeted support in response to incidents, complaints, and statutory reviews. Provided hands-on guidance to teams managing adults with care and support needs at risk of abuse or neglect.
A continued increase in the number of safeguarding referrals made to adult social care demonstrated improved reporting on eclipse.

**Safeguarding children and young people – key achievements**
Strengthened review of Eclipse safeguarding records through weekly monitoring by a dedicated CYP facilitator.
Completed internal audits for Solar and perinatal services, focusing on voice of the child, safeguarding risk assessments, and early help—resulting in clear improvement plans. Delivered targeted ICPC audit for CMHTs, updated the ICPC process, and embedded revised practice across services.
Enhanced capacity with additional safeguarding resource allocated to Solar and Perinatal services, including facilitators based at Bishop Wilson Clinic.
Safeguarding supervision embedded for Solar management and LATCH team, with the Solar supervision model reviewed and refreshed.
The Safeguarding Team now sighted on all SUDIC notifications, improving oversight and preventing gaps in case recognition.
Thematic review of perinatal incidents completed and shared with the Safeguarding Management Board (SMB).
Review of the Safeguarding lead role for SIAS completed; responsibility now held within the core safeguarding team to strengthen assurance and accountability.
The safeguarding team are notified of referrals made to Children's services for Birmingham and Solihull and there has been a marked improvement in recognition and reporting for 2024-25: o Over the last 5 quarters there has been a steady rise in the number of Safeguarding Children referrals which is positive.
This quarter's figures show a 68% increase when compared to the same period last year.
The safeguarding team are doing continued work around how to complete a good referral, consistent messaging through comms and improving engagement with teams.
As expected, Solar community CAMHS is the source of the most referrals so far, this financial year and they made 30% of referrals this quarter.

**Statutory reviews:**
During 2024–25, BSMHFT's Safeguarding Team actively contributed to statutory multi-agency reviews including Domestic Abuse Related Death Reviews (DARDRs), Child Safeguarding Practice Reviews (CSPRs) and Safeguarding Adult Reviews (SARs).

Mental health expertise from team shaped key learning and system responses, with findings embedded into training, supervision, and policy updates.

The team conducted thematic analysis across reviews and translated insights into staff-facing tools, such as a growing suite of 7-minute briefings on topics such as self-neglect, child sexual abuse, care experienced parents. This learning was cascaded Trust-wide via Safeguarding Connect, team communications, and dedicated sessions, with planned safeguarding assurance visits helping monitor the embedding of key actions into clinical practice.

**Think Family:**
BSMHFT launched its Think Family approach in November 2023, following learning from national safeguarding reviews, including the tragic case of Arthur Labinjo-Hughes. These reviews highlighted the need for improved recognition of risk across family systems, particularly when individuals experiencing mental illness have

dependent children or vulnerable family members.
Implementation and Embedding was a focus for 2024/25
Think Family was Promoted Trust-wide in colleague briefings, Executive communications, and staff webinars.
Resources included a Think Family Standard, posters, staff video, and interactive training content.
Think Family was embedded into practice through reflective supervision, Level 3 training, duty consultations, and roadshows and was a designated a Key Line of Enquiry (KLOE) for 2024–25 safeguarding assurance visits.
The team worked with the recovery college and EBEs and this collaborative approach led to the safeguarding team being awarded the Trust Quality Mark, recognising the impact, inclusivity, and trauma-informed design of the Think Family approach.

**Key risks:**
Demand on Safeguarding Team's Duty and Advice Line - The demand has steadily increased over recent years, reflecting deeper systemic pressures and rising complexity in both children's needs and those of our adult service users. This is expected to increase in 2025-26 with FTB joining the Trust and potential of increased calls, increased complexity and strain on capacity of the team.

**Conclusion**
Safeguarding across Birmingham and Solihull Mental Health NHS Foundation Trust remains a significant undertaking—complex, demanding, and not without its difficulties. As a large and diverse Trust delivering mental health care across two major urban areas, and with secure offender and tertiary services, we operate within high-acuity services, navigate wide-ranging risk profiles, and face persistent systemic pressures. 2024-25 safeguarding work has demonstrated growth and innovation but also exposed areas that require continued attention.

Good practice and learning in relation to Safeguarding requires constant reinforcement and the safeguarding team are committed to supporting all staff at BSMHFT to continually improve our safeguarding recognition and response.

In 2025–26, our focus will be on embedding safeguarding more deeply across systems and teams, expanding supervision where it's needed, improving referral quality and early identification, and continuing to learn from lived experience.

## Recommendation

The Board is asked to review the attached Safeguarding Annual Report

## Enclosures

Safeguarding Adults and Children Annual Report 2024/25

**Report Title**

| Strategic Priorities | | |
|---|---|---|
| Priority | Tick ✓ | Comments |
| Clinical services | | |
| People | | |

| Quality | | |
|---|---|---|
| Sustainability | | |

| Board Assurance Framework | | |
|---|---|---|
| Strategic Risk | Tick ✓ | Comments |
| | | |
| | | |
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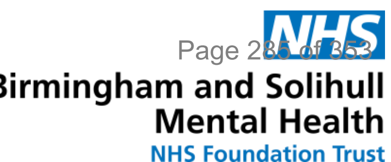


# Birmingham & Solihull Mental Health NHS Foundation Trust

# Safeguarding Adults and Children Annual Report

## April 2024 – March 2025

Melanie Homer
Associate Director of Safeguarding
July 2025

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## 🍀 Safeguarding Overview and Governance – 2024–25 Summary

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) continues to deliver comprehensive and responsive safeguarding practice, rooted in our Trust Values and aligned with national legislation, including Section 11 of the *Children Act 2004* and the *Care Act 2014*. This report demonstrates how safeguarding duties are met across services and systems.

## 🌍 Trust-wide Safeguarding Foundations

- Safeguarding applies across BSMHFT's wide-ranging mental health services for both children and adults in Birmingham and Solihull.
- Staff are supported to respond to safeguarding concerns proportionately and in partnership with families and services.
- Work is aligned with statutory duties and the Trust's Think Family ethos to make safeguarding everyone's business.

## 🏛 Governance and Leadership

- The Chief Nurse/Executive Director of Quality and Safety holds executive accountability for safeguarding.
- Strategic oversight is led by the Associate Director of Safeguarding, supported by the Named Nurses and the wider safeguarding team, who deliver expert advice, supervision, and support across children's safeguarding, adult safeguarding, domestic abuse, and Prevent.
- The safeguarding team works closely with the Heads of Nursing and AHPs and divisional leads and teams across the Trust to try and ensure safeguarding learning is embedded into practice.
- The Safeguarding Strategic Plan is presented quarterly to the Safeguarding Management Board (SMB) and the Integrated Care Board (ICB).

## ✅ Quality Assurance

Safeguarding is embedded into organisational culture and practice via:

- Annual report, statutory roles, effective policies, safe recruitment, and competency-based training.
- Supervision structures for frontline staff and the safeguarding team.
- Active engagement in multi-agency systems and shared learning culture.
- Quarterly compliance and updates submitted to commissioners at BSOL ICB.

## 🔍 Assurance Framework

- Internal assurance is monitored through the Safeguarding Management Board (SMB), which reports to the Quality, Patient Experience and Safety Committee (QPES).
- The safeguarding team participate in multiagency audits and identify key learning for the Trust.
- Directorate safeguarding leads attend SMB to embed priorities operationally.
- Named Nurses participate in local clinical governance committees to strengthen safeguarding recognition and reporting and embed learning identified in statutory reviews.

## 🤝 Partnership Working & System Learning

- Strong collaboration with Birmingham and Solihull Safeguarding Adults Boards, Children's Partnerships, and Domestic Abuse Boards.
- Participation in statutory reviews (SARs, CSPRs, DHRs, SUDICs and JARs), multi-agency audits, and partnership events.
- Safeguarding priorities are aligned across the system, with learning from reviews embedded into training and everyday practice.
- Pilot safeguarding assurance visits completed and reported to SMB, supporting continuous improvement.

## 📚 Safeguarding Training Compliance – Strengthening Practice Through Learning

BSMHFT maintains a robust training framework to ensure all staff are equipped to deliver safe, effective, and confident safeguarding practice.

The Trust's Training Needs Analysis (TNA) is aligned to national standards, including the *Intercollegiate Document for Safeguarding Children and Young People (2019)* and *Adult Safeguarding Roles and Competencies for Health Staff (2024)*. This framework sets out clear expectations for training level and frequency, tailored to role and responsibility.

BSMHFT continues to maintain high standards in safeguarding training across all levels. Level 1 and Level 2 training for both safeguarding adult and children is delivered via an accessible online package and remains fully compliant with national standards.

The mandatory level 3 safeguarding curriculum covers:

- Safeguarding Children and Adults
- Domestic Abuse
- Prevent Duty

Training is delivered through a flexible and accessible model: including face-to-face sessions, webinars, e-learning modules, and external partnership opportunities provided by Safeguarding Adults Boards and Children's Safeguarding Partnerships.

The Trust also meets its statutory responsibilities regarding counter-terrorism awareness, with full compliance in WRAP (Workshop to Raise Awareness of Prevent) training. This ensures staff are equipped to identify vulnerabilities linked to radicalisation and respond appropriately in line with the Prevent Duty.

Feedback from delegates attending BSMHFT's safeguarding training has been consistently positive, reflecting the quality, relevance, and impact of the training offer. The blend of digital and live formats enables strong engagement across the workforce while meeting operational and regulatory requirements.

In 2024–25, the Trust consistently achieved compliance with its commissioner target of 85% for all levels of safeguarding training across adult and children-facing services.

| Safeguarding Training | Compliance (%) : NB: target rate is 85% | | | |
|---|---|---|---|---|
| | Q1 24/25 | Q2 24/25 | Q3 24/25 | Q4 24/25 |
| **Safeguarding Children Level 1** | 97% | 96% | 96% | 96% |
| **Safeguarding Children Level 2** | 96% | 96% | 97% | 98% |
| **Safeguarding Children Level 3** | 87% | 89% | 88% | 91% |
| **Safeguarding Children Level 2 - Priority Services** | 98% | 98% | 98% | 99% |
| **Safeguarding Children Level 3 - Priority Services** | 90% | 91% | 87% | 89% |
| **Safeguarding Adults Level 1** | 96% | 92% | 94% | 95% |
| **Safeguarding Adults Level 2** | 98% | 98% | 97% | 98% |
| **Safeguarding Adults Level 3** | 90% | 88% | 87% | 88% |
| **Domestic Abuse (as per adults level 3)** | 90% | 88% | 87% | 88% |
| **Prevent** | 95% | 95% | 96% | 96% |

The Associate Director of Safeguarding has led targeted work to address the remaining 15%, implementing monthly data reviews and sharing non-compliance reports with Heads of Nursing and AHP and the Named Doctor for adult safeguarding. These actions are embedded within governance reporting to the Safeguarding Management Board (SMB), resulting in a clear improvement in overall training figures. This work will continue into 2025-26.

The safeguarding team have delivered bespoke training sessions to teams across the Trust, tailored to teams' specific needs, on topics such as routine enquiry, financial abuse, learning from statutory reviews, self-neglect and Think Family.

This proactive and sustained focus reflects BSMHFT's commitment to safeguarding excellence, workforce development, and continuous quality improvement.

# 🌟 Training Enhancements and Strategic Developments (April 2024 –March 2025)

### 🛡️ Safeguarding & Family-Centred Practice

- **Safeguarding Adults Level 3 F2F/Webinar Training**: Now includes Sexual Safety Charter.
- **Think Family Standard & Approach**: Embedded in all Level 3 training; revised to include EBE (Experts by Experience) perspectives and emphasize cultural competence.
- **Supplementary Children's Services Training**: In development to reinforce Think Family principles in statutory safeguarding processes (e.g. referral, case conference).

### 🧠 Quality Improvement Initiatives

- **ICCR Patient 'Passports' QI Project**: Safeguarding features incorporated into passport concept and accompanying training package.

### 🌍 Equity, Diversity & Inclusion

- **Diversity Statement in L3 Training**: Co-created with EDI lead and Trust colleagues.
- **Use of Culturagrams**: Supports consideration of service users' cultural context in clinical interactions.

### 👦🏫 External Collaboration & Outreach

- **Birmingham Children's Trust CPD Session**: Delivered half-day training to newly qualified social workers focused on safeguarding children in families with parental mental illness.

### 🤝 Co-Production & Engagement

- **EBE Collaboration**: Plans underway to co-produce resources to promote clinical good practice.

# 🛡️ Safeguarding Supervision at BSMHFT – Embedding Excellence

Safeguarding supervision remains a priority to support safe, reflective and accountable clinical practice across Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT). In line with our commitment to trauma-informed care and defensible decision-making, the Safeguarding Team has continued to develop a robust supervision offer for both children's and adult-facing services.

Supervision is a statutory requirement for professionals working with children, as outlined in *Working Together to Safeguard Children (2023)*. BSMHFT exceeds this standard—providing consistent supervision to all children-facing services including SOLAR, forensic, and perinatal pathways. Compliance data is now included in quarterly returns to BSOL ICB.

While not mandated for adult-facing roles, BSMHFT recognises safeguarding supervision as best practice under the *Care Act (2014)* and NHS safeguarding frameworks. In 2024–25, the Safeguarding Team expanded regular supervision to acute and urgent care, forensics, and high-risk areas—with plans to scale up provision across all inpatient wards by 2025–26.

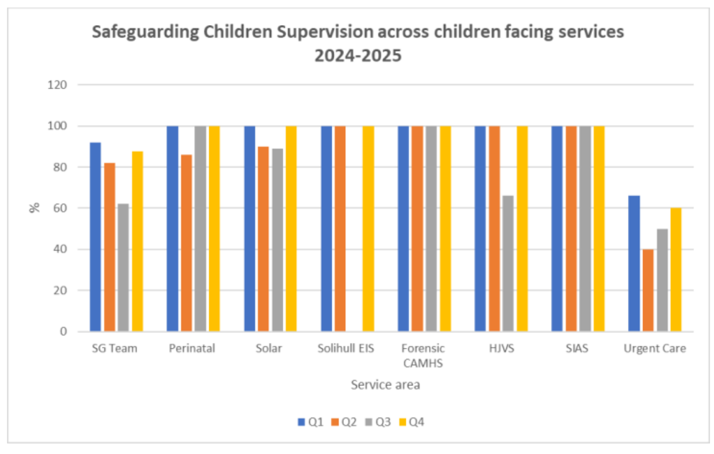
Supervision is delivered through a strategic and responsive model, with targeted sessions following incidents, scopes, statutory reviews, or direct team requests. This ensures staff receive bespoke support tailored to specific teams.

Importantly, the Trust has introduced a standalone Safeguarding Supervision Policy, applicable to all staff and volunteers, alongside a refreshed Clinical Supervision and Reflective Practice Policy which reinforces safeguarding as a key component of good clinical supervision.

To support this delivery, every member of the Safeguarding Team has completed dedicated safeguarding supervision training, including NSPCC accredited modules, Bond Solon Restorative Safeguarding Supervision, Talking Life safeguarding supervision or the Richard Swann safeguarding supervision programme. This equips the team with the advanced skills and reflective practice frameworks required to lead supervision confidently across diverse care settings.

In an increasingly high-acuity environment, our safeguarding supervision model fosters system-wide learning, emotional resilience, and evidence-informed practice.

**Graph illustrating Safeguarding Children Supervision Compliance across identified teams within BSMHFT for Q1 – Q4 2024-25**



## 🛡️ Prevent Duty – Key Activities and Governance

- The Counter Terrorism and Security Act (2015) mandates NHS Trusts to embed the Prevent strategy into service delivery.
- BSMHFT's Executive Director for Quality and Safety/CNO holds delegated executive accountability for Prevent; operational leadership lies with the Associate Director of Safeguarding as the Trust's Prevent Lead.
- The Prevent Lead oversees policy development and ensures access to appropriate staff training—delivered as part of the wider safeguarding curriculum. Training compliance across the Trust is strong.
- The safeguarding team submits quarterly returns to NHS England via NHS Digital and the BSOL ICB, providing assurance on Trust performance.
- BSMHFT actively participates in Channel panels, Prevent Operational and Delivery Groups for Birmingham and Solihull, ensuring multi-agency collaboration.

## 🛡️ Domestic Abuse and Sexual Safety Workstream – Achievements for 2024-25

The Domestic Abuse and Sexual Safety workstream at BSMHFT has made significant strides in strengthening trauma-informed, rights-based safeguarding practice across adult and children's mental health services. Key achievements include:

### 💡 Training & Workforce Development

- Introduced bespoke, mandatory domestic abuse training as a standalone module in Adult Safeguarding, incorporating the link between domestic abuse and suicide, and BSMHFT's commitment to sexual safety.
- Supported the rollout and integration of NHS England's Sexual Safety Charter (2023), with development underway for a dedicated sexual safety training programme for Trust staff.
- Delivered co-facilitated domestic abuse awareness training based on the IRIS model, in partnership with BSWAID's IDVA, embedding clinical insight with specialist advocacy.

### 🧠 Culture & Awareness

- Promoted routine enquiry and Think Family principles across all mental health services through training, safeguarding supervision, and staff consultation.
- Conducted assurance visits (e.g. Sutton HTT, Feb 2025), leading to targeted learning and joint teaching sessions focused on domestic abuse.

- Raised awareness of “adult/child to parent/carer abuse” as a key theme emerging from incident reviews, supervision, and duty consultations—now designated as a **Quality Goal for 2025–26.**

### 🧰 Tools, Guidance & System Improvement

- Developed tailored MARAC and DASH guidance to support BSMHFT clinicians in assessing domestic abuse risk and understanding referral thresholds.
- Strengthened the Trust’s Independent Domestic Violence Advisor (IDVA) role, now operating across five clinical teams and available to female staff.
- Participated in multi-agency Domestic Abuse-Related Death Reviews (DARDRs), contributing mental health expertise and insight.

### 🌍 Strategic Leadership & Representation

- Contributed to Birmingham’s Domestic Abuse Strategy review and launch; BSMHFT’s Named Nurse for Domestic Abuse now sits on the DA Board’s Priority Operational Group
- Supported managers in Acute and Urgent Care to implement domestic abuse action plans based on learning events and external reviews.
- Elevated the Trust’s response to domestic abuse at national level—highlighted by the Named Nurse’s participation in the Domestic Abuse Round Table at the House of Lords with the Domestic Abuse Commissioner.

### 📊 Impact & Assurance

- Ongoing rise in domestic abuse reporting through Eclipse, reflecting improved awareness and staff confidence.
- Continued embedding of trauma-informed safeguarding across BSMHFT services, ensuring the safety, dignity, and rights of service users and staff remain central.

### 🔗 Multi-Agency Risk Assessment Conference (MARAC) – Summary

- BSOL ICB commissioned the Interpersonal Violence Team (IVT) to deliver the health function to Birmingham and Solihull MARACs in 2021 to relieve provider pressure and enhance consistency.
- BSMHFT joined the IVT model in March 2024, formalised via a memorandum of understanding.
- This shift has increased safeguarding capacity, enabling more robust follow-up and targeted supervision based on MARAC intelligence.
- Substantive funding was secured in February 2024 for an IDVA role, in collaboration with Birmingham and Solihull Women’s Aid.
- The Named Nurse for Domestic Abuse chairs Birmingham MARAC meetings and represents BSMHFT at governance forums for both Solihull and Birmingham.

## 😳 Safeguarding Adults Workstream – Achievements 2024–25

BSMHFT's Safeguarding Adults workstream continues to drive high-quality, responsive safeguarding across adult services, with key achievements in training, operational support, policy development, and partnership working.

### 🎓 Training and Development

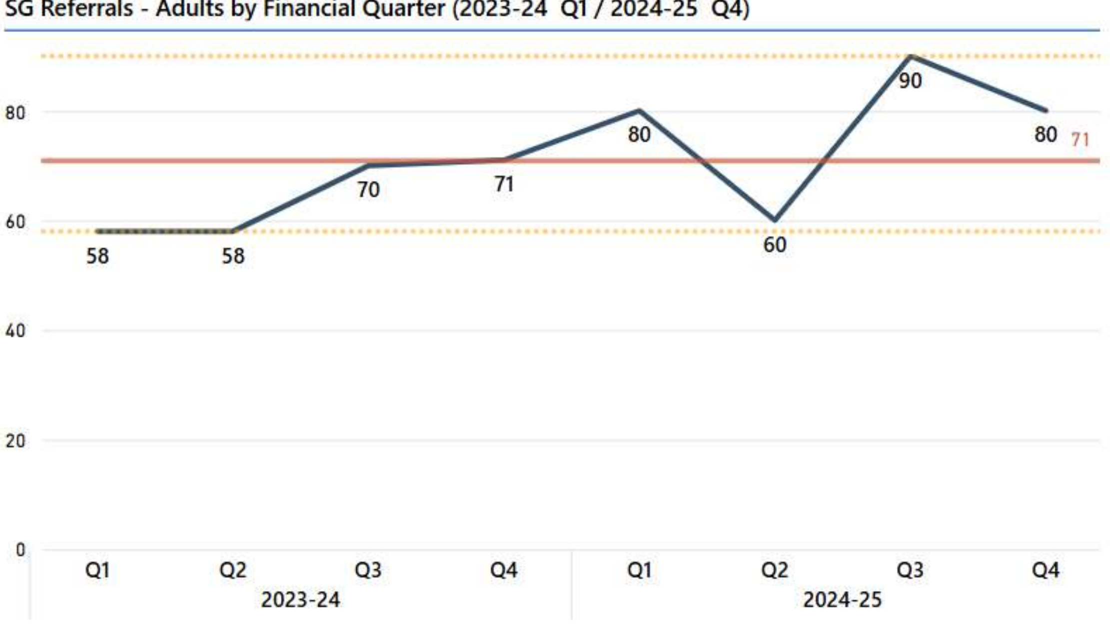
- Refreshed Level 3 face-to-face training adopting a streamlined, back-to-basics approach with emphasis on Care Act criteria and referral pathways.
- Developed bespoke sessions on Safeguarding Basics, Financial Abuse, and Organisational Abuse, delivered to priority teams including North Acute Inpatients and Urgent Care.
- Published new 7-minute briefings on topics such as Making Safeguarding Personal, Professional Curiosity, and Prevent, supporting just-in-time learning.
- Rolled out self-neglect guidance Trust-wide, aligned with Safeguarding Adults Board priorities and supported by targeted teaching.

### 🔍 Operational Support and Visibility

- Embedded safeguarding supervision across high-risk services including inpatients, urgent care, dementia/frailty, and forensics.
- Delivered targeted support in response to incidents, complaints, and statutory reviews.
- Provided hands-on guidance to teams managing adults with care and support needs at risk of abuse or neglect.

### 🔍 Oversight of safeguarding referrals:

- The safeguarding team are notified via Eclipse of referrals made to adult social care. There has been a steady increase in the number of referrals reported, evidence of improved recognition and reporting for the Trust.
- Following the dip in Q2, there had been a steep rise in the number of Safeguarding adult referrals reported via Eclipse in Q3, this has plateaued in Q4 and Q4 had the same number of referrals reported as Q1.
- This financial year to date, Dementia and Frailty remain the highest Division for referrals (this is split between Older Adults Community and Dementia and Frailty Community services). Acute Care is the next highest referring division. This is also the same for the quarter specific data.




| Fin Year, Fin Quarter | Referrals |
|---|---|
| 2023-24, Q1 | 58 |
| 2023-24, Q2 | 58 |
| 2023-24, Q3 | 70 |
| 2023-24, Q4 | 71 |
| 2024-25, Q1 | 80 |
| 2024-25, Q2 | 60 |
| 2024-25, Q3 | 90 |
| 2024-25, Q4 | 80 |

### Policy and Assurance

- Reviewed and ratified the **Adult Safeguarding Policy**, ensuring accessibility and alignment with legislation, guidance, and local procedures.
- Developed and implemented a **safeguarding assurance visit template**, enabling structured, systematic quality review across clinical services

### Partnership and System Working

- Maintained strong engagement with multi-agency safeguarding boards and review panels.
- Actively contributed to multiagency audits and cascaded relevant learning across the Trust.

# 🧒 Safeguarding Children and Young People Workstream – Achievements 2024–25

BSMHFT has made substantial progress across its children and young people safeguarding agenda this year, demonstrating leadership in oversight, assurance, and responsive practice.

### 📊 Quality Assurance & Audit

- Strengthened review of Eclipse safeguarding records through weekly monitoring by a dedicated CYP facilitator.
- Completed internal audits for Solar and perinatal services, focusing on voice of the child, safeguarding risk assessments, and early help—resulting in clear improvement plans.
- Delivered targeted ICPC audit for CMHTs, updated the ICPC process, and embedded revised practice across services.

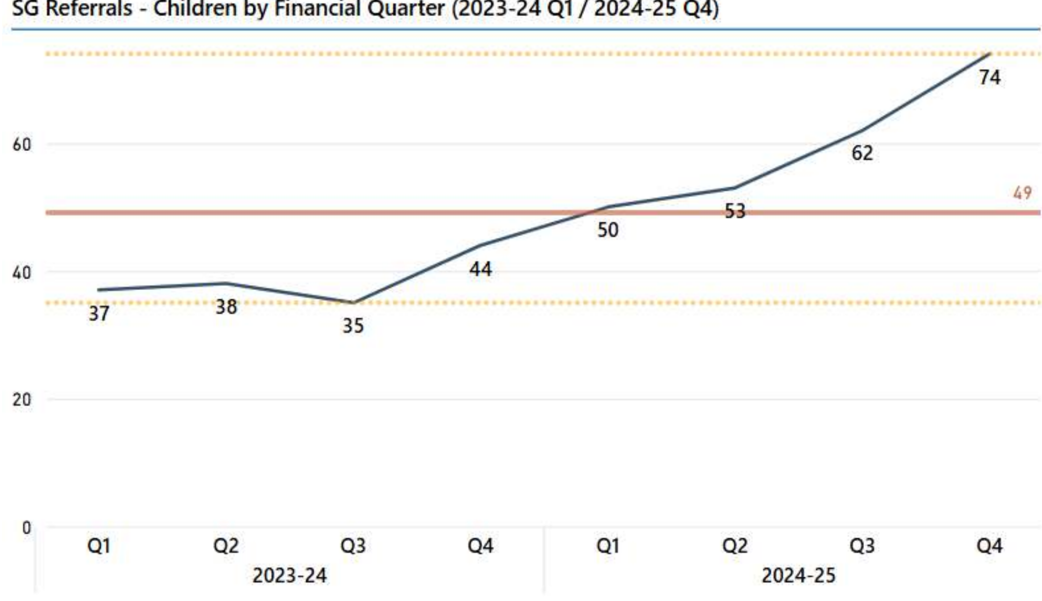
### 🔍 Operational Oversight & Supervision

- Enhanced capacity with additional safeguarding resource allocated to Solar and Perinatal services, including facilitators based at Bishop Wilson Clinic.
- Safeguarding supervision embedded for Solar management and LATCH team, with the Solar supervision model reviewed and refreshed.
- Development of a specific safeguarding supervision policy tailored to clinical roles and practice needs.
- Psychological abuse remains the highest category of abuse for referrals followed by Physical abuse.

### ⚠️ System Learning & Notification

- Safeguarding Team now sighted on all SUDIC notifications, improving oversight and preventing gaps in case recognition.
- Thematic review of perinatal incidents completed and shared with the Safeguarding Management Board (SMB).
- Review of the Safeguarding lead role for SIAS completed; responsibility now held within the core safeguarding team to strengthen assurance and accountability.
- The safeguarding team are notified of referrals made to Children's services for Birmingham and Solihull and there has been a marked improvement in recognition and reporting for 2024-25:
    - Over the last 5 quarters there has been a steady rise in the number of Safeguarding Children referrals which is positive. This quarters figures shows a 68% increase when compared to the same period last year.
    - The safeguarding team are doing continued work around how to complete a good referral, consistent messaging through comms and improving engagement with teams.
    - As expected, Solar community CAMHS is the source of the most referrals so far, this financial year and they made 30% of referrals this quarter.

- ○ The most common category of abuse this quarter remains emotional abuse followed by neglect and physical abuse




| Fin Year, Fin Quarter | Referrals |
|---|---|
| 2023-24, Q1 | 37 |
| 2023-24, Q2 | 38 |
| 2023-24, Q3 | 35 |
| 2023-24, Q4 | 44 |
| 2024-25, Q1 | 50 |
| 2024-25, Q2 | 53 |
| 2024-25, Q3 | 62 |
| 2024-25, Q4 | 74 |

### 🤝 Multi-Agency Collaboration

- Re-established the neglect working group to support BSCP and SSCP priorities, including quarterly data submissions.
- Participated in scopes, CSPRs, SUDICs, and attended all relevant meetings such as Rapid Reviews, JARs, panel meetings and Serious Case Review subgroup,
- Participated in multiagency audits and ensured learning for the Trust was identified and cascaded back to the teams as required.

### 📚 Learning Tools & Briefings

- Continued development of 7-minute briefings covering multi-agency working, information sharing, child sexual abuse, care-experienced parents, CP-IS preparation, and system-specific tools such as RiO Child and Sibling Forms.
- Briefings used across supervision, training, and team dissemination to build workforce confidence and shared understanding.

## Statutory Reviews – DARDRs, CSPRs, and SARs

During 2024–25, BSMHFT's Safeguarding Team actively contributed to statutory multi-agency reviews including:

- Domestic Abuse Related Death Reviews (DARDRs)
- Child Safeguarding Practice Reviews (CSPRs)
- Safeguarding Adult Reviews (SARs)

Mental health expertise from the team shaped key learning and system responses, with findings embedded into training, supervision, and policy updates. The team conducted thematic analysis across reviews and translated insights into staff-facing tools, such as a growing suite of 7-minute briefings on topics such as self-neglect, child sexual abuse, care experienced parents.

This learning was cascaded Trust-wide via Safeguarding Connect, team communications, and dedicated sessions, with planned safeguarding assurance visits helping monitor the embedding of key actions into clinical practice.

As a Trust serving both Birmingham and Solihull, with a footprint that regularly requires contributions to reviews led by other local authorities—including Leicester, London Boroughs, Stockport and Sandwell—the safeguarding team manages a high volume of scopes, reviews, and action plans across multiple systems and regions.

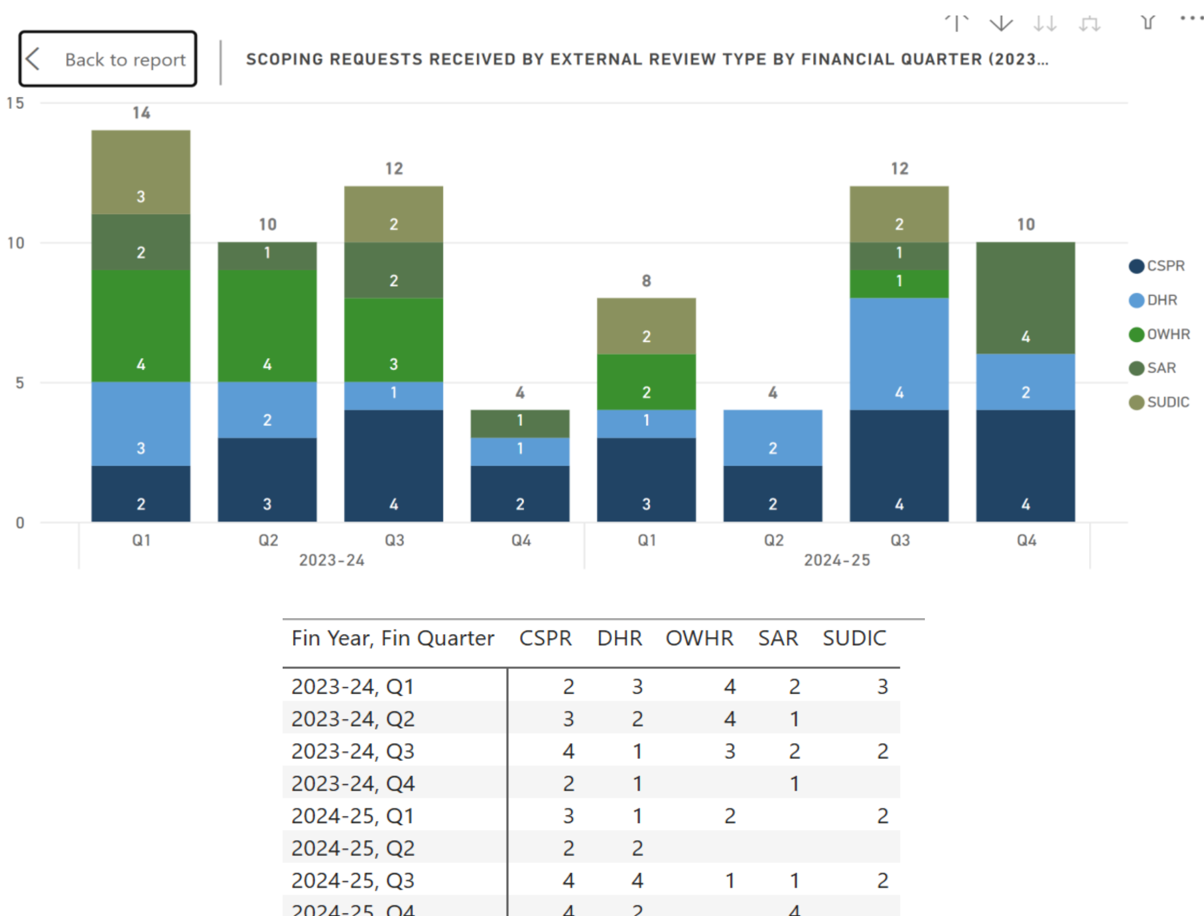
This demand is further intensified by Birmingham's profile as an area of significant deprivation and poverty, contributing to heightened complexity and risk.

Despite this, the safeguarding team consistently:

- Prioritises statutory safeguarding obligations
- Submits all scopes and responses on time
- Receives positive feedback on the depth and clarity of contributions
- Embeds key learning from reviews into supervision, policy, briefings and training

This performance is a direct reflection of the team's dedication, capacity to manage complexity, and unwavering commitment to improving outcomes for vulnerable service users and families.

The below chart illustrates the number of information scopes received for statutory reviews




| Fin Year, Fin Quarter | CSPR | DHR | OWHR | SAR | SUDIC |
|---|---|---|---|---|---|
| 2023-24, Q1 | 2 | 3 | 4 | 2 | 3 |
| 2023-24, Q2 | 3 | 2 | 4 | 1 | |
| 2023-24, Q3 | 4 | 1 | 3 | 2 | 2 |
| 2023-24, Q4 | 2 | 1 | | 1 | |
| 2024-25, Q1 | 3 | 1 | 2 | | 2 |
| 2024-25, Q2 | 2 | 2 | | | |
| 2024-25, Q3 | 4 | 4 | 1 | 1 | 2 |
| 2024-25, Q4 | 4 | 2 | | 4 | |

## 👨‍👩‍👧 Think Family – Trust-Wide Approach and Impact

BSMHFT launched its **Think Family approach** in November 2023, following learning from national safeguarding reviews, including the tragic case of Arthur Labinjo-Hughes. These reviews highlighted the need for improved recognition of risk across family systems, particularly when individuals experiencing mental illness have dependent children or vulnerable family members.

### 🚀 Implementation and Embedding

- Promoted Trust-wide colleague briefings, Executive communications, and staff webinars.
- Resources included a Think Family Standard, posters, staff video, and interactive training content.
- Embedded into practice through reflective supervision, Level 3 training, duty consultations, and roadshows.
- Designated a Key Line of Enquiry (KLOE) for 2024–25 safeguarding assurance visits.

### 🤝 Co-Production and Recognition

- Co-developed with Experts by Experience (EBEs) via the Participation and Engagement Team.
- Their insights shaped the Think Family Standard and are shared in mandatory training and via the safeguarding hub.
- This collaborative approach led to BSMHFT being awarded the Trust Quality Mark, recognising the programme's impact, inclusivity, and trauma-informed design.

### 🧠 Practice Impact and External Engagement

- Promotes professional curiosity and systemic thinking around risks to children and adults within family contexts.
- Presented externally at the Solihull Practitioners Event and the BSOL ICB Health Safeguarding Board, receiving excellent feedback

*"Think Family – Look Closer, See More"*

## 📈 Demand on Safeguarding Team’s Duty and Advice Line

The demand has steadily increased over recent years, reflecting deeper systemic pressures and rising complexity in both children’s needs and those of our adult service users.

### 🔍 Key Trends Driving Increased Demand

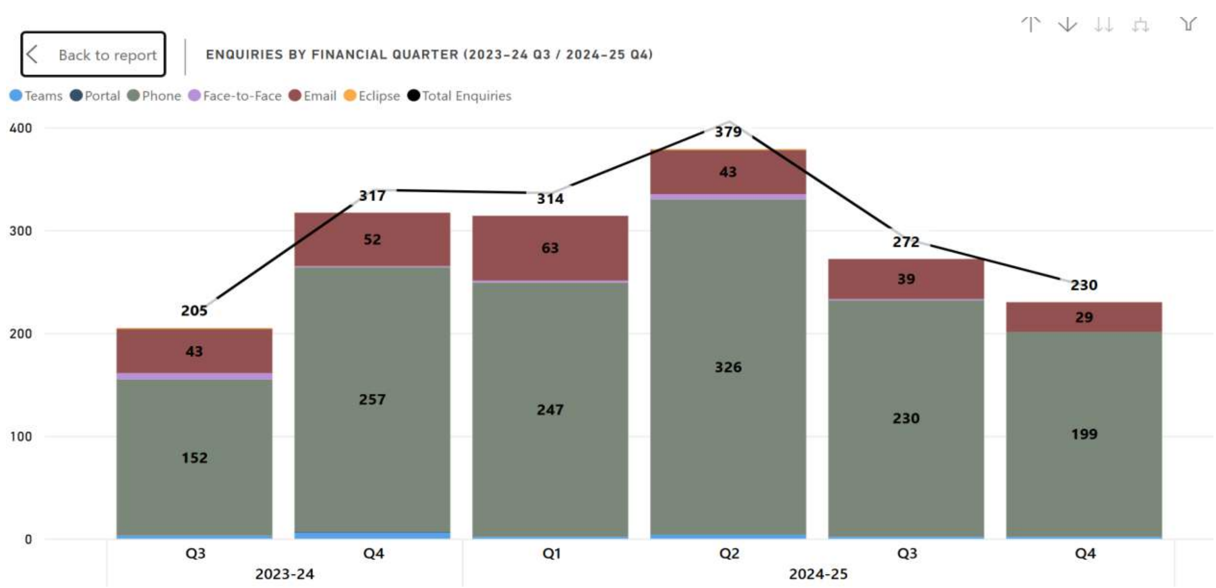
- **Mental health concerns**: Poor parental mental health has now overtaken domestic abuse as the most common factor in social care assessments.
- **Housing instability**: Overcrowding, temporary accommodation, and unaffordable housing are contributing to family distress and breakdown.
- **Post-pandemic impact**: COVID-19 has left lasting effects on children’s development, behaviour, and resilience, leading to more entrenched safeguarding needs.
- **Online risks**: There's been a surge in safeguarding activity linked to children’s online behaviour, including grooming, exploitation, and exposure to harmful content.
- **Increased referrals**: Early help assessments for child sexual exploitation, trafficking, and gang involvement have doubled in just two years.

### 🧠 What This Means for Duty and Advice Teams

- **Higher call volumes** during operating hours (Monday–Friday, 9–4), often from professionals seeking urgent guidance or referrals.
- **More complex cases** requiring multi-agency coordination and nuanced decision-making.
- **Strain on capacity**, with social workers needing to triage and respond quickly while maintaining quality and safeguarding standards.

| Fin Year, Fin Quarter | Teams | Portal | Phone | Face-to-Face | Email | Eclipse | Total Enquiries |
|---|---|---|---|---|---|---|---|
| 2023-24, Q3 | 3 | | 152 | 6 | 43 | 1 | 205.00 |
| 2023-24, Q4 | 6 | 1 | 257 | 1 | 52 | | 317.00 |
| 2024-25, Q1 | 2 | | 247 | 2 | 63 | | 314.00 |
| 2024-25, Q2 | 4 | | 326 | 5 | 43 | 1 | 379.00 |
| 2024-25, Q3 | 2 | | 230 | 1 | 39 | | 272.00 |
| 2024-25, Q4 | 2 | | 199 | | 29 | | 230.00 |

The below chart shows the number of safeguarding referrals per quarter.




## 🔻 Overall Enquiries

- **15% decrease** in safeguarding duty line enquiries compared to Q3.
- **Possible cause:** Under-reporting by the team, though not confirmed.
- It is anticipated that demand will increase when Forward Thinking Birmingham join BSMHFT on July 1st, 2025.

## 🧠 Points to Consider

- Domestic abuse remains a dominant concern across both adult and child safeguarding, highlighting the need for continued multi-agency vigilance and support.
- Emotional abuse in children is notably high, which may reflect increased awareness or better recognition by frontline staff.

## 🔚 Conclusion – Safeguarding at BSMHFT (2024–25)

Safeguarding across Birmingham and Solihull Mental Health NHS Foundation Trust remains a significant undertaking—complex, demanding, and not without its difficulties. As a large and diverse Trust delivering mental health care across two major urban areas, and with secure offender and tertiary services, we operate within high-acuity services, navigate wide-ranging risk profiles, and face persistent systemic pressures.

This year's safeguarding work has shown growth and innovation but also exposed areas that require continued attention. Good practice and learning in relation to Safeguarding requires constant reinforcement and the safeguarding team are committed to supporting all staff at BSMHFT to continually improve our safeguarding recognition and response.

Our progress in 2024–25 has laid stronger foundations through initiatives like expanded safeguarding supervision, the Think Family approach, and focused responses to domestic abuse and sexual safety. Tools, training, and policy improvements have helped strengthen recognition and reporting—but none of this is static. Our efforts are ongoing, and improvement is a process.

We've learned from statutory reviews, engaged meaningfully with Experts by Experience, and continued to grow multi-agency relationships. But more importantly, we've acknowledged where practice needs to improve and made plans to address it.

In 2025–26, our focus will be on embedding safeguarding more deeply across systems and teams, expanding supervision where it's needed, improving referral quality and early identification, and continuing to learn from lived experience.

Thank you to the safeguarding team, our staff, and partners who work through this complexity every day. Your efforts make the difference—and we remain collectively committed to better outcomes, stronger accountability, and safer care.

# 14. People Committee Report

## Committee Escalation and Assurance Report

| Name of Committee | People Committee |
| --- | --- |
| Report presented at | Board of Directors |
| Date of meeting | 4 February 2026 |
| Date(s) of Committee Meeting(s) reported | 20 January 2026 |
| Quoracy | Membership quorate: Y |
| Agenda | The Committee considered an agenda which included the following items:<br>• Board Assurance Framework<br>• Corporate Risk Register<br>• People Dashboard Overview<br>• Workforce Plan<br>• Shaping our Future Workforce Committee Assurance Report<br>• Transforming our Culture and Staff Experience Group Assurance Report<br>• Staff Survey Highlight Report<br>• Women's Network Report<br>• Multi-Professional, Education and Training Group Assurance Report<br>• Safer Staffing Report<br>• People Committee Sub-Committee Terms of Reference |
| Alert: | The Committee wished to alert the Board of Directors to the following key areas:<br>• Sub-committee quoracy remained a challenge, and the Committee noted ongoing work to address this.<br>• The Committee noted the underutilisation of the apprenticeship levy, with 35% usage.<br>• There was a reported backlog of e-learning packages licences, however there was a plan to clear this by autumn.<br>• An ESR data cleanse was in progress to rectify reporting lines and data errors. |
| Assure: | • Medical workforce planning was robust, and the Committee received assurance on recruitment plans and industrial action coverage.<br>• Assurance continued to be received on management of mental health-related sickness absence, and the Committee noted the targeted interventions related to anxiety, stress and depression absences.<br>• Engagement with the staff survey had improved, with increased participation across the organisation. The Committee particularly noted the significant increased engagement of the Home Treatment Team.<br>• The Committee was assured by the work of the Women's Network, including menopause initiatives, inclusion of baby loss awareness and leave provision for family support, and good engagement from colleagues. An International Women's Day celebration was being planned for March.<br>• Positive assurance was received from the Safer Staffing Report, with good retention and ongoing training focus. |

<table>
<tr><td></td><td colspan="2">• The Committee approved the terms of reference of its sub-committees.</td></tr>
<tr><td>Advise:</td><td colspan="2">The Committee noted the implementation plan for auto-rostering which would be brought into effect across acute wards from April. This aimed to improve efficiency and reduce manual roster changes.<br><br>The Committee noted training available to refresh management skills and interview techniques.<br><br>The Workforce Plan submission deadline was 12 February, and the Committee noted ongoing alignment of the plan to the refreshed Trust strategy and the NHS 10-Year Plan.<br><br>The Committee supported the standard operating procedure for multidisciplinary apprenticeships.</td></tr>
<tr><td rowspan="2">Board Assurance Framework</td><td colspan="2">The Committee scrutinised the following risks:<br>• Failure to create a positive working culture that is anti-racist and anti-discriminatory.<br>• Inability to attract, retain or transform our workforce in response to the needs of our communities.</td></tr>
<tr><td colspan="2">New risks identified: No additional risks were identified.<br><br>The Corporate Risk Register was reviewed and further clarification would be undertaken at Risk Management Group into digital and workforce risks.</td></tr>
<tr><td>Report compiled by:</td><td>Sue Bedward, Non-Executive Director</td><td>Minutes available from:<br>Kat Cleverley, Company Secretary</td></tr>
</table>

# 15. Guardian of Safe Working Hours Quarterly Report

| Report to Board of Directors | | | | | |
|---|---|---|---|---|---|
| Agenda item: | 15 | | | | |
| **Date** | 4 February 2026 | | | | |
| **Title** | Guardian of Safe Working Hours Q3 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 remained relatively stable this quarter. 8 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 decreased to 3

The number of vacant shifts continues to be high. 350 locum bookings occurred in Q3 (in 2024-2025, Q1 had 370, Q2 had 260, Q3 had 191, Q4 had 280). 41% of the gaps were due to post vacancies. 350/350 on call locum vacancies during this period were filled.

## Recommendation

This report is for assurance to the Board 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

**High level data**
Number of doctors / dentists in training (total): 153 in October and November, 155 in December

Number of doctors / dentists in training on 2016 TCS (total): 153 in October and November, 155 in December

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 | 0 | 0 | 0 |
| CT1-3 | 5 | 6 | 8 | 3 |
| ST 3-6 | 2 | 2 | 4 | 0 |
| GPVTS | 0 | 0 | 0 | 0 |
| Total | 7 | 8 | 12 | 3 |

| 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) | 5 | 6 | 8 | 3 |
| ST North | 0 | 2 | 2 | 0 |
| ST South | 2 | 0 | 2 | 0 |
| ST Forensic | 0 | 0 | 0 | 0 |
| Total | 7 | 8 | 12 | 3 |

| Exception reports (response time) | | | | |
|---|---|---|---|---|
| | Addressed within 48 hours | Addressed within 7 days | Addressed in longer than 7 days | Still open |
| F1 | 0 | 0 | 0 | 0 |
| F2 | 0 | 0 | 0 | 0 |
| CT1-3 | 0 | 1 | 7 | 3 |
| ST3-6 | 0 | 2 | 2 | 0 |
| GPVTS | 0 | 0 | 0 | 0 |
| Total | 0 | 3 | 9 | 3 |

**b) Type of exceptions in the quarter:**

There were no immediate safety concerns raised. 8 exception reports were raised in total.

Of the 8 exception reports; 8 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 OCTOBER 2025 by ROTA** | | | | |
|---|---|---|---|---|
| Rota | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked* |
| Rota 1 | 9 | 9 | 78.50 | 78.50 |
| Rota 2 | 9 | 9 | 87.50 | 87.50 |
| Rota 3 | 13 | 13 | 127.00 | 127.00 |
| Rota 4 | 11 | 11 | 110.00 | 110.00 |
| Rota 5 | 2 | 2 | 9.00 | 9.00 |
| Rota 6 | 8 | 8 | 73.50 | 73.50 |
| CAMHS CT | 5 | 5 | 74.50 | 74.50 |
| ST4-6 North & East | 18 | 18 | 174.00 | 174.00 |
| ST4-6 Rea/Tam | 9 | 9 | 168.00 | 168.00 |
| ST4-6 South & Solihull | 23 | 23 | 228.50 | 228.50 |
| CAMHS ST | 11 | 11 | 192.00 | 192.00 |
| FTB (CYP) ST | 0 | 0 | 0 | 0 |
| Total | 118 | 118 | 1322.50 | 1322.50 |

| **Locum bookings NOVEMBER 2025 by ROTA** | | | | |
|---|---|---|---|---|
| Rota | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked* |
| Rota 1 | 19 | 19 | 200.00 | 200.00 |
| Rota 2 | 2 | 2 | 24.00 | 24.00 |
| Rota 3 | 7 | 7 | 84.50 | 84.50 |
| Rota 4 | 8 | 8 | 52.00 | 52.00 |

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

| | | | | |
|---|---|---|---|---|
| Rota 5 | 13 | 13 | 130.00 | 130.00 |
| Rota 6 | 10 | 10 | 84.00 | 84.00 |
| CAMHS CT | 13 | 13 | 224.00 | 224.00 |
| ST4-6 North & East | 7 | 7 | 70.50 | 70.50 |
| ST4-6 Rea/Tam | 6 | 6 | 112.00 | 112.00 |
| ST4-6 South & Solihull | 7 | 7 | 71.00 | 71.00 |
| CAMHS ST | 9 | 9 | 176.00 | 176.00 |
| FTB (CYP) ST | 0 | 0 | 0 | 0 |
| Total | 101 | 101 | 1228.00 | 1228.00 |

| Locum bookings DECEMBER 2025 by ROTA | | | | |
|---|---|---|---|---|
| Rota | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked* |
| Rota 1 | 13 | 13 | 142.50 | 142.50 |
| Rota 2 | 13 | 13 | 135.00 | 135.00 |
| Rota 3 | 6 | 6 | 35.00 | 35.00 |
| Rota 4 | 17 | 17 | 160.00 | 160.00 |
| Rota 5 | 17 | 17 | 152.50 | 152.50 |
| Rota 6 | 15 | 15 | 135.00 | 135.00 |
| CAMHS CT | 3 | 3 | 64.00 | 64.00 |
| ST4-6 North & East | 13 | 13 | 143.00 | 143.00 |
| ST4-6 Rea/Tam | 4 | 4 | 80.00 | 80.00 |
| ST4-6 South & Solihull | 14 | 14 | 140.00 | 140.00 |
| CAMHS ST | 14 | 14 | 264.00 | 264.00 |
| CYP SAS | 2 | 2 | 48.00 | 48.00 |
| Total | 131 | 131 | 1499.00 | 1499.00 |

| Locum bookings OCTOBER 2025 by grade | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| CT1-3 | 57 | 57 | 560.00 | 560.00 |
| ST4-6 | 61 | 61 | 762.50 | 762.50 |
| Total | 118 | 118 | 1322.50 | 1322.50 |

| Locum bookings NOVEMBER 2025 by grade | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| CT1-3 | 72 | 72 | 798.50 | 798.50 |
| ST4-6 | 29 | 29 | 429.50 | 429.50 |
| Total | 101 | 101 | 1228.00 | 1228.00 |
| | | | | |

| Locum bookings DECEMBER 2025 by grade | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| CT1-3 | 84 | 84 | 824.00 | 824.00 |
| ST4-6 | 47 | 47 | 675.00 | 675.00 |
| Total | 131 | 131 | 1499.00 | 1499.00 |

| Locum bookings OCTOBER 2025 by reason** | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| Vacancy | 36 | 36 | 432.50 | 432.50 |
| Sickness | 22 | 22 | 217.00 | 217.00 |
| Off Rota | 40 | 40 | 433.00 | 433.00 |
| Study Leave | 2 | 2 | 9.00 | 9.00 |
| Unpaid Leave | 2 | 2 | 24.00 | 24.00 |
| Emergency Leave | 2 | 2 | 25.00 | 25.00 |
| Maternity / Paternity / Paternal Leave | 0 | 0 | 0 | 0 |
| Acting Up Consultant | 14 | 14 | 182.00 | 182.00 |
| Total | 118 | 118 | 1322.50 | 1322.50 |

| Locum bookings NOVEMBER 2025 by reason** | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| Vacancy | 53 | 53 | 658.50 | 658.50 |
| Sickness | 25 | 25 | 289.00 | 289.00 |
| COVID | 0 | 0 | 0 | 0 |
| Off Rota | 13 | 13 | 139.00 | 139.00 |
| Comp Leave /Bereavement | 0 | 0 | 0 | 0 |
| Study Leave | 4 | 4 | 48.00 | 48.00 |
| Parental Leave | 0 | 0 | 0 | 0 |
| Emergency Leave | 2 | 2 | 25.00 | 25.00 |
| Acting Up Consultant | 4 | 4 | 68.50 | 68.50 |
| Total | 101 | 101 | 1228.00 | 1228.00 |

| Locum bookings DECEMBER 2025 by reason** | | | | |
|---|---|---|---|---|
| Specialty | Number of shifts requested | Number of shifts worked | Number of hours requested | Number of hours worked |
| New intake | 8 | 8 | 36.00 | 36.00 |
| Vacancy | 56 | 56 | 702.00 | 702.00 |
| Sickness | 28 | 28 | 320.50 | 320.50 |

| | | | | |
|---|---|---|---|---|
| Off Rota | 34 | 34 | 372.50 | 372.50 |
| Coroners Court Preparations | 1 | 1 | 12.00 | 12.00 |
| Special Leave | 2 | 2 | 24.00 | 24.00 |
| Actg up Consultant | 2 | 2 | 32.00 | 32.00 |
| Total | 131 | 131 | 1499.00 | 1499.00 |

**Fines levied**

Three fines have been levied in Q3. 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 remined relatively stable, with 8 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. 350 locum bookings occurred in Q3 (in 2024-2025, Q1 had 370, Q2 had 260, Q3 had 191, Q4 had 280). 41% of the gaps were due to post vacancies. 350/350 on call locum vacancies during this period were filled.

The nationwide exception reporting reform deadline for all trusts to be concordant with the new processes is 4th February 2026. Key points of the reform include:

- All educational exception reports will go to the directors of medical education (DME) for approval.
- All other exception reports to go to HR or medical workforce HR for approval.
- The guardian of safe working hours will retain oversight of all exception reports, these will be reviewed to identify exception reporting patterns to ensure reports are accurate, valid and adhere to the purpose of exception reporting.
- Additional fines: fines will be introduced to ensure that doctors have timely access to systems and are not prevented from exception reporting. Employers will face additional fines to ensure that doctors are not adversely affected by the unnecessary sharing of exception reporting information.
- A requirement for the guardian of safe working hours to oversee quarterly surveys of breach of ‘access and completion’, ‘information breach’ and actual or threatened detriment.
- Additional board reporting requirements which will be to a standardised national template.

There are ongoing concerns arising from the fact that we are continuing to provide a CAMHS CT rota for Parkview clinic even though we will not be running this facility and therefore have limited powers to enact change if there are concerns from resident doctors.

**Actions taken to resolve issues**
See above.

**Summary**

No immediate safety concerns were raised during this quarter. Exception reporting rates have remained stable. 8 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, 0% were within 48 hours and a further 25% 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. 350 locum bookings occurred in Q3 (in 2024-2025, Q1 had 370, Q2 had 260, Q3 had 191, Q4 had 280). 41% of the gaps were due to post vacancies. 350/350 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.

# 16. Finance, Performance and Productivity Committee Report

# Committee Escalation and Assurance Report

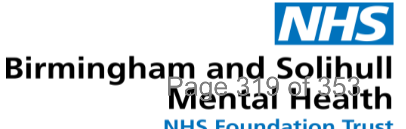
| Name of Committee | Report of the Finance, Performance and Productivity Committee |
|---|---|
| Report presented at | Board of Directors |
| Date of meeting | 4 February 2025 |
| Date(s) of Committee Meeting(s) reported | 22 January 2026 |
| Quoracy | Membership quorate: Y |
| **Agenda** | The Committee considered an agenda which included the following items:<br>• Board Assurance Framework Risks<br>• Corporate Risk Register<br>• Integrated Performance Report<br>• Finance Report<br>• Cyber Assurance Framework – Data Protection Toolkit internal audit review<br>• Planning 2026/27-2028/29 Report<br>• Children and Young People's Services Transfer Assurance Report<br>• Forward Planner 2026/27<br>• Sub-Committee Terms of Reference |
| **Alert:** | The Month 9 position was a reported surplus of £175k. This was £3m adverse to plan, but £0.35m ahead of the financial recovery plan trajectory. Although the Trust was maintaining a positive position, its challenges around out of area placements, clinically ready for discharge numbers and bank spend remained challenging.<br>The Trust remained in National Oversight Framework segment 4, however the financial position had improved favourably and was viewed as being within segment 2 (although the Trust position had not changed overall). |
| **Assure:** | The Committee was assured by the positive progress the Trust was making in its financial recovery plan.<br>The overall positive progress being made in improving performance across the Trust's Talking Therapy services was also recognised.<br>The Committee was assured by the process for monitoring and managing the Cyber Assurance Framework requirements.<br>The Committee highlighted strong improvements in key areas such as bank and agency, and the continued reduction in out of area bed placements. |
| **Advise:** | The plan for 2026/27 was maturing, and the Committee noted the improved position. However, the Committee remained concerned about recurrent and non-recurrent savings plans and confidence around delivery – both of which |

| | | |
|---|---|---|
| | were very high risk. The final planning document would be received by the Committee before submission to NHSE in February.<br><br>The Committee received good assurance through the CYP Services Transfer Assurance Report, particularly around the transfer of services and how the remaining risks of the transfer were being proactively mitigated. However, the outcomes, timelines and transformational narrative required further clarity. The Committee noted that this would become clearer through the refreshed Trust strategy. | |
| **Board Assurance Framework** | The Committee considered the three risks:<br>• Failure to maintain a long-term, sustainable financial position<br>• Failure to maintain acceptable governance and national standards<br>• Failure to deliver optimal outcomes with available resources<br><br>The Committee discussed how the regular Digital and Cyber Assurance Report should include not only technical and cyber content, but to also include how digital aligned with and supported the Trust's wider transformation agenda.<br><br>The proposal to move SR7 to a 4x3 scoring matrix was also reviewed and agreed in principle. | |
| | **New risks identified:** No new risks were identified, however SR5 and SR6 were discussed in terms of their current score, relative to the recovery plan for the financial year and the development of the multi-year finance plan. | |
| **Report compiled by:** | Bal Claire<br>Deputy Chair/<br>Non-Executive Director | **Minutes available from:**<br>Kat Cleverley, Company Secretary |

# Committee Escalation and Assurance Report

<table>
<tr><td>Name of Committee</td><td colspan="2">Report of the Extraordinary Finance, Performance and Productivity Committee</td></tr>
<tr><td>Report presented at</td><td colspan="2">Board of Directors</td></tr>
<tr><td>Date of meeting</td><td colspan="2">4 February 2026</td></tr>
<tr><td>Date(s) of Committee Meeting(s) reported</td><td colspan="2">10 December 2025</td></tr>
<tr><td>Quoracy</td><td colspan="2">Membership quorate: Y</td></tr>
<tr><td>Agenda</td><td colspan="2">• Draft Planning Submission (Activity Return; Finance Return; Workforce Return; Board Assurance Statements)<br>• Finance Report</td></tr>
<tr><td>Alert:</td><td colspan="2">• The Month 8 position was a reported £80k surplus, which was £2.7m adverse to plan but £0.3m ahead of the financial recovery trajectory.<br>• The Committee noted the financial risk within the planning submissions, particularly the 6.95% savings requirement in 2026/27. Concern remained in relation to achievability and delivery of plans.</td></tr>
<tr><td>Assure:</td><td colspan="2">The Committee was assured that compliant plans had been submitted for both years, and was satisfied with the Board Assurance Statements, noting that these would mature over the coming months.</td></tr>
<tr><td>Advise:</td><td colspan="2">Service developments, Cost Improvement Plans and productivity improvements would be included in the February planning submissions. The Committee noted that assumptions had been made that fewer external beds would be utilised, but internal bed use remained the same.</td></tr>
<tr><td rowspan="2">Board Assurance Framework</td><td colspan="2">The BAF was not considered as part of the extraordinary meeting.</td></tr>
<tr><td colspan="2">New risks identified: No new risks were identified.</td></tr>
<tr><td>Report compiled by:</td><td>Bal Claire<br>Deputy Chair/<br>Non-Executive Director</td><td>Minutes available from:<br>Kat Cleverley, Company Secretary</td></tr>
</table>

# 17. Finance Report






| Report to Board of Directors | | | | | | |
|---|---|---|---|---|---|---|
| **Agenda item:** | **17** | | | | | |
| **Date** | 22 January 2026 | | | | | |
| **Title** | Month 9 2025/26 Finance Report | | | | | |
| **Author/Presenter** | Emma Ellis, Head of Finance & Contracts / Richard Sollars, Deputy Director of Finance | | | | | |
| **Executive Director** | David Tomlinson, Executive Director of Finance | **Approved** | **Y** | ✓ | **N** | |

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

**Summary of Report**

| Alert | ✓ | Advise | | Assure | |
|---|---|---|---|---|---|

**Purpose**

To provide an overview of the Group quarter 3 year to date financial position.

**Introduction**

The month 9 year to date consolidated Group position is a surplus of £175k. This is £3m adverse to original plan and £0.35m ahead of the financial recovery trajectory.

**Key Issues and Risks**

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

**Financial position and recovery plan** –The month 9 year to date position is £0.35m better than the financial recovery trajectory. Temporary staffing expenditure is adverse to trajectory (see below). However, significant reductions in non-Trust bed expenditure is helping to offset this. The recovery plan assumed receipt of £2m Toucan Provider Collaborative income in month 10, discussions are ongoing.

- **Temporary staffing** - The month 9 year to date spend of £26m is £2m adverse to the temporary staffing trajectory set as part of the financial recovery plan (£1.6m bank, £0.6m agency). The Bank Reduction Gold project is ongoing, lead by the Executive Director of Nursing. Monthly bank spend year to date is £0.3m on average less than in 2024/25 and several actions are underway to pursue further reductions. There has been significant reduction in agency spend, in particular, from July, CYP agency has reduced by 41% (part offset by increased bank).

- **Savings** – The 2025/26 savings target is £36m. The month 9 year to date savings achieved is £24m, this is £2.6m adverse to plan. It is forecast that the full year savings target will be achieved but £14.4m will be via non-recurrent means.

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

**Advise:**

- **National Oversight Framework (NOF)** – the quarter 3 NOF score will be formally published in due course but the combined finance score and the finance and productivity domain score remain at a 2, consistent with quarter 2. It is forecast that these scores will improve to a 1 by the end of quarter 4, in line with the financial recovery trajectory.
- **Medium Term Plan** – The first draft plan was submitted to NHSE in December 2025. The final 3 year revenue plan and 4 year capital plan are due to be submitted to NHSE on 12.2.26. An update will be presented at the FPP Committee meeting.

**Capital position:**

The month 9 year to date 2025/26 Group capital expenditure is £6.7m, this is £5.7m adverse to original 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 9 was £95m, including £32m Trust cash balance.

## Recommendation

The Committee is asked to review the month 9 year to date financial position and discuss the key alerts noted.

## Enclosures

Month 9 2025/26 finance report

# Finance Report

## Financial Performance:

## 1st April 2025 to 31st December 2025

# Group financial position £0.2m surplus YTD

| Group Summary | Annual Budget | 0.68% Pay Award Funding | CYP Transfer | Revised Plan | YTD Position | | |
|---|---|---|---|---|---|---|---|
| | | | | | Budget | Actual | Variance |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Income** | | | | | | | |
| Patient Care Activities | 706,067 | 4,638 | 401 | 711,106 | 533,268 | 534,833 | 1,565 |
| Other Income | 24,081 | - | 8,343 | 32,424 | 23,623 | 26,682 | 3,059 |
| **Total Income** | **730,148** | **4,638** | **8,744** | **743,530** | **556,891** | **561,515** | **4,624** |
| **Expenditure** | | | | | | | |
| Pay | (319,512) | (2,750) | (24,460) | (346,722) | (257,976) | (258,273) | (297) |
| Other Non Pay Expenditure | (369,431) | (1,888) | 18,112 | (353,207) | (266,389) | (273,530) | (7,142) |
| Drugs | (6,058) | - | (1,320) | (7,378) | (5,423) | (7,116) | (1,693) |
| Clinical Supplies | (684) | - | (23) | (707) | (529) | (661) | (132) |
| PFI | (13,896) | - | - | (13,896) | (10,422) | (10,222) | 200 |
| **EBITDA** | **20,566** | **-** | **1,053** | **21,619** | **16,153** | **11,712** | **(4,440)** |
| **Capital Financing** | | | | | | | |
| Depreciation | (10,033) | - | (795) | (10,828) | (8,055) | (7,442) | 613 |
| PDC Dividend | (500) | - | - | (500) | (375) | (375) | - |
| Finance Lease | (6,939) | - | - | (6,939) | (5,867) | (5,905) | (38) |
| Loan Interest Payable | (882) | - | (258) | (1,140) | (833) | (670) | 164 |
| Loan Interest Receivable | 3,376 | - | - | 3,376 | 2,532 | 3,195 | 663 |
| **Surplus / (Deficit) before taxation** | **5,588** | **-** | **-** | **5,588** | **3,554** | **516** | **(3,038)** |
| Taxation | (380) | - | - | (380) | (285) | (293) | (8) |
| **Surplus / (Deficit)** | **5,208** | **-** | **-** | **5,208** | **3,269** | **223** | **(3,046)** |
| **Adjusted Financial Performance:** | | | | | | | |
| Remove capital donations/grants/peppercorn lease I&E impact | 5 | - | - | 5 | - | 58 | 58 |
| Adjust PFI revenue costs to UK GAAP basis | (1,013) | - | - | (1,013) | (106) | (106) | - |
| **Adjusted financial performance Surplus / (Deficit)** | **4,200** | **-** | **-** | **4,200** | **3,162** | **175** | **(2,988)** |

The Group position is driven by a £279k surplus in the Trust, £116k deficit for Summerhill Services Limited (SSL), break even position for the Mental Health Provider Collaborative (MHPC) and a surplus of £188k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

**Month 9 2025/26 Group Financial Position**

The quarter 3 year to date consolidated Group position is a surplus of £0.18m (after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 of £0.1m). This is £3m adverse to original plan and £0.35m better than the year to date financial recovery plan submitted to NHSE in September.

The December surplus of £42k is £0.1m less than November. December temporary staffing expenditure is £0.2m less than in November (driven by bank) but year to date spend remains adverse to the financial recovery trajectory (pages 10 to 12).

Non-Trust bed expenditure is £0.3m higher than November (which was reduced due to a favourable one off CYP adjustment). The reductions in adult bed expenditure continue, with quarter 3 spend £2.5m less than quarter 1, and ahead of the year to date financial recovery trajectory for beds (page 9).

On 8.1.26, NHSE advised of national funding to cover industrial action costs, with the expectation that it will support providers in delivering a balanced position for 2025/26. BSMHFT allocation is £0.7m.

| NOF - Finance | Q1 | Q2 | Q3 |
|---|---|---|---|
| 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

| 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 | 324,929 | - | 135,489 | 359,804 | (285,389) | 534,833 |
| Other Income | 26,258 | 22,078 | - | 0 | (21,654) | 26,682 |
| **Total Income** | **351,187** | **22,078** | **135,489** | **359,805** | **(307,043)** | **561,515** |
| **Expenditure** | | | | | | |
| Pay | (243,619) | (10,024) | (2,107) | (2,743) | 220 | (258,273) |
| Other Non Pay Expenditure | (79,907) | (5,767) | (134,060) | (358,113) | 304,316 | (273,530) |
| Drugs | (7,426) | (1,914) | - | - | 2,224 | (7,116) |
| Clinical Supplies | (661) | - | - | - | - | (661) |
| PFI | (10,222) | - | - | - | - | (10,222) |
| **EBITDA** | **9,351** | **4,374** | **(678)** | **(1,051)** | **(283)** | **11,712** |
| **Capital Financing** | | | | | | |
| Depreciation | (4,841) | (2,452) | - | - | (149) | (7,442) |
| PDC Dividend | (375) | - | - | - | - | (375) |
| Finance Lease | (5,895) | (267) | - | - | 257 | (5,905) |
| Loan Interest Payable | (670) | (1,521) | - | - | 1,521 | (670) |
| Loan Interest Receivable | 2,757 | 42 | 865 | 1,051 | (1,521) | 3,195 |
| **Surplus / (Deficit) before Taxation** | **327** | **176** | **188** | **0** | **(175)** | **516** |
| Taxation | - | (293) | - | - | - | (293) |
| **Surplus / (Deficit)** | **327** | **(116)** | **188** | **0** | **(175)** | **223** |
| **Adjusted Financial Performance:** | | | | | | |
| Remove capital donations/grants/peppercorn lease I&E impact | 58 | - | - | - | - | 58 |
| Adjust PFI revenue costs to UK GAAP basis | (106) | | | | | (106) |
| **Adjusted financial performance Surplus / (Deficit)** | **279** | **(116)** | **188** | **0** | **(175)** | **175** |

# Draft System position Month 9 YTD

The draft month 9 year to date financial position for Birmingham and Solihull Integrated Care System (BSOL ICS) is a deficit of £45m which is £33m adverse to plan. This is predominantly driven by UHB deficit of £37m, BWCH deficit of £7m and ICB deficit of £1m.

The £45m year to date system deficit is £10m adverse to the year to date financial recovery plan, with UHB £13m behind recovery plan.

| Total Performance | YTD | | | FOT | | | Prior Month variance £000s |
|---|---|---|---|---|---|---|---|
| | Current Plan £000s | Actual £000s | Variance £000s | Annual Plan £000s | FOT £000s | Variance £000s | |
| BSOL ICB | -3,161 | -1,142 | 2,019 | 0 | 0 | 0 | 1,064 |
| BSMHT | 3,141 | 175 | -2,966 | 4,200 | 4,200 | 0 | -2,716 |
| BCHC | 500 | 504 | 4 | 0 | 0 | 0 | -714 |
| BWC | 0 | -6,841 | -6,841 | 0 | 0 | 0 | -5,999 |
| ROH | -505 | -496 | 9 | 35 | 35 | 0 | 5 |
| UHB | -11,187 | -36,766 | -25,579 | -4,200 | -4,200 | 0 | -23,960 |
| Total | -11,212 | -44,566 | -33,354 | 35 | 35 | 0 | -32,320 |

| 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 | -3,161 | -1,142 | 2,019 |
| BSMHT | 4,209 | 4,200 | 9 | -176 | 175 | 351 |
| BCHC | 0 | 0 | 0 | -225 | 504 | 729 |
| BWC | 0 | 0 | 0 | -7,102 | -6,841 | 261 |
| ROH | 35 | 35 | 0 | -505 | -496 | 9 |
| UHB | -15,318 | -4,200 | -11,118 | -23,502 | -36,766 | -13,264 |
| Total | -11,074 | 35 | -11,109 | -34,670 | -44,566 | -9,896 |

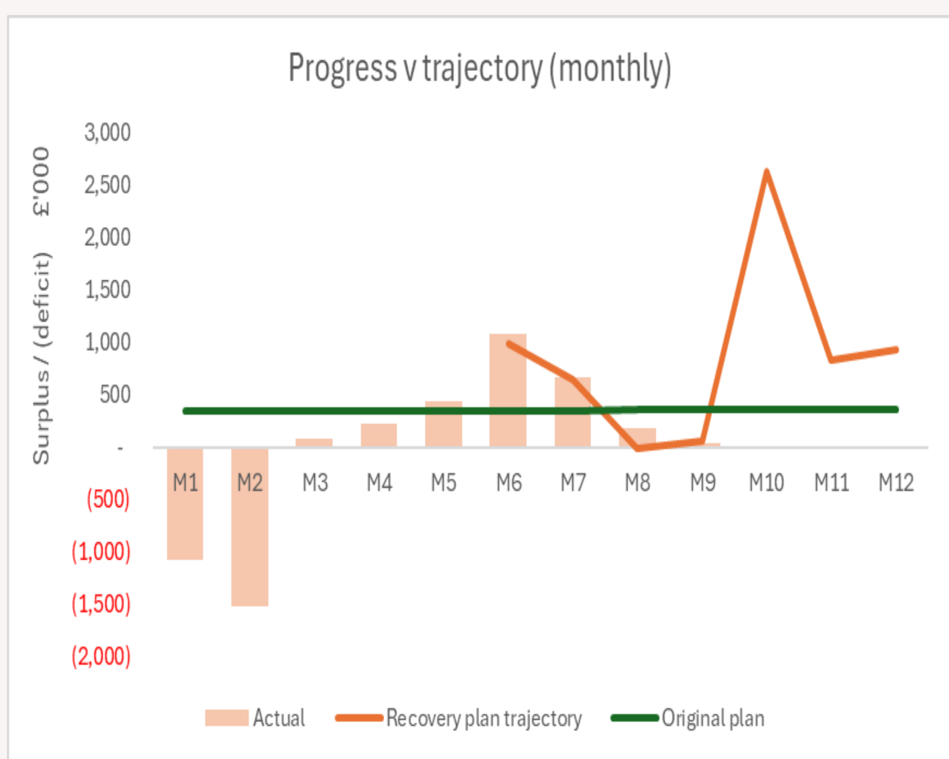
# Actual v financial recovery trajectory

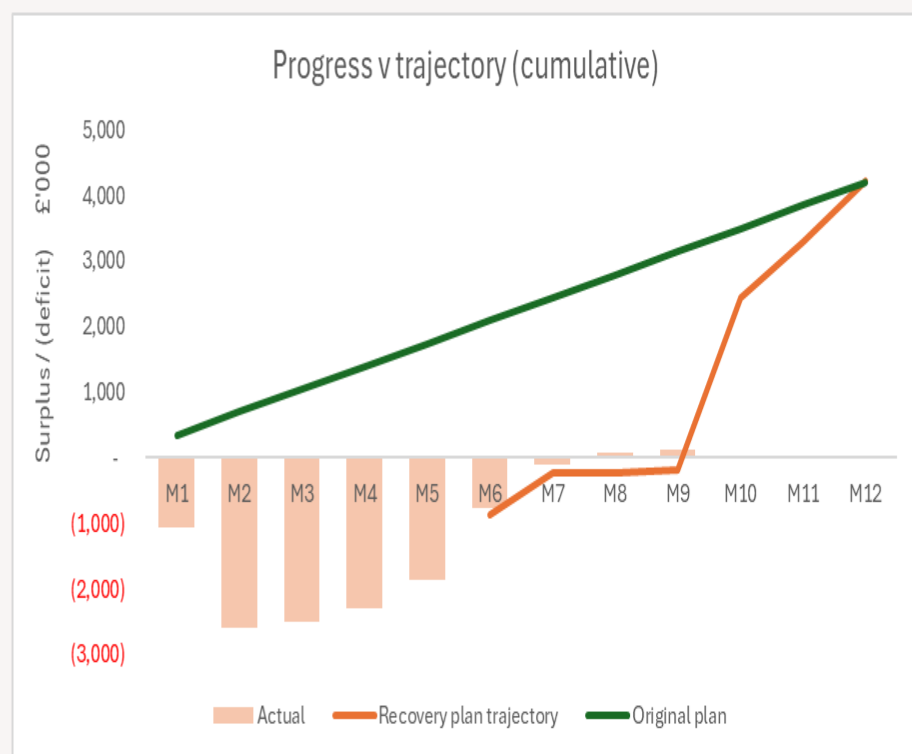


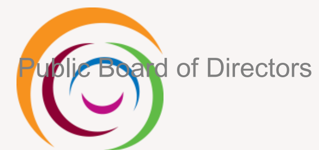
Birmingham and Solihull Mental Health NHS Foundation Trust

**BSMHFT Financial Recovery Plan**

Submitted to NHSE September 2025. Trajectory for month 6 to 12 to recover the financial position. It is forecast that the original 2025/26 plan surplus of £4.2m will be achieved. Month 9 year to date £0.35m ahead of trajectory. The trajectory assumes receipt of £2m Toucan Provider Collaborative income in month 10, discussions are ongoing.






# Underlying position

**Group Underlying position**

The underlying position is currently assessed as £25m deficit:

- £14.4m rollover of recurrent savings target (forecast to deliver non-recurrently in 2025/26) (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.

| Provider Underlying position<br><br>Internal use only - Underlying Position as submitted in 26/27 planning returns will be used by the national team. | Expected Sign | 27BRD04A<br>Income Forecast 31/03/2026<br>Year ending<br>£'000 | 27BRD04B<br>Employee Expenses Forecast 31/03/2026<br>Year ending<br>£'000 | 27BRD04C<br>Operating expenses excluding employee expenses Forecast 31/03/2026<br>Year ending<br>£'000 | 27BRD04D<br>Non Operating Items Forecast 31/03/2026<br>Year ending<br>£'000 | 27BRD04E<br>Adjusted Financial Performance Forecast 31/03/2026<br>Year ending<br>£'000 | 27BRD04F<br>Commentary Desc 31/03/2026<br>Year ending<br>FREE TEXT |
|---|---|---|---|---|---|---|---|
| **2025/26 Forecast** | +/- | 759,360 | (348,492) | (401,271) | (5,396) | 4,200 | |
| Forecast non-recurring efficiencies | +/- | (3,143) | (3,723) | (7,547) | 0 | (14,413) | |
| 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 | | 77 | (77) | 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** | +/- | 748,517 | (352,215) | (415,741) | (5,473) | (24,913) | |

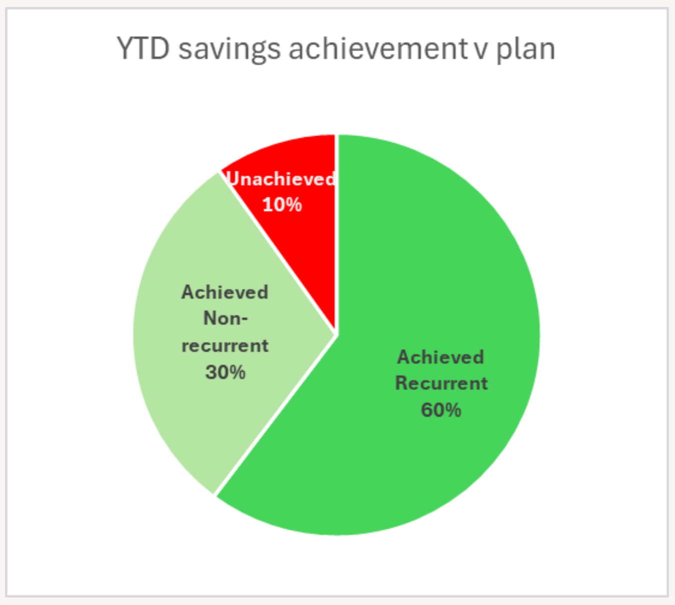
# National Oversight Framework (NOF)

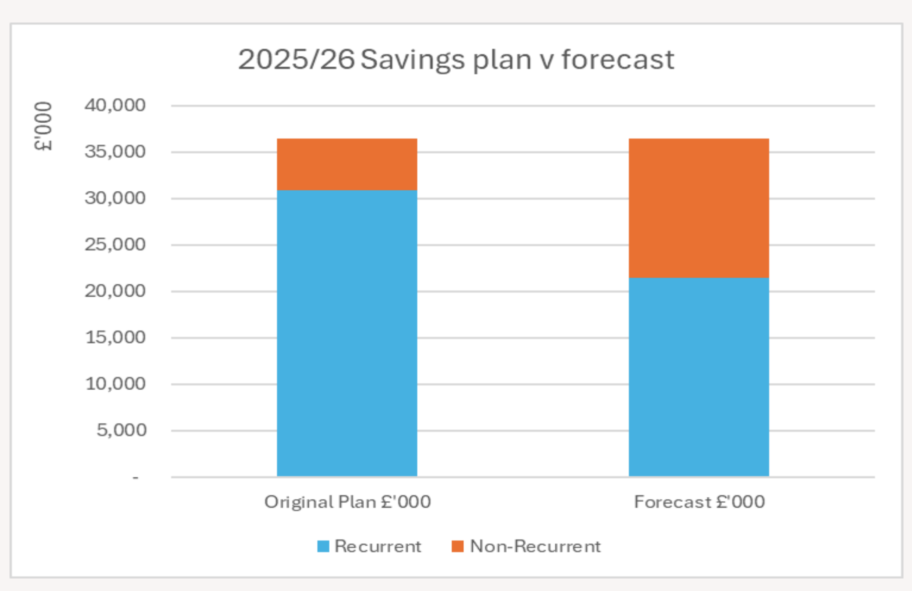
| | Actual £'000 | | | Forecast |
|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 |
| YTD actual | (2,506) | (770) | 175 | 4,202 |
| **YTD variance to trajectory** | **-** | **104** | **351** | **(7)** |
| YTD plan | 1,041 | 2,086 | 3,141 | 4,200 |
| **YTD variance to plan** | **(3,547)** | **(2,856)** | **(2,966)** | **2** |
| **YTD income** | **179,694** | **364,145** | **561,515** | **759,359** |
| **YTD variance to plan as % of YTD income** | -1.97% | -0.78% | -0.53% | 0.00% |

| **National Oversight Framework** | | | | |
|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 |
| **NOF - Finance** | | | | |
| NOF variance YTD to plan score | 4 | 3 | 3 | 1 |
| | | | | |
| NOF plan surplus/deficit score | 1 | 1 | 1 | 1 |
| | | | | |
| **NOF combined finance score** | 3 | 2 | 2 | 1 |
| **NOF - Productivity** | | | | |
| Relative difference in costs score | 2.1 | 1.6 | 1.6 | 1.6 |
| | | | | |
| **NOF Finance & productivity domain score** | 3 | 2 | 2 | 1 |

# Efficiencies

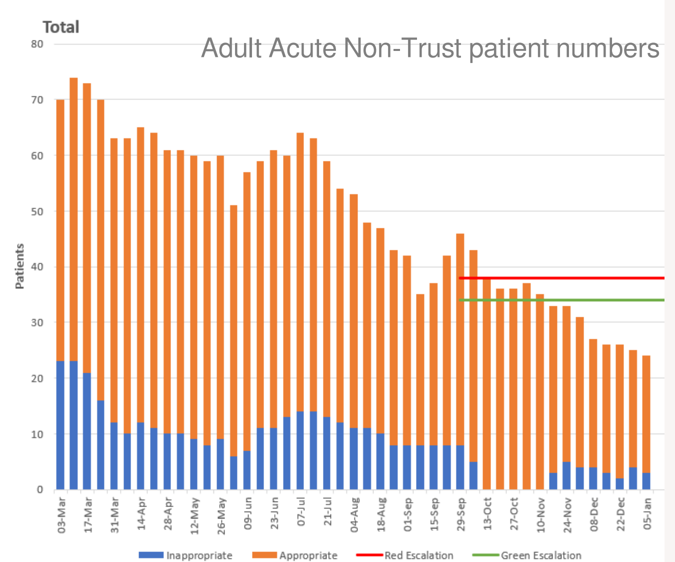
| | Year to date | | | Annual | | |
|---|---|---|---|---|---|---|
| | Original Plan £'000 | Actual £'000 | Variance £'000 | Original Plan £'000 | Forecast £'000 | Variance £'000 |
| Non-Recurrent | 4,149 | 8,121 | 3,972 | 5,529 | 14,362 | 8,833 |
| Recurrent | 22,908 | 16,296 | (6,612) | 30,879 | 22,046 | (8,833) |
| **Total** | **27,057** | **24,417** | **(2,640)** | **36,408** | **36,408** | **-** |

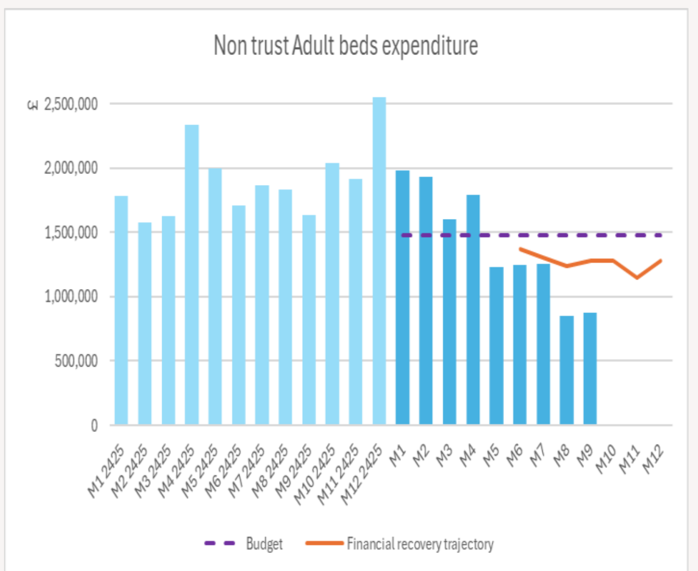


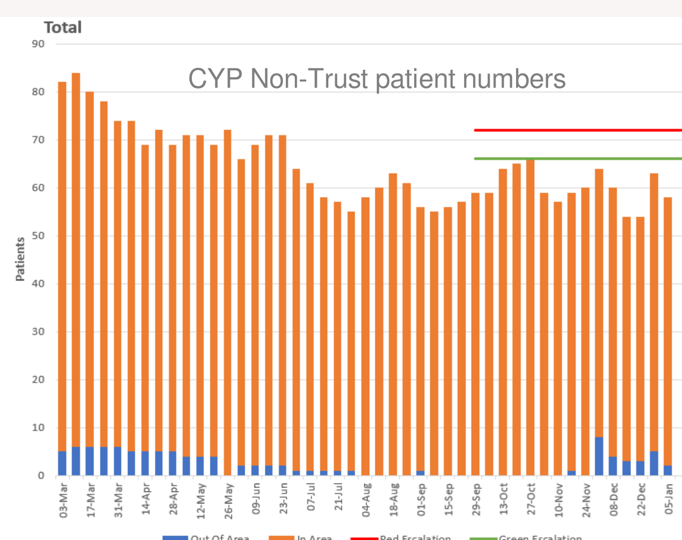



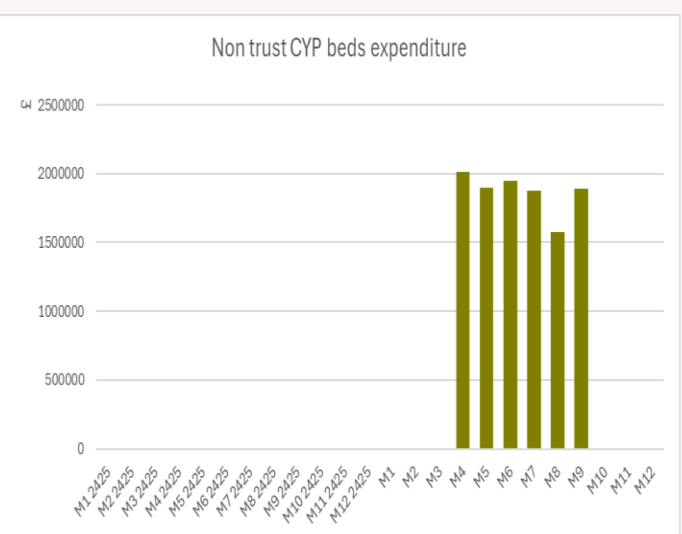

- The 2025/26 efficiency target is £36.4m. This comprises £30.9m recurrent and £5.5m non recurrent targets.
- The month 9 year to date savings achieved is £24m, this is £2.6m adverse to plan.
- It is currently forecast that £36m savings will be delivered but £14.4m savings will be achieved non-recurrently.

# Non-Trust Beds




**Adult non-Trust beds**

- The 2025/26 non-Trust Adult bed budget is £17.8m. The month 9 year to date spend of £12.8m is an underspend of £0.6m.
- Month 9 spend is consistent with the stepped reduction of month 8 at less than £0.9m. Non-Trust bed usage has reduced significantly since the beginning of the financial year, with the quarter 3 spend being £2.5m less than in quarter 1.
- Year to date expenditure is £3.6m less than at month 9 in 2024/25.

**Children and Young People's (CYP) non-Trust beds**

- CYP non-Trust bed expenditure has averaged £1.9m per month since the transfer from BWCH on 1 July 2025. The December expenditure continues to be in line with this. The November reduction was predominantly attributable to a year to date one off adjustment.

# Temporary staffing expenditure

**Agency & Bank Spend by Type**

£000s: 4,000 / 3,500 / 3,000 / 2,500 / 2,000 / 1,500 / 1,000 / 500 / -

Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

Agency Medical · Agency Nursing · Agency Other Clinical · Agency Admin & Clerical · Bank Nursing · Bank Other Clinical · Bank Admin & Clerical · Financial recovery trajectory

The month 9 year to date spend of £26.2m is £2.2m above the temporary staffing trajectory set as part of the financial recovery plan (£1.6m bank, £0.6m agency).

Temporary staffing spend in December is £0.2m less than November, driven by bank. December expenditure of £2.9m is in line with the year to date monthly average spend.

**Bank expenditure £22.8m (87%)** – the majority of bank expenditure relates to nursing bank shifts - £20.8m

**Agency expenditure £3.3m (13%)** – the majority of agency expenditure relates to medical agency - £2.3m.

# Agency expenditure

Agency Spend by Service Area

£'000

600
500
400
300
200
100
0

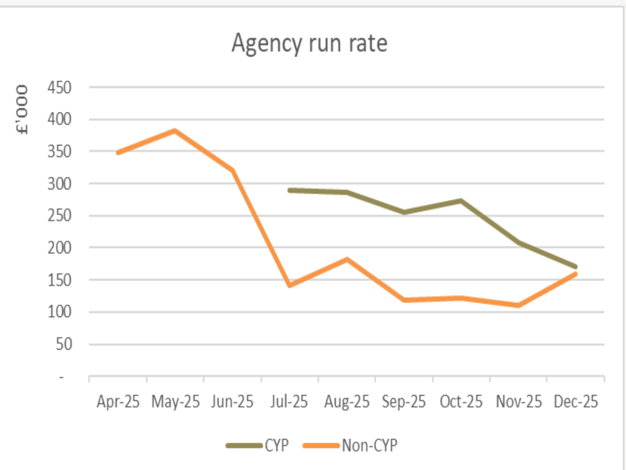
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

ACUC CORPORATE ICCR SCOH SPEC SPP SSL TRUSTWIDE CYP Financial recovery trajectory

**Agency expenditure**

- The month 9 year to date agency expenditure is £3.6m which is £0.6m adverse to the year to date agency trajectory set as part of the financial recovery plan and exceeds the full year trajectory (£3.2m) by £0.2m.

- The transfer of CYP to BSMHFT from 1 July 2025 increased monthly agency spend by £276k on average for the first 4 months post transfer. Work has been underway to reduce CYP expenditure, with reductions in both November and December (predominantly in nursing agency) such that December expenditure is 41% less than in July. This is part offset by an increase in CYP bank spend. Although there has been significant progress, CYP expenditure for July to December still equates to 44% of the total BSMHFT agency expenditure year to date.



# Bank expenditure

Bank Spend by Service Area

£'000

3,500
3,000
2,500
2,000
1,500
1,000
500
0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

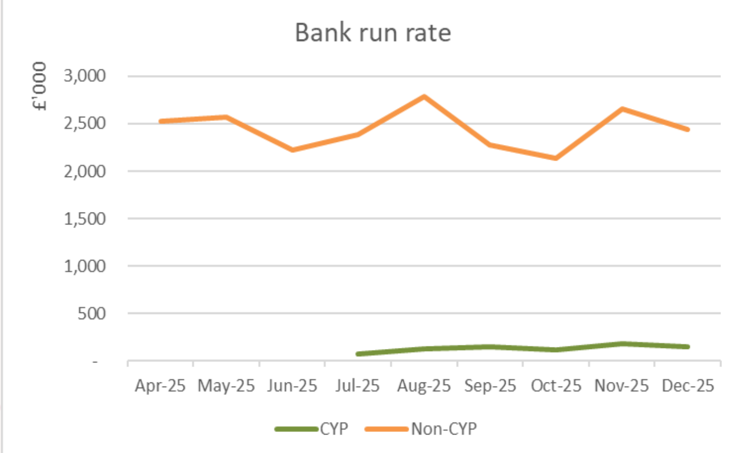
ACUC CORPORATE ESTATES ICCR R&I SCOH SPEC SPP SSL TRUSTWIDE CYP Financial recovery trajectory

**Bank expenditure**

- The month 9 year to date bank expenditure is £22.8m which is £1.6m adverse to the bank trajectory (set for months 6 to 12) as part of the financial recovery plan developed at the beginning of September.

- £251k decrease in December compared to November, mainly Specialties, ICCR and CYP. December expenditure is £70k above the monthly year to date average of £2.5m. This is driven by ACUC expenditure which is £155k above the year to date monthly average spend, with all other service areas being below the average spend.

- The 2025/26 year to date monthly average spend is £0.3m less than the 2024/25 monthly average. However, a reduction of £1m per month, from the December level, is required to meet financial recovery trajectory for the remainder of the year.



# Consolidated Statement of Financial Position (Balance Sheet)

| Statement of Financial Position - Consolidated | EOY - 'Audited' 31-Mar-25 £m's | NHSI Plan YTD 31-Dec-25 £m's | Actual YTD 31-Dec-25 £m's | NHSI Plan Forecast 31-Mar-26 £m's |
|---|---|---|---|---|
| **Non-Current Assets** | | | | |
| Property, plant and equipment | 221.1 | 224.9 | 220.4 | 227.5 |
| Prepayments PFI | 1.2 | 1.2 | 2.9 | 1.2 |
| Finance Lease Receivable | 0.0 | - | - | - |
| Finance Lease Assets | - | - | - | - |
| Deferred Tax Asset | - | - | - | - |
| **Total Non-Current Assets** | 222.4 | 226.1 | 223.3 | 228.8 |
| **Current assets** | | | | |
| Inventories | 0.6 | 0.6 | 0.9 | 0.6 |
| Trade and Other Receivables | 31.0 | 31.0 | 27.9 | 31.0 |
| Finance Lease Receivable | - | - | - | - |
| Cash and Cash Equivalents | 86.4 | 83.9 | 94.6 | 83.0 |
| **Total Curent Assets** | 117.9 | 115.5 | 123.4 | 114.6 |
| **Current liabilities** | | | | |
| Trade and other payables | (86.2) | (86.3) | (77.0) | (86.2) |
| Tax payable | (6.7) | (6.7) | (8.9) | (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) | (48.6) | (35.6) |
| **Total Current Liabilities** | (133.7) | (133.7) | (139.0) | (133.7) |
| **Non-current liabilities** | | | | |
| Deferred Tax Liability | 0.2 | 0.2 | 0.2 | 0.2 |
| Loan and Borrowings | (20.8) | (19.0) | (18.6) | (18.6) |
| PFI lease | (79.4) | (80.2) | (79.7) | (78.9) |
| Finance Lease, non current | (4.8) | (4.4) | (4.4) | (4.1) |
| Provisions | (2.4) | (2.4) | (2.3) | (2.4) |
| **Total non-current liabilities** | (107.1) | (105.7) | (104.8) | (103.8) |
| | | | | |
| **Total assets employed** | 99.6 | 102.2 | 102.9 | 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) | (67.3) | (62.3) |
| **Total taxpayers' equity** | 99.6 | 102.2 | 102.9 | 105.9 |

## SOFP Highlights

The Group cash position at the end of December 2025 is £94.6m.

For further detail on the current month cash position and movement of trade receivables and trade payables see pages 14 to 15.

## Current Assets & Current Liabilities

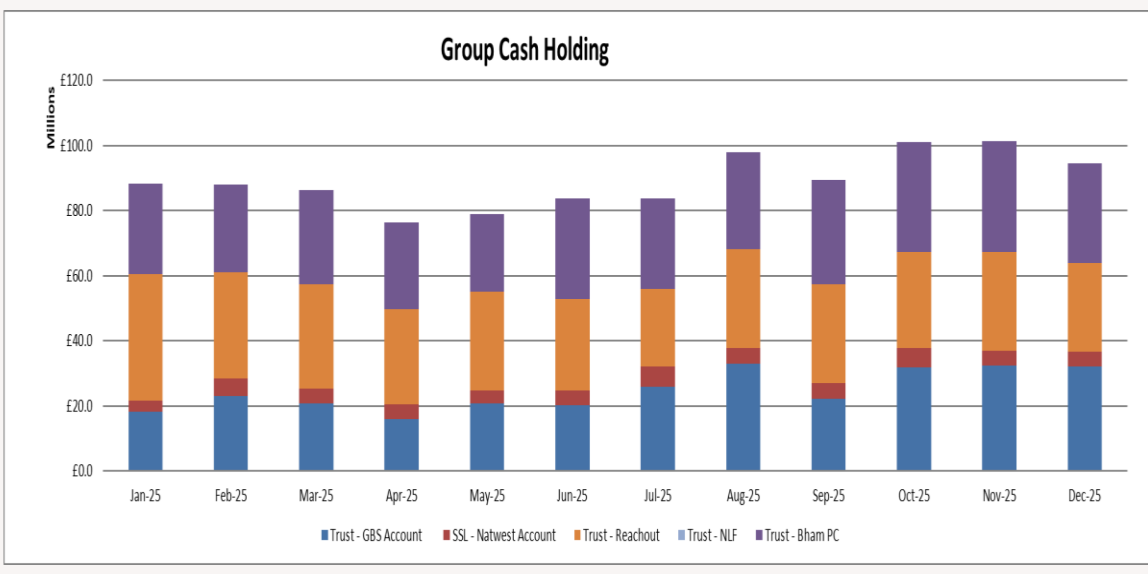
### Ratios

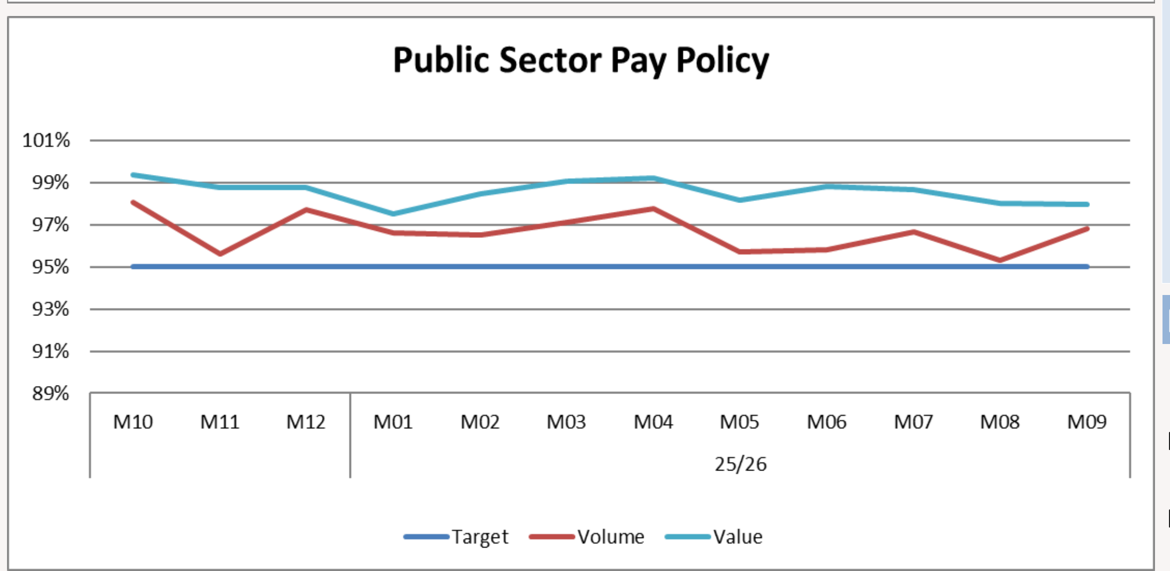
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

| **Current Ratio :** | **£m's** |
|---|---|
| Current Assets | 123.4 |
| Current Liabilities | -139.0 |
| **Ratio** | 0.9 |

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

# Cash & Public Sector Pay Policy




**Cash**

The Group cash position at the end of December 2025 is £95m. This comprises of Trust £32m, SSL £4m, Reach Out Provider Collaborative £27m and Mental Health Provider Collaborative £31m.

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**

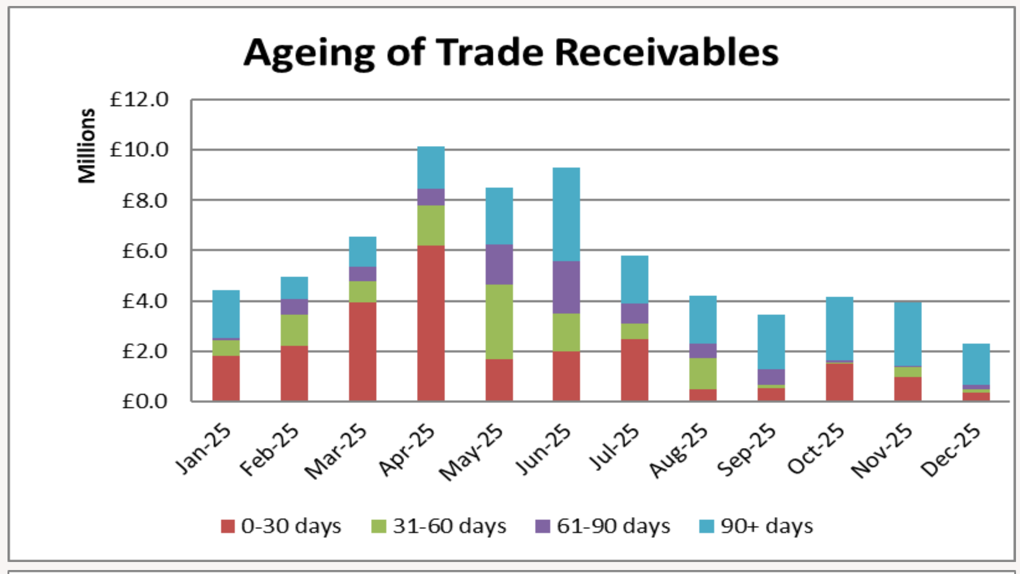
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

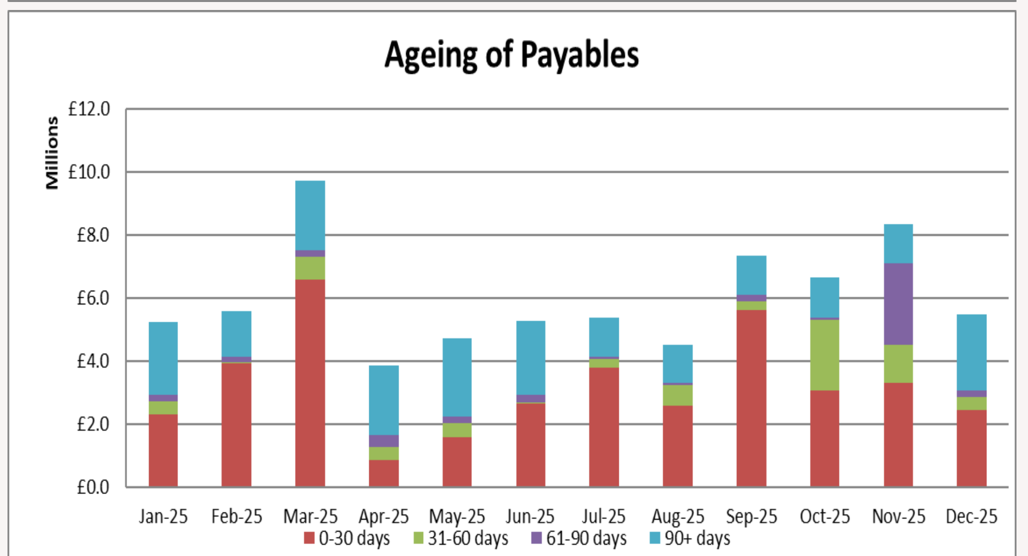
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

## Better Payment Practice Code :

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

# 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 £325k- decrease 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 or have been settled in Jan 26.

- **31-60 days-** Overall Balance £138k – decrease in balance. Several debts are awaiting approval/payment or have been settled in January 2026. Remaining balance mainly staff overpayments (on payment plans).

- **61-90 days-** Overall Balance £174k- increase in balance. Several debts are awaiting approval/payment or have been settled in January 2026. Remaining balance mainly staff overpayments (on payment plans).

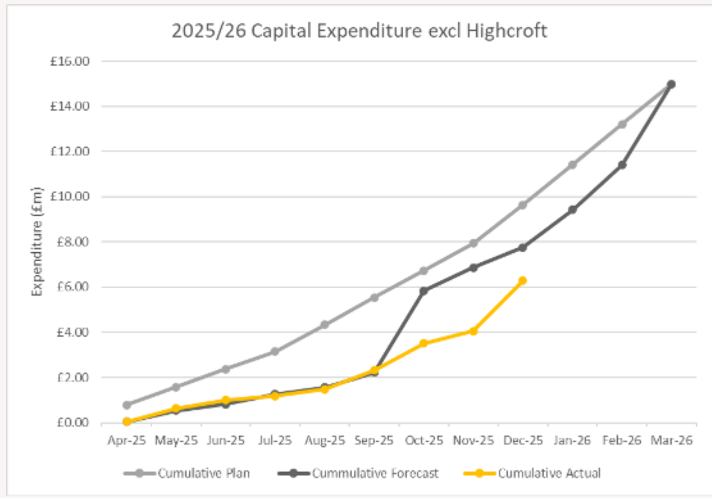
- **Over 90+ days-** Overall Balance £1.8m–decrease in balance. *Awaiting authorisation:* BWC £962k, UHB - £208k, BSOLMHPC - £38k, UofB - £95k, ATW - £37k, SDSmy HC - £59k, Mecury Pharma - £79k. Remaining balance mainly staff overpayments (on payment plans).

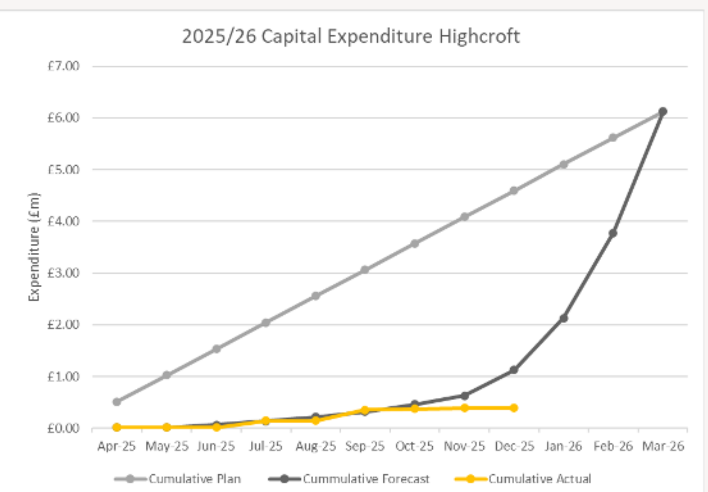
**Trade Payables-Over 90 days:**
**NHS Suppliers** £656k: WMAS £461k awaiting PO to be approved, UHB £63k in query (working directly with UHB to resolve accordingly), CNWL £55k in query, Nottinghamshire £52k in query, some approvals in Jan 26.

**Non-NHS Suppliers** (54+) £1.7m 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 January 2026.

# Capital Expenditure Month 9 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 | 1.0 | 0.9 | 0.1 |
| ACUC Bathrooms | 0.2 | 0.2 | | 0.2 | 0.2 | 0.0 | 0.2 |
| SSBM Works | 2.1 | 2.1 | | 2.1 | 0.8 | 1.3 | (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 | 0.4 | 0.0 | 0.4 |
| ICT | 0.1 | 0.1 | 2.4 | 2.5 | 0.4 | 0.2 | 0.2 |
| Minor Works | 4.0 | 4.0 | (0.5) | 3.5 | 1.3 | 1.0 | 0.2 |
| 2025/26 Estates Safety | 1.1 | 1.1 | | 1.1 | 0.2 | 0.1 | 0.1 |
| 24/7 | 0.0 | 0.0 | 3.2 | 3.2 | 2.7 | 2.1 | 0.6 |
| Decarbonisation Fund | 0.0 | | 0.3 | 0.3 | 0.0 | 0.0 | 0.0 |
| **Total** | 9.5 | 9.5 | 5.5 | 15.0 | 7.8 | 6.3 | 1.5 |
| Highcroft New Build | 6.1 | 6.1 | | 6.1 | 1.1 | 0.4 | 0.7 |
| **Total** | 15.6 | 15.6 | 5.5 | 21.1 | 8.9 | 6.7 | 2.2 |




**Group Capital Expenditure**

The total revised planned capital expenditure for 2025/26 including CYP ICT works is £21m.

**Capital Excluding Highcroft** – Year to date spend of £6.3m is £1.5m behind the year to date forecast of £7.8m. This is mainly due to the 24/7 lease being delayed, Priestly Wharf, and lease cars.

**Highcroft Project** – Year to date spend of £0.4m is £0.7m behind the year to date forecast of £1.1m. Construction due to start February 2026.

# 18. Summerhill Services Ltd (SSL) Overview Report

# Summerhill Services Limited (SSL) Business Report

## April 2025- December 2025

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

The past ten months remain very busy, supporting the Trust with various projects, as well as developing new systems and opportunities within SSL and beyond.

Our financial results for this period show savings of approximately **£790k** against the agreed budget. These savings are primarily due to lower-than-expected energy costs, driven by a combination of reduced rates and usage. In addition, we released a £416k Rates provision carried forward from the previous year following the resolution of a dispute.

SSL has supported the Trust with the recent transfer of CYP services, the development of the new 24/7 service, and progress on the Highcroft hospital project. This year will also see the largest capital spend in many years, with several major projects underway across the Trust.

SSL completed this year's Staff Perception Survey, achieving an **86% response rate**. Positive scores increased across multiple categories, with employees strongly agreeing or agreeing with statements relating to Values and Culture, Environment and Inclusivity, Leadership and Communication, Support and Tools, Development, Role Alignment, and Career Growth.

SSL continues to work with the ICB and BSol trusts to identify potential areas for collaboration and service enhancement across BSol. Progress includes:

- **Recruitment and retention** improvements following completion of an initial report identifying significant operational and performance opportunities.
- Gathering transport data from BSol trusts to inform options for a **unified transport service** across the network.
- Work has also started to understand and develop **Payroll Services**. We are looking to invest in new systems which includes the possible introduction of AI technology.

SSL is also developing major collaborative projects with **Black Country Mental Health Estates and Facilities, Black Country Primary Care,** and **BSol/BC ICT Teams**. These initiatives are in early stages but progressing well.

SSL Pharmacy services continue to perform well, and we have successfully implemented our **new pharmacy robot** which went operational in January 2026.

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

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

**SSL Estates and Facilities Management**

**Domestic and Housekeeping Services**

General:

- Pest control policy has been to PDMG prior to formal ratification.
- Cleaning Policy is progressing through formal consultation.
- Food Safety Policy is progressing through formal consultation.
- GH has been liaising across SSL and the Trust to a combined compliance and audit matrix.

*Training / Inductions:*

- **Bethany Bannigan** joined SSL November 2025 from Birmingham City Council where she was Operations Manager - Food lead.
- Allergen awareness training has been completed by all Hotel Services Managers.
- L&D team to review the food hygiene training on the traffic lights system and presented to the Multi -Professional, Workforce Training, Education and Finance Sub-Committee.
- SSL now Co-Chairs the (refreshed) Trust Food Group
- SSL now chairs the new **NHS-wide Food Safety Expert Group**

**Catering Services**

- HACCP plans for all SSL production kitchens is progressing.
- Draft PAP (Primary Authority Partnership) has been formulated between SSL and Birmingham City council. This will allow a closer working relationship with their EHO department
- All sites now registered fully with BCC and the Council have started work on updating the FHRS website
- FM First progressing new food auditing tool which will align with the EHO audits.
- Rio recording allergens form is being developed and is in live testing.
- The Dynamic Spaces Event held in September was a success and kick started the work on the Trust's 5 Year Food and Drink Strategy.
- **The EHO inspected kitchens all achieved a 5-star rating**.
- Compostable eco-friendly cutlery, takeaway containers, and carrier bags with approximately 80% of all disposable items purchased compostable, to support the NHS "Plastic Pledge".
- A detailed review of all retail prices across our five commercial kitchen has been completed and reported to the Trust. In the interest of fairness and equality.
- Notice given to Community Trust @ Moseley Hall regarding food supply to Juniper. SSL proposing to self-deliver via own Reaside kitchen conventional cooking.

**Laundry and Linen Management**

- New laundry provider Oxwash under acquisition from previous national supplier Elis.

**Medical Equipment**

- SSL discussing with Trust Risk Management new management of Med Equip.

**Trust Health and Safety**

- Assisted Bathrooms have been converted into Therapeutic Rooms further to instruction and derogation letter from the Trust at:
    1. Oleaster: Melissa, Japonica, Tazetta, Cafra, and Magnolia.
    2. Zinnia: Safron and Lavender Eden and George Ward have been completed and converted into wet rooms.
    3. Barberry: Camomile (mother and baby) proposal to convert the assisted bathroom into a Mother and Baby Sensory Room. Of the 13 remaining Trust to confirm requirement: Endeavour House x4, Reservoir Court x5 and Newbridge x4
- Courtyard fence heights, fixed point anti-ligature building items. SSL have responded to Environmental and Ligature Risk Assessments over many years and eradicated specific concerns. BSMHFT Clinicians have noted issues associated with courtyard supervision due to their resource challenges and are requesting increased environmental provision as an offset. – Action. Trust to clarity and specific direction requested.
- The use of bedrooms for service user temporary seclusion, which involves altering the locking mechanism by Clinical Staff preventing the door lock operating normally, is under review by the Trust through the Reducing Restrictive Practice Group. SSL has recently been invited to contact this Trust group to understand more clearly Trust operating procedure, governance, and approvals (in workweeks and out-of-hours) as well as seek clarity on the risk assessments associated with this activity.
- Passive Fire Safety: SSL respond to Trust Fire Risk Assessments and complete all prioritized work as direct actions. SSL have also developed their own invasive surveys and are responding to works further identified across premises. Action plans prioritised in capital programs.

**Transport & Logistics**
**Replacement Fleet Programme**

- SSL continues with the fleet replacement 15 received, further 7 on order for 25/26

**NEPT / Portering**

- As part of the **CYP** transfer, SSL developed a new medicine delivery service for CYP. This has been tested over 5 months of SSL operating the CYP pharmacy delivery via general route. Feedback has been very positive, and we have delivered a £50k saving.

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

**Warehouse**

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

**Capital Projects**

Capital Programme 25/26 progressing well, now at circa £20m- largest programme in 10+ years. We have a number of key projects including:

- **Highcroft New Hospital Development** – £25m approved Scheme currently at Procurement stage to commence on site February 2026 for handover August 2027.
- **Main House Redevelopment** – new accommodation for the First Team and CMHT
- **24/7 Service** – construction work completion December 2025

**SSL PFI/Contract Management**

- **North Food Supplier**
  Food contract moved suppliers to Bon Collina; SSL considering in-house supply via Ardenleigh

- **Parking Project**
  Parking project underway targeting Barberry/ Oleaster, group reviewing recent parking survey, potential options/ solutions, and health and safety concerns.

- **Northcroft**
  Major cladding, window upgrade, and insulation works 90% completed.

**ICS Primary Care**

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

- Significant progress with completion of Locality Clinical and Locality Estates Strategies.
- SSL is supporting ICS with a primary care capital programme of c £2.6m 25/26.

**Property Management**

- Property aspects very challenging at present including CYP, 24/7, and potential opportunities for NHS Mental Health Commissioning, LD and A and R and D. Opportunity has arisen in a UHB facility Yardley Court- under review.

- Bids submitted to WMCA in sum of £5m to achieve green project fund; 12% match fund required

- **Green Plan**: BSMHFT approval achieved. Plus ICS Green Plan been ICB approved.

**Outpatient Dispensing Services**

- Summerhill Pharmacy dispenses 17,000 items on average per month accounting for 64% of medication items dispensed by the Trust pharmacy services.
- SSL Pharmacy as of 1st July-25 successfully transferred Forward Thinking Birmingham pharmacy services into SSL. The forecasted items for transfer in phase one were 2,500 items. The actual items transferred were circa 4000 items. As part of phase two an additional 2,900 are scheduled to transfer in April 2026.
- SSL implemented an upgrade to its Prescription Tracker which tracks our pharmacy prescriptions. At present, 370 outpatient Trust staff are registered and actively use the tracker daily.

- SSL Pharmacy are launching a service with HMP Birmingham, providing cost effective supply of high-cost opioid substitution therapy. This will deliver both savings and improve clinical pharmacy capacity at HMP Birmingham
- SSL Pharmacy upgraded its compliance aid robot to a state-of-the-art Omnicell robot. The robot has automated accuracy checking technology, optimising human interaction in the pharmacy production pathway
- SSL carried out minor renovation changes to is dispensary, to improve both efficiency and capacity
- SSL robot continues to deliver an accuracy of 99% on compliance aids (see appendices)

| Mar-25 | Apr-25 | May-25 | Jun-25 | July-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 |
|---|---|---|---|---|---|---|---|---|
| 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% |

**Period Ending M9 25/26**
SSL is showing a saving which is (£793K) (3%) behind budgeted revenue after the first 9 months of this financial year. This is mainly due to the lower than expected energy costs due to a combination of rate and usage. In addition, we released a Rates provision (£416k) which was carried across from the previous year to cover a dispute which was resolved.

As in previous years, SSL is committed to a pay award for all SSL staff and mirrored the Trust pay award.

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

Drugs costs have increased due to the introduction of CYP. This is increasing to over £50k a month.

We continue to financially support the BSOL Shared Services Project, with external consultancy and associated costs. Our BSoL partners are expected to refund this activity as the project progresses.

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

- Primary Care – We continue support over 270 GPs across BSOL. The focus of work has now moved away from COVID and now more around monitoring Rent, Space Utilisation and Capital work. In terms of Capital, the team will now be managing c£2.6m worth of work in the financial year 25/26.
- Trust/ICS – We continue to support the ICB with their Sustainability/Green plan

PFI Consultancy – We have been commissioned by 2 organisations to complete PFI support work. There is an additional pipeline of projects for the 2nd half of the financial year which the team are working on. This project is being reviewed constantly to ensure we are managing any risk.

**Resourcing**

- SSL has 2 Graduates in PFI and Capital and 8 Apprentices, spread across Analytics, Sustainability and Waste, and other operational and support areas. All participate in early years events, training. and projects to grow their skills and experience.
- SSL has successfully launched its own bank system which has seen a significant reduction in spend in overtime, greater control over rosters and resources through one-to-one training being provided by the HR Team to Supervisors and Managers.
- Those candidates unsuccessful in securing a permanent position are encouraged to become bank employees to gain experience, and obtain the necessary skills to become permanent employees, which is allowing SSL to then fast bank employees into permanent positions.
- SSL strength has increased to 403 employees and it continues to maintain its current staffing profile with vacant positions being filled through "our refer a friend scheme", working with charities, recruitment fairs, and external advertisement.

**Reward and Recognition**

- SSL following a review of their pension scheme, have moved their pension scheme from the government NEST Scheme to an Aegon Salary Sacrifice Scheme. SSL has reinvested the savings it would have made in terms of employer contributions by providing all employees with an additional **½ % pension contribution** for all SSL contracted employees.

**Engagement**

- SSL has completed our second staff perception staff. **86%** of its workforce completed the survey with SSL increasing on its positive scores in many categories, whereby it's employees have strongly agreed or agreed with our positive statements in relation Values and Culture, Environment and Inclusivity, Leadership and Communication, Support, Tools, and Development, Role alignment and career growth.
- SSL has now developed it's next Yours Survey Action plan with key development activities identified in relation training and development, and career growth, whereby **Workpal** becomes an important tool to assist SSL to identify training needs and career growth actions.

**Staff Development**

- SSL is implementing **Workpal** its new performance management system across the organisation. Approximately 85% of the workforce have downloaded the application on their mobile phone and registered. SSL has trained all its Managers and Supervisors on how to utilise the system**.**
- Workpal guides have been developed to assist managers and staff navigate the system**.**
- Common Objectives have been written by the Hotel Services Managers, and Catering Manager for all Hotel Services and Domestic Staff.
- SSL has set KPS's for the system that all staff will have their objectives on the system for March and one, One to One conversation will be held as a minimum.
- Moving forward SSL's performance year will be April to April and therefore all staff's next full appraisal will be due in April 2027.
- SSL Operations Team have developed a new SSL Operations Induction which consists of a day's full training which complements corporate induction and standard operating procedures, and risk assessments have been developed which will utilised by Supervisors to train new staff on the job.

- SSL has also undertaken two Supervisory 3 day boot camps within the last six months, the programme has been reviewed and will moving forward become a first and new line manager programme.

**Equality, Diversity & Inclusion**

- SSL has completed its review of EDI statistics which were presented to the EDI forum and key themes were decided upon.to being included within its new EDI Strategy and action plan.
- The key themes identified and actions were presented back to the December EDI forum who agreed they were an accurate representation of the ideas generated, and now approved will be completed into SSL's ESI framework for 2026 – 2028.

## Business Development, Opportunities and Plans

**PFI Consultancy**

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

**Wholly Owned Subsidiaries- Black Country**

- SSL is currently developing massive collaborative works with Black Country Mental Health Estates and Facilities, Black Country Primary Care and BSol/ BC ICT Teams.

**Wholly Owned Subsidiaries Consultancy**

- Following the recent announcement from Jim Mackay and letter from Glen Burley restricting the development of new WOS, SSL has focused on developing ways to expand the business and other existing WOS's.

**ICB / BSol Shared Services Project**

- SSL is working with the ICB and the BSol trusts to identify potential services where trusts can collaborate and enhance services across BSol.
- Progress has been made on Recruitment and Retention following the completion of initial report which identifies significant operational and performance opportunities. We now starting to gather transport information from BSoL trusts, which will give us the data to develop options and opportunities to hopefully provide a unified transport service across the BSoL network.

## Governance and Assurance

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

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

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

**Appendix A – Financial Statement April 24 – Oct 24**

| SSL Financial Position | Annual budget | M9 Budget | M9 Actuals | M9 Variance |
|---|---|---|---|---|
| | £'000s | £'000s | £'000s | £'000s |
| Sale & Leaseback | 16,175 | 12,132 | 11,678 | (454) |
| Lease & Long License | 3,476 | 2,607 | 2,299 | (308) |
| Contract Management | 2,486 | 1,864 | 1,599 | (265) |
| Facilities Services | 4,319 | 3,239 | 3,166 | (74) |
| Grounds and Garden | 408 | 306 | 170 | (136) |
| PPE & Warehouse | 323 | 242 | 321 | 79 |
| Pharmacy | 2,506 | 1,879 | 2,224 | 345 |
| External Services - Head of Assets | 511 | 383 | 543 | 160 |
| External Services - STP | 0 | 0 | 18 | 18 |
| External Services - CCG Vaccine Progr | 0 | 0 | 0 | 0 |
| External Services - PFI | 250 | 188 | 46 | (142) |
| External Services - FM | 40 | 30 | 14 | (16) |
| Total income | 30,494 | 22,871 | 22,078 | (793) |
| Pay costs | (13,570) | (10,178) | (10,068) | 109 |
| Drug costs | (2,112) | (1,584) | (1,914) | (330) |
| Non pay costs | (8,762) | (6,571) | (5,755) | 816 |
| Internal Recharge | 48 | 36 | 33 | (3) |
| Total Expenditure | (24,396) | (18,297) | (17,704) | 593 |
| | | | | |
| **EBITDA** | **6,098** | **4,574** | **4,373** | **(200)** |
| Depreciation | (3,314) | (2,485) | (2,452) | 34 |
| Interest Payable | (2,028) | (1,521) | (1,521) | 0 |
| Interest Receivable | 0 | 0 | 42 | 42 |
| Finance Lease | (356) | (267) | (267) | (0) |
| **Profit / (Loss) before tax** | **401** | **300** | **176** | **(124)** |
| Taxation | (380) | (285) | (293) | (8) |
| **Profit / (Loss) after tax** | **21** | **15** | **(116)** | **(132)** |

## Appendix B – 5 Yr Forecast and Benefits Statement

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

# 19. Audit Committee Report

## Committee Escalation and Assurance Report

| **Name of Committee** | **Audit Committee** |
|---|---|
| **Report presented at** | **Board of Directors** |
| **Date of meeting** | **4 February 2026** |
| **Date(s) of Committee Meeting(s) reported** | **28 January 2026** |
| **Quoracy** | **Membership quorate: Y** |
| **Agenda** | The Committee considered an agenda which included the following items:<br>• Board Assurance Framework<br>• Corporate Risk Register<br>• Commissioning Board Assurance Framework<br>• Summerhill Services Ltd (SSL) Risk Summary<br>• Internal audit progress report<br>• Action tracking report<br>• E-Rostering and Temporary Staffing Internal Audit Review<br>• Appraisals Process Internal Audit Review<br>• Local Counter Fraud Progress Report<br>• External Audit Progress Report<br>• Single Tender Waivers Report<br>• Committee Forward Planner 2026/27 |
| **Alert:** | The Committee wished to alert the Board of Directors to the following:<br>• The Committee raised significant concern in relation to the **E-Rostering and Temporary Staffing internal audit review,** highlighting weaknesses in documentation and justification of uplifts, ID verification and inconsistent policies. The Committee was concerned about the financial implications and the risk related to further bank staff reductions for the next financial year.<br>• The Committee raised significant concern in relation to the **Appraisals Process internal audit review**, highlighting weaknesses in data, difficulties in obtaining evidence and inconsistent application of processes. The Committee was concerned about potential patient safety implications with insufficient appraisal processes in place.<br>• The Committee remained concerned about the pace and progress of **Medical Job Planning**, noting continued overdue and extended deadlines. |
| **Assure:** | The Committee was assured on the following areas:<br>• The Committee was assured by the risk management process in relation to the Corporate Risk Register, Board Assurance Framework |

| | |
|---|---|
| | and Risk Management Group, noting particularly that the BAF was fully dynamic and drove conversations at meetings.<br>• The Committee was assured that the 2024/25 audit certificate had been successfully issued.<br>• Planning for the 2025/26 external audit was underway, and deadlines for accounts noted.<br>• The Committee was assured by a strong programme of awareness events, investigations and proactive Counter Fraud exercises. |
| **Advise:** | The Committee escalated the **E-Rostering and Temporary Staffing Internal Audit Review** and **Appraisals Process Internal Audit Review** to People Committee for further scrutiny.<br><br>The Committee noted that estates and ICT formed the majority of Single Tender Waivers, due to the nature and scale of the projects. Training was ongoing to ensure awareness and understanding of procurement requirements. |
| **Board Assurance Framework** | The Committee reviewed the Board Assurance Framework and was satisfied with the management of the strategic risks, noting that a review would take place to align the BAF to the refreshed Trust Strategy.<br><br>The Corporate Risk Register was received. The Committee challenged the Risk Management Group to review risks related to Children and Young People's Services for visibility.<br><br>The Committee received the Commissioning BAF and was satisfied with the significant improvements and notable progress made, noting that a review of the BAF would take place to align to the Mental Health Strategy.<br><br>Positive assurance was received on the SSL Risk Summary, and additional information was requested for narrative on amber and red risks. |
| | **New risks identified:** the Committee highlighted significant concerns about potential cultural and operational issues related to the appraisals, job planning and temporary staffing reviews. |

| **Report compiled by:** | Winston Weir<br>Non-Executive Director | **Minutes available from:**<br>Kat Cleverley, Company Secretary |
|---|---|---|

# 20. Living the Trust Values

# 21. Board Assurance Framework reflections

# 22. Any other business

# 23. Questions from Governors and members of the public