BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST Board of Directors Public Meeting 10.30, Wednesday 3 June 2026, Uffculme Centre AGENDA				
Ref	**Item**	**Purpose**	**Report type**	**Time**
	Staff Talk 10.30-11.00			
1	**Chair's Welcome and Introduction**			11.00
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of meeting held on 1 April 2026**	Approval	Enc	11.05
5	**Matters arising from meeting held on 1 April 2026**	Assurance	Enc	
6	**Chair's Report** *Phil Gayle, Chair*	Assurance	Enc	11.10
7	**Chief Executive and Director of Operations Report** *Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Executive Director of Operations*	Assurance	Enc	11.15
8	**Board Assurance Framework** *Kat Cleverley, Company Secretary*	Assurance	Enc	11.25
9	**Integrated Performance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	11.30
	Quality and Clinical Services			
10	**Quality, Patient Experience and Safety Committee Report** *Nick Moor, Non-Executive Director*	Assurance	Enc	11.40
11	**Quality and Safety Report, inc Safer Staffing** *Lisa Stalley-Green, Chief Nurse*	Assurance	Enc	11.45
12	**Quality Account 2025/26** *Lisa Stalley-Green, Chief Nurse*	Approval	Enc	11.55
	People			
13	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	12.00
14	**Health Inequalities Report** *Patrick Nyarumbu, Deputy Chief Executive Officer*	Assurance	Enc	12.05
	Sustainability			
15	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	12.15
16	**Finance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	12.20
17	**Audit Committee Report** *Winston Weir, Non-Executive Director*	Assurance	Enc	12.25
	Reflections			
18	**Living the Trust Values** *Fabida Aria, Executive Medical Director*		Verbal	12.30
19	**Board Assurance Framework reflections**		Verbal	12.35
20	**Any other business**		Verbal	12.40
21	**Questions from Governors and members of the public**			
Close by 13.00 **Date and Time of Next Meeting: Wednesday 5 August 2026, 09.00-12.30**				

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST Minutes of the Public Board of Directors Meeting Wednesday 1 April 2026, 09.00, Uffculme Centre			
Members	Phil Gayle	PG	Chair
	Peter Axon	PA	Non-Executive Director
	Bal Claire	BC	Deputy Chair/Non-Executive Director
	Monica Shafaq	MS	Non-Executive Director
	Sue Bedward	SB	Non-Executive Director
	Nick Moor	NM	Associate Non-Executive Director
	Roisin Fallon-Williams	RFW	Chief Executive Officer
	Patrick Nyarumbu	PN	Deputy Chief Executive/ Executive Director of Strategy, People & Partnerships
	Lisa Stalley- Green	LSG	Executive Director of Quality and Safety/Chief Nurse
	Dave Tomlinson	DT	Executive Director of Finance
	Fabida Aria	FA	Executive Medical Director
	Vanessa Devlin	VD	Executive Director of Operations
Attending	Hannah Sullivan	HS	Corporate Governance and Membership Manager
	David Tita	DTi	Associate Director of Governance
	Emma Randle	ER	Freedom To Speak Up Guardian
	Mary Elliffe	ME	Recovery & Co-Production Lead (supporting Patient Council Talk TS)
	Katherine Allen	KA	Lead, recovery, service user, carer and family experience (supporting Patient Council Talk TS)
Observers	3 governors observed the meeting in person.		

Ref	Item
0	**Patient Council Talk** The Board started the meeting by remembering Barry Dangerfield who had sadly passed since sharing his story with the Board in December 2025. KA shared details of Barry's life remembering his inspirational journey. The Board welcomed TS supported by ME. TS shared his journey from the age of 11 he was in the care system and eventually ended up in Edenfields in a children's medium secure unit He noted he was one of the youngest men to be admitted to Ashworth and he talked through his experience there alongside the onset of been mentally unwell. He shared his decision making with regards to engaging with therapy, gaining insight and working towards transfer from high secure to medium secure. TS shared the initial negative care experiences he had on admission to Reaside and shared how engaging with the right teams helped him to start the road to recovery. TS shared his views on what he feels the ingredients for a good care environment are and wanted the Board to hear that from his perspective in the hope that this will create change. TS is now on the road to discharge and is looking at what his future holds. The Board recognised TS reflections on his care journey are key to his future stability in utilising key skills and coping mechanisms developed on his care journey. TS confirmed he hopes to work to support service users down the line when he has been discharged with support from services, continues to develop new skills, finds employment and feels confident enough to engage in peer work.

	TS was clear about the impact of negative attitudes of staff behaviours have had on his journey. However, he also described, staff positive attitude and compassion, open and honest clinicians and the development of new skills through therapy as key to his recovery as well as usage of medication. TS spoke of having hope for the future and the importance of this for him in his journey and for others. TS has engaged with the increased opportunity to speak out through the development of co-production at Reside and feels that the service can learn so much from the service users input, ensuring safer environments and improved service user outcomes. He feels that staff need to want the recovery for him even when he cannot engage with it. One of the key components to TS journey has also been the friendships he has developed with fellow service users and he spoke of how important this has been to him as a support mechanism. Over the last 18 months TS has engaged with the Recovery and Co-Production pathway at Reaside. He was pleased to have participated in numerous events especially in consultations events, Culture of Care meetings and staff recruitment and is a regular attender of the Recovery Suppers. Alongside of this he has also been undertaking formal psychological interventions, using medication and using leave to enhance his recovery. He has also been very supportive of his fellow service users and positively engages with new service users supporting them in their rehab journey. TS thanked the Board for the opportunity to share his journey. PG thanked TS for sharing his journey of hope and congratulated him on his positive attitude to recovery. RFW thanked TS for being open and queried what improvements could be made to ensure service users feel heard earlier in their journey? TS noted the importance of staff engaging with service users and finding out what is important to them as individuals and to give them the time and space to recognise they need help. RFW queried whether TS has shared his experiences locally? TS confirmed he has participated in the Good Lives and Aces programme and shared his experiences with consultants on the ward. BC thanked TS for sharing his journey and for being so brave noting TS should be very proud of himself. He queried whether the attitudes of consultants and doctors differs on wards? TS confirmed there are different attitudes depending on the ward and support staff do not feel able to challenge decisions. FA confirmed she would take the learning and share with the consultant and doctors with support from ME. She thanked TS for sharing his inspiring journey. FA queried whether there has been a noticeable change since the introduction of the culture of care programme at Reaside? TS confirmed there has been significant improvement including night management and service user involvement in active change. NM thanked TS for being brave in sharing his journey and was pleased to hear there has been a positive impact following the culture of care. LSG queried with ME whether leadership changes have been positive and whether they are sustainable? ME confirmed there have been a number of positive changes that are sustainable at Reaside following the culture of care programme including recovery meetings and the power of presence of staff on wards. There has been positive changes for night routines and clinical meetings include input from service users ensuring they feel heard and included in their care. She confirmed hope is key for service users and patient reported outcomes have

	allowed for deep dives into discharge data, equal say and how safe service users feel. She noted the results have allowed for profiling and opened up wider considerations that are being explored. PG thanked ME for her inspirational leadership. PG reflected on the importance of remembering Barry Dangerfield and thanked KA for sharing details of his life. The Board thanked TS for sharing his story and wished him all the best in the future. The Board thanked ME and the team at Reaside for their continued dedication to improving patient experience.
1	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting.
2	**Apologies for absence** Kat Cleverley, Company Secretary Winston Weir, Non- Executive Director
3	**Declarations of interest** None.
4	**Minutes of meeting held on 2 February 2026** The minutes were agreed as a true and accurate record with one minor amendment.
5	**Matters arising from meeting held on 2 February 2026** All actions were updated.
6	**Chair's Report** The Board received the report. PG highlighted the following key points: • PG participated in shortlisting for the Trust's Value Awards, highlighting exceptional individual contributions and dedication across the organisation. This process showcased commitment and innovation among staff members. • PG visited staff at the Juniper Centre, he noted the visit provided firsthand insight into staff and patient experiences, reinforcing Board engagement and understanding of operational challenges and strengths. Future visits are planned to other key sites. • PG provided a summary of both the staff and service user stories throughout 2025 highlighting continued efforts to improve recruitment and support for internationally educated nurses, the importance of living the Trust values and the inspiring positive feedback from various staff groups, which informed the sharing of good practices across the Trust. He confirmed catering concerns were escalated to the supplier, with assurances of review and consideration of cultural needs. • PG provided a summary of the Board of Directors' visits to various service sites during 2025, emphasising the importance of visible leadership and direct engagement with staff and service users to enhance governance and assurance. PA thanked PG for the focussed reports in line with the strategy and requested an appendix is included in future staff and service user stories reports and service and site visits reports to highlight feedback and actions. PG confirmed there is a focus to communicate with staff via a 'you said, together we did' and 'you said, together we didn't' approach for open communications and audit.
7	**Chief Executive Officer and Director of Operations Report** The Board received the report for information. RFW and VJD highlighted the following key points: • Notification for industrial action has been received.

- Russell Hardy has been appointed for the position as NHSE Midlands Regional Chair.
- Thank you to Lisa Stalley- Green for her dedication and leadership in delivering the culture of care.
- Workforce shows sustained improvements with sickness absence reduced to 5.1% and vacancies down to 6.8%, notably nursing Band 5 vacancies below 4%. Turnover remains low at 4.2%, and agency staffing use has dropped by 48.3% month-on-month.
- Older adult inpatient wards face significant discharge delays due to patient complexity and extended health and social care approval processes, including a new funding approval stage increasing length of stay. The division is collaborating with system partners and exploring future pathway bed provisions to address these issues. Community Mental Health Teams are enhancing engagement with minority communities and strengthening quality assurance after a Care Quality Commission visit.
- Operational improvements continue with the Acute and Urgent Care Leadership Forum celebrating its first year. The Care Quality Commission inspection provided strong assurance of compassionate care delivery.
- CYP services remain operationally stable with strong access and outcome measure completion despite increasing referrals. The Crisis and Home Treatment Team manages high caseloads with enhanced oversight and a recovery plan.
- The Birmingham & Solihull Mental Health, Learning Disability & Autism Provider Collaborative launched its Mental Health Strategy in February 2026, aligned with public health priorities for the next five years, with a delivery plan in development. The strategy launch in Solihull is planned for April 2026.
- The Trust remains optimistic about delivering the current financial plan, aided by reductions in out-of-Trust inpatient placements. Financial plans for the next three years have been submitted and approved by NHS England.
- An independent governance review commissioned jointly by the CEO and ICB CEO is complete, with an action plan monitored by the Quality, Patient Safety & Experience Committee.
- The 2025 NHS Staff Survey shows sustained improvement with a 60.6% response rate. Staff report better experiences than many mental health trusts in learning, morale, engagement, and teamwork.
- Approximately 600 nominations were received for the 2026 Values Awards, with shortlisted candidates announced.
- The Secretary of State confirmed continued growth in mental health investment, reaching £15.7 billion in 2025–26 and £16.1 billion in 2026–27, a real-terms increase of about £140 million. Despite this, mental health's share of NHS spending is projected to fall from 9% in 2023/24 to 8.4% in 2026/27, while mental health needs represent 20% of illness.
- An additional £7 million is allocated for early support hubs across England, providing drop-in mental health support for ages 11 to 25 to prevent severe illness without referrals. This funding supports 10,000 extra interventions and aligns with the 10 Year Health Plan commitment.

VJD highlighted ongoing challenges as older adult wards continue to experience significant discharge delays, with a high number of patients clinically ready for discharge but awaiting placement. Delays are primarily linked to the complexity of patient needs and behavioural risk, alongside extended health and social care approval processes. A recently introduced additional stage in the funding approval process appears to have increased approval times, contributing to longer lengths of stay and additional bed days, we are currently exploring to see if this is the case and will feedback to social care colleagues.

She confirmed that despite the challenges, the division continues to deep dive into cases and work collaboratively with system partners to improve length of stay within this bed base. She noted that we are also working with the provider collaborative and integrated care board around future provision of pathway beds.

An escalation letter has been sent to local authority colleagues escalating concerns and a meeting has been arranged for 13 April 2026.

PG noted out of area placements have increased and queried how the Trust will resolve in the long term?

	VJD confirmed work continues to manage out of area placements and there has been significant and sustained improvements. She confirmed a new standard operating procedure has been implemented and this has had an impact. RFW noted contract changes have on inappropriate out of area placements. DET confirmed the development of Highcroft will support with placements as 18 beds will be made available. PG recognised the challenge and queried how effective partners are in supporting timely solutions? VJD confirmed local authority colleagues have commissioned a full review of AMHPS and concerns in relation to funding delays for nursing homes have been escalated to the Health and Wellbeing Board. PN confirmed escalations through system meetings continue. The Board recognised that the infrastructure for improvements is key for moving forward.
8	**Board Assurance Framework** The Board received the BAF noting the controls, mitigations, and assurance language have been strengthened, actions reviewed with some closed, and internal audit plans for 2026/27 will be incorporated once approved. The Board noted the ask to ratify the reduction of the following risks following endorsement from Board Committees: • SR3 reduction in risk score from 4x4=16 to 4x3=12 • SR4 reduction in risk score from 4x3=12 to 4x2=8 • SR7 reduction in risk score from 4x3=12 to 4x2=8 The Board ratified the reduction in the proposed risks. The Board were assured the BAF has progressed and noted their thanks to Kat Cleverly. BC confirmed the Finance, Performance and Productivity Committee will review SR5 at the April Committee meeting. The Board noted a Board development session is being developed for a deep dive review of the BAF. **DECISION: The Board ratified the reduction in the proposed risks.**
9	**Corporate Risk Register** The Board received the Corporate Risk Register for information and additional assurance that risks were linked to the BAF, and to demonstrate the continued improvement of the Trust's risk management process. The Board were assured the Corporate Risk Register triangulates across the Board Committees for oversight and review allowing further assurances.
10	**Integrated Performance Report** The Board received the report for information. The Board noted there are currently 20 QPES risks, 5 finance risks, and 3 people risks on the Corporate Risk Register, with the highest scoring risks related to financial delivery and capital funding challenges. Key highlights were noted as: • New Talking Therapies • National Oversight Framework Metrics • Clinically Ready for Discharge • Inappropriate and Appropriate Out of area placements PA queried whether the current bed position is in line with the forecast plan?

	DET confirmed the Trust remains below the mean and this has been sustained. He noted clinically ready for discharge is monitored weekly with a focus on length of stay. PA thanked DET for ensuring the position presented remains live. VJD confirmed system partners are aware of the challenges and remain committed to making improvements. PG confirmed the Board remain confident that current interventions will support improvements. VJD confirmed a deep dive will be presented to the Finance, Performance and Productivity Committee.
11	**Quality, Patient Experience and Safety Committee Report** The Board received the reports for information. NM highlighted the following key points from the February and March meetings: • Availability of AMHPs and Social Workers has been escalated to Birmingham City Council, causing significant delay in the Trust's ability to discharge clinically ready for discharge patients and also impacting on the time taken to detain patients in need of urgent detention under the MHA. The Committee will maintain oversight of the outcomes to ensure the safe delivery of services. • The Committee received the first Health Inequalities Project Board Assurance Report noting the data gaps in spoken languages and the need for improved data quality to support divisional workstreams. The Committee suggested setting specific improvement targets to improve overall compliance. • The Committee received the Reducing Restrictive Practice Report • noting the challenges in reporting and managing restrictive practices, the introduction of bedroom seclusion with deadbolts as an exceptional measure. Work is ongoing to improve data quality and therapeutic activity. • Committee were assured by the progress made in handling of complaints regarding closure of old previously unresolved cases and bringing current cases to a resolution more quickly, and the positive feedback from the CQC regarding complaints handling. • Recent CQC inspections of urgent care and older adult CMHTs yielded positive feedback, with minor issues addressed or in progress. Additional data requests are being managed, and action plans are nearly complete for fire safety at Ardenleigh. • The formal phase of the Reaside Culture of Care programme has concluded, with a summary report from Dr. Helen Smith highlighting positive outcomes in staff and service user experience. The Committee recognised the transformative impact in secure care and has asked for a report identifying the impact to be brought to the Board at an appropriate date in the near future. MS noted the importance of highlighting the celebrations within reports. SB noted the positive triangulation between Committee assurance reports through a holistic approach. RFW confirmed the Executive Team meet weekly and finish every meeting with celebrations for escalation. HS confirmed the assurance report template has been updated to include health inequalities and considerations for how to include celebrations will be taken forward.
12	**Quality and Safety Report** The Board received the report for assurance. LSG highlighted the following key points: • Incident reporting remains within expected variation with 2,759 incidents, mainly assaults, self-harm, and staffing issues; moderate harm or above is stable at 1.9%, and Duty of Candour compliance is 100%. • Eleven suspected suicides have been reported, with structured judgement reviews commissioned for all, highlighting consistent themes around care transitions and service interface vulnerabilities. • Self-harm, assaults, and restrictive practices are within normal variation but clustered in specific wards and individuals; improvement efforts focus on risk formulation, MDT actions, escalation, and trauma-informed support.

	• Three ward absconsions and fifteen failures to return were recorded, with all individuals returning safely; a themed review is underway to analyse patterns and ward variations. • The Restrictive Practice Group is leading on actions including a bedroom seclusion review, new escalation protocols, and training to reduce prone restraints, especially on Melissa Ward, alongside increased activity options for patients and families. • The CQC inspected urgent care and older adult CMHT services, providing positive feedback with some concerns resolved promptly. Steps to Recovery sites received positive feedback with minor issues addressed. PG noted the positive reporting with no PFDs received. BC highlighted the disparities in data and asked for one data pull to ensure information provided is accurate and one single version of the data is reported. LSG confirmed this would be escalated to the relevant teams.
13	**People Committee Report** The Board received the reports for information. SB highlighted the following key points from the February and March meetings: • There continued to be system limitations that constrained appraisal effectiveness. This was an NHS-wide issue, and a new ESR system was planned for release by 2030. • There was some lower-than-expected uptake of formal management development modules, which was prompting a reconsideration of delivery. • There were some ongoing risks in relation to fixed-term contracts linked to non-recurrent transformation funding, which was impacting on workforce sustainability and continuity of care. The Committee also highlighted the challenge in relation to staff transitioning from pilot services into business-as-usual models. • The Committee noted positive feedback on recently launched 'Lunch and Learn' sessions, which were bite-sized learning sessions that had been implemented in response to operational pressures. • A new Fundamental and Role Recommended Training Group had been established to review training and to ensure a realistic balance of mandated and appropriate requirements. • There had been a reduction in HR casework volumes and average case duration, which reflected improved early resolution and people management. • Apprenticeship levy remains a concern with the Trust under utilising the resource. • 360 appraisals have received positive feedback. PG noted the progress being made for workforce sustainability and agency reductions and queried whether this is sustainable? SB confirmed the reduction in agency spend has been sustained for a period of time and the Committee remain optimistic and reassured the use of bank staff will continue to reduce. MS noted the positive return of staff into the organisation and the overall reduction in vacancy rates. FA confirmed the use of Locum Doctors continues to reduce and work is ongoing to support CYP colleagues to reduce overall agency use. BC noted the importance of implementing the strategy to support ongoing change and learning. PG highlighted the positive reduction of sickness levels and the positive impact of cultural change in supporting staff to feel safe at work.
14	**Staff Survey Results Report**

	The Board received the report. PN highlighted the following key points: • BSMHFT's key people goal measure—whether colleagues would recommend the Trust as a workplace—remained at 65.7%, which is above the mental health trust average of 64% and an increase of 8.8 percentage points since 2022 (56.9%). • Staff report better access to learning opportunities, with 32.1% stating appraisals helped improve job performance (vs 25.5% sector average). Opportunities for career development and access to appropriate learning resources are also above average. • The Trust achieved the highest national score among mental health trusts for the statement "My immediate manager asks for my opinion before making decisions that affect my work" (71.48%). Additional strengths include clear feedback (71.5% vs 66.5%) and managers working with staff to understand problems (79.5% vs 77.3%). • Morale remains higher than comparator trusts. Engagement improvements are driven mainly by increased involvement in decision-making (7.27 vs 7.03 sector average), while motivation and advocacy showed less change. • High levels of trust and clarity in roles are reported, with 91.6% feeling trusted to do their job and 86.1% always knowing their responsibilities. • Reporting of bullying has improved for six consecutive years, with 68.3% of those experiencing bullying, harassment, or abuse reporting it, above the national average (64.6%). • The Trust scores below average in Compassionate and Inclusive Culture, driven by higher reported discrimination from both colleagues (9.9% vs 7.2%) and service users, carers, and families (14.2% vs 8.7%). • The Trust scores notably below average in the raising concerns sub-theme (6.46 vs 6.64), indicating staff feel less able to raise issues safely. • Survey participation increased for the seventh consecutive year, achieving a 60.6% response rate, surpassing the mental health average of 52% and the Trust's People Goal target of 57.5%. The sample size grew from 4,719 in 2024 to 5,524 in 2025 due to the inclusion of the CYP division. The number of completed responses rose by 697, from 2,650 to 3,347, indicating greater engagement among staff. PN thanked John Travers and the wider team for their dedication in supporting staff to complete the survey. PG noted the positive improvements with results being meaningful and purposeful. He noted challenges and risks have been mitigated. RFW noted there is more to do but highlighted the significant improvements made and need for thanks to be passed onto staff for their continued efforts and dedication. She confirmed results have been tailored to each time and data is being used to make further improvements. PN confirmed a deep dive into results will be scheduled at the People Committee. BC and PA noted the strategic results as positive and highlighted the importance of the People Committee maintaining oversight through a route cause analysis. The Board noted their assurance from the report and positive journey the Trust continues on.
15	**Freedom to Speak Up Guardian Annual Report 2025/26** The Board received the report. ER highlighted the following key points: • 475 cases were raised, with 37% involving worker safety and wellbeing, 22.5% concerning patient safety and quality, 12% related to bullying and harassment, and 34% involving inappropriate attitudes and behaviours. These figures are compared to national averages, showing some areas above and some below national benchmarks. • Only 2.5% of cases were raised anonymously, significantly lower than the national average of 11.6%. Detriment for speaking up was indicated in 6% of cases, which is double the national average of 2.9%.

	• Nearly 78% of those who provided feedback said they would speak up again, close to the national average of 79%. • Nurses accounted for the largest share of cases at 29%, aligning closely with the national figure of 28.3%. • Speaking up is now a key strategic driver in the Trust's refreshed strategy, linked explicitly to safety and a listening organisation culture. • Actions taken in response to concerns include temporary uniform relaxation during extreme heat, opening staff well-being spaces, improvements in ICT support for pay-related issues, and contributions to cultural change initiatives. Positive inspection outcomes reflect improvements in speaking-up culture in specific service areas. • The Trust has expanded its network of Freedom to Speak Up Champions to 30, aiming for 40 by April 2027, with increased frontline clinical representation. • An external review supported by NHS England is underway to enhance assurance of FTSU arrangements. Analysis of staff survey data shows improvements in some areas but ongoing challenges in confidence and perceptions of detriment. A corporate program is being developed to embed speaking up as business as usual within a compassionate and inclusive culture. RFW thanked ER for her dedication to supporting staff and congratulated her on her master class has been recognised nationally. She noted the low levels of concerns being raised with anonymity and the opportunity to triangulate data. ER confirmed the team remain committed to zero tolerance. SB thanked ER for continuing to support staff to speak up. She queried how projects and programmes of support link to the culture of care programme? ER confirmed the model is formally included in the response to staff and a master class for culture of care is being delivered to band 6 and 7 staff across the organisation. FA queried how the health and wellbeing offer to staff is being communicated noting the opportunity to gain intelligence on a larger scale? ER confirmed a campaign is being developed to include case studies and this will be included in regular communications across the Trust via the intranet and colleague briefings. RFW noted the importance of positive action learning and importance of learning. PG queried whether the option to raise concerns via an app has been explored? ER confirmed this had been reviewed by NHS England and it is not a viable option. PG thanked ER, the wider team and champions noting positive change.
16	**Finance, Performance and Productivity Committee Report** The Board received the reports. BC highlighted the following key points from February and March meetings: • Acute and PICU out of area placements continued to be reported as inappropriate, pending internal approved of the Standard Operating Procedure required to meet NHSE criteria. • £4.8m of savings remained unidentified, with several high-risk schemes. • There was a reported £2.2m surplus at M11, and the Committee was assured that there was no material risk to delivering the £4.2m financial recovery plan. • Agency spend had significantly reduced, notably CYP medical agency use which had reduced from eight to two posts, with further reduction expected. PG queried whether the Trust will deliver the year end position? DET confirmed the Trust remain confident in delivering a breakeven position.

	The Board of Directors recognised the challenging impact of delays from NHS England and thanked staff for their dedication and commitment to delivering savings plans with a continued focus on improving patient care.
17	**Finance Report** The Board received the report, noting the following key points: • The month 11 year to date position is £1m adverse to the financial recovery trajectory. Temporary staffing expenditure is adverse to trajectory. However, significant reductions in non-Trust bed expenditure is helping to offset this. • The month 11 year to date spend of £32m is £3.9m adverse to the temporary staffing trajectory set as part of the financial recovery plan. In 2026/27 and beyond it will be particularly challenging to meet the bank limits set by NHSE. Bank spend will need to reduce by £0.75m per month from current levels. The Bank Reduction Gold project is ongoing, lead by the Executive Director of Nursing. An updated project plan has been agreed for the next 12 months, including auto-rostering and enhanced controls and bank shift sign off. • The 2025/26 savings target is £36m. The month 11 year to date savings achieved is £30.3m, this is £3m adverse to plan. It is forecast that the full year savings target will be achieved but 41% will be via non-recurrent means. There is a challenging £40m savings target set within the 2026/27 Group financial plan. £11m of savings plans are non-recurrent and £12m of plans are currently considered high risk. • The final medium term financial plan was submitted to NHSE on 11.2.26. Feedback received from NHSE on 11.3.26 identified BSMHFT as Regional Acceptance Category 1: compliant and deliverable – plan accepted. • UHB financial position has improved. The Board of Directors discussed the financial position for the next financial year noting the current breakeven forecast as positive. Challenges continue however the Trust remains in a strong position. DET noted the importance of system changes and need for the Trust to remain transformational and sustainable.
18	**Trust Strategy 2026-2031** The Board received the report for approval. PN highlighted the following salient points: • The previous five-year strategy ended in March 2026, and since April 2025, the Trust has been refreshing the strategy, involving over 1,750 participants in 113 meetings and events to help shape the new plan. • The strategy incorporates national and local health plans, including the 10 Year Plan for Health and the Birmingham and Solihull Provider Collaborative strategy, ensuring relevance to broader health objectives. • Following the development of a strategy blueprint and feedback phase called 'Taste our Brew,' the final strategy is ready for Board approval, with a planned internal launch in April 2026 and an external launch in May 2026 after local elections. • The Trust will continue refining accountability frameworks, annual goals, KPIs, and governance arrangements in the first quarter of the new strategy period, with final document design and proofing underway before printing. PN thanked Abi Broderick, Louise Johnson and the wider team for their dedication in developing Trust Strategy and the Board of Directors for their active engagement. The Board reflected on the noticeable improvements and significant changes that have supported the delivery of the strategy and achieve the quality mark. PN confirmed inequalities will be a continuous theme across all four priorities supported by leadership to demonstrate the impact.

	PG echoed the Board of Directors thanks to staff who have been involved in the development of the strategy noting the positive co- production including the council of governors. RFW noted the positive achievements and need to ensure this is widely shared with colleagues. SB thanked the team for the format of the document as it has been developed to be user friendly. PN confirmed the strategy has been developed to be anchored in the Trust values with clear guiding principles. The Board of Directors were assured the strategy will be linked to the Board Assurance Framework with Board Committees maintaining regular oversight for progress. The Board of Directors formally approved the Trust Strategy 2026-2031. **DECISION: The Board of Directors formally approved the Trust Strategy 2026-2031.**
19	**Caring Minds Committee Report** The Board received the report. MS highlighted the following key points from meeting in February: • The Committee supported the portfolio transition from the Charity Multi-Asset Fund to the Sustainable Multi-Asset Fund (SMAF), which maintains the same investment objective and risk profile but incorporates a sustainable investment policy, excluding certain sectors and reporting on non-financial impact. • The Caring Minds Strategy is being developed and is structured around five elements: preventative projects, waiting well, enhancing inpatient and outpatient care, supporting transitions home (Caring Arms), and nurturing staff. The strategy aims to support both service users and staff, focusing on initiatives beyond core NHS provision. The Board were assured the development of the strategy will support the charity moving forward noting positive progress made.
20	**Caring Minds Committee Terms of Reference** The Board received the Caring Minds Committee Terms of Reference for ratification following the approval by the Committee in February 2026. The Board were assured the review of the terms of reference included the Committee's responsibilities in relation to risk management. **DECISION: The Board of Directors ratified the Caring Minds Committee Terms of Reference.**
21	**Board of Directors Terms of Reference** The Board of Directors received the terms of reference for formal approval noting there have been no significant changes made. **DECISION: The Board of Directors approved the terms of reference.**
22	**Board Effectiveness Self-Assessment** The Board received the report for endorsement. DTi highlighted the following key points: • The Board is well-composed with a strong balance of skills, experience, and governance structures, effectively fulfilling its statutory responsibilities and core functions. • The Board actively uses the Board Assurance Framework (BAF) for strategic oversight of risks but shows variability in confidence regarding the quality and consistency of assurance reporting. • The Board maintains strong visibility and actively engages with internal and external stakeholders, including patients, staff, governors, and system partners. • The Board demonstrates strong oversight of strategy and performance with constructive challenge and accountability, though confidence in the credibility of the long-term strategy varies among members.

	• The Board shows strong leadership capacity and commitment to fostering a transparent, open, and quality-focused organisational culture. • Recommendations include increasing the survey response rate, enhancing the quality and length of Board papers, focusing more on quality and safety, improving forward planning beyond 12 months, and strengthening partnerships with non-NHS stakeholders. • The main risk identified is the low response rate to the self-assessment, which will be addressed through improved publicity, engagement, and timing of the survey. PG noted the importance of Board members responding to the survey noting disappointment in the latest uptake. The Board reflected on the content of the report and endorsed its content and proposed recommendations for implementation. **DECISION: The Board endorsed the content and proposed recommendations for implementation.**
23	**Living the Trust Values** The Board reflected on the importance of living the Trust values and recognised the values throughout the reports and discussions. MS highlighted the opening of the meeting in remembering Barry Dangerfield was an example of the compassion and dedication of staff in delivering the values at the core of everything we do.
24	**Board Assurance Framework reflections** The Board were assured the Board Assurance Framework continues to be developed in line with the strategy.
25	**Any other business** None.
26	**Questions from Governors and members of the public** • A governor queried the waiting list for AFRID pathways alongside the further diagnosis of ASD. Details will be shared directly. • A governor noted the positive inclusions of governor feedback in the 2026-31 strategy. • A governor highlighted the service user story was a positive refection of the improvements at Reaside and the bravery in sharing the details in requesting a change in consultant. They noted the importance of language used and the positive impact it can have on individuals. • A governor highlighted the opportunity to include learning from Solihull at the upcoming meeting with Birmingham City Council. • A governor noted the improved engagement with staff survey responses and queried how the Trust has communicated to staff? It was confirmed a listen up live has taken place and local discussions continue with a focus on teams with low or no responses.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
Board Assurance Framework	The Board ratified the reduction in the proposed risks.		
Trust Strategy 2026-2031	The Board of Directors formally approved the Trust Strategy 2026-2031.		

Caring Minds Committee Terms of Reference	The Board of Directors ratified the Caring Minds Committee Terms of Reference.
Board of Directors Terms of Reference	The Board of Directors approved the terms of reference.
Board Effectiveness Self-Assessment	The Board endorsed the content and proposed recommendations for implementation.

Report to the Board of Directors

Agenda item:	**6**					
Date	3 June 2026					
Title	Chair's Report					
Author/Presenter	Phil Gayle, Trust Chair					
Executive Director	Phil Gayle, Trust Chair	**Approved**	**Y**	✓	**N**	

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

Summary of Report

Alert		**Advise**		**Assure**	

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

Recommendation

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

Enclosures

N/A

BOARD OF DIRECTORS CHAIR'S REPORT

Introduction

I am pleased to present the Board with a summary of my activities and key engagements since our last meeting. This report reflects a period of significant strategic momentum for the Trust, important governance activity and a continued programme of service visits that have provided valuable and direct insight into the realities of our services and the experiences of the people who deliver and receive them. In early May we were pleased to formally launch the Trust Strategy for 2026 to 2031, setting a clear and ambitious direction for the organisation in the years ahead. This is a landmark moment for the Trust and one that reflects the sustained effort and collective vision of colleagues across every part of our organisation.

Care, Communities, Culture and Creativity, are our four strategic priorities that provide the organising framework for the Trust's work over the next five years. They reflect what matters most to the people we serve and to the staff and partners who work alongside us. Our strategy will shape and inform everything we do as an organisation going forward. It provides both a clear statement of our values and a practical framework for decision making, resource allocation and performance management at every level. Alongside these priorities the Trust is embarking on a number of significant organisation-wide transformations designed to improve how we deliver care and support. These include adopting a life-course approach to wellbeing, strengthening community-based services and developing new models of care for children and young people that place families at their centre.

We are also working to enhance urgent and emergency mental health pathways, improve inpatient flow and ensure people receive the right care in the right place at the right time. Underpinning all of this is our Culture of Care alongside a strong focus on digital innovation to help us work smarter and provide more responsive and joined-up services across Birmingham and Solihull. Together these changes will enable us to deliver high quality, compassionate care for our service users, their carers and families both now and into the future. The launch of this strategy marks the beginning of an exciting chapter and I look forward to reporting on our progress against it at future Board meetings.

Governance Matters

Effective governance continues to underpin the Trust's ability to deliver safe and high-quality mental health services for the people of Birmingham and Solihull. Over the past month I have continued to work closely with Board colleagues to maintain strong and active oversight of key risks, performance and statutory responsibilities, particularly as the wider health and care system experiences sustained operational and financial pressures.

Mental Health Act Reform

In May we held a dedicated Board development session focused on the forthcoming changes to the Mental Health Act. This was an important and timely opportunity for the Board to deepen its collective understanding of the legislative reforms and to consider how the Trust can best prepare as an organisation to ensure we continue to deliver safe, person-centred and rights-based care in line with the new statutory framework. The session was well engaged and generated constructive and forward-looking discussion about our organisational readiness and the implications for our clinical and governance practice.

Committee Cycle and Non-Executive Director Contribution

Our committee cycle continues to provide an essential and structured source of assurance across quality, workforce, finance and transformation. I would like to take this opportunity to acknowledge the valuable scrutiny and constructive challenge provided by our Non-Executive Directors throughout this period. Their engagement plays a central and indispensable role in strengthening accountability, supporting robust decision making and ensuring the Board discharges its governance responsibilities with rigour and integrity.

Service visits

Service visits remain one of the most important and valued elements of my role as Chair and of our broader Board and Council of Governors engagement programme. Non-Executive Directors and Governors are continuing their programme of site visits over the coming months and I am pleased to report on several significant visits I have undertaken since our last meeting. These visits provide an irreplaceable and direct insight into the experiences of staff, patients and service users. They help the Board understand both areas of genuine strength and the places where further support, investment or improvement is needed. This direct engagement ensures that the voices of those delivering and receiving care remain central to our governance and strategic leadership, and that Board discussions remain grounded in the lived reality of our services rather than paper-based reporting alone.

Opening of the New 24/7 Neighbourhood Mental Health Centre

I had the great privilege of attending the official opening of our new 24/7 Neighbourhood Mental Health Centre, the first of its kind in Birmingham. It was a genuinely proud and moving occasion to be present alongside the colleagues whose dedication and sustained hard work have made this extraordinary development possible, as well as the service users who joined us to mark the occasion with such warmth and generosity of spirit. As one of only six national pilot sites selected for this programme, the centre will serve the communities of Small Heath, Heartlands and Bordesley Green, offering immediate and accessible mental health support whenever it is needed, around the clock throughout the year. This is a significant and exciting step forward in the Trust's commitment to removing barriers to care and ensuring timely, compassionate support for all who need it. I have no doubt that this service will make a profound and lasting difference to the lives of people across those communities.

Visit to Birmingham Healthy Minds Shenley Fields, Northfield

I had the pleasure of visiting Birmingham Healthy Minds at their Shenley Fields site in Northfield, which provides Talking Therapies services to the local community. I was given a tour of the building and had the opportunity to speak with a number of staff about their work, their experiences and the realities of delivering this important service on the ground. The visit gave me a genuine and valuable insight into the breadth and quality of the work being delivered at Birmingham Healthy Minds and I was struck by the commitment, skill and compassion of the team. What was also clearly evident, however, was the significant level of demand that the service is experiencing. Staff spoke openly and thoughtfully about the challenges this creates, including the pressures on waiting times, clinical capacity and staff wellbeing. These are challenges that the Board is already aware of through our performance reporting but hearing them directly from those delivering the service gave them an immediacy and human dimension that is invaluable. I was grateful to the team at Shenley Fields for their openness and their warm welcome and I came away with a deepened appreciation of both the impact of this service and the importance of the Board's continued focus on supporting Birmingham Healthy Minds to meet the level of demand it faces.

Visit to Attwood Green The Homeless Health Exchange

I had the pleasure of visiting Attwood Green, home to the Homeless Health Exchange service, which represents one of the Trust's most important commitments to reaching those who are most vulnerable and most often overlooked by mainstream health services. The service provides responsive NHS General Practice services designed specifically to meet the needs of people who are homeless or in unstable accommodation as well as those who have come to Birmingham as refugees or to seek asylum. The visit reinforced for me the critical importance of this provision and the skill and dedication of the team in reaching people who face the greatest barriers to accessing the care they need. I look forward to sharing further reflections on this visit with the Board.

Visit to HMP Birmingham

I also had the opportunity to visit HMP Birmingham where I was able to see first-hand the dedication and compassion of our frontline teams working within a uniquely challenging environment. I was struck both by the quality of the care being delivered and by the very real pressures that staff continue to face including estate constraints, workforce demands and the increasing complexity and volume of need among the prison population. Visits such as this one are invaluable in ensuring that our Board

discussions remain firmly grounded in the day-to-day realities of the services we commission and oversee and in the experiences of those who deliver and receive that care. I am deeply grateful to the teams at HMP Birmingham for their openness and their continued commitment under such demanding conditions. I look forward to continuing this programme of visits to other Trust sites, services and staff and to meeting more of our service users over the summer months.

Partner and System Development

As Chair I continue to maintain an active and visible presence within key strategic and system forums across the region, providing leadership, influence and constructive challenge on behalf of the Trust. This engagement is an essential part of my role and supports the development of strong and productive relationships with partners and stakeholders across the health and care system. I recently attended events hosted by the NHS Confederation and the NHS Alliance as well as a Midlands NHS leadership meeting. These forums provided valuable and timely opportunities to connect with system partners, share learning and insight and reflect on the wider challenges and opportunities facing mental health services nationally and regionally. Engaging with these networks ensures that the Trust remains outward-looking, well-informed and well-positioned to contribute to and influence the broader mental health agenda as we continue to shape our own strategic direction. These activities provide the Board with assurance 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 and consistent focus on improving outcomes for the communities we serve. I will continue to report on significant developments from these forums at future Board meetings.

Stakeholder Engagement

Strong and meaningful stakeholder engagement remains a core focus and priority of my role as Chair. Planning is underway for further engagement activities in the coming period to ensure the Trust remains closely aligned with the needs, expectations and perspectives of our communities and system partners. I continue to chair the Council of Governors meetings, which provide an important and valued 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 and probing discussion that supports effective oversight and ongoing organisational development. The Council continues to provide a vital bridge between the Board and the wider communities and constituencies the Trust serves.

People / Quality

I continue to chair the Board Strategy sessions, which provide a critical and regular forum for strategic alignment, collective leadership and continuous improvement across the Trust. These sessions play a central role in shaping the Trust's strategic direction and provide assurance to the Board that quality, safety and workforce considerations are fully integral to our decision making rather than being treated as separate or secondary concerns. I also maintain regular one-to-one meetings with our Chief Executive and with individual Non-Executive Directors to ensure strong leadership cohesion, clarity of roles and effective oversight across the full breadth of Board responsibilities. These relationships are fundamental to the collective functioning of the Board and to our ability to respond swiftly and with confidence to emerging challenges. In addition, I meet monthly with our Freedom to Speak Up Guardians, which represents one of the most important sources of assurance available to me on staff experience and organisational culture. These conversations provide candid and invaluable insight into themes relating to staff wellbeing, workload, inclusion and psychological safety. They support the Board in maintaining a clear and continuous line of sight to workforce risks and the actions being taken in response, reinforcing our commitment to creating and sustaining a respectful, supportive and genuinely open working environment for all our people.

PHIL GAYLE
CHAIR

Report to Board of Directors							
Agenda item:	**7**						
Date	3 June 2026						
Title	Chief Executive Officer and Director of Operations Report						
Author/Presenter	Vanessa Devlin, Executive Director of Operations Roisin Fallon-Williams, Chief Executive Officer						
Executive Director	Roisin Fallon-Williams, CEO	**Approved**	**Y**	✓	**N**		

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

Summary of Report					
Alert		**Advise**	✓	**Assure**	✓

Purpose

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

The report to the Board provides information on areas of work focused on the future, our challenges and other information of relevance to the Board in relation to our Trust strategy, local and national reports, and emerging issues.

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

Enclosures
N/A

CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT

CULTURE

Performance Overview (April)

- Sickness absence stable at 5.3% (second lowest in system).
- Improved productivity: ER case resolution reduced by 15 days.
- Workforce indicators broadly stable: turnover 5.7%, bank fill 92.4%, vacancy rate reduced to 6.7% (nursing 6.6%; Band 5 at 4.8%).
- Reduced agency reliance, now 2.3% of shifts, with overall shift demand down 26% month-on-month.
- Medical workforce strengthened, with significant reduction in agency use (–88% in CYP).
- Compliance metrics: training 94.3% (near target), appraisal 81.2% and return-to-work 65.3% remain the areas for improvement.
- Industrial action managed safely with effective contingency arrangements.

Key Workforce Developments

- People policy modernisation progressing, strengthening consistency, inclusion and early resolution.
- Transformation of People Services underway, including digital self-service and a Copilot-enabled virtual assistant.
- Job evaluation and workforce alignment improving governance and pay consistency.
- Medical workforce governance strengthened through new approval controls.
- Workforce systems and planning: ESR optimisation and future workforce system preparation underway; early 2026/27 plan shows slight pressure on bank/agency usage and substantive staffing.

Culture of Care Excellence

- New Quality Governance System implemented (April 2026), aligned to 12 national standards.
- Framework embedded in Trust strategy and recognised as best practice, with external interest from other Trusts and national forums.
- Trust-wide self-assessment (Bronze/Silver/Gold) underway, with plans to celebrate and scale high-performing services.
- National recognition via invitations to share at conferences.

Celebrations

- HSJ Equality Diversity and Inclusion Digital – award winners
- Trust For Student Placement of the Year (Nursing Times) - award winners
- Trust Colleague Sharon-Nira King attended the Kings Garden Party

CARE – Delivery

Primary Care, Dementia Services & Specialties

Older Adult Inpatients

Older adult wards continue to experience significant discharge delays, with a high number of patients clinically ready for discharge but awaiting placement. Delays are primarily linked to the complexity of patient needs and behavioural risk, alongside extended health and social care approval processes. A recently introduced additional stage in the funding approval process appears to have increased approval times, contributing to longer lengths of stay and additional bed days, we are currently exploring to see if this is the case and will feedback to social care colleagues.

Despite the challenges, the division continues to deep dive into cases and work collaboratively with system partners to improve length of stay within this bed base. We are also working with the provider collaborative and integrated care board around future provision of pathway beds such as P2 beds.

*A P2 bed is a non-acute hospital or community bed where patients receive short-term rehabilitation and reablement before safely returning home.

Older Adults Community Mental Health Teams

Work continues to improve community engagement and equitable access to dementia and older adult services. Following engagement with South Asian communities, targeted outreach with the Chinese community is being developed to address health inequalities.

Following a recent Care Quality Commission visit, the service is strengthening quality assurance, including increased audit activity. Current audits focus on clinical documentation and depot medication management.

The post-diagnosis dementia support programme, delivered with the Trust's Recovery College and Voluntary Community and social enterprise partners, is now underway.

A joint marketplace event (13 March 2026) will bring together service users, carers and partners to improve awareness of support and strengthen community pathways. The outputs of this will be shared more wider within the division and reported through to the Operational Management Team meeting to share good practice.

Eating Disorders

A quality improvement programme is underway to strengthen therapeutic observations and ward care. Work is also progressing on a pathway for severe and enduring eating disorders, co-produced with peer support workers and experts by experience.

Birmingham Health Minds

The service has achieved reliable improvement for five consecutive months. Reliable recovery remains below the 50% target (currently ~45%) and completed treatment volumes remain below trajectory. A recovery action plan is in place and monitored through partnership governance

Perinatal services

The recently developed outreach service continues to perform well and works effectively within the collaborative, meeting the needs of service users and their families.

The Bipolar Service

The service has delivered its first national multi-Trust training for Mood on Track, expanding reach and generating income. Research funding has also been secured to support development of a randomised controlled trial of the digital Mood on Track intervention, the first of its kind in the UK

Veterans service

An Armed Forces healthcare training programme has been launched to improve staff awareness of the Armed Forces Covenant and veteran support pathways.

Acute and Urgent Care

Service Development and System Working

Priority work continues across patient flow, discharge improvement and future service design.

Exploration of a Mental Health Emergency Department model has continued; however, current system feedback does not support a standalone local model at this stage. Further analysis and data review will inform future options. Subject to any future capital opportunities at Midland Metropolitan University Hospital, there is greater support for exploring a Cherry Suite-style model aligned with provision at Heartlands Hospital, or further investment in Talking Spaces.

Patient Flow and Length of Stay

The Red2Green pilot, aligned to NHS England High Impact Actions, has commenced to strengthen multidisciplinary review of delays and improve discharge planning. Early learning continues to identify barriers relating to social care provision, accommodation and legal processes.

Supporting initiatives include development of a “To Take Away” medication on discharge Standard Operating Procedure, implementation of Fair Access and Choice principles, and development of a Housing Needs Assessment approach to identify discharge barriers earlier in the patient pathway.

System Collaboration and Strategic Development

Work is progressing to review the Admission, Discharge and Follow-Up Policy and strengthen the operational framework across acute and urgent care pathways.

Inpatient bed pressures remain, with escalation processes continuing to support patient flow, manage demand and maintain oversight of waiting lists.

Continued collaboration with our Urgent care transformation group with a focus on section 136 improvement in collaboration with the police.

Discussions with the Ambulance Service are underway to review and enhance the mental health response vehicle (street triage). The team is assessing demand, response times, and clinical outcomes to find the best service configuration, including options for joint triage, faster mental health

assessments during crises, and fewer unnecessary Emergency Department transfers. Positive progress is being made toward a sustainable model aligned with the Right Care Right Person approach, with further proposals dependent on activity data and stakeholder feedback.

Early update to develop a Mental health surge plan in collaboration with NHSE to recognise the difference of calendar pressure in MH versus the traditional winter pressure felt in the Acute trust space.

Integrated Community Care & Recovery (ICCR)

Birmingham Neighbourhood Mental Health Teams

Dialectical Behavioural Therapy (DBT) skills groups are being rolled out across teams, with three of eight programmes now completed. A full evaluation will follow completion of the final cohort.

Recruitment has commenced for new Family Link Worker roles, which will be embedded within teams in partnership with Birmingham Children's Trust.

Community Mental Health Teams

A four-day Bipolar and Psychosis training programme continues to roll out across the division, with three cohorts completed to date. A one-day Trauma Informed Care training package has also been developed and is currently in soft launch phase.

East Community Mental Health Teams continue to experience workforce pressures due to sickness absence and vacancies. Additional Band 5 nursing support has been secured, alongside enhanced operational oversight through weekly monitoring meetings.

A "Circuit Breaker" pilot focused on caseload management is underway within Zinnia Community Mental Health Teams, with plans for wider implementation should outcomes prove successful.

On 13th May, clinical and operational leads convened for a dedicated Demand and Capacity workshop focused on CMHT (Community Mental Health Team) caseloads. With guidance from Dr Fabida Aria, the group explored the current pressures facing the teams and developed both immediate and longer-term solutions. The session was collaborative, with leads actively contributing to identifying short-term for immediate implementation. There was strong collective agreement to support and facilitate these changes, with the understanding that these actions will feed into a broader programme of improvement work over the next 12 months.

Assertive Outreach Teams (AOT)

Fortnightly interface meetings with Community Mental Health Team Hub Managers and Clinical Leads are now established and are demonstrating positive impact on waiting times. Weekly acute bed management meetings continue to support performance, with bed occupancy remaining below allocation thresholds over the last eight months.

Intensive Community Rehabilitation Team (ICRT)

Phase 2 staffing funding has been approved, with the model of care and staffing structure currently in development with a timeframe of completion March 2027 The team has secured Decider Skills training for all staff to support delivery of evidence-based interventions.

Homeless Mental Health Services and Rough Sleepers

Plans are underway to refurbish the Homeless Exchange site at Attwood Green to expand clinic capacity and consolidate provision onto one floor.

The Rough Sleepers Team continues to review caseloads and strengthen partnership working through the Make Every Adult Matter and Connecting Healthcare Communities strategies. Improvements in completion of Dialog+ continue across services. A new Clinical Service Manager is due to commence in post in June 2026.

Solar

Progress continues against the Remedial Action Plan, with all 17+ cases reviewed. Recruitment to the new Screening Team has been completed, with staff expected to be in post by September 2026. This will strengthen screening and triage processes and increase capacity within core teams.

Steps to Recovery

Steps to Recovery is now working with local Birmingham providers for high dependency male beds, reducing reliance on out-of-area placements and strengthening local governance arrangements to support improved flow and reduced length of stay.

A high-level rehabilitation cessation plan has been submitted to the Executive Team on 30th of April in response to recent NHS England requirements. Work continues with commissioners and local authority partners to strengthen discharge pathways.

Drug, Alcohol and Substance Support Services

Reduced funding for Recovery Near You / Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG) has required implementation of a revised service model. Despite this, performance remains strong, including effective Emergency Department navigator roles, a well-utilised health assessment pathway, and delivery of over 1,500 community fibro scans over the last 12 months.

COMPASS is shifting from direct clinical delivery towards training and system-wide workforce development, including Level 2 training planned for summer 2026.

SIAS continues to work with commissioners to secure future contracting arrangements and improve outcomes through new multidisciplinary “pods” and tailored intervention pathways.

Secure Care & Offender Health (SCOH)

Tamarind

The recent Forensic Quality Network Peer Review received positive feedback, particularly regarding co-production and Expert by Experience involvement. Areas for improvement were identified, reviewing night-time staffing levels on acute wards, CCTV in communal areas, learning from staff

experiences of racism, timely decisiveness of care decisions. Strengthening communication systems with families and. enhancing staff rest spaces and décor action plans will be put in place.

The service remains largely substantively staffed, with a nursing vacancy rate of 4.4%. Psychology staffing pressures continue to affect therapy provision and recruitment to the vacant posts continue. Bank usage remains high due to sustained clinical acuity and 100% bed occupancy.

Freedom to Speak Up (FTSU) clinics have commenced with positive feedback received. A reduction in incidents of racial abuse towards staff has also been noted, particularly on Laurel Ward.

Reaside and Hillis Lodge

Sickness absence remains above Trust target. Psychology provision continues to be impacted by vacancies, although recent recruitment is expected to improve resilience.

Environmental pressures associated with the ageing estate continue, with multiple capital works projects underway across the site. Culture of Care work continues positively, supported by strong Expert by Experience involvement.

Ardenleigh and Medium Secure Unit, Children and Adolescent Mental Health Service

Recruitment and retention remain key priorities at Ardenleigh. Clinical acuity has reduced and staff morale has improved, with continued focus on relational security and Culture of Care initiatives.

Medium Secure Unit Children and Adolescent Mental Health Service remains clinically busy with increasingly complex presentations, including young people over 18 years of age, creating additional safeguarding challenges. Recent staffing changes have improved morale and collaborative working with young people. A Quality Network for Inpatient Children and Adolescent Mental Health Services review took place on 5 May 2026. Positive verbal feedback was provided on the day which included good access to outside space, activities and structure for the young people, families reported feeling listened to, respected and supported. The formal report will be received in approximately 6 weeks.

Youth First

Recruitment into vacant posts continues, although staffing pressures are expected until new staff commence in post. Clinical quality remains strong. The service continues to monitor the impact of the Southport Inquiry as references were made to Forensic Children and Adolescent Mental Health Services within the review. This includes a Structure Assessment of Violence Risk in Youths not being completed and early closure of the case by Forensic Children and Adolescent Mental Health Services. Although there were no recommendations for Forensic Children and Adolescent Mental Health Services within the report. A recommendation from the Southport inquiry included the Department of Health and Social Care and NHS England should review whether there is a need for further guidance on the thresholds for when complex risk assessments, including Structure Assessment of Violence Risk in Youths should be completed. This is being discussion nationally and Youth First continue to engage in discussions around the enquiry.

FIRST (Forensic Intensive Recovery Support Team)

FIRST is preparing for phased relocation to Main House commencing the week of 18 May 2026, with the first clinic scheduled for 26 May.

Medical secretary provision remains a key operational risk due to increasing caseloads. Physical health assessment compliance has improved significantly, with non-compliance reduced to 7.5%.

The service is progressing a wider service model review and continues engagement with Integrated Care Boards through Reach Out pilot programmes aimed at preventing admission to secure care.

HMP Birmingham

The prison has welcomed a new Governor with a strong focus on staff wellbeing and partnership working. Joint work is ongoing to address infection prevention and environmental concerns across the estate.

Population pressures remain significant, alongside increased illicit substance use within the prison. The impact of Right Care Right Person "Red Route" processes on mentally unwell individuals entering custody continues to present operational challenges. There are collaboration of multi-agency working taking place with the next meeting being on the 10th of June with West Midlands Police, NHS England Integrated Care Board services across the West Midlands to discuss Right Care Right Person and the legal framework.

HM Inspectorate of Prions (HMIP) and CQC will return in June 2026 for follow-up inspection activity, with ongoing partnership work focused on delivery of recommendations.

Health and Justice Vulnerability Service

Demand across custody, court, outreach and Mental Health Treatment Requirement pathways remains high. Partnership working with secondary mental health services continues to strengthen and is beginning to improve pathway alignment.

A key ongoing risk relates to the service being referenced within discharge plans for individuals returning to custody following A&E review by Psychiatry Liaison Teams. This risk has been escalated and mitigating actions are underway.

Children & Young People's (CYP) Services

Children and Young People's Services continue to experience sustained operational pressure across Urgent Care, Neurodevelopmental Services and Referral Management pathways.

Bronze, Silver and Gold oversight arrangements remain in place for CAMHS Urgent Care, with improvement work progressing through strengthened operational grip, enhanced reporting and focused recovery actions. Improvements are beginning to emerge, including reductions in crisis pathway length of stay and improved discharge planning processes. However, pressures relating to caseloads, response times and workforce resilience remain significant.

Early scoping has commenced for a similar Bronze/Silver/Gold improvement approach within Learning Disabilities and Referral Management Centre pathways to strengthen demand management and operational resilience.

The Division has also experienced increased demand linked to adult inpatient admissions, placing additional pressure on bed management pathways. Recovery actions are progressing through the "Get to Green" improvement structure, focusing on patient flow, discharge coordination and reducing out-of-area placements.

Despite these pressures, performance improvements continue in several areas. CYP Access performance has improved across a number of clinical groups through enhanced recording, increased activity and pathway optimisation.

The Eating Disorders Service continues to maintain low inpatient admission rates and receives positive system feedback regarding avoidance of Tier 4 admissions. However, access performance remains challenged within the Avoidant and Restricted Food Intake Disorder pathway due to increasing complexity and limited capacity.

Neurodevelopmental Services continue to experience significant waiting time pressures and high volumes of 52-week breaches, particularly within ADHD pathways. Work continues to improve throughput, optimise booking processes and reduce historical backlogs.

The Referral Management Centre also continues to experience high demand and increasing complexity, creating sustained operational pressure the aforementioned Bronze, Silver & Gold support structure will be mobilised to define what actions we are able to take to manage this demand. Early views in the team are that more could be done to signpost demand for the large proportion of referrals we receive that do not need secondary mental healthcare. This will require primary care and commissioning team support.

Across the Division, progress continues in data quality, outcome measure reporting and operational governance. Several services are demonstrating reductions in un-outcome appointments, improved paired outcome measure completion and strengthened discharge oversight processes.

Workforce pressures remain a significant operational risk across multiple services, including sickness absence, vacancies, maternity leave and administrative capacity constraints. Recruitment, pathway redesign and operational improvement activity continue to support recovery and long-term sustainability.

CARE – Quality

Care Quality Commission (CQC)

- Draft reports pending for Urgent Care and Steps to Recovery inspections (Jan–Mar 2026); initial feedback positive, particularly on staff care, professionalism, and expertise.
- Mental Health Act assessment access issue identified during inspection was immediately addressed and has led to a joint review with Birmingham City Council.
- Review completed with a clear improvement plan to optimise existing capacity and increase responsiveness, ongoing oversight via Trust committees.
- Older Adults CMHT inspection rated ‘Good’ overall (draft), proactive improvements already underway, particularly in medicines management, staffing, and caseloads.

CREATIVITY

Funding and Finances

The NHS continues to operate in a difficult financial environment and while the Trust was able to deliver the required financial position as planned by the end of the last financial year, we are now focusing on the challenges for this year.

The Trust has a significant savings target for the year driven by our plans for continued reductions in the number of patients placed in inpatient beds outside the NHS, transformation into the way we deliver services alongside national expectations for reductions in our bank and agency spend.

Quality Account

Trust Quality Account (2025/26)

- Completed and due for publication; demonstrates improvements in safety, learning, and patient involvement.
- Governors noted stronger outcomes and increased activity offer for service users.
- 2026/27 priorities endorsed, focusing on:
    - Safer, faster care transitions and reduced waiting times
    - Improved experience and co-production with service users, families, and carers
    - Development of a consistent "Culture of Care", including enhanced therapeutic activity and night-time care

LOCAL TRUST, BIRMINGHAM AND SOLIHULL (BSoL) SYSTEM, BLACK COUNTRY & BSoL AND MIDLANDS REGIONAL NEWS

Birmingham's first Neighbourhood Mental Health Centre officially opens

Delivered by BSMHFT, Birmingham's first Neighbourhood Mental Health Centre (NMHC) has officially opened at Golden Hillock, marking a significant step forward in delivering more accessible, community-based mental health care. The centre, launched as one of six national pilot sites, provides integrated, person-centred support in partnership with voluntary and community organisations.

Since its initial launch in January 2025, the service has already supported over 550 referrals, reflecting strong local demand. The new purpose-built facility enables an expanded offer, including well-being spaces, short-stay accommodation and a broad range of clinical and practical support tailored to local community needs.

The official opening represents both a celebration of the progress made so far and the Trust's commitment to developing services that meet the evolving mental health needs of local people across Birmingham and Solihull.

The service has since hosted individual visits from Dr Penny Dash, Chair of the NHS and Lord Victor Adebowale, Sir Ciaran Devane, Baroness Gillian Merron, Parliamentary Under-Secretary of State for Women's Health and Mental Health, reflecting the level of national interest in the model.

For more information about the Golden Hillock Neighbourhood Mental Health Centre, visit **www.bsmhft.nhs.uk/247NMHC**

Neighbourhood Mental Health Centre (NMHC) Framework

Further to the successful launch of the Neighbourhood Mental Health Centre model, a national capital funding opportunity is currently available to support expansion and we have made a bid against this to develop additional centres across Birmingham and Solihull. Our bid has been shortlisted and is at

the final review stage, reflecting strong regional and national confidence in the model. Alongside this, a supporting framework is being considered at executive level to ensure a sustainable approach to delivery, with a focus on aligning resources, strengthening neighbourhood provision and supporting the continued rollout of integrated services across the system.

High Potential Scheme (HPS)

The NHS High Potential Scheme is a 24-month accelerated development programme designed to support mid-level health and care leaders to progress into senior executive roles, open to all health and care sector colleagues. Three Integrated Care Clusters in the country are being supported nationally to run the first cohorts of the programme. Across the Black Country and BSoL system we had the highest level of expressions of interest with circa 160 applicants, our programme will work with 66 in the first cohort. BSMHFT has seen strong success, with our congratulations being extended to our 11 colleagues accepted onto the scheme, all of whom are being supported through structured development, including dedicated career guides and executive mentors.

Provider Capability Assessment

NHS England recently published the outcomes of the Provider Capability Assessment (PCA), completed by NHS Trusts in October 2025 as part of the NHS Oversight Framework.

The Trust received an overall of Amber/Red rating, reflecting areas where further improvement is required, the assessment was based on members of the NHSE Regional Teams views on the Trust and some areas of performance during 2024/25. The process of assessment against the criteria will commence again in the coming months and we expect to be able to reflect the improvements we have made in this.

The Trust is continuing to work closely with regulators and is already providing evidence of progress in addressing considered gaps, supported by a range of improvement and transformation programmes that are either completed or progressing well. To support sustained improvement, the Executive Team is strengthening arrangements for delivery and oversight through clear accountability, measurable outcomes, and robust monitoring to further enhance organisational capability and governance maturity.

System Plan — Birmingham, Solihull and Black Country

NHS Chief Executive Sir Jim Mackey issued a national letter recognising the significant progress made across the NHS in 2025/26, including improvements in waiting times and urgent and emergency care performance despite ongoing financial and operational pressures. The letter set a clear expectation for systems to build on this momentum through strengthened strategic commissioning, neighbourhood health models, and multi-year planning aligned to the 10-Year Health Plan, with a focus on delivering sustainable transformation and improved population outcomes.

In response, Birmingham, Solihull and the Black Country have submitted a **single, unified system plan**. The plan focuses on stabilising urgent care, accelerating prevention and neighbourhood health, and shifting care closer to communities, underpinned by stronger accountability, aligned financial flows and a clear commitment to improving quality, outcomes and patient experience across the system.

Anchor Organisation
The Birmingham, Black Country & Solihull ICS has confirmed its intention to work with University Hospitals Birmingham NHS Foundation Trust (UHB) as the designated "Anchor" organisation for Birmingham and Solihull, operating in shadow during 2026/27.

This represents an important step in progressing neighbourhood-based, integrated care, with the focus on collaboration, co-design and system learning rather than structural change. All system partners will play a key role in shaping this approach as part of a shared commitment to improving outcomes for local communities.

It has further, and equally importantly, confirmed its intention to undertake a similar process to establish an 'Anchor' organisation (and contract) approach for mental health strategy and provision across the cluster, ensuring equity of consideration of the mental health needs of the population and communities served. The process for this element has just been initiated, and we and Black Country Healthcare NHS Foundation Trust are working with the ICS to progress the approach.

NATIONAL NEWS

Secretary of State for Health & Social Care Resigns
Wes Streeting resigned as Secretary of State for Health and Social Care in May 2026, citing a loss of confidence in the Prime Minister following recent political and electoral pressures. His departure formed part of a wider period of instability within government and prompted a rapid Cabinet reshuffle.

James Murray has since been appointed as the new Health and Social Care Secretary, bringing prior Treasury experience to the role.

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	**8**					
Date	3 June 2026					
Title	Board Assurance Framework Risks					
Author/Presenter	Kat Cleverley, Company Secretary					
Executive Director	Dave Tomlinson, Executive Director of Finance	**Approved**	**Y**	✓	**N**	

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

Summary of Report

Alert		**Advise**		**Assure**	✓

Executive Summary

An effective Board Assurance Framework provides a structured approach for a Board to identify, monitor, and gain assurance over the key strategic risks that could prevent the organisation from achieving its objectives. It links strategic goals to principal risks, controls, and sources of assurance, enabling the Board to assess whether risks are being managed effectively and where gaps in control or assurance exist. The BAF supports informed decision-making, strengthens oversight and accountability, and helps ensure that governance, risk management, and internal control arrangements are robust and aligned with organisational priorities.

Purpose

The current BAF risks have been attached for information. The Board is aware that work is ongoing to realign the risks to the new Strategy. Following feedback at Committees and the Board Strategy Session in May, consideration would be given to how transformation, digital and AI are reflected more prominently in the risks. This may result in some changes to the current risks.

The Board is asked to note that the process of the BAF is well-embedded within the organisation, and this alignment to the strategy reflects an evolvement of risks and the BAF as a dynamic tool.

SR1 and SR2 have been revised to reflect the new Trust Strategy, as follows:

SR1: Failure to create and sustain an inclusive, psychologically safe, anti-discriminatory and anti-racist organisational culture that enables equitable staff experience, effective speaking up, workforce wellbeing and high-quality care outcomes.

SR2: Failure to develop, transform and sustain a future-ready workforce with the capacity, capability, diversity and leadership required to meet changing population needs, service transformation and long-term organisational resilience.

Recommendation

The Board is asked to review the current BAF risks and consider what future risks could be to align to the new Strategy and remain fit for purpose.

Enclosures

- Board Assurance Framework SR1
- Board Assurance Framework SR2
- Board Assurance Framework SR3
- Board Assurance Framework SR4
- Board Assurance Framework SR5
- Board Assurance Framework SR6 (shared risk)
- Board Assurance Framework SR7 (shared risk)
- Board Assurance Framework SR8
- Board Assurance Framework SR9

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
Culture: Building a values-led culture where people and teams feel supported, skilled and confident throughout their employment journey							
SR1	Failure to create and sustain an inclusive, psychologically safe, anti-discriminatory and anti-racist organisational culture that enables equitable staff experience, effective speaking up, workforce wellbeing and high-quality care outcomes.	June 2024	April 2026	DSPP	**3x3 = 9**	**4 x 3=12**	**4 x 3=12**
SR2	Failure to develop, transform and sustain a future-ready workforce with the capacity, capability, diversity and leadership required to meet changing population needs, service transformation and long-term organisational resilience.	June 2024	April 2026	DSPP	**3x3= 9**	**4 x 3=12**	**4 x 3=12**
Care: Creating simpler, more connected, high quality and responsive services where care is safe and inclusive, with service users and carers at the centre							
SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.	Sept 2024	April 2026	CN	**4 x 2 = 8**	**4 x 4 = 16**	**4 x 3 = 12**
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 2026	CN	**4 x 2 = 8**	**4 x 3 = 12**	**4 x 2 = 8**
Creativity: Empowering and enabling people to make positive and bold change through innovation, improvement and research							
SR5	Failure to maintain a sustainable financial position.	Sept 2024	April 2026	DOF	**5 x 2 = 10**	**5 x 5= 25**	**5 x 5= 25**
Care and Creativity (Shared Risks)							
SR6	Failure to maintain acceptable governance and national standards.	Sept 2024	April 2026	DOF / COO	**3 x 3 = 9**	**5 x 4= 20**	**5 x 4= 20**
SR7	Failure to deliver optimal outcomes with available resources.	Sept 2024	April 2026	DOF / CN	**3x 3 = 9**	**4 x 3 = 12**	**4 x 2 = 8**
Communities: Working with and understanding our diverse local communities so that we are responsive to their specific needs							
SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.	Sept 2024	April 2026	MD	**3 x 3 = 9**	**4 x 3 = 12**	**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 2026	COO	**3x 3 = 9**	**4 x 3 = 12**	**4 x 3 = 12**

Heat Map

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

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**Failure to create and sustain an inclusive, psychologically safe, anti-discriminatory and anti-racist organisational culture that enables equitable staff experience, effective speaking up, workforce wellbeing and high-quality care outcomes.**	**Building a values-led culture where people and teams feel supported, skilled and confident throughout their employment journey**	• Increased FTSU contacts. • Lack of early local resolution • Staff survey results • Colleague feedback	• Sickness and recruitment challenges. • Lack of engagement. • Loss of trust and confidence with communities. • Services that do not reflect the needs of service users and carers. • Inequality across patient population. • Workforce that is not culturally competent to support populations and colleagues.	People Committee	Executive Director of Strategy, People and Partnerships	SR2

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 3 = 12	Due to the consistent improvements in colleague engagement and improvements experienced across people processes although events are likely it is considered there will be moderate impact due to the 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	**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.	**Jan 2025** 20 **June 2025** 12
		DATE OF LAST REVIEW	10 March 2026	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
Workforce Planning and Supply • Delivery of a robust workforce plan to ensure sustainable staffing levels • Implementation of a structured international recruitment programme to support workforce supply • Development of "grow our own" workforce initiatives, including apprenticeships and internal career pathways • Completion of training needs analysis to inform workforce development priorities • Implementation of stay conversations and exit surveys to improve staff retention and understand workforce drivers **Leadership and Management Capability** • Delivery of first line manager training to strengthen leadership capability • Implementation of the Authentic Leadership Programme to support inclusive and compassionate leadership behaviours • Delivery of a masterclass series on policies and management practices to improve management capability and consistency **Organisational Culture and Staff Experience** • Implementation of the Values in Practice framework to embed organisational values and behaviours • Delivery of the FLOURISH staff wellbeing programme • Implementation of the No Hate Zone initiative to promote a safe and inclusive workplace • Delivery of Active Bystander training to support respectful behaviours and challenge inappropriate conduct • Implementation of the Culture of Care programme, incorporating anti-racism and inclusive culture initiatives • Monitoring of staff experience through the NHS Staff Survey • Regular pulse surveys to monitor staff experience and engagement **Patient Safety and Learning Culture** • Implementation of the Patient Safety Incident Response Framework (PSIRF)	**Workforce Attraction and Recruitment** • Lack of a formalised workforce marketing and attraction strategy to support recruitment and promote the Trust as an employer of choice • Ongoing national and local workforce shortages limiting the organisation's ability to fully meet recruitment requirements **Governance, Accountability and Compliance** • Inconsistent adherence to organisational policies and procedures, resulting in areas of potential non-compliance • Variable levels of local accountability and oversight for implementation of organisational controls **Organisational Culture and Values** • Inconsistent application of the Trust's values and behaviours framework across teams and services. **Staff Engagement and Insight** • Low or variable participation in staff surveys, limiting the Trust's ability to gain comprehensive workforce insight **Workforce Development and Training** • Non-attendance or low completion rates for mandatory and developmental training, reducing assurance that staff have the required knowledge and skills

• Delivery of the Restorative Just and Learning Culture programme to support learning from incidents • Ongoing monitoring and management of complaints and concerns to identify improvement opportunities **Equality and Reducing Health Inequalities** • Development and implementation of divisional Reducing Inequalities plans • Delivery of programmes focused on reducing health inequalities across services • Use of Data with Dignity principles to ensure equitable and appropriate use of data • Engagement with partners through the Community Collaborative to improve population health outcomes	

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 framework currently being rolled out. Inclusive supervision model being developed. • Comms shared in relation to current surgency in hate crime and violence against racialised communities. • QI project commenced in Acute and Urgent Care to co-produce ways in addressing racism from Service users. • Second cohort of Authentic Leader programme underway. • 521 colleagues trained as Active Bystanders across the Trust. • 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. • PCREF to be incorporated into HI plans and also key corporate frameworks i.e. PSIRF. • Embed PCREF in frontline services. • PCREF to become part of the Culture of Care programme.

Develop a learning and development framework 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	• Learning and Development deep dive held at People Committee strategy session, ensuring alignment with the Trust Strategy 2026-2031.

PLANNED ASSURANCES	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
Internal audit reviews 2026-27: • Compliance with Anti-Racism Policy • Compliance with Sexual Safety Policy	Limited confidence in the quality and completeness of workforce demographic data, reducing assurance in monitoring equality and diversity outcomes. Changes and initiatives not consistently translating into improved staff experience or sustained outcomes, limiting evidence of control effectiveness.	**Workforce Planning and Recruitment** • Delivery of divisional workforce plans to support staffing needs. • Reduced time to recruit through NHSP and direct engagement. • Executive and system-level vacancy controls in place. • Implementation of temporary staffing reduction plans. • Values-based recruitment embedded in hiring practices. **Leadership, Culture and Staff Experience** • Rollout of Culture of Care programme to embed values and behaviours. • Implementation of Values in Practice feedback process and behavioural framework. • Management essential and people-related training delivered. • Improved staff survey scores and engagement, supporting retention. • Improved retention rates through workforce initiatives and flexible working. **Equality, Diversity and Inclusion** • Delivery of Workforce Race and Disability Equality Standards.	• Persistent diversity gaps in senior positions, limiting representative leadership. • Workforce Race Equality Standard (WRES) and Disability Equality Standard (WDES) indicators highlight ongoing inequality risks. • Gender pay gap remains, indicating unequal pay progression. • AfC pay scales and cost-of-living increases may be less competitive than comparable private sector roles, affecting recruitment and retention. • Partial assurance **Appraisal Process** internal audit review, indicating inconsistency in approaches to appraisals, recording of conversations and impact on progression. • Partial assurance **E-Rostering/Temporary Staffing** internal audit review, highlighting need to continue to strengthen temporary staffing controls and consistent application of process.

		• EDI Improvement Plan in place to drive inclusion. • Inclusive health and wellbeing offer supporting staff needs. • Recognition as Model Employer and achievement of Race Code Quality Mark. • Compliance with Public Sector Equality Duty reporting and NHSE High Impact Actions. • Programmes to reduce health inequalities and implement Patient Carer Race Equality Framework.	
Update since last review:			
12 May 2026: • Risk title reframed to align to new Strategy • Planned assurance updated			

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR2	**Failure to develop, transform and sustain a future-ready workforce with the capacity, capability, diversity and leadership required to meet changing population needs, service transformation and long-term organisational resilience.**	**Building a values-led culture where people and teams feel supported, skilled and confident throughout their employment journey**	• Increased demand. • Reduced pipeline locally and nationally to fill workforce gaps. • Reduced training commissions. • Hard to fill specialty posts across multiple professions on a national scale. • Poor management of people related matters. • Insufficient HWB offer.	• Reduced capacity to deliver key strategies, operational plan and high-quality services. • Increased staff pressure. • Continued reliance on temporary staffing. • Reduced ability to recruit the best people due to deterioration in reputation. • High turnover • Increased sickness levels.	People Committee	Executive Director of Strategy, People and Partnerships	SR1

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 3 = 12	Despite continuing demand and acuity pressures, workforce is in a healthier position with the vacancy factor reduced, turnover improved and pipelines have been strengthened. Challenges remain in hotspot areas which are now being addressed through a more targeted approach.	**Impact 3 x Likelihood 3 = 9**	A number of workforce plans focused on recruitment, retention and improved culture would have positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce.	**Jan 2025** **20** **June 2025** **12**
		DATE OF LAST REVIEW	10 March 2026	

CONTROLS/MITIGATIONS			**GAPS IN CONTROL**	
Workforce Planning and Recruitment • International recruitment pipeline in place to support workforce supply. • Divisional workforce plans implemented to address local staffing needs. • Reduced time to recruit through targeted processes and NHSP/direct engagement. • Executive and system-level vacancy controls in place to manage workforce gaps. • Robust temporary staffing processes and reduction plans operational. • Alignment with system priorities including Reconnect, Recruit, Train and Retain, Resilience and Reform. • Focused interventions in hotspot areas to address critical staffing pressures. **Workforce Deployment and Staffing Assurance** • Safer staffing model applied to ensure safe and effective staffing levels. • MHOST and E-Rostering compliance support workforce deployment and monitoring. **Workforce Experience, Retention and Engagement** • Retention plan implemented to improve workforce stability. • Implementation of stay conversations, leavers questionnaires, staff survey and pulse survey to monitor staff experience. • Training Needs Analysis conducted to inform development priorities. • Provision of flexible retirement options and health and wellbeing offers. • Embedding of values and behavioural framework across teams. • Robust people processes to support consistent HR practice and compliance.			**Workforce Recruitment and Supply** • Delays in recruitment processes for hard-to-fill roles, impacting timely staffing (although improving). • No formalised marketing and attraction strategy for some critical clinical roles. • High dependency on temporary staffing, increasing risk to workforce stability. • Insufficient vacancies at Band 5 nursing levels to support workforce pipeline. • No overarching talent management strategy to develop and retain key staff. **Workforce Systems and Processes** • E-Rostering not fully utilised, limiting staffing efficiency and oversight. • People processes not consistently adhered to, reducing assurance over HR compliance. • Inconsistent application of values and behaviours framework, affecting culture and staff experience.	
ACTIONS PLANNED				
Action	**Lead**	**Due date**	**Update**	
Decrease use of bank in line with growth of substantive workforce.	Head of Workforce Transformation/Executive Director of Quality and Safety	31 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	31 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	31 March 2026	People promise workshop and staff survey results led to focus on EDI and freedom to speak up. Turnover continues to improve. 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	31 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	31 March 2026	Framework agreed in principle at TCSE. Currently developing a toolkit.

PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
Internal audit action tracking reports	Limited confidence in the quality and completeness of workforce demographic data, reducing assurance in monitoring equality and diversity outcomes. Changes and initiatives not consistently translating into improved staff experience or sustained outcomes, limiting evidence of control effectiveness.	**Workforce Engagement and Experience** • Increased proportion of staff recommending BSMHFT as a place to work, reflecting improved staff satisfaction. • Improved staff engagement scores, indicating stronger workforce morale and commitment. **Workforce Recruitment and Retention** • Reduction in the vacancy gap from 10.4% to 7.1% (24/25), demonstrating progress in staffing levels. • Improved recruitment timelines, supporting faster onboarding of staff. • Increased use of social media to attract candidates to hard-to-fill roles. • Monitoring via HR KPI reports to provide oversight of workforce performance.	• Diversity gaps remain in senior leadership roles, limiting representative leadership. • Gender pay gap persists, indicating inequality in pay progression. • WRES and WDES indicator 2 results highlight disparities in likelihood of appointment from shortlisting. • Cost-of-living pressures and AfC pay scales may be less competitive than some private sector roles, impacting recruitment and retention. • Inconsistent adherence to flexible working initiatives across some areas. • Variable application of values-based recruitment principles, limiting consistency in recruitment practice.

Update since last review:
12 May 2026 • Risk title reframed to align to new Strategy • Planned assurance updated

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.	**Creating simpler, more connected, high quality and responsive services where care is safe and inclusive, with service users and carers at the centre**	• Unwarranted variation of quality of care. • Inconsistent use of data • Insufficient focus on prevention and early intervention. • Poor estate reducing the provision of the therapeutic environment. • Ineffective partnership working across system • Transitions/gaps in care pathways • Delays in access/waiting times	• Failure to meet population needs and improve safety. • Variations in care standards and outcomes. • Unwarranted incidents • Failure to reduce harm. • Poor patient experience. • Risk to the public of harm • Harm to staff	Quality, Patient Experience and Safety Committee	Executive Director for Quality and Safety/ Chief Nurse	SR4 SR8 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	18 October 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
Impact 4 x Likelihood 4 = 16	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 2 = 8**	Aligns with the Trust's risk appetite and reflects the threshold at which risk could be tolerated as it can't be eliminated and due to controls being embedded.		
		DATE OF LAST REVIEW	08 May 2026	**Jan 2025**	**16**
				Dec 2025	**20**
				March 2026	**12**
				May 2026	**16**

CONTROLS/MITIGATIONS	GAPS IN CONTROLS
Learning from Incidents and Clinical Effectiveness • Processes to review and learn from deaths, Coroner's reports, and QSIS compliance. • Learning from complaints • Clinical Effectiveness programme including Clinical Audit, NICE guidance, and NCAPOP (National Clinical Audit and Patient Outcomes Programme) • Embedding of PSIRF • Patient safety education, training, and promotion of a culture of continuous learning • CYP waiting well policy – initial meeting with Head of LDA to attend, agreed alternative consultant to support Clinical Director of CYP **Safety and Oversight Structures** • Trust Safety Huddles and Safer Staffing Committee • Bronze/Silver/Gold escalation and resolution process • Clinical supervision maintained above 80% • Psychological support for staff & AVERTS training **Quality Assurance and Improvement** • Internal quality/assurance processes including AMaT implementation • Development and use of RRP Dashboard, QAG and Safe Care Dashboards • QI resources and projects in place • Programme of external audits • CQC Insight data and regular joint meetings with regulators • Enhanced Therapeutic Observations of Care QI • Bands 5 – 6 training programme for new graduates May 2026onwards • Nigel's Plan (Assertive & Intensive Plan) oversight through NHSE **Policies, Procedures and IT Systems** • Clinical policies, procedures, guidelines, pathways, supporting documentation, and IT systems • Shared Care Platform to support safe care delivery **Stakeholder Assurance and Compliance** • Agreed processes for sharing information and providing assurance to MHPC, ICB, NHSE, and CQC • Oversight of MHA Action Plan from CQC inspections, now complete and reporting via CGC • Capital prioritisation process aligned to quality and governance needs • Business case for Reaside Clinic	• Variation in MDT standards • Full utilisation of Dialog+ to support clinical outcomes and data capture • Targeted audits on MDT standards, risk assessment, and safety planning • Data dashboard providing teams and the Trust with an Early Warning System; finalisation of Heat Map component. • Variation in compliance with mandatory training programmes (ILS, ELS, AVERTS, ETOC) • Inconsistent completion and knowledge of physical health assessments • Staff feedback indicates the WHAT Tool is time-consuming during handovers • Non-compliance with fridge temperature checks and actions in response causing medicines risk • Community Team Caseloads across ICCR, HTTs and Care for Older People • Searching policy compliance • Non-compliance with enhanced therapeutic observations and recording • Patients in bedroom seclusion • Access and waiting times • PFD and knowledge gaps relating to physical health • Experienced staff nurse vacancies HTT, PLT & CMHT • Caseload stratification and effective shared care model

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
Ensure harm reduction and long-term support for physical health. Implement strategy, monitor work plan, audit care and safety plans	ED Q&S	September 2026	Physical health needs assessment completed, implementation plan to be completed Strategic plan to be derived from the strategy with clear deliverables, in particular to focus on the identification and management of Diabetes Assurance report monthly through CEAG on training and skills
Implement Nigel's Plan	ED Q&S	March 2027	Nigel's plan assured at NHSE & CQRM Board Story to provide assurance with plan Case stratification across community teams to take place, all SMI patients to be identified with associated risk and safety planning, caseload review tool
Safecare dashboard to be utilised for Divisional assurance and provide Ward to Board assurance and Regulatory Assurance	ED Q&S	September 2027	Safe care dashboard in place, Quality Assurance Group established with attendance through Quality Days CQRM established with Regulators, quarterly CQC engagement sessions
Assure on effective use of Dialog+ and MDT standards across all services	ED Q&S	March 2027	MDT standards launched, audits in place, deep dive Juniper Centre Physical health parameters added to dialog+
Joint implementation of AMPH review with Birmingham City Council	ED &Q&S	September 2027	AMPH review completed, joint delivery plan expected for May to be delivered through MHLC

PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	GAPS IN ASSURANCE
Internal audit reviews 2026/27: • CQC planned and unannounced inspection reports • Reaside commissioned support programme and Culture of Care Programme • Door alarm implementation programme	• 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.	Learning for improvement: • Structured Judgment Reviews reviewed at local safety panels • Corporate-led learning from deaths meeting • Executive Director's Assurance Reports to QPES Committee and Board • NHS Digital Quarterly Data • Commissioner and NED quality visits	• PFD on learning identification through internal investigations, SOP for staff support at inquest • CQC Inspection 'North' Acute Wards • CQC breach regulation 12 Community Teams for Older People • Staffing levels for experienced RMNs Crisis pathway and community teams

• Triple A reporting to QPES from CGC • Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting • QMS update reporting to QPES • QI reporting to Trust and Local CGCs, STMB and requested for regular QPES/Board • Patient Safety Report to Trust CGC, QPES, and Board • Independent annual assessment against the 68 NHS Core Standards for EPRR • Safety Huddles review staffing on a daily basis • DIPC/IPC/Estates monthly escalation meeting. • Safer staffing assurance report for QPESC • Safety Alert process • AMHP review completed	• Staff training via e-learning and lack of assurance on competence • Assurance process with data on physical health checks and admission assessments to be added to dashboard	• CGC Local review has been completed and actions implemented • Nigels Plan (A&I) • Physical Health Strategy • CQC inspections Urgent care Pathways and Steps to Recovery	
Update since last review:			
April/May 2026 Enhanced Therapeutic Observations of Care improvement progressing, monthly audit reporting across all divisions, deep dive to be undertaken in Acute Care 29 April, divisional action plan & daily oversight reporting Nigel's plan endorsed by NHSE, each division to have their own derived plan, monitoring through Quality Assurance Group, case load stratification and reviews/reduction, shared care discussion with GPs Response to CQC and PFDs on caseloads and physical health knowledge and care planning			

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.**	**Creating simpler, more connected, high quality and responsive services where care is safe and inclusive, with service users and carers at the centre**	• Limited ability to collate, share, and use incident intelligence to improve patient experience • Workforce challenges: knowledge gaps in recovery/personalised care, high turnover, and overreliance on bank/agency staff • Difficulty sharing good practice and lack of a central hub for engagement activities • Increased waiting times negatively impacting patients, families, and carers • Families and carers not consistently engaged in care planning • Limited understanding of team influence, compliance with MDT standards on patient care and pathways	• Reduction in quality care and recovery-focused provision. • Services not aligned with the needs of service users, families, and carers, leading to disengagement. • Increased regulatory scrutiny, intervention, and enforcement. • Reactive service model and rising service demand. • Insufficient resources to support health, wellbeing, and workforce development.	Quality, Patient Experience and Safety Committee	Executive Director for Quality and Safety/ Chief Nurse	SR3 SR8 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	4	16
		DATE RISK WAS ADDED	18th October 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
Impact 4 x Likelihood 2 = 8	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 2 = 8**	Aligns with the Trust's risk appetite and reflects the threshold at which risk could be tolerated as it can't be eliminated and due to controls being embedded.		
		DATE OF LAST REVIEW	May 2026	**Jan 2025**	**12**
				Dec 2025	**16**
				March 2026	**8**

				May 2026	12

CONTROLS/MITIGATIONS	GAPS IN CONTROL
Community Engagement and Transformation • Delivery of the Community Transformation Programme • Development of a Community Engagement Framework, led by ICBQI Programmes with Experts by Experience (EbEs) and aligned to the HOPE Strategy • Participation of service users and carers via IPEAR representation, EBE recruitment panels, and Participation and Experience team members in each division • HOPE and LEAR action groups driving local engagement and service improvements • Input from Recovery for All Team, Recovery College, and EBE educator programme to support co-production and learning **Governance and Oversight** • QPESC, Chair, Non-Executive, and Executive Director visits providing oversight and assurance • Board and QPESC patient stories highlighting lived experience • Mustak's 15 Steps visits and ward dashboards providing service-level assurance. **Patient and Carer Feedback** • Implementation of carer strategy • Feedback mechanisms including Healthwatch reports, PALS, and Complaints with resolution and learning • Culture of Care patient and staff surveys reported through PEAR • PLACE reports and Nutrition and Food Group updates submitted to PEAR • Delivery and assurance of the National CQC Community MH Survey through PEAR **Workforce Training and Development** • Trust induction sessions for new staff • Matrons training to support clinical leadership and quality improvement	• Lack of audit compliance monitoring on MDT standards, risk assessments and safety plans • Uptake of national community MH survey to be supported through SULEG • Roll out across all in-patient services of use of 'Reaside model' of use of Patient Reported Outcome and Experience Measures • Written role descriptions and expectations for Experts by Experience • Implementation of 15 steps model for assurance visits • Divisional Service insights at QPESC • Uptake of CQC Community Services Survey

ACTIONS PLANNED

Action	Lead	Due date	Update
Implement a range of opportunities and mechanisms for Service Users and Carers to inform service improvement.	Chief AHP	31 March 2027	Patient councils underway in all divisions PREOMS to be reviewed at Board development and implemented via SULEG, evidence of actions following escalations e.g. Night Care

Implement HOPE Strategy including the findings of the review of the Recovery College	Chief AHP	30 September 2026	
Work with third sector providers to enable engagement of Carers and family members in personalised care and service improvement	Chief AHP	31 March 2027	

PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
• Monthly reports on participation and engagement presented QPES • QI Reports • Participation and Experience team provide quarterly reports to divisional teams. ICCR have requested bi-monthly reporting to support with actions related to negative comments in Community Mental Health survey • Executive oversight of the engagement activities • Participation worker visits to clinical areas reported via Participation and Experience Team monthly meetings and escalated through PEAR	• Inability to integrate and effectively use data in reporting – Inability to integrate and triangulate data from patient experience and PALS/Complainants effectively • Increase in PALS activity due to ADHD pathway and CYP additional work • Measure family involvement in risk formulation through MDT standards audit	• Friends and Family Test feedback • Healthwatch feedback • EbE Observer project • Patient councils in Secure Care, Urgent Care, CMHT and Dementia and Frailty • Timeliness of complaints responses improving	Community Mental Health survey 2025 Temporary pause of Recovery College Activities

Update since last review:

April/May 2026

- Gaps in assurance continue
- Recovery College & Experts By Experience Celebrations planned

- Addition to positive assurance – PREOMs (Patient Related Experience and Outcome Measures) work – SCOH unambiguous & strong in this arena
- Work agreed with Family and Carer Advocacy Group

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR5	Failure to maintain a sustainable financial position	**Empowering and enabling people to make positive and bold change through innovation, improvement and research**	• Poor financial management by budget holders. • Inadequate financial controls. • Cost pressures are not managed effectively. • Savings plans are not implemented. • Cash releasing efficiency schemes not identified	• Trust not meeting its financial targets limiting available funds for investment in patient pathways. • Ranking in lower segments for financial metrics in Oversight Framework. • Reliance on non-recurrent balance sheet flexibility (which is reducing)	Finance, Performance and Productivity Committee	Executive Director of Finance	SR6 SR7

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
Impact: 5 x Likelihood 5= 25	Current score demonstrates the current performance, controls in place and level of assurance evidenced.	**Impact 5 * Likelihood 2 = 10**	Aligns with the Trust's risk appetite and reflects the threshold at which risk could be tolerated as it can't be eliminated and due to controls being embedded.	**Jan 2025**	**20**
		DATE OF LAST REVIEW	15 April 2026	**August 2025**	**25**

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Governance controls including Standing Financial Instructions (SFIs), Scheme of Delegation (SoD), and the business case approval process, supported by Financial Management teams, with regular performance reporting to the Finance, Performance and Productivity Committee and the Board. • Development of a Performance Assurance Panel to strengthen oversight and scrutiny of areas demonstrating poor or deteriorating performance. • Ongoing review and appropriate utilisation of balance sheet flexibilities to support financial management. • Implementation and monitoring of the Savings Policy to support delivery of efficiency programmes. • Oversight and review through the Planning and Delivery Subcommittee. • Alignment with Integrated Care System (ICS) expectations and reporting requirements.	• Limited escalation or further review in response to instances of poor financial performance. • Lack of accountability for overspends, or not managing financial resources • Requests for cost pressure funding are sometimes submitted outside of the agreed governance and approval processes. • Inconsistent attendance at the Sustainability Board. • The Trust has been unable to establish a robust pipeline of savings schemes to support delivery of financial targets. • Recovery Action Plans are not consistently delivering the required financial impact.

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
To improve reporting and governance arrangements	Deputy Director of Finance	September 2026	Policies that impact on governance arrangements for financial management, including around pricing, training and savings will be updated. Also explore technological opportunities around workflow and real time reporting. Finance department structures to be reviewed to determine whether appropriate resources are available to support organisational priorities.
Planning for savings delivery in 27/28 to commence early	Deputy Director of Finance	1 May 2026	Completed – DDOF written to all executives requesting plans for 27/28 savings delivery to be identified and submitted by mid September (2% for operational divisions, 3% for corporate divisions)
Financial strategy for 26/27 identified requirement for operational divisions to break even with plans to be identified if off track	Executive Director of Operations/ Deputy Director of Operations	1 July 2026	Financial strategy, including this requirement, shared with Exec team, Planning and Delivery sub committee, FPP and with all ADs by DDOF
Transformation Delivery Group to be established to lead work on organisational transformation	Deputy Director of Operations	1 April 2026	Initial scoping meeting held 26/3/26 – further meeting schedule including Terms of Reference to be circulated
Controls around usage of non NHS inpatient beds, and bank spend to be maintained	Executive Director of Operations / Executive Director of Quality and Safety	1 July 2026	Re inpatient beds – weekly meetings continue with focus around CRFD and flow Re bank spend – bank gold meetings revised to wider quality and safety panels. Executive Director of Quality and Safety signing off all bank requests

PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
Internal Audit Reviews 2026/27: • Ability to deliver planned financial position dependent on sufficient controls • External Audit review • Audit Committee and FPP oversee financial framework and monthly	• HFMA sustainability audit has identified a number of development areas that would improve controls and performance. • Plans for future years as part of the medium-term	• Ability to deliver planned financial position dependent on sufficient controls. • Financial recovery plan focused attention on trajectory and mitigations. • Recovery plans in key areas on beds and bank spend demonstrating run rate reductions. • National Oversight Framework and improvements in segmentation	• Planning round 2026/27: not able to secure 100% delivery of savings plans before the start of the financial year leading to in year risks that will need to be managed • In-year financial position: no mechanism for managing operational performance across all divisions (will need to be developed)

reporting of financial position and any deviation from plans. • Ongoing oversight from NHSE around delivery of financial recovery plan.	financial plan not well developed		• A high proportion of savings schemes remain non-recurrent, causing risks in the underlying position.
Update since last review:			
15 April 2026: • CRR risks moved to appendix • Goals/enablers updated to reflect new Trust strategy • Actions reviewed and updated.			

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR6	**Failure to maintain acceptable governance and national standards.**	**Empowering and enabling people to make positive and bold change through innovation, improvement and research**	• Adult and older adult bed numbers below national average. • High Mental Health Act admissions and patient acuity increasing lengths of stay. Limited bed capacity due to high numbers of Clinically Ready for Discharge (CRFD) patients. • Delays in discharge destinations caused by social care availability and placement issues. • High bed occupancy and CMHT caseloads impacting service user engagement. • Non-compliance risks undermining quality of care and leadership.	• Service users placed out-of-area, reducing local support and increasing costs. • National targets for inappropriate OOA placements not being met, affecting patient experience. • Delays in local admissions and prolonged CRFD stays increasing length of stay. • Long waits for ADHD assessments and high DNA rates impacting timely care. • Financial and operational risks if Talking Therapies activity and follow-up within 3 days of discharge are not achieved. • Ineffective patient flow across services, increasing escalation, crisis needs, and regulatory scrutiny.	Finance, Performance and Productivity Committee/ Quality, Patient Experience and Safety Committee	Executive Director of Finance/ Executive Director of Operations	SR5 SR7

RISK APPETITE		INHERENT RISK SCORE	Impact	Likelihood	Risk score
Cautious - Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions. ***Target risk score range 6-8.***			5	5	25
		DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
Impact 5 x Likelihood 4 = 20	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 3 = 12**	Aligns with the Trust's risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	**Jan 2025**	**20**
		DATE OF LAST REVIEW	15 April 2026		

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Established Shareholder, Liaison, Contractor, and Operational Management Team meetings to ensure effective communication, service delivery, and compliance with quality standards. • Trust Sustainability and Net Zero Group overseeing progress on environmental priorities. • Site-wide heat decarbonisation reviews to ensure energy efficiency and compliance. • Prioritisation of risk assessments, statutory standards, and backlog maintenance programmes to maintain infrastructure and service quality. • Delivery of the Trust Green Plan and associated action plan to meet sustainability targets. • Regular audits and horizon scanning to monitor compliance and identify potential risks. • Staff training and awareness programmes to promote compliance and appropriate behaviours. • Strengthened internal control systems and processes to mitigate operational and regulatory risk. • Daily 3-day follow-up notifications for clinical teams, with reporting via Trust and local FPPCs. • Monitoring of community waiting times via FPPC against trajectory, with detailed reports for clinical management. • Patient Flow Steering Group overseeing reduction of Out-of-Area placements and associated workstreams on demand management, Locality Model, CRFD, and length of stay. • Service-level deep dive meetings covering national indicators, waiting times, and benchmarking. • Remedial action plan for Talking Therapies to address performance gaps. • Performance Assurance Panel providing oversight of key metrics and improvement actions. • Establishment of Planning and Delivery subcommittee to receive escalations from Performance Assurance Panels and Transformation Delivery Group • Identified Non-Executive Director provides oversight for Sustainability, Net Zero Carbon, and the Green Plan.	• Physical environment risks are captured in the Estates and Facilities Risk Schedule, with mitigation actions and regular reviews. • All properties are routinely reviewed by professional Estates and Facilities Managers. • Condition surveys, statutory standards reviews, compliance assessments, and independent AE audits ensure premises meet required standards. • Operational pressures limit staff capacity to fully implement controls. • Self-assessment, accreditation, and self-certification processes require strengthening. • Governance arrangements around compliance are currently insufficient.

ACTIONS PLANNED

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

Development of Business cases and securing of major capital to address Reaside functional suitability.	Trust/ SSL	31 March 2027	Mitigation of backlog is progressed via SSBM, Capital programmes and Maintenance regimes where Trust finances allow. Replacement of current Reaside facility to address poor functionality, Service user accommodation and environmental system life cycle impacts is a Trust led major project. This is as before a Trust not SSL action. In any event it is logical that the action will remain until either the Trust decides to stop trying to replace Reaside and / or secures the necessary funding for a major project.
Implementation of the Talking Therapies Action Plan to address performance issues.	AD for Specialties	31 Dec 2025	Recovery action plan in place with good oversight from the Divisions leadership team. Regular reporting and scrutiny and the Performance Delivery Group and service deep dives. Meeting with MH provider collaborative took place in September 2025 to further review and explore additional actions to mitigate the risks of underperformance.
Productivity Improvement Plan developed and implemented within Acute & Urgent Care.	AD for Acute & Urgent Care, and AD for Children and Young People	31 March 2026	Plan on track. Weekly patient flow meetings in place to review performance against plan. Other operational divisions called to the meeting to support flow and focus on patient who are clinically ready for discharge (CRFD). Additional weekly Gold escalation meeting stepped up in July 2025 to drive down the increasing spot purchasing bed activity. Plan achieved over the planned 6-week period. Meeting has good clinical leadership representation. New bed contract mobilised in September 2025 to further reduce use of non-contract beds and to aid patient flow.
New divisional performance and assurance panel commenced Oct 2025 to strengthen oversight and ensure deliver against standards and national requirements.	AD's for Specialities, AD for secure and offender Health, AD for Integrated Community Care and Recovery, AD for Acute and Urgent	31 March 2026	Review planned with Executives and Deputies in April 2026

	Care and AD for Children and Young person Division		
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. AD CYP Division	April 2026	On track

PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
Internal audit reviews 2026/27: Inspection reports Compliance audits Self-assessment, accreditation and self-certification reports External visit reports Peer Reviews Board Assurance Framework Report National Oversight Framework	• Lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply. • Poor learning from previous regulatory inspections. • Self-assessment, accreditation and self-certification culture not strong enough to be relied upon for assurance. • Peer review not very regular. • The culture of BAF not fully developed and embedded.	• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Multi-disciplinary Trust Sustainability Group including SSL, Finance, Procurement, Clinical/ Nursing Teams, etc. • Performance reported to FPPC. • Governance arrangements for monitoring the quality of care provided to patients in non-BSMHFT beds in place.	• Operational pressures are limiting the implementation of environmental and estates controls. • Self-assessment, accreditation, and self-certification processes are inconsistent or weak. • Governance around compliance and oversight is insufficient to ensure standards are consistently met. • Condition surveys and audits may not fully capture emerging risks or deficiencies. • Sustainability, Net Zero, and Green Plan objectives may be delayed or partially implemented due to resource constraints. • Residual risks exist where physical environments may not meet statutory or safety standards.
Update since last review:			

15 April 2026

- CRR risks moved to appendix
- Goals/enablers updated to reflect new Trust strategy

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR7	**Failure to deliver optimal outcomes with available resources**	**Empowering and enabling people to make positive and bold change through innovation, improvement and research**	• Inadequate resources • Staff do not understand or commit to the standards • Competing priorities • Variation in performance between teams • Shortage of suitably qualified and experienced staff and leaders • Lack of meaningful data and evidence. • Unwarranted variation of quality of care.	• Patient outcomes and satisfaction are less than optimal • Staff assaults and Patient harm • psychological harm • Services are not responsive or consistent • Regulatory oversight • High bank utilisation • Gaps in ward to board governance • Complaints and concerns • Financial claims • Regulatory costs	Finance, Performance and Productivity Committee/ Quality, Patient Experience and Safety Committee	Executive Director of Finance/ Executive Director for Quality and Safety/ Chief Nurse.	SR3 SR4 SR5 SR6 SR8

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
Impact 4 X Likelihood 4= 16	We are developing measures to demonstrate these outcomes in a systematic way, or focus our resources on their achievement, so there is currently no data to provide assurance of a lower risk	**Impact 3 * Likelihood 3 = 9**	It is a core purpose of the Trust to deliver against the culture of care standards, although there will always be competing demands		
		DATE OF LAST REVIEW	**11 May 2026**	**Jan 2025**	**16**
				March 2026	**8**
				April 2026	**16**

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Implementation of the Culture of Care Programme. • Established processes to review and learn from deaths, including consideration of Coroner's reports. • Clinical Effectiveness framework including Clinical Audit and compliance with NICE guidance. • Implementation of the Patient Safety Incident Response Framework (PSIRF). • Oversight of workforce safety through the Safer Staffing Committee and Bank Gold arrangements. • Promotion of a culture of continuous learning and improvement. • Delivery of the Mental Health Improvement Programme aligned to the Patient Safety Strategy. • Development and application of the RRP Dashboard to support quality and risk monitoring. • Comprehensive clinical policies, procedures, guidelines, pathways, and supporting IT systems. • Implementation of AMaT to support transparent quality assurance processes. • Monitoring of CQC Insight data with regular joint engagement meetings. • Participation in National Clinical Audit and Patient Outcomes Programmes (NCAPOP). • Workforce management through e-rostering compliance and reduction in temporary staffing reliance. • Capital prioritisation processes aligned to quality, safety, and operational requirements. • Implementation of the Quality Management System (QMS), including action plan amnesty to identify organisational themes and trends. • Monitoring of e-roster compliance metrics to support workforce governance.	• Assurance on levels of therapeutic activity on all wards • Implementation of care Excellence Framework • Compliance with e-roster metrics • Bank reduction requirement 2026/27 £9 • Culture of Care Excellence self-assessments • Variation in completion of Dialog+ • Variation in capability and effectiveness at Divisional Leadership level

ACTIONS PLANNED

Action	Lead	Due date	Update
Implement Culture of Care Excellence Framework across all services with plan for reducing variation in standards by end 2027	ED Q&S	31 March 2027	Framework presented, quarter one plan for service self-assessments Milestone plan for the year to be developed and reported to QPESC
Develop Bronze, Silver, Gold model for Divisional Leadership Well Led assurance.	ED Q&S	30 July 2026	Well Led KLOES and Trust Leadership standards to be brought together in model for Divisional Leadership Team assurance on capability

Ensure and monitor utilisation of e-roster providing assurance on safer staffing and use of resources and build substantive teams, minimising the use of bank resources.	ED Q&S/CFO	31 March 2026	Plan for further reductions in 2026/27, weekly sign off for shifts, monthly assurance through Quality Days and PAP Implementation of Auto Roster Targets agreed on bank utilisation reduction for all Divisions
Model, plan and assurance on delivery of optimal levels of therapeutic and recovery activities on all wards	Chief Psych / Chief AHP	31 March 2026	Agreement of reporting through CEAG and QPES, addition of CP and Chief AHP to Reducing Restrictive Practice Group Baseline assessment of ward based activities, number and range

PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
Internal audit reviews 2026/27: • Ongoing culture of care and leadership external review of Reaside. • CQC planned and unannounced inspection reports. • Internal and External Audit reports • Triple A reporting to QPES from CGC • Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting. • Co-produced Trauma informed recovery focussed training rolled out (NMHT).	• Variations in inputs across pathways. • Non-compliance e-roster • Above plan utilisation of TSS	Learning for improvement: • Structured Judgment Reviews reviewed at local safety panels • Corporate led learning from deaths meeting. • Participation Experience and Recovery (PEAR) Group.	• Acute Wards Regulatory Inspections, patient acuity and incidents • Regulation 12 breach Older People's Community Teams • Internal audit workforce deployment, rostering and bank utilisation • Variation in uptake of bank shifts
Update since last review:			

11 May 2026

- Bank authorisation and divisional safer staffing committees to be implemented with target and roster rules agreed for each Division
- Bank booking reasons decreased from 32 – 9 incorporating training
- Each Division to implement internal governance with enhanced roster rules and agreed targets for reduction
- Urgent Care – review of vacancies and recruitment
- SCOH – analysis of external escort work
- Older Adults and Ardenleigh – reassessment of establishments
- Over 18s – reconsideration of crisis pathway staffing
- Consultation on Auto-roster

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.**	**Working with and understanding our diverse local communities so that we are responsive to their specific needs**	• Limited capacity to use time effectively to drive learning and service transformation. • Challenges embedding a consistent organisational learning and safety culture. • Failure to consistently identify and embed learning from deaths processes. • Insufficient involvement and support for families and carers. • Limited staff understanding of the Recovery Model and its expectations. • Services not consistently tailored to local community needs or aligned with partner services. • Insufficient understanding and use of population, community and health inequalities data. • Limited system-wide collaboration to address inequalities across the BSOL system.	• Staff feel unable to speak up safely or with confidence. • Failure to learn from incidents and improve care. • Lack of integrated care pathways across the ICS. • Inequitable access and outcomes for diverse communities. • Ineffective relationships with key partners. • Poor continuity of care and unclear accountability between services. • Negative impact on service user access, experience and outcomes. • Poorer recovery outcomes and longer lengths of stay. • Disengagement and mistrust from some communities. • Increased local and national scrutiny. • Increased risk of incidents due to unsuitable physical environments. • Reputational damage with partners.	Quality, Patient Experience and Safety Committee	Executive Medical Director	**SR3** **SR4** **SR9**

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

<table>
<tr><th>CURRENT RISK SCORE</th><th>RATIONALE</th><th>TARGET RISK SCORE</th><th>RATIONALE</th><th>RISK HISTORY</th></tr>
<tr><td rowspan="2">Impact 4 x
Likelihood 3 = 12</td><td rowspan="2">Current score demonstrates the controls in place and level of assurance evidenced.</td><td>Impact 3 x
Likelihood 3 = 9</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><table><tr><td>Jan 2025</td><td>16</td></tr><tr><td>April 2025</td><td>12</td></tr></table></td></tr>
<tr><td>DATE OF LAST REVIEW</td><td>11 March 2026</td><td></td></tr>
<tr><th colspan="3">CONTROLS/MITIGATIONS</th><th colspan="2">GAPS IN CONTROL</th></tr>
<tr><td colspan="3">Patient Safety and Learning: PSAG oversight; standardised learning groups with terms of reference and agendas; Freedom to Speak Up processes; LFE implementation.
Clinical Governance and Quality: Trust, divisional, and service-level clinical accountability and governance; clinical policies, procedures, pathways, IT systems; PSIRF implementation with group and PMO support.
Cultural and Workforce Development: Just Culture and cultural change programmes; active bystander, culture, humility, safety, and community-specific training.
Quality Improvement and Health Inequalities: Culture of Care rollout; QI projects addressing inequalities; PCREF framework; divisional and provider collaborative inequalities plans; Synergy Pledge.
Service User and Family Engagement: HOPE strategy; Experience of Care campaign; family and carer strategy and pathway; Expert by Experience involvement in recruitment, induction, recovery college, service developments, and QI projects; EbE reward/recognition and educator programmes.
System and Collaborative Development: BSOL Provider Collaborative development plan; joint planning with BSOL Community Integrator and neighbourhood teams; system approaches to improving services.</td><td colspan="2">Limited assurance from current approach to review of quality and governance metrics at Divisional level.
Limited reporting of Divisional quality reviews to QPES and Board.
No organisational wide reporting of LFE metrics.
Family and carers pathway not consistently applied or suitable for all services.
Performance in these areas is not effectively measured.
Divisional inequalities plans not fully finalised for all areas.
Availability of sufficient capital funding for developments.
Capacity within teams to deliver transformation and service developments alongside day job.
Inability to identify milestones that reduce health inequalities and improve patient experience.
Inability to identify clear data metrics to demonstrate impact (cause and effect) in reducing health inequalities.</td></tr>
</table>

• **Community and Service Transformation:** Community Transformation Programme; caseload review and transition; Out of Area programme; Transforming Rehabilitation Programme; Forensic Intensive Recovery Support Team redesign; Reach Out strategy. • **Commissioning and Planning:** BSOL MHPC commissioning and development plans.	

ACTIONS PLANNED

Action	Lead	Due date	Update
Review and refresh of the family and carer pathway.	AD for Allied Health Professions and Recovery	30 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	30 June 2026	All divisions except CYP have a baseline plan with milestones being identified
Dialogue+ roll out	Deputy Medical Director for Quality & Safety	31 March 2026	On track
Development and implementation of a health inequalities dashboard.	Associate Director Performance	31 March 2026	On track

PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
Internal audit reviews 2026/27: • Updates on PSIRF Implementation to QPES and Board. • Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • BSOL MHPC Executive Steering Group. • Health Inequalities Project Board.	• 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.	• Learning from Peer Review/National Strategies shared through PSAG. • Serious Incident Reports. Increased scrutiny and oversight through SI Oversight Panel. • Executive Chief Nurse's Assurance Reports to CGC, QPES Committee and Board. • New processes have been devised to improve learning from deaths including improved oversight of Structured Judgement Reviews (SJR's) and associated learning/actions.	• Limited evidence that lessons from incidents, deaths, or complaints are consistently embedded into practice. • Gaps in staff understanding or engagement with the Recovery Model, QI initiatives, or health inequalities frameworks. • Inconsistent application of cultural change initiatives, including Just Culture and active bystander training.

• Community Transformation governance structures. • Out of Area Steering • Performance Panel reviews • Highlight and escalation reporting into BSOL MHPC Executive Steering Group. • Each division has its own health inequalities action plans that feed to Inequalities board	• Safety Summits are in early conception and may not be adopted well by Divisions/services. • Work to be undertaken to embed human factors/just culture. • Inability to engage with all parts of the Trust.	• Participation Experience and Recovery (PEAR) Group. • Community collaboration with system partners. • Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme. • PREOMS data from Secure and Offender Health showing a move towards parity for Black and white groups	• Limited engagement of families, carers, or Experts by Experience in co-production of services and QI projects. • Fragmented data on population health, community needs, or health inequalities limiting targeted interventions. • Evidence of persistent inequities in access, experience, or outcomes for some communities. • Weak cross-system collaboration impacting integrated care pathways and service transformation.
Update since last review:			
15 April 2026 • CRR risks moved to appendix • Goals/enablers updated to reflect new Trust strategy			

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.**	**Working with and understanding our diverse local communities so that we are responsive to their specific needs**	• Service demand exceeds capacity (inpatient and community). • Limited social care and system collaboration. • Transformation not fully integrated across services. • Long waiting times and fragmented pathways. • Insufficient support and engagement for service users, families, and carers. • Lack of system-wide planning and prioritisation. • Challenging financial environment.	• Service users cared for in inappropriate or unavailable environments. • Increased out-of-area placements and associated costs. • Rising pressure on acute hospitals and A&E. • Longer waiting times, backlogs, and delayed access to care. • Negative impact on recovery, length of stay, and service user outcomes. • Fragmented pathways leading to gaps in care. • Increased risk of poor-quality care and incidents.	Quality, Patient Experience and Safety Committee	Executive Director of Operations	SR3 SR4 SR8

RISK APPETITE		Impact	Likelihood	Total score
Open - Receptive to taking difficult decisions to support the achievement of the Partnership or Provider Collaborative when benefits outweigh risks. Processes, oversight / monitoring and scrutiny arrangements in place to enable considered risk taking**.** **Target risk score range 9-10.**	**INHERENT RISK SCORE**	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.	**Jan 2025**	**16**
				June 2025	**12**

		DATE OF LAST REVIEW	15 April 2026	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
Governance and oversight: • Establishment of the Transformation Delivery Group (from 26 March 2026) to provide strategic oversight. • Implementation of the Life Course Delivery Group to ensure governance and effective programme delivery. **Service Transformation and Pathway Improvement** • Delivery of the Inpatient Bed Strategy and associated quality improvement programme. • Implementation of the Inpatient Flow Improvement Programme to optimise patient pathways. • Progressing Urgent Care and Community Transformation Programmes to enhance integrated service provision. • Delivery of the Solihull Children and Young People Transformation Programme. • Development of dual diagnosis pathways and adoption of a locality working model. • Operationalisation of 24/7 NMHC clinical services. **Digital and Process Innovation** • Execution of the Digital Transformation Programme to improve service efficiency. • Implementation of Patient-Initiated Follow-Up (PIFU) processes. • Introduction of enhanced triage and prioritisation systems for patients on waiting lists. • Management of SPOA referrals for PCNs without ARRs to ensure timely access to mental health support. **Workforce, Coproduction and Engagement** • Active involvement of Experts by Experience in recruitment, induction, recovery college, service development, and quality improvement initiatives. • Deployment of multi-disciplinary triage hubs in partnership with Talking Therapies to improve patient outcomes. **System and Community Working** • Implementation of system-wide strategies to enhance service development and transformation. • Strengthened partnership working with the Voluntary Sector. • Comprehensive transformation planning and implementation to ensure sustainable improvements.	• Insufficient inpatient bed capacity relative to national benchmarks. • Limited team capacity to deliver transformation and service development alongside routine responsibilities. • Family and carer pathway not consistently implemented or fully suited to all services. • Partnership strategy under review, incorporating gap and opportunity analysis of current pathways. • Utilisation of BSOL Mental Health Needs Assessment feedback to inform and embed practice improvements.

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	31 March 2028	Urgent Care pathway group TOR currently being reviewed to ensure it has full oversight of urgent care transformation. Recover House procurement completed, with opening due in Oct/Nov 2025, which will bring additional capacity into the system which will improve access and flow through urgent care pathway. Winter plan development along with 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. 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	30 June 2026	Recovery action plan in place with good oversight from the division's leadership team. Regular reporting and scrutiny and the Performance Delivery Group and service deep dives. Meeting with MH provider collaborative took place in September 2025 to further review and explore additional actions to mitigate the risks of underperformance. Refresh of Action Plan to take place, including future delivery model.
Implementation of pilot 24/7 service in East Birmingham.	Akilah Duffus 24/7 Programme Lead	31 May 2026	Regular monthly steering group meetings in place to monitor delivery along with assurance meeting and visits from NHSE. The service is now formally called the Neighbourhood Mental Health Centre. The service has moved to its new premises. A capital bid has been submitted to NHSE to rollout NMHC across BSOL. A draft specification has been received from the national team.

			The team is working to facilitate Night Hospitality.
To deliver the recovery business case to support the repatriation of out-of-contract and rehabilitation OOA service users to in area in contract beds (Phase 1)	AD for ICCR	31 March 2026	On track. Implementation work in train and recruitment of the team continues as part of phase 1

PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
Internal audit reviews 2026/27 • Review of two-week wait performance. • Clinical governance improvement initiatives. • Recently approved financial plans. • Reports submitted to Strategy & Transformation Boards. • System trajectory monitoring for 104- and 78-week waits. • BSOL Mental Health performance dashboard. • Outcome measures, including Dialog+. • Co-produced trauma-informed, recovery-focused training implemented (NMHT). • Physical health connectors pilot programme.	Having a strong service user/carer voice across all of our governance forums. Variations in inputs across pathways. Gaps in the CYP Pathways.	• BSOL MHPC Executive Steering Group. • Participation Experience and Recovery (PEAR) Group. • Highlight and escalation reporting to Strategy and Transformation Board. • BSMHFT is one of six pilot sites working with NHSE in developing a new 24/7 MH neighbourhood Community service. • Evidence that the Community transformation is working as people are getting better access.	The new Neighbourhood Mental Health Centre is still in its early stages.

Update since last review:

15 April 2026

- CRR risks moved to appendix
- Goals/enablers updated to reflect new Trust strategy

Corporate Risk Register Links

BAF Risk	CRR reference	Risk title
SR1/SR2	CRR020/950	High risk of clinical incidents and staff burnout as OA CMHT caseloads continue to be above 35
	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 at Senior Band 6 nurse
	CRR040/2099	Efficiency and accuracy risks associated with the administration workforce not utilising new technology and modernising admin practices
	CRR041/2100	BSMHFT's current workforce plan may not be effective in meeting the demands of the future
	CRR050/2174	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.
SR3	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.
	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.
	CRR020/950	High risk of clinical incidents and staff burnout as OA CMHT caseloads continue to be above 35
	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.
	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.
	CRR030/2010	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 at Senior Band 6 nurse
	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.
	CRR032/1989	There may be a lack of capital availability to fund major capital works at Reaside.
	CRR033/2049	Risk of the Trust not meeting its Governance requirements from July 1st 2025 with regards to the transfer of the Children & Young People Service (CYP)
	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
	CRR035/1236/1929/2058	Risk that serious delays in Mental Health Assessments may lead to harm to service users and/ or the general public, due to the lack of AMHP provision in Birmingham.
	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.
	CRR039/2072	Complex patients who struggle to engage with mental health services and treatments may cause significant harm to themselves or the public.

BAF Risk	CRR reference	Risk title
	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.
	CRR046/CYP1262	Risk that BSMHFT are unable to deliver safe and effective care to 0–18-year-olds requiring an urgent care response.
	CRR047/CYP907	There may be significant delays in patients receiving appropriate treatment in the CYP ADHD Service
	CRR048/2154	Potential harm caused by commissioning issues with dementia drugs
	CRR049/2172	Risk that service users may come to harm by taking illicit substances whilst at Reaside clinic.
	CRR050/2174	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.
SR4	**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.
	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.
	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.
	CRR035/1236/1929/2058	Risk that serious delays in Mental Health Assessments may lead to harm to service users and/ or the general public, due to the lack of AMHP provision in Birmingham.
	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.
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	CRR046/CYP1262	Risk that BSMHFT are unable to deliver safe and effective care to 0–18-year-olds requiring an urgent care response.
	CRR047/CYP907	There may be significant delays in patients receiving appropriate treatment in the CYP ADHD Service
	CRR050/2174	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.
SR5	**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.
	CRR029/1225	Lack of available capital funding and investment requirements could lead to misunderstandings, over commitment and inter-departmental tension.

BAF Risk	CRR reference	Risk title
	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.
	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
SR6	**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.
	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.
	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).
	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.
	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).
	CRR032/1989	There may be a lack of capital availability to fund major capital works at Reaside.
	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)
	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.
	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.
	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.
	CRR047/CYP907	There may be significant delays in patients receiving appropriate treatment in the CYP ADHD Service.
SR7	**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.
	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.
	CRR029/1225	Lack of available capital funding and investment requirements
	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.

BAF Risk	CRR reference	Risk title
	CRR032/1989	There may be a lack of capital availability to fund major capital works at Reaside.
	CRR035/1236/1929/2058	Risk that serious delays in Mental Health Assessments may lead to harm to service users and/ or the general public, due to the lack of AMHP provision in Birmingham.
	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.
	CRR046/CYP1262	Risk that BSMHFT are unable to deliver safe and effective care to 0–18-year-olds requiring an urgent care response.
	CRR047/CYP907	There may be significant delays in patients receiving appropriate treatment in the CYP ADHD Service.
	CRR050/2174	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.
SR8	**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.
	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.
	CRR035/1236/1929/2058	Risk that serious delays in Mental Health Assessments may lead to harm to service users and/ or 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.
	CRR046/CYP1262	Risk that BSMHFT are unable to deliver safe and effective care to 0–18-year-olds requiring an urgent care response.
	CRR047/CYP907	There may be significant delays in patients receiving appropriate treatment in the CYP ADHD Service which may have a significant impact on patient's ability to succeed in school.
	CRR040/2099	Efficiency and accuracy risks associated with the administration workforce not utilising new technology and modernising admin practices.
	CRR041/2100	BSMHFT's current workforce plan may not be effective in meeting the demands of the future.
SR9	**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.
	CRR020/950	High risk of clinical incidents and staff burnout as OA CMHT caseloads continue to be above 35
	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.
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	CRR039/2072	Complex patients who struggle to engage with mental health services and treatments may cause significant harm to themselves or the public.
	CRR046/CYP1262	Risk that BSMHFT are unable to deliver safe and effective care to 0–18-year-olds requiring an urgent care response.
	CRR047/CYP907	There may be significant delays in patients receiving appropriate treatment in the CYP ADHD Service.
	CRR048/2154	Potential harm caused by commissioning issues with dementia drugs.

Report to Board of Directors						
Agenda item:	9					
Date	3 June 2026					
Title	Integrated Performance Report					
Author/Presenter	Richard Sollars, Deputy Director of Finance Sam Munbodh, Clinical Governance Team Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information					
Executive Director		**Approved**	**Y**	✓	**N**	

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

Summary of Report					
Alert	✓	**Advise**		**Assure**	

Executive Summary

The key issues to note for consideration by the Board are as follows:

Summary points:

- **NEW: Proxy demand/capacity community measure**
  At the Trust FPPC meeting in April 2026, members requested consideration be given to developing a proxy demand/capacity measure for our community mental health services. This was discussed with the Executive Director of Operations and Service Area ADs and it was agreed that this was a timely request as there are plans to take forward a Community Services Improvement Programme that will incorporate demand/capacity as part of reviewing caseload capacity and demand management.

  The programme of work is in the early stages of development and the programme components including a governance structure will be in place by end June 2026. Key metrics will be identified to support this work including a reflection of available national and benchmarking data. Trust FPPC members are therefore asked to note that an update on this work together with an identification of proxy measure/s will therefore be provided for the July 2026 meeting.

- **New: NHSE Draft National Oversight Framework 2026/27 (see Appendix 1 for detail on progress)**

  Following a review of the 2025/26 NOF metrics, NHSE have confirmed changes to the mental health metrics that will inform the 2026/27 assessment. This currently remains in draft stage and a finalized version is awaited which will also confirm the overall scoring methodology that will be applied. It should be noted that a national webinar has been arranged to take place on 21st May to discuss the metric specifications.

  Appendix 1 provides an update on the Trust's current position on the draft 2026/27 NOF metrics for measures where sufficient detail on the national methodology is available.

- LOS metrics are now aligned to the national planning guidance and based on a rolling 3 month average for adults and older adults.
  Whilst both services are meeting this trajectory, LOS levels remain higher than national median and impacted by CRFD. Forecast performance – band 4, low performing will remain without a step change in actions including CRFD.
- Percentage of patients in crisis receiving face-to-face contact within 24 hours.
  Service level action plans implemented, improving trend observed, April at 62% meeting local Trust trajectory. Forecast performance band 2.
  Proportion (%) of total open CYP MH related waits that are over 104 weeks (help -intervention based clock stop and referral spells methodology) - *April local data at 29%, above the national planning submission improvement trajectory. Forecast performance – band 3*
- 72 hour follow up – April at 84.68%, above the national 80% target. Forecast performance band 2.

- **New: Integrated Performance Dashboard (IPD) Quality Domain – Metric changes**

  FPPC is asked to note that following a review by the Executive Director of Nursing, the quality domain metrics have been revised and replaced with 8 new metrics introduced for 2026/27. These metrics align with the quality domain areas within the 'Early Warning Dashboard' which provides a service and team level view for internal assessment and alignment to external feedback. This alignment ensures a 'Board to Ward/team' framework. The detail of progress and action planning will be addressed via QPES. The 8 metrics are:

  - AWOL patients coming to harm
  - Deaths within 30 days post discharge
  - Episodes of rapid tranquilisation
  - Incidents of moderate harm and above
  - Number of patients prone restrained for anything other than intramuscular tranquilisation
  - Number of Prone restraints for more than 10 minutes
  - Safeguarding Incidents
  - Harm-free Days

- **NEW: Children and Young People (CYP) Performance Reporting**
  As previously reported to FPPC, the Birmingham Women's and Children's RAG rated CYP monthly performance report has been stood down from April 2026. CYP data has now been incorporated into the Trust's overall Integrated Performance Dashboard framework.

- **Inappropriate and Appropriate Out of area placements**
  At the end of April 2026, the Trust did not meet the zero trajectory as there were 15 inappropriate out of area placements, 3 adult and 12 CYP due to clinical need and demand.
  Improved trend being achieved in reducing all out of area placements impacting on improving the Trust's financial recovery plan.

- **Clinically Ready for Discharges** – high levels remain in both adult and older adult services. The main reasons for the delays in adult acute care remain delays in allocation of a social worker, supported accommodation and care packages, and in older adults continues to be waits for nursing home placements and care packages.
  At the April FPPC meeting, members requested a CRFD action plan which is being developed and taken forward by the Deputy Director of Operations. A separate report has been provided for May FPPC meeting.

- **2026/27 Length of stay (LOS) progress against the national planning trajectories** – Both adult and older adult services are current achieving the trajectories as at April 2026. The delivery of the improvement trajectories is reliant on progressing the Trust's inpatient bed strategy plan, the acute and urgent care productivity plan and reducing CRFDs.

- **CYP Eating Disorders National waiting time standard – Routine 28 days (target 95%)**
  April saw performance reduced to 55% and below the 95% national standard. This relates to 13 of 29 service users not being seen within the 28 day standard. Compliance is being impacted by Avoidant/ Restrictive Food Intake Disorder (ARFID) referrals which require more complex consultation and consideration.

- **Sickness absence** - Reducing trend observed with April 2026 at 5.4% below the improvement trajectory of 5.8%.
- **Bank and agency reduction** –Bank at 622.9 WTE in April above the trajectory of 592.9 WTE for April and Agency at 24.8 WTE below the trajectory of 32.96 WTE for April
- **Appraisals** – April at 80.9% above improvement trajectory of 79.9%.
- **Vacancies** – April vacancy rate at 6.6% below trajectory of 10.55%.
- **Fundamental Training** has increased to 94.3% in April, marginally below the 95% target.

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.

The detailed summary of progress against action plans is included in Appendix II.

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

Domain and metric	On Track	Plan in Place	Progress	Pages
Performance				
Inappropriate out of area Number of placements			Inappropriate OOA placements at 15	3, 13-14
People				
Vacancies			Reduction in last month at 6.6% in April below trajectory	7
Sickness			Improvement in last 6 months April at 5.4%	7, 21-22
Appraisals			Deterioration in month April (80.9%) but above trajectory	7, 23-24
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 (51.92%) and above national 50% target	
Talking Therapies Reliable Recovery Rate			Improving trend in last 2 months (48.5%) and below national target of 50%	5, 19-20
Talking Therapies Reliable improvement rate			Sustained trend in last 6 months (69.5%) above the national target of 68%	5, 17-18

Clinically Ready for Discharge: percentage of bed days			Deterioration in last month. April 2026 at 14.13%.	2,
Clinically Ready for Discharge: Number of delayed days			Deterioration in last month. April 2026 at 2192 bed days.	2, 15-16

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Improving trend in last 2 months (94.3%) below Trust target of 95%.	7, 25-27

Table 4: Quality

	On Track	Plan in Place	Progress- Reviewed at QPES.	Page
AWOL patients coming to harm			Increasing trend in last month from 2 to 5	7, 28-29
Deaths within 30 days post discharge			Sustained at 1 from last month.	7, 30-31
Episodes of rapid tranquilisation			Decreasing trend over last 3 months April at 60	7, 32-33
Incidents of moderate harm and above			Decrease in last month from 50 to 34	7, 34-35
Number of patients prone restrained for anything other than intramuscular tranquilisation			Decrease in last month from 14 to 7	7, 36-37
Number of Prone restraints for more than 10 minutes			Decrease in last 2 months – 1 in April	7, 38-39
Safeguarding Incidents			Decrease in month from 155 to 143	7, 40-41
Harm-free days			Level sustained for last 3 months April at 85	7, 42

- **Purpose**
  For assurance on progress and action planning relating to Trust performance on national, commissioner and local standards.

- **Key Issues and Risks**
- CRFDs, Talking Therapies Recovery Plan targets, 2026/27 NOF standards including LOS, patients in crisis receiving face-to-face contact within 24 hours, reducing overall out of area placements, Eating Disorders national waiting time target – routine, 104 week waits and referrals not seen within 3 months.

Recommendation

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

Enclosures

May 2026 Performance Report and Integrated Performance Dashboard
Appendix I FPPC May 2026 National Oversight Framework Update 2026/27
Appendix II FPPC May 2026 FPPC Performance Improvement Metrics
Appendix IIa FPPC May 2026 Talking Therapies 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 and NOF progress are planned to be addressed via the Performance Assurance Panels (PAPs) going forwards to assess progress and delivery of recovery action plans where relevant. Feedback from PAPs is planned to be provided separately by relevant Leads.

Appendix II outlines an update on improvement plans as provided by relevant KPI Leads. Where relevant trajectories have been updated by KPI leads for 2026/27.

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: Proxy demand/capacity community measure

At the Trust FPPC meeting in April 2026, members requested consideration be given to developing a proxy demand/capacity measure for our community mental health services. This was discussed with the Executive Director of Operations and Service Area ADs and it was agreed that this was a timely request as there are plans to take forward a Community Services Improvement Programme that will incorporate demand/capacity as part of reviewing caseload capacity and demand management. This programme was commenced within the ICCR division with plans now for other divisions with community services to contribute to this work and adopt the agreed methodology for assessing community capacity going forwards.

The programme of work is in the early stages of development and the programme components including a governance structure will be in place by end June 2026. Key metrics will be identified to support this work including a reflection of available national and benchmarking data. Trust FPPC members are therefore asked to note that an update on this work together with an identification of proxy measure/s will therefore be provided for the July 2026 meeting.

Trust Performance in April 2026

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.

New: Quality Metrics

FPPC is asked to note that following a review by the Executive Director of Nursing, the quality domain metrics have been revised and replaced with 8 new metrics introduced for 2026/27. These metrics align with the quality domain areas within the 'Early Warning Dashboard' which provides a service and team level view for internal assessment and alignment to external feedback. This alignment ensures a 'Board to Ward/team' framework. The detail of progress and action planning will be addressed via QPES. The 8 metrics are outlined below:

- AWOL patients coming to harm
- Deaths within 30 days post discharge
- Episodes of rapid tranquilisation
- Incidents of moderate harm and above
- Number of patients prone restrained for anything other than intramuscular tranquilisation
- Number of Prone restraints for more than 10 minutes
- Safeguarding Incidents
- Harm-free Days

NEW: Children and Young People (CYP) Performance Reporting

As previously reported to FPPC, the Birmingham Women's and Children's RAG rated CYP monthly performance report has been stood down from April 2026. CYP data has now been incorporated into the Trust's overall Integrated Performance Dashboard framework.

Clinically Ready For Discharge (CRFD) – The percentage level of occupied bed days (OBDs) lost to CRFD increased in April 2026 to 14.13% from 13.15% in March, with overall levels remaining high. The increase this month was seen in both adult and older adult acute inpatient services. The percentage of OBDs taken up by CRFD service users in April 2026 for Adult Acute & Urgent Care was at 17.8% of OBDs (47 patients), an increase of 1.7% since March. In Older Adult Services, the CRFD levels increased to 38.37% of OBDs (34 patients), a 2% increase on March's position.

The main reasons for the delays in adult acute care remain delays in allocation of a social worker, supported accommodation and care packages, and in older adults continues to be waits for nursing home placements and care packages.

At the April FPPC meeting, members requested a CRFD action plan which is being developed and taken forward by the Deputy Director of Operations. A separate report has been provided for May FPPC meeting.

Update on the 2026/27 Draft National Oversight Framework (NOF) Metrics (Appendix I)

Following a review of the 2025/26 NOF metrics, NHSE have confirmed changes to the mental health metrics that will inform the 2026/27 assessment. This currently remains in draft stage and a finalized version is awaited which will also confirm the overall scoring methodology that will be applied. It should be noted that a national webinar has been arranged to take place on 21st May to discuss the metric specifications.

Appendix 1 provides an update on the current Trust position on the draft 2026/27 NOF metrics for measures where sufficient detail on the national methodology is available. Local data will be more up to date than national data and provides us with an indication of likely impact on the quarter 1 national assessment for the Trust. National publication timescales

have yet to be confirmed.

Draft NOF metrics which can be influenced by in-year action:

- LOS metrics are now aligned to the national planning guidance and based on a rolling 3 month average for adults and older adults.
  Whilst both services are meeting this trajectory, LOS levels remain higher than national median and impacted by CRFD. Forecast performance – band 4, low performing will remain without a step change in actions including CRFD.
- Percentage of patients in crisis receiving face-to-face contact within 24 hours.
  Service level action plans implemented, improving trend observed, April at 62% meeting local Trust trajectory. Forecast performance band 2.
- Proportion (%) of total open CYP MH related waits that are over 104 weeks (help - intervention based clock stop and referral spells methodology) - *April local data at 29%, above the national planning submission improvement trajectory. Forecast performance – band 3*
- 72 hour follow up – April at 84.68%, above the national 80% target. Forecast performance – band 2.

It should be noted that all the above areas of improvement are not new for the Trust and a range of work and action plans are being taken forward to improve the Trust's performance in these areas. For more detail, please refer to Appendix 1.

2025/26 NOF

- The quarter 4 national assessment for 2025/26 NOF has not yet been published.
- FPPC is also asked to note that due to the Trust being in segment 4, Low Performing to date, NHSE have put in place monthly Joint Improvement, Oversight and Assurance meetings with the Executive Team. It should be noted that the agenda for these meetings is wider than NOF performance.

NEW - Active Inappropriate Out of Area placements

The Trust trajectory agreed with NHSE as part of the 2026/27 national planning requirements is to maintain zero acute and PICU inappropriate placements.

From 29th September a new framework arrangement with private providers commenced, placing out of area placements in Cygnet hospitals. From 30th March 2026 these beds are now classified as 'appropriate' following review and approval of the Trust's Standard Operating Protocol (SOP) by the MH Provider Collaborative. The SOP confirms that the qualitative care criteria for these patients is equivalent to care standards provided locally.

At the end of April 2026, the Trust did not meet the zero trajectory as there were 15 inappropriate out of area placements, 3 adult and 12 CYP due to clinical need and demand. The charts below outline the overall trends and position as at end April 2026.

CYP had an increase in those requiring admission in March resulting in patients being placed in beds not covered by the SOP which continued into April. Plans are in place to discharge or repatriate a number of these in the next week. It should be noted that a small number of patients are moved to an 'inappropriate' OOA bed to facilitate discharge to local services outside Birmingham and to be nearer family (117 aftercare remains with Birmingham for these patients)

It should be noted that progress continues in reducing the number of all out of area placements, this having a positive impact on patient experience and the financial recovery plan.

Process improvements as part of the productivity action plan are continuing to be implemented and have helped to address underlying issues and have reduced levels of inappropriate out of area placements.

The percentage of CRFD patients continues to impact on our ability to maintain patient flow and maintain zero inappropriate out of area placements. The percentage of occupied bed days due to CRFD in April 2026 for Adult Acute & Urgent Care was at 17.8% of OBDs.

The Acute and Urgent Care Q1 productivity plan actions are outlined in Slide 9 of Appendix II and in summary include extending piloting the Red2Green model in adult acute wards, undertake a deep dive to understand why more first episode of Psychosis patients are being admitted, discuss the use of section 17 leave vs CTOs, align CRFD lists for Learning Disability and Autism patients, review MDT discharge decision timing and continuing to escalate delays in section 117 referrals to the social care review panels and embedding the use of estimated date of discharge and ensure related timely and accurate recording.

Fig 1. Adult Acute Inappropriate Out of area placements

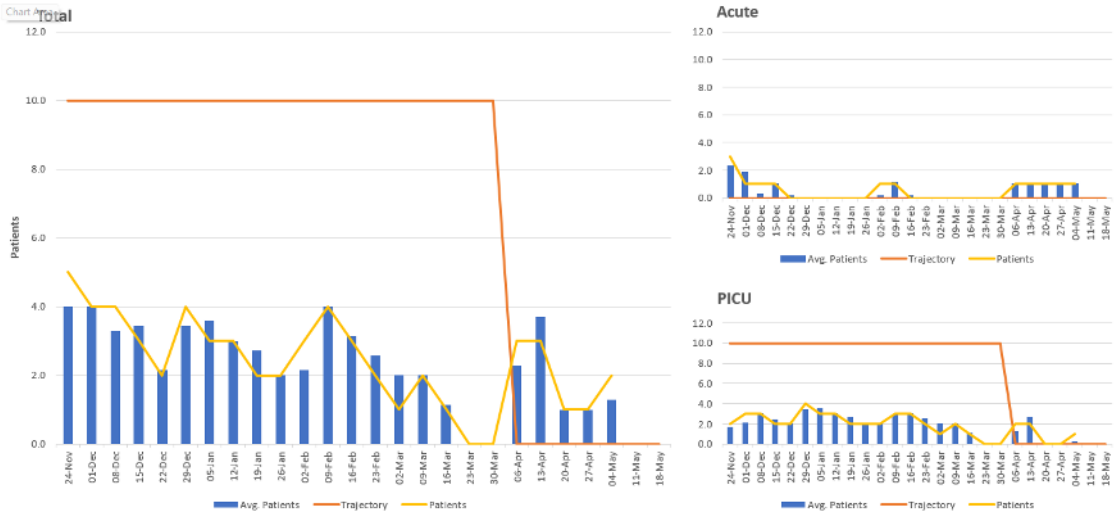
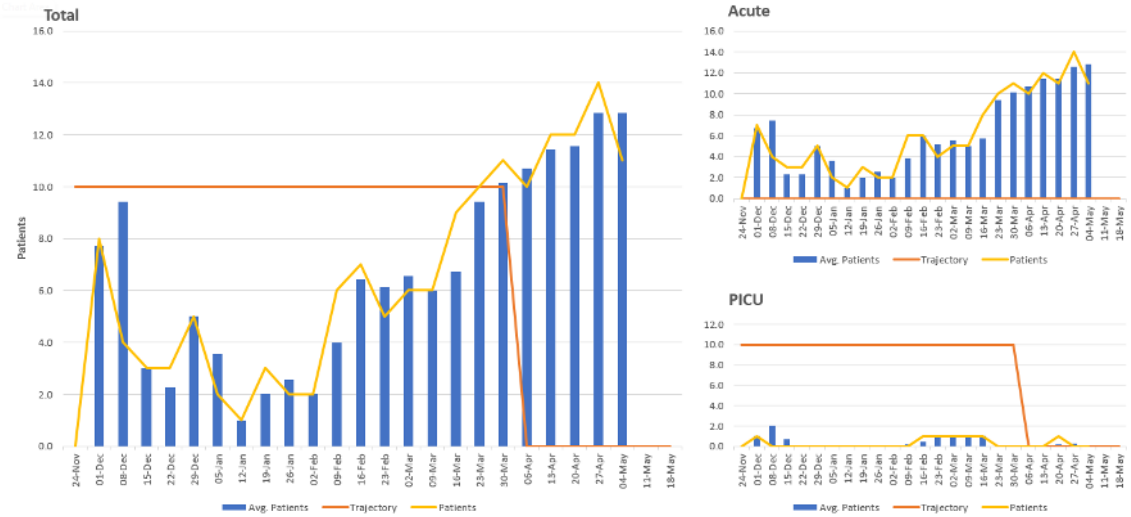


Fig 2. CYP Inappropriate Out of area placements



Reducing Length of Stay (LOS)

Trusts were required to submit improvement trajectories for 2026/27 as part of the national planning submission using previous year as a baseline for improvement. The Trust's submitted improvement trajectory is designed to deliver:

- Adults - 5% improvement (on average across the year) by the end of the year compared with the NHSEs June - August 2025 national baseline data.
- Older Adults -. 12% improvement (on average across the year) by the end of March 2027

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

The Adult LOS has risen in the last quarter but remains below trajectory and Older Adult LOS levels are below trajectory and have remained the same as the previous rolling quarter. CRFDs also continue to impact on the LOS position. In addition, as previously indicated, discharge of long stay patients will impact negatively on the agreed trajectories in the short to medium term and once LOS improvements are achieved routinely with a reduction in longer lengths of stay, this impact will reduce over time.

In summary, the current position for adults shows 71.2 days as at April against the planned trajectory of 76.5 days. Excluding CRFDs, the position is 60.2 days remaining below trajectory. Older adults LOS was 132.4 days for April, below the trajectory of 145 days, however excluding CRFDs, LOS would be below trajectory at 85.7 days.

The delivery of the improvement trajectories is reliant on progressing the Trust's inpatient bed strategy plan, the acute and urgent care productivity plan and reducing CRFDs.

Other actions being taken forward to aid patient flow and support discharge planning include:

- The review taking place with the Local Authority with the aim of agreeing actions to help address some of the challenges to support timely discharge of patients who are clinically ready and do not require inpatient care.
- 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.

Talking Therapies – 2026/27 Birmingham Healthy Minds Recovery action plan

Trust FPPC were provided with a detailed update on progress with the recovery plan in place by the Associate Director for Specialties at the March FPPC meeting.

Context: The MH Provider Collaborative issued a performance notice in September 2025 relating to underperformance in activity levels and reliable recovery and reliable improvement rates. The improvement plan in place and progress being achieved on the following key areas of action is outlined in Appendix IIa. The key areas of focus include:

- Meeting 2026/27 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 to be seen within 6 weeks and 95% of service users seen within 18 weeks.

Current Position:

It should be noted that the ICB activity and income trajectory for Birmingham Healthy Minds is currently below trajectory with a financial activity performance deficit of £52,205 for April 2026.

Reliable Improvement Rate has increased in April to 69.5% above the national target of 69% (which increased in April from 68%). The Reliable Recovery rate increased for the third month in a row to 48.5% but remains below the 51% national target (the target increased in April 2026 from 50%). An update on performance based on the service action plan is attached as appendix IIa.

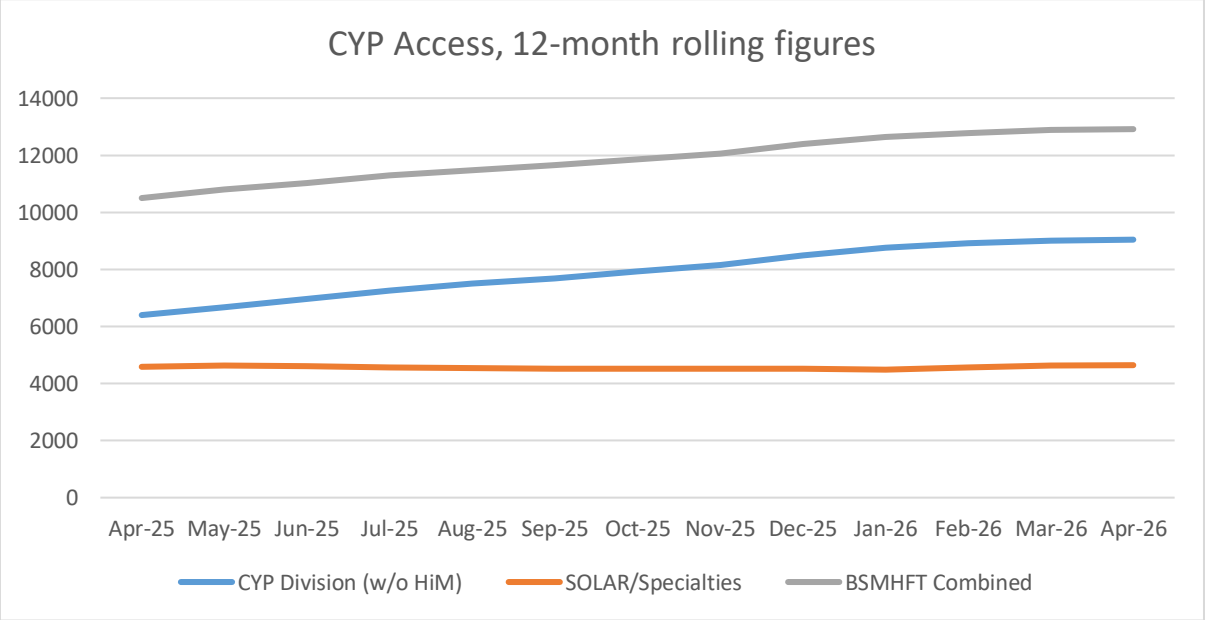
CYP Talking Therapies – FPPC is asked to note that this service is commissioned via Living Well. Under current contract timelines for data submission, this means that the activity and performance data will be reported to FPPC a month in arrears. April 2026 position will be provided at the May 2026 meeting.

CYP Eating Disorders National waiting time standard – Routine 28 days (target 95%)

April saw performance reduced to 55% and below the 95% national standard. This relates to 13 of 29 service users not being seen within the 28-day standard. Compliance is being impacted by Avoidant/ Restrictive Food Intake Disorder (ARFID) referrals which require more complex consultation and consideration.

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 increased to 75% in April and below the local CYP division standard of 95%, this relates to 1 of 4 service users not seen within 28 days.

CYP Access Rate – Improving trend observed.



Notes:

- Figures are based on the current scope of BSMHFT and include earlier activity delivered by BWCT
- All figures include activity for all ICBs, not just BSol
- The combined figures exclude duplicates where both organisations have seen the same young people
- CYP Division figures do not include patients seen by Health in Mind

Quality - The detailed position on the 8 new metrics will be discussed at QPES Committee. A summary of the position as at April 2026 is outlined below:

- AWOL patients coming to harm increased to 5 compared to 2 last month
- Deaths within 30 days post discharge – has remained at 1 this month
- Episodes of rapid tranquilisation decreased to 60 from 75 last month
- Incidents of moderate harm and above – decreased to 34 from 50 last month
- Number of patients prone restrained for anything other than intramuscular tranquilisation- has decreased to 7 from 14 last month
- Number of Prone restraints for more than 10 minutes at 1 compared to 2 last month
- Safeguarding Incidents decreased to 143 compared to 155 last month
- Harm-free Days at 85 compared to 86 last month

People workforce measures – The detailed position including actions being taken are outlined in Appendix II and are discussed and managed via the People Committee.

2026/27 action plans - The HR Leads have reviewed the metrics and provided updated trajectories and action plans for 2026/27 as approved by the People Committee. The CYP data is now included within the IPD.

- Sickness absence: a reducing trend observed with April 2026 at 5.4% below the improvement trajectory of 5.8% for April.

- Bank and Agency WTE reduction – Bank at 622.9 WTE in April above the trajectory of 592.9 WTE for April and Agency at 24.8 WTE below the trajectory of 32.96 WTE for April.

- Staff vacancy levels: April vacancy rate at 6.6% below the trajectory of 10.55% for April.

- Appraisal: April position has declined to 80.9% but is above the trajectory of 79.9% for April.

- Mandatory Training: April position at 94.3%, marginally below the 95% target.

Sustainability – (details in finance report)

Integrated Performance Dashboard

April 2026

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

Hover over values to see more context

Performance

Bed Occupancy (%)	90	↑
Clinically Ready for Discharge: Bed Days	2193	
Clinically Ready for Discharge: Bed Days (%)	14	
CPA 3 Day Follow Up (%)	85	
CPA 7 Day Follow Up (%)	92	
Eating Disorders: Waiting Time - Routine (%)	55	↓
Eating Disorders: Waiting Time - Urgent (%)	100	↑
First Episode Psychosis: Waiting Time (%)	50	↓
Out of Area: Inappropriate Placement Bed Days	54	↑
Out of Area: Inappropriate Placements Active	15	
People on CPA with a Formal Review in last 12 Months (%)	90	↓
Referrals over 3 Months with no Contact	4901	↓
Talking Therapies: Reliable Improvement Rate (%)	70	↑
Talking Therapies: Moving to Recovery (%)	52	
Talking Therapies: Reliable Recovery Rate (%)	49	
Talking Therapies: Seen in 18 Weeks (%)	100	↑
Talking Therapies: Seen in 6 weeks (%)	96	↑

People

Bank & Agency Fill Rate (%)	95	
Fundamental Training (%)	94	
Staff Appraisals (%)	81	
Staff Sickness (%)	5	
Staff Turnover: Rolling 12m (%)	6	↑
Staff Vacancies (%)	7	↑

Quality

AWOL patients coming to harm	5	↓
Deaths within 30 days post discharge	1	
Episodes of rapid tranquilisation	60	↗
Harm-free Days	85	
Incidents of moderate harm and above	34	
Number of patients prone restrained for anything other than intramuscular tranquilisation	7	
Number of Prone restraints for more than 10 minutes	1	
Safeguarding Incidents	143	↓

Sustainability

Agency as % of Pay Spend	1	
Agency Staff Spend	£262k	
Bank as % of Pay Spend	8	↑
Capital Expenditure	£559k	↓
Cost Improvement Programmes	£1,790k	↓
Group Cash Balance	£73,265k	↓
Info Governance (%)	87	
Operating Surplus	£3,224k	↑

Integrated Performance Dashboard

April 2026

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	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	
Clinically Ready for Discharge: Bed Days		2211	2163	2570	2187	2121	2193	
Clinically Ready for Discharge: Bed Days (%)		14	13	16	15	13	14	
CPA 3 Day Follow Up (%)	80	84	86	82	84	88	85	
CPA 7 Day Follow Up (%)	95	90	95	91	89	96	92	
Eating Disorders: Waiting Time - Routine (%)	95	100	90	100	100	100	55	↓
Eating Disorders: Waiting Time - Urgent (%)	95	100	100	100	100	100	100	↑
First Episode Psychosis: Waiting Time (%)	60	100	100	100	100	100	50	↓
Out of Area: Inappropriate Placement Bed Days	328	662	625	631	754	604	54	↑
Out of Area: Inappropriate Placements Active	10	24	17	24	24	0	15	
People on CPA with a Formal Review in last 12 Months (%)	95	94	94	93	94	93	90	↓
Referrals over 3 Months with no Contact		3905	4036	4235	4272	4213	4901	↓
Talking Therapies: Reliable Improvement Rate (%)	69	68	68	68	69	69	70	↑
Talking Therapies: Moving to Recovery (%)	50	49	51	46	48	51	52	
Talking Therapies: Reliable Recovery Rate (%)	51	48	46	43	45	47	49	
Talking Therapies: Seen in 18 Weeks (%)	95	100	100	100	100	100	100	↑
Talking Therapies: Seen in 6 weeks (%)	75	95	96	95	97	96	96	↑

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

Integrated Performance Dashboard

April 2026

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	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Bank & Agency Fill Rate (%)		94	91	90	92	91	95
Fundamental Training (%)	95	94	94	94	94	94	94
Staff Appraisals (%)	90	85	85	76	81	81	81
Staff Sickness (%)	4	6	6	6	6	6	5
Staff Turnover: Rolling 12m (%)		5	5	6	5	6	6 ↑
Staff Vacancies (%)	6	7	7	8	7	7	7 ↑

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

Integrated Performance Dashboard

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

Measure	Latest Target	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
AWOL patients coming to harm		0	0	0	0	2	5 ↓
Deaths within 30 days post discharge		1	0	3	3	1	1
Episodes of rapid tranquilisation		101	82	110	79	75	60 ↗
Harm-free Days		85	85	84	85	86	85
Incidents of moderate harm and above		20	29	26	34	50	34
Number of patients prone restrained for anything other than intramuscular tranquilisation		11	11	17	10	14	7
Number of Prone restraints for more than 10 minutes		3	1	2	8	2	1
Safeguarding Incidents		150	130	155	149	155	143 ↓

Integrated Performance Dashboard

April 2026

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	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	
Agency as % of Pay Spend		1	1	1	1	0	1	
Agency Staff Spend		£319k	£330k	£363k	£232k	£254k	£262k	
Bank as % of Pay Spend		10	9	9	9	7	8	↑
Capital Expenditure		£1,046k	£2,220k	£1,840k	£2,307k	£10,394k	£559k	↓
Cost Improvement Programmes		£2,990k	£2,957k	£3,018k	£2,778k	£6,105k	£1,790k	↓
Group Cash Balance		£101,385k	£94,619k	£98,034k	£93,166k	£67,580k	£73,265k	↓
Info Governance (%)		100	92	100	100	100	87	
Operating Surplus		-£487k	-£345k	-£1,931k	-£1,450k	-£3,648k	£3,224k	↑

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

Out of Area: Inappropriate Placements Active

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2026

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Trust

Divisions

Services

Commentary

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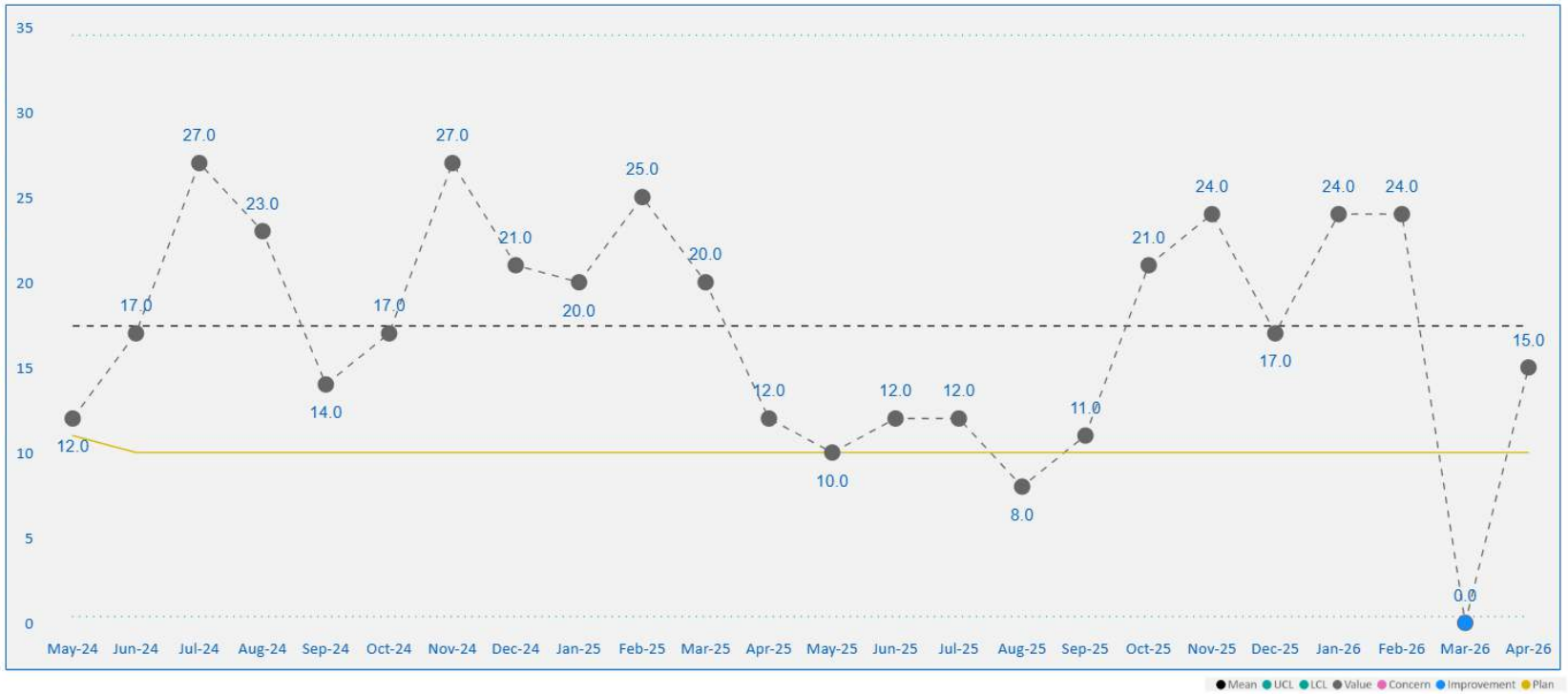

Question	Answers
A: What has happened?	The number of inappropriate out of area placements at each month end remains a metric in the 2025/26 national planning guidance. A Trust trajectory agreed with NHSE as part of the 2026/27 national planning requirements will to maintain zero acute and PICU inappropriate placements each month As part of the framework arrangement with private providers, patients are being placed in Cygnet hospitals and from 30th March these beds will be counted as appropriate following review and approval of the Trust's Standard Operating Protocol (SOP) for these beds by NHSE. There are 15 'inappropriate' out of area placements at the end of April above the trajectory of 0. 3 of these were adults and 12 were CYP. 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 clinically ready for discharge bed days 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 2193 overall in April with adults at 1174 lost bed days which equates to 17.78%, an increase of 1.7%. Adult bed occupancy has remained at 95.9% and length of stay has increased to an average of 112 in April. CYP had a sudden increase in those requiring admission in March resulting in patients being placed in beds not covered by the SOP, which continued in April. The bed waiting list for service users being managed by Home Treatment Teams in the community are a further added pressure to capacity requirements. The combination of these challenges and the inter dependencies continually impact on creating sufficient flow within the acute and urgent care pathway in particular to allow repatriation of out of area placements. Demand for 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 have classified this bed use as 'inappropriate' but from 30th March these beds will be counted as appropriate following review and approval of the Trust's Standard Operating Protocol (SOP) for these beds by the MH Provider Collaborative. A OOA reduction programme is in place with 3 key workstreams are in place to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. The 3 workstreams and Q1 actions include: Admission avoidance Goal: Ensure admissions are appropriate and alternatives are considered. • Deep Dive on Early Intervention Admissions: Conduct a deep dive analysis on all early intervention admissions to understand why more first episode patients are being admitted. • Convene a discussion with Responsible Clinicians and relevant medical colleagues to review/ address the use of Section 17 leave versus Community Treatment Orders (CTOs)—particularly the impact on length of stay data, recall/admissions Inpatient Care & Reducing Length of Stay Goal : Increase timely discharges and reduce delays in discharge • Pilot Red2Green Model on 2 wards – to drive daily progress towards discharge- extend to a further 2 wards • Compare and align CRFD (Clinically Ready for Discharge) lists for learning disability and autism patients. Discharge Planning and Support Goal : Increase timely discharges and reduce delays in discharge and active use of data to inform reporting and decision making • Audit of estimated Discharge date to ensure accurate and timely recording to inform proactive discharge planning • Review MDT discharge decision timing and work jointly with pharmacy to establish an escalation or fast-track process for same-day TTOs, particularly where discharge decisions or medication changes occur late in the day, with the aim of reducing avoidable next-day discharge delays.
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 not using any inappropriate 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

April 2026

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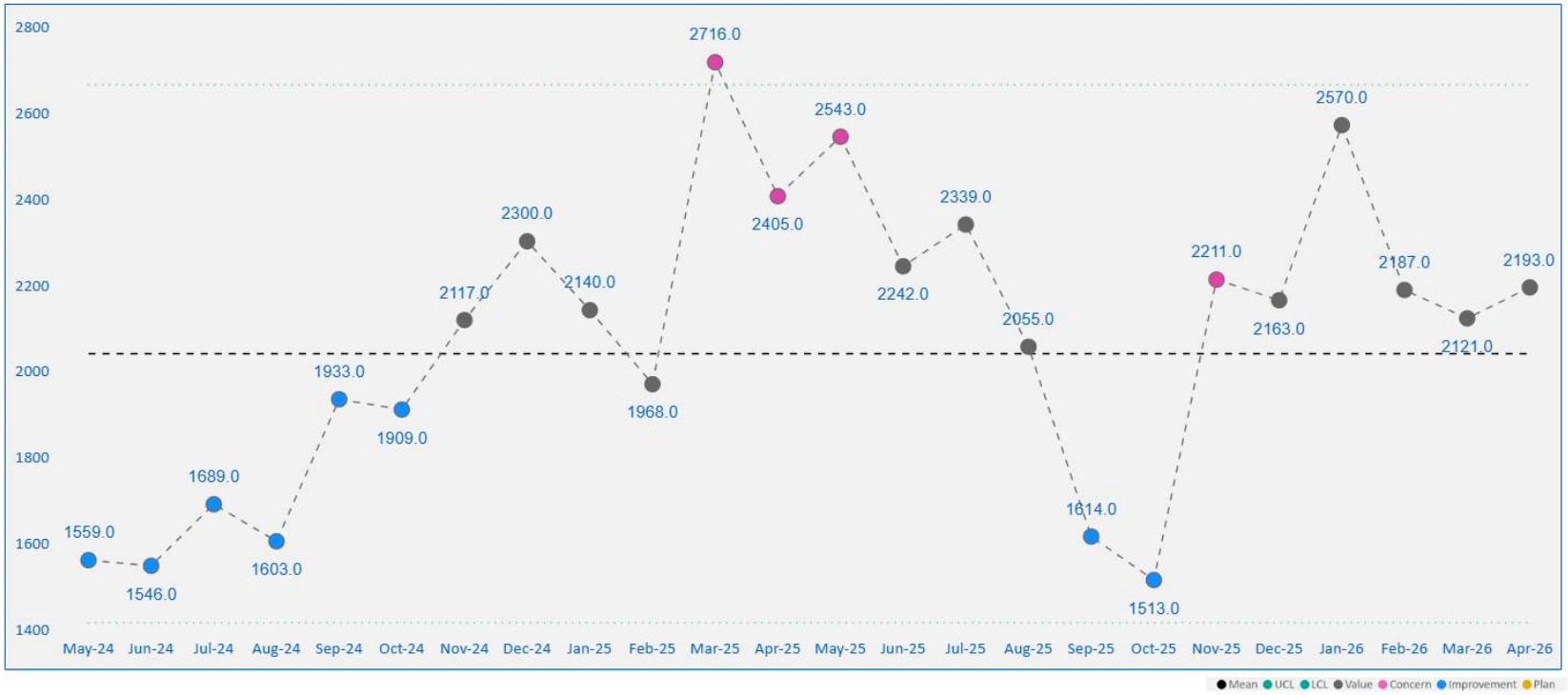

Question	Answers
A: What has happened?	The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. The number of CRFD bed days has been on an increasing trend since May 24 and reaching a peak in March 2025 at 2716 bed days. Between August 2025 - October there was an overall decrease, but this was reversed in November - January 2026. April has seen an icnrease to 2193 with Adults moved from 1089 days in March to 1174 days in April, which related to 47 patients, with a main delay reason of supported accommodation and care packages and older adults moved from 691 days in March to 698 in April and related to 34 patients, who were waiting for care home placements and care packages.
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?	A letter has been written to the Director of Social care outlining concerns about AMPH availability, allocation of social workers and completion of CTO's and a meeting is taking place in April to discuss these areas with the Local Authority. A review is also taking place with the Local Authority with the aim of agreeing actions to help address some of the challenges with timely discharge and for those who are Clinically ready for Discharge. In addition internally reviewing patient flow and activities as part of operational and strategic management of demand and capacity as part of both community and acute and urgent care transformation work plans. A multi-agency bed management meeting is in place to support improved bed flow across inpatient services, along with production boards which provide an update on each patient's delay, identifying progress and tasks required to support discharge. There are some gaps in the current CRFD recording which the localities will be working with the discharge managers to address.
E: What do we expect to happen?	Via the partnership working, to begin to see reductions in delays due to availability of alternatives including social care support and nursing home capacity that is not in our immediate control.
F: How will we know when we have addressed issues?	Begin to see partnership and system wide solutions being implemented contributing to a reduction in these delayed discharges.

Talking Therapies: Reliable Improvement Rate (%)

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2026

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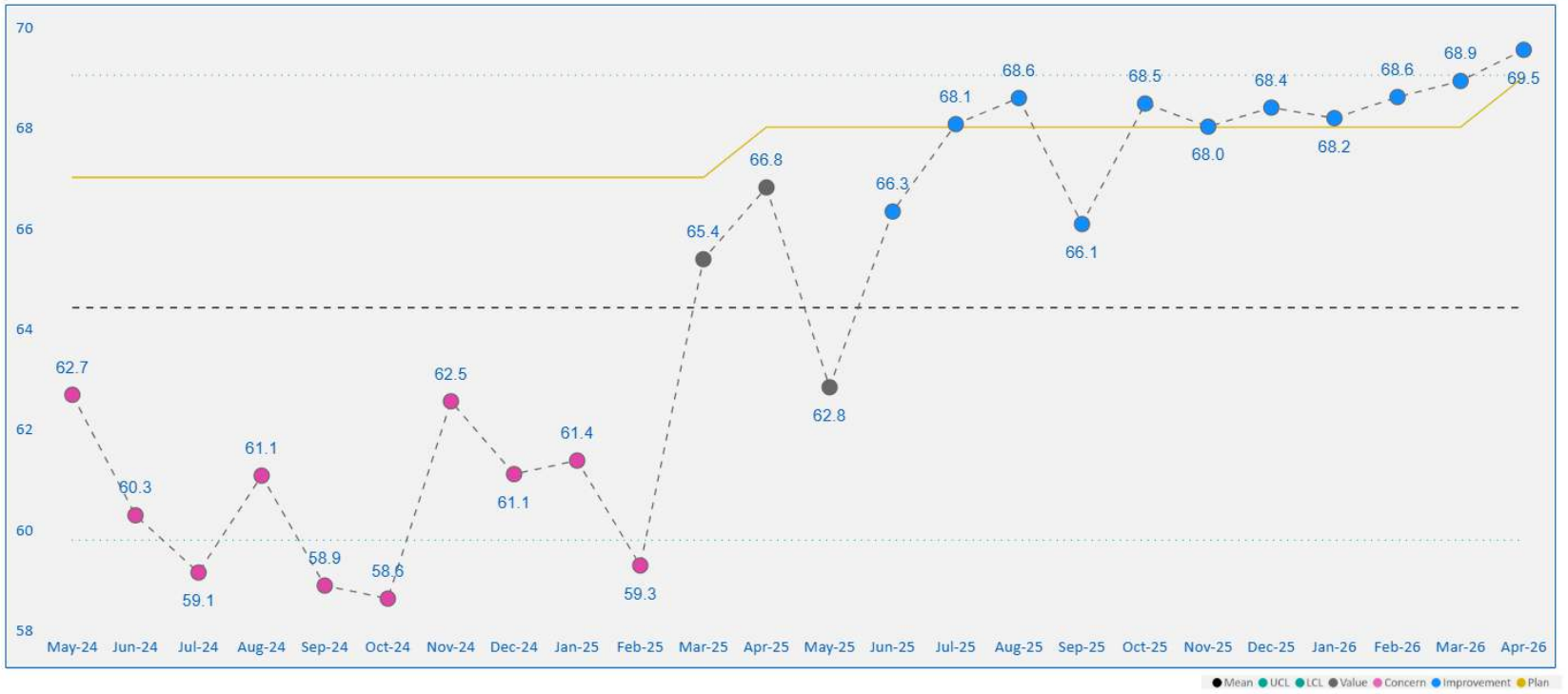

Question	Answers
A: What has happened?	This was a new national metric for 2024/25 with an increased focus on recovery and the target has increased 69% from April 2026. April 2026 at 69.54% above the 69% target for the seventh month in a row. Reliable Improvement Rate is the outcome measure to assess 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. A range of actions are in place to increase the recovery rate and recovery training took place in January for the whole service
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 in September 2025
D: What are we doing about it?	The provider Collaborative have issued a performance notice in September 2025 relating to the Talking Therapies current reliable recovery and reliable improvement rates. A range of further supportive measures are being put in place by the commissioners to review the recovery action plan which is in place. The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable improvement rate. An Action Plan is in place to explore ways that recovery rates can be increased. This includes: 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, using TT Inequalities report, increasing the number of treatment sessions with each service user and reducing DNA rates within the service by engaging proactively with service users, introduction of case management supervision at step 3. 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 for April has remained at 10%.
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 69% Reliable Improvement rate.

Talking Therapies: Reliable Recovery Rate (%)

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2026

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Services

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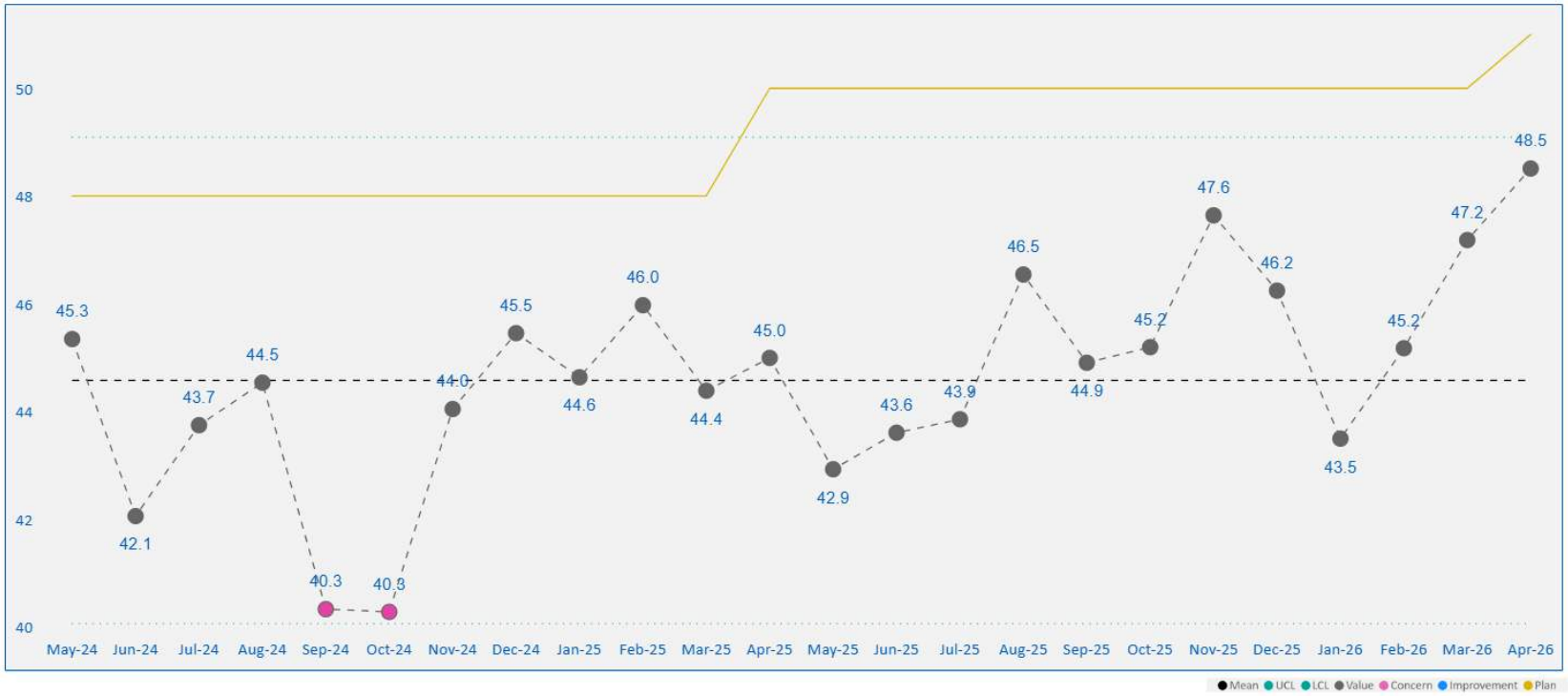

Question	Answers
A: What has happened?	The national target has increased from 50% to 51% from April 2026. The Reliable Recovery rate has fluctuated and is not meeting the 51% target, however April 2026 position has seen an increase for the third month in a row to 48.5%, just below target. Reliable Recovery 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 51% 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. A range of actions are in place to increase the recovery rate and recovery training took place in January for the whole service
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 in September 2025.
D: What are we doing about it?	The provider Collaborative have issued a performance notice in September 2025 relating to the Talking Therapies current reliable recovery and reliable improvement rates. A range of further supportive measures are being put in place by the commissioners to review the recovery action plan which is in place. The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable improvement rate. An Action Plan is in place to explore ways that recovery rates can be increased. This includes: 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, using TT Inequalities report, increasing the number of treatment sessions with each service user and reducing DNA rates within the service by engaging proactively with service users, introduction of case management supervision at step 3. 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 remained at 10% in April 2026
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 51% Reliable Recovery rate.

Staff Sickness (%)

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

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Divisions

Services

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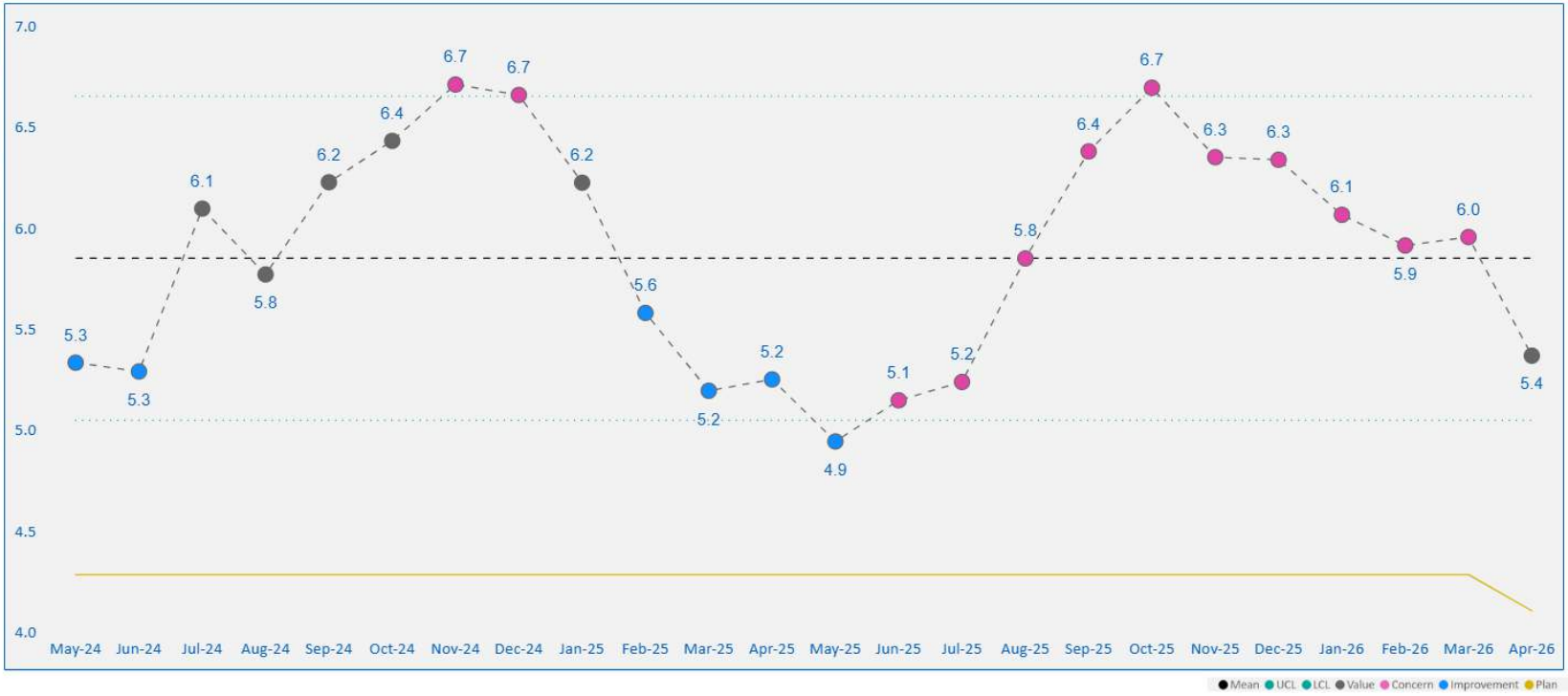

Question	Answers
A: What has happened?	Trust wide sickness absence rate for April 2026 was 5.4% against 6%
B: Why has it happened?	Historically, long-term absence is largely driven by mental health conditions (stress/anxiety/depression) and musculoskeletal (MSK) issues. Nationally, sickness absence tends to be highest Oct–Mar and commonly includes cold/flu/respiratory illness, which can inflate short-term episodes during winter months.
C: What are the implications and consequences?	Higher sickness absence can mean reduced productivity, short staffing, and greater reliance on bank/agency cover, with knock-on effects for quality and flow. Services with the highest absence rates face increased rota disruption, pressure on remaining staff, and heightened risk of burnout—potentially feeding back into further absence.
D: What are we doing about it?	Return-to-Work (RTW) meetings after every sickness episode (recorded on the RTW form) within 7 calendar days, with OH referral considered for long-term absence (>28 days). Growing use of trigger/insight views to spot repeat short-term absence (e.g., 3+ episodes/12 months; 8+ days/12 months) and focus on hotspots, reasons, and missing RTWs. Targetted support and action planning in place to prioritise mental wellbeing support and early MSK intervention/ergonomics to reduce long-term cases.
E: What do we expect to happen?	With tighter RTW/trigger management and targeted support, we'd expect the highest-absence services to start converging toward the Trust average.
F: How will we know when we have addressed issues?	Sustained month-on-month reduction toward the Trust KPI benchmark Higher RTW completion within 7 days and consistent documentation. Fewer staff repeatedly breaching short-term triggers (3+ episodes / 8+ days) Fewer long-term cases dominating days lost (especially stress/anxiety/depression and MSK), and visible reduction in hotspot rates for the highest-absence services

Staff Appraisals (%)

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Trust

Divisions

Services

Commentary

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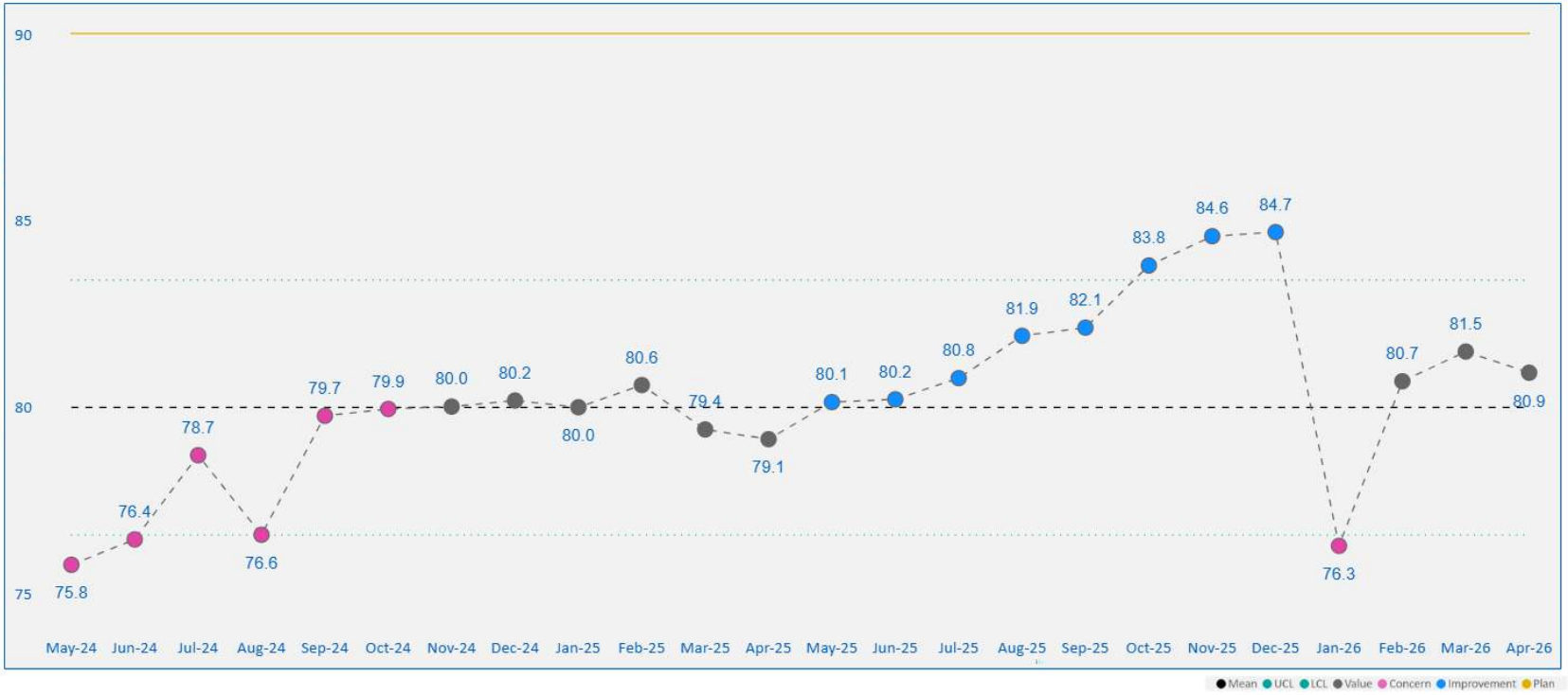

Question	Answers
A: What has happened?	April Appraisal compliance of 80.9%. This isi a decrease from April (81.5%). This remains below Trust target of 90 % and commissioners target of 85%.
B: Why has it happened?	The teams within the Trust are below 75% compliance are: Acute And Urgent Care Services 72.7% Cyp 57.1% Exec Dir - Medical 71.2% Exec Dir - Nursing 69.7% Exec Dir - Resources 70.2% New Care Models 44.1% Trustwide 28.6%
C: What are the implications and consequences?	The above information demonstrates an increase in compliance and we would expect appraisal compliance to improve now that the system issues are resolved. However we are still currently supporting work to obtain accurate data on Insights for the CYP division as this remains unresolved.
D: What are we doing about it?	Continuing current practice to raise compliance and monitoring. Additional VBA training dates scheduled and we continue with targeted to work with those teams with low compliance.
E: What do we expect to happen?	The BAU appraisal work will continue to positively support staff in achieving quality values based appraisal conversations and also improve compliance.
F: How will we know when we have addressed issues?	When we have 3 months consistently at 85% compliance. FTB areas will be treated as hot spot areas from August onwards to mitigate against fall in compliance.

Fundamental Training (%)

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2026

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Trust

Divisions

Services

Commentary

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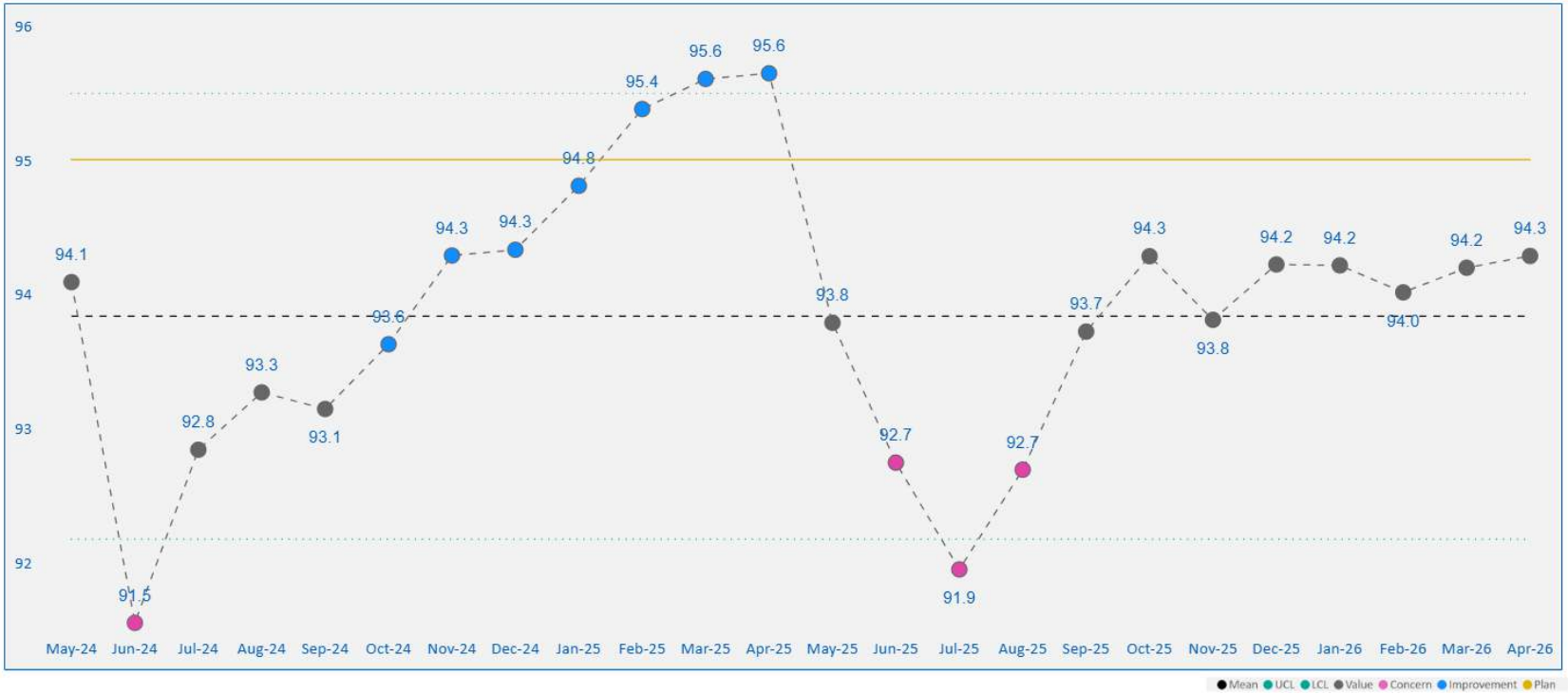

Question	Answers
A: What has happened?	Fundamental Training compliance increased slightly from 94.2 to 94.3%. While this reflects continued progress, it remains below the Trust's 95% target for substantive staff, though it continues to exceed the Commissioners' target. Areas currently below 95% compliance include: Chief Executive Office-80.8% Acute And Urgent Care Services -93.7% Cyp-87.3% ICCR-94.1% New Care Models-89.9% Trustwide (24/7 Team)-89.1% Temporary staffing compliance has increased from 92.2% to 92.3% and remains well above the Trust's 75% target.
B: Why has it happened?	The expiry of grace periods for Patient Safety, Moving and Handling Level 2, and Dual Diagnosis has had a direct impact on overall compliance performance. In addition, several subjects remain within their current grace periods and are anticipated to further affect compliance once these periods conclude, most notably Oliver McGowan Tier 1 and Tier 2 in August 2026. Compliance for Suicide Prevention training has also reduced following a recent update to the training matrix, which has expanded the staff cohort required to complete this training. Whilst this has resulted in a short-term reduction in compliance, it reflects improved alignment of mandatory training requirements with service need and workforce risk. A further contributory factor has been the TUPE transfer of FTB staff into the Trust. These staff members were not previously subject to the same mandatory training requirements, and the expiry of the associated face-to-face training grace period has now impacted reported compliance levels. The following subjects currently remain below 90% compliance and continue to be monitored through the recovery plan: CRAM: 88% Resus – ELS: 73.8% Resus – ILS: 80.1% Safeguarding Adults (Version 2) – Level 3 (3 Years): 89.8% SRS Conveyance: 72.6% Suicide Prevention – Level 1: 89.5% The Care Certificate: 87.2%

Question	Answers
	Targeted actions are in place to improve compliance across these areas, with continued oversight through monthly reporting and service-level escalation where required.
C: What are the implications and consequences?	Implications and Consequences - Low Fundamental Training (FT) compliance presents a significant risk to patient safety and staff wellbeing. There is a risk that staff may not possess the required knowledge, skills, and competencies to practise safely within clinical environments, which could adversely impact the quality and safety of care delivery. - Failure to meet the commissioners' compliance requirements may constitute a contractual breach, which could result in substantial financial penalties. These penalties may exceed £210,000 per subject, per month, for each month that BSMHFT remains non-compliant. - The continued expansion of FT subjects included within the Trust's traffic light reporting framework may place additional pressure on overall compliance performance. While this strengthens governance and assurance arrangements, it may have a short-term adverse impact on reported Trust-wide compliance figures. - Although Temporary Staffing Services (TSS) are not included within the overall Trust compliance metric, they remain required to complete mandatory training. It is essential that required training is provided in a timely manner to ensure TSS staff are competent to practise safely. Failure to complete the necessary training may prevent TSS staff from booking shifts, particularly on inpatient wards, which may in turn affect workforce capacity and service delivery.
D: What are we doing about it?	Mitigating Actions / What We Are Doing About It • A formal recovery plan is in place for all Fundamental Training subjects with compliance below 95%, supported by monthly improvement trajectories and ongoing performance monitoring. Progress against these trajectories is reviewed regularly to ensure targeted actions are delivering the required improvement. • A range of business-as-usual compliance management processes continue to support improvement activity, including: o direct emails to employees and line managers following Did Not Attend (DNA) instances, requesting prompt rebooking; o reminder emails issued to both employees and managers in advance of booked training sessions; o monthly DNA reports escalated to Clinical Directors and Heads of Service for local follow-up and management action; o monthly reminder communications to staff whose training has expired or is approaching expiry, prompting timely rebooking. • For all newly introduced Fundamental Training subjects, the FT team issues advance communication to all affected staff at least one month prior to launch. This ensures staff and managers have early visibility of new requirements and sufficient time to plan completion. • In addition, newly introduced training subjects are assigned a six-month grace period within the traffic light reporting framework, allowing staff a reasonable timeframe to complete the training before compliance performance is formally impacted.
	• The Corporate Induction model has been updated from May 2026 to include Fundamental training sessions on Day 2 of Induction which will reduce DNAs of new starters and ensure they are compliant sooner These actions are intended to support sustained improvement in compliance performance and reduce associated patient safety, workforce, and contractual risks.
E: What do we expect to happen?	Expected Position / Forecast • Based on the current recovery plans and projected trajectories, overall compliance is expected to remain below the 95% target in the short term. This is primarily due to the recent expiry of grace periods for Dual Diagnosis, Patient Safety, and Moving and Handling Level 2, together with the impact of the TUPE transfer of CYP staff, whose mandatory training requirements have now been aligned to Trust standards. • Whilst this is expected to continue to place downward pressure on compliance performance, recovery actions remain in place and are intended to support gradual improvement over the coming months. • For newly introduced Fundamental Training subjects, the use of an extended grace period is not expected to adversely affect overall Trust compliance during the grace period itself, as it provides staff with sufficient time to complete the required training before the subject becomes reportable within the Trust's compliance metrics. This approach is intended to support planned compliance achievement while maintaining safe implementation of new training requirements. A gradual improvement trajectory is anticipated following the completion of grace-period-related impacts and the embedding of recovery actions across affected services.
F: How will we know when we have addressed issues?	Resolution will be evidenced when substantive Fundamental Training compliance achieves and sustains the Trust target of 95% or above, as reported through the Insight Reporting System over consecutive reporting periods.

AWOL patients coming to harm

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

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Trust

Divisions

Services

Commentary

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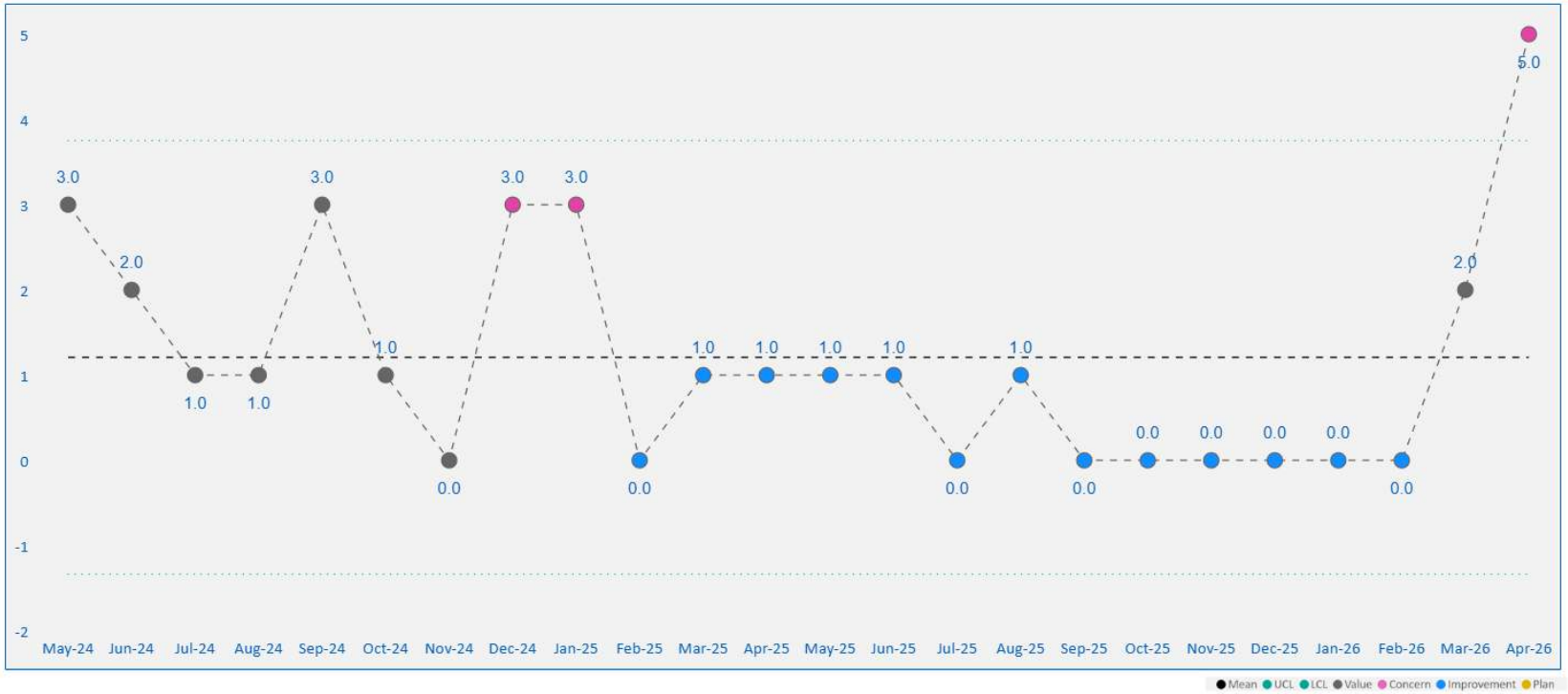

Question	Answers
A: What has happened?	Five absconsions/failure to return incidents were reported during the month across Acute Care and Recovery Services.
B: Why has it happened?	Incidents occurred across different wards with no single emerging hot spot identified at this stage.
C: What are the implications and consequences?	All incidents are recorded as minor harm. All patients were located and returned to the ward.
D: What are we doing about it?	Incidents continue to be reviewed through divisional governance processes with themes and learning monitored.
E: What do we expect to happen?	Continued monitoring of absconsion and failure to return incidents to identify emerging themes, hot spots or repeat patterns requiring a deeper review.
F: How will we know when we have addressed issues?	Reduction in repeat absconsion/failure to return, identified hot spots or recurring themes and ongoing assurance through divisional governance monitoring.

Deaths within 30 days post discharge

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

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Trust

Divisions

Services

Commentary

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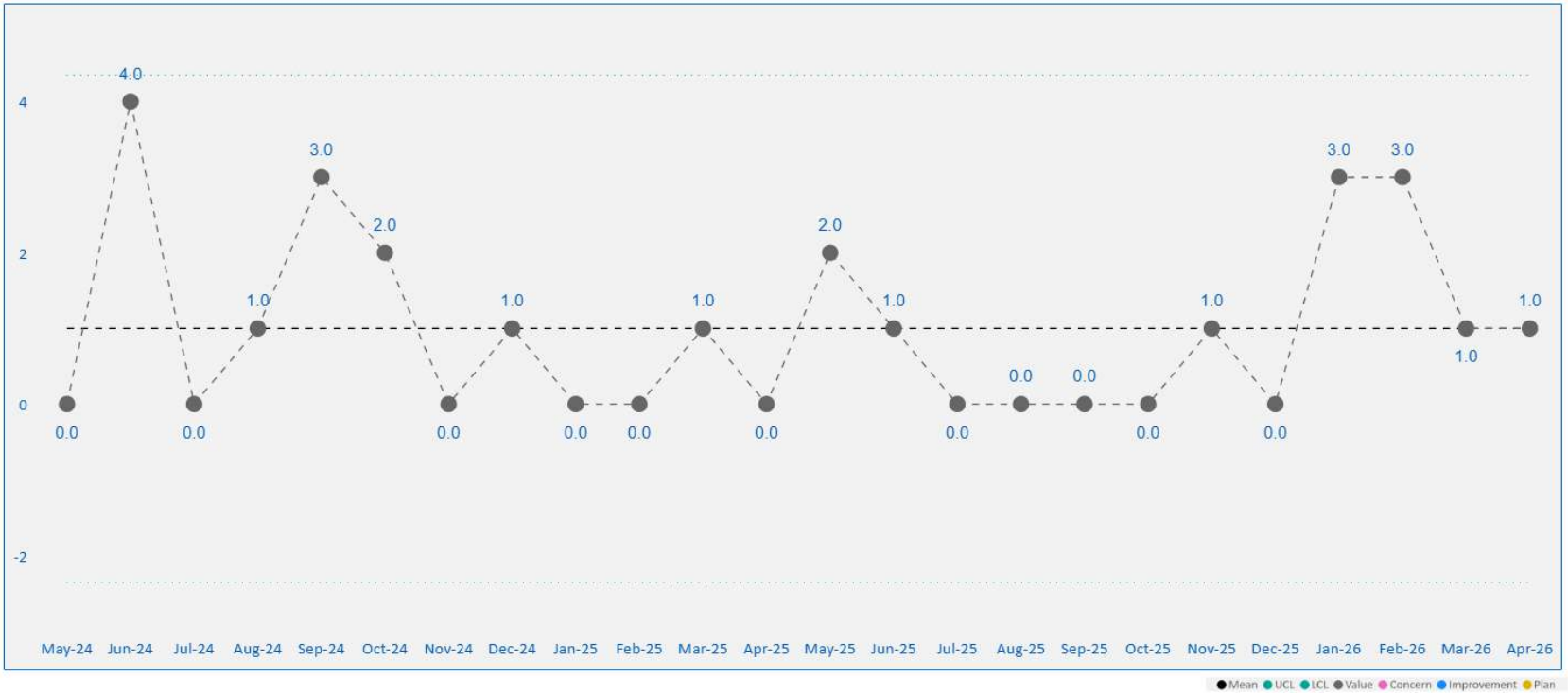

Question	Answers
A: What has happened?	One death within 30 days of ward discharge was reported during the month and is currently recorded as a suspected suicide.
B: Why has it happened?	Learning remains under review
C: What are the implications and consequences?	Implications include the impact and distress caused to the family and staff involved. The death is likely to proceed to Coroners inquest.
D: What are we doing about it?	There will be a Structured Judgement Review and a referral for a LeDer review has been made. Family Liaison Officer will offer support where needed.
E: What do we expect to happen?	The case will progress through the SJR, LeDer and Coroner processes. Any identified learning, themes or recommendations will be reviewed through governance processes and shared.
F: How will we know when we have addressed issues?	Completion of the SJR and LeDer review, implementation of any recommendations identified and oversight through Learning from Deaths.

Episodes of rapid tranquilisation

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

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Trust

Divisions

Services

Commentary

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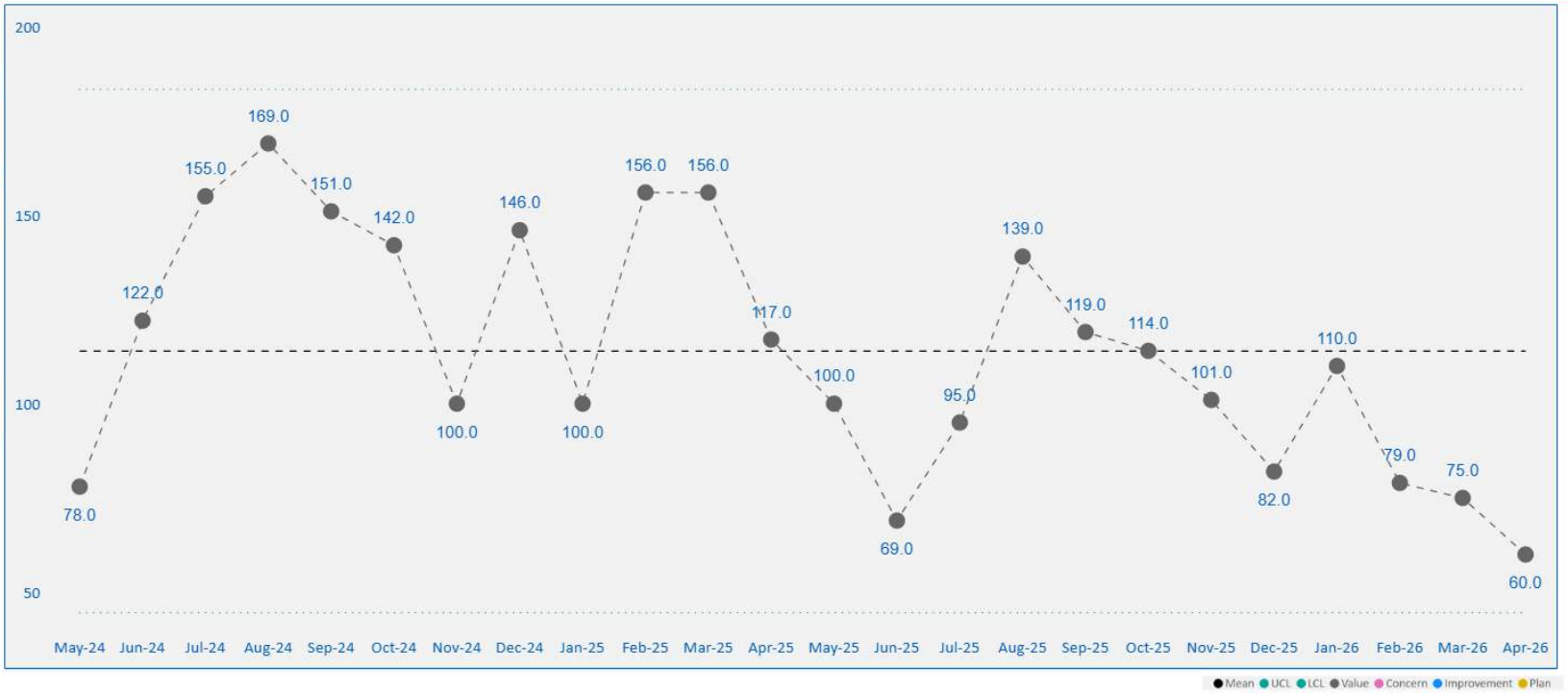

Question	Answers
A: What has happened?	This is the 3rd month showing special cause improvement with 60 episodes of RT for the month. Of these, 19 were oral and 10 were deltoid, the remaining were administered into the glute 10 of which involved prone holding. Variety of causes were recorded. Prevention of harm to self, prevention of harm to staff, administer medication and to prevent extreme/ prolonged over activity were all cited. 58 incidents were categorised at level 1 oe 2 harm. 1 incident was recorded as level 3 moderate harm. RT was administered in D&F x12, ICCR x 1, SCOH x 5, 42 instances were Acute care. the highest usage within acute was Lavender on 17 occassions and Eden PICU x 11. of the 31 instances of IM RT the deltoid could have been utilised in the majority of cases. On occassion the glute may be a preference where RT has been administered in seclusion or prior to seclusion transfer if staff are already in prone holding. This should be an exceptional emergency event.
B: Why has it happened?	
C: What are the implications and consequences?	Increased use of RT will have an impact upon service user experience. Unecessary use of prone holding is against national guidace and could impact regulatory governance feedback for th eorganisation.Failure to consider the use of 'deltoid first' will increase the use of prone to access the glute. The deltoid is a more trauma informed site and is being utilised nationally as a way to avoid prone interventions. Other ways to access the glute such as side lying and kneeling are being incorporated into AVERTS training. Looking to develop an all age PBS appropach for BSMHFT that will incorporate primary and secondary prevention to avoid the more restrictive tertiary interventions. This will involve and ensure service user voice and experience is at the centre of interventions.
D: What are we doing about it?	Looking to encourage the proactive use of medication to avoid the need for RT. Where RT is required, consider 'deltoid first'. Exploring options with the governance intelligence team to ask if deltoid was considered on the eclipse entry. Discussions around improving RT monitoring post administration. Improved training for staff regarding alternative IM sites involving clinical educators, AVERTS team and pharmacy input. Monitoring and oversight in local RRP meetings and feedback through RRPSG utilising AAA template.
E: What do we expect to happen?	A decrease in the overall use of RT with an steady increase in the uptake of deltoid as a first line consideration. Encourage the proactive planning of Rt with service user involvement in the MDT planning around medicatiopns during MDT discussions.
F: How will we know when we have addressed issues?	Incident data- both qualitative and quantitative. Feedback from service users carers and staff.

Incidents of moderate harm and above

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

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Trust

Divisions

Services

Commentary

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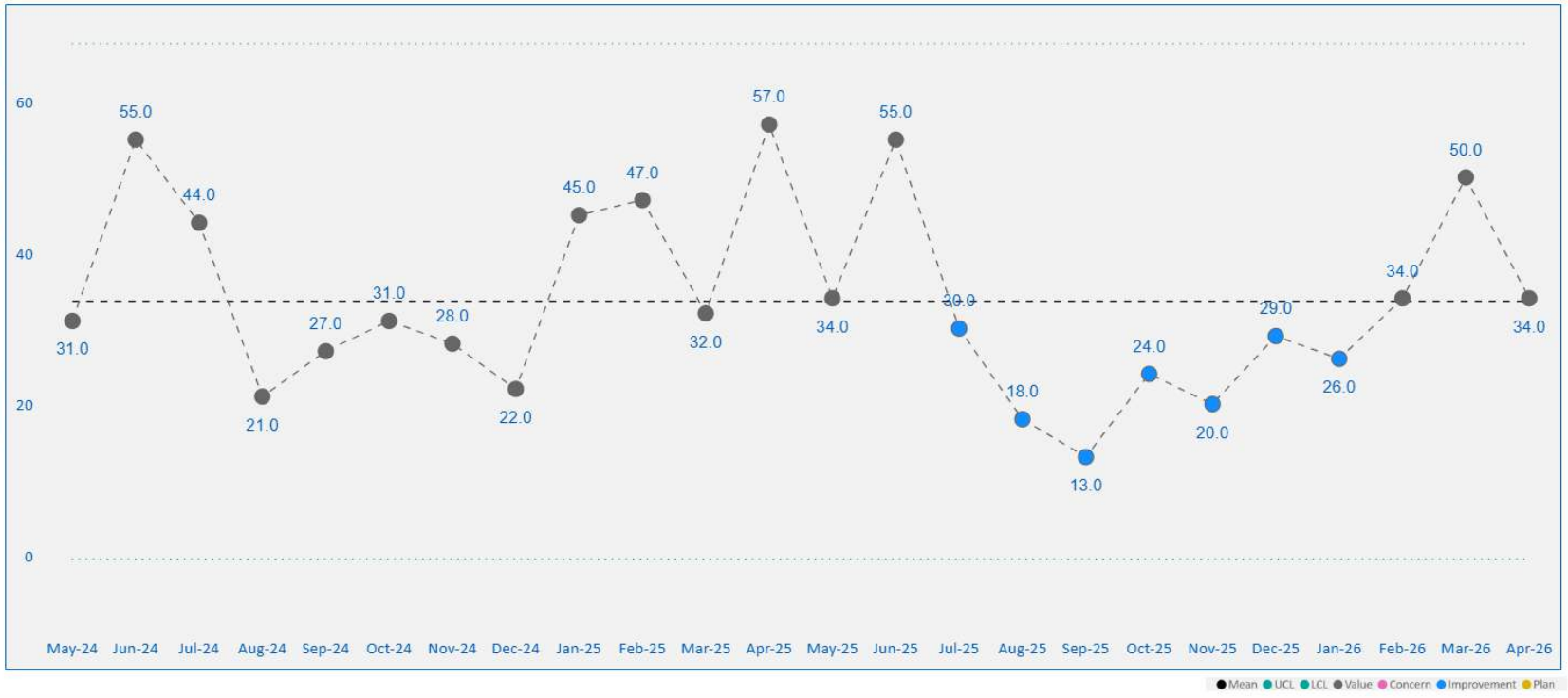

Question	Answers
A: What has happened?	34 incidents resulting in moderate harm and above were reported during the month, compared to the monthly mean of 32 and reduced from 50 in the previous reporting period. Incidents related to both staff and patients across inpatient wards.
B: Why has it happened?	The majority of incidents relate to assaults, violence and aggression occurring in the inpatient setting, where patients present may present with more distress and behavioural dysregulation.
C: What are the implications and consequences?	Incidents resulting in moderate harm and above can have a significant impact on patients and staff, including physical and psychological impact for those involved. Staff support mechanisms are available, including access to occupational health and well-being support. Incidents continue to reviewed through MDT and governance processes to identify themes and opportunities for learning.
D: What are we doing about it?	Ongoing monitoring of moderate harm and above incidents across inpatient settings, with thematic review and learning used to support reduction in harm and improvement activity.
E: What do we expect to happen?	Sustained reduction or stabilisation in moderate harm and above incidents, with monitoring of trends, themes and learning
F: How will we know when we have addressed issues?	

Number of patients prone restrained for anything other than intramuscular t…

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2026

HOME PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

Trust

Divisions

Services

Commentary

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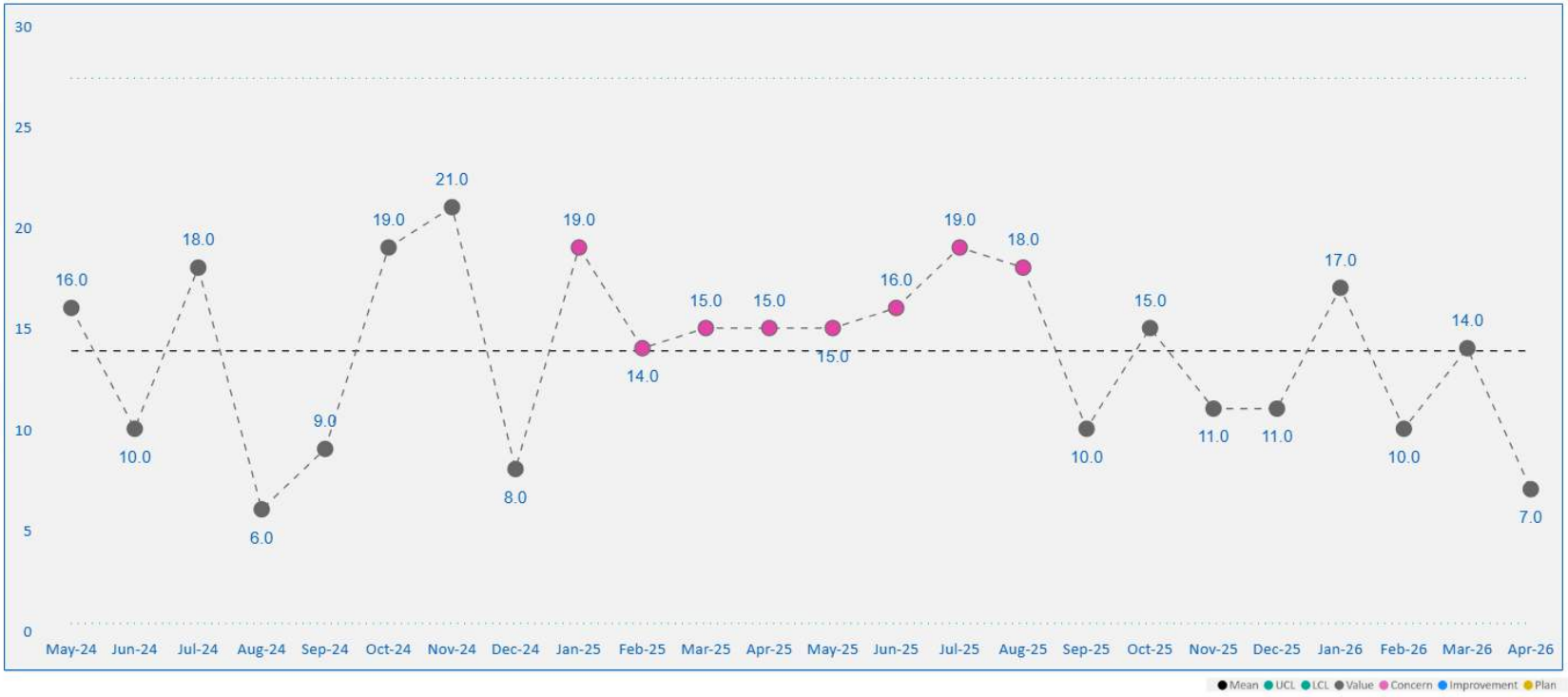

Question	Answers
A: What has happened?	SPC charts continue to show random variation with an improvement for the month of April 2026. there were 7 incidents of prone intervention, 6 were between 1-5 minutes in duration and 1 was recorded as a 25 minute prone intervention.
B: Why has it happened?	6 incidents were categorised as self-harm across different in-patient services, 1 incidents was categorised as 'Assault, Violence and harrassment' and was a joint restrictive physical intervention with West Midlands Police withion the Place of Safety whereby Trust staff assisted officers in holding onto an individual whilst handcuffs were re-applied. All incidents we categorised as level 1 or level 2 harm.
C: What are the implications and consequences?	Increased risk of staff and service user injury. Not adhering to trauma informed principles, reduced service user and staff experience. Increased staff absenteeism. Prone restraint seen as a default rather than an emergency response. The Trust needs to ensure that prone intervention is a last resort for the minimal amount of time to ensure safer and appropriate care and treatment and to meet with regulatory requirements.
D: What are we doing about it?	Averts training has been modified to highlight preventative strategies followed by core skills. Exceptional emergency responses are delivered at the end of the trainimng with prone highlighted as an emergency response. There will be deeper scrutiny around prone interventions to determine why it was necessary to use prone holding. The Trust has invested in Safety Pods as an alternative to floor restraint, we need to ensure that the culture around the use of pods is positive and that any negative language and terminology is challenged byall staff within the organisation. The safety pod should not be viewed as a Deltoid RT chair, and NG tube chair or a restraint chair. The item is designed to be integrated into existing units as a self-soothing de-escalatory appliance that can also be used for holding.
E: What do we expect to happen?	we should start to see a sustained improvement in the number of Prone restraints as the odifications to AVERTS training are rolled out and embedded within the organisation. As staff attend their training annually, there will be a 12 month lead in for all staff to have received the modified training. The changes to training are compatible with existing training with the focus around standing, seated and safety pod interventions. there should be an improvement in the number of reported prone interventions.
F: How will we know when we have addressed issues?	When we see a sustained reduction and improvement in the number of reported prone interventions. There should be a decrease in restraint related injuries and improved service user and staff experience. This can be measured through service user questionnaires, Participation and experience team feedback and staff survey results.

Number of Prone restraints for more than 10 minutes

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2026

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Trust

Divisions

Services

Commentary

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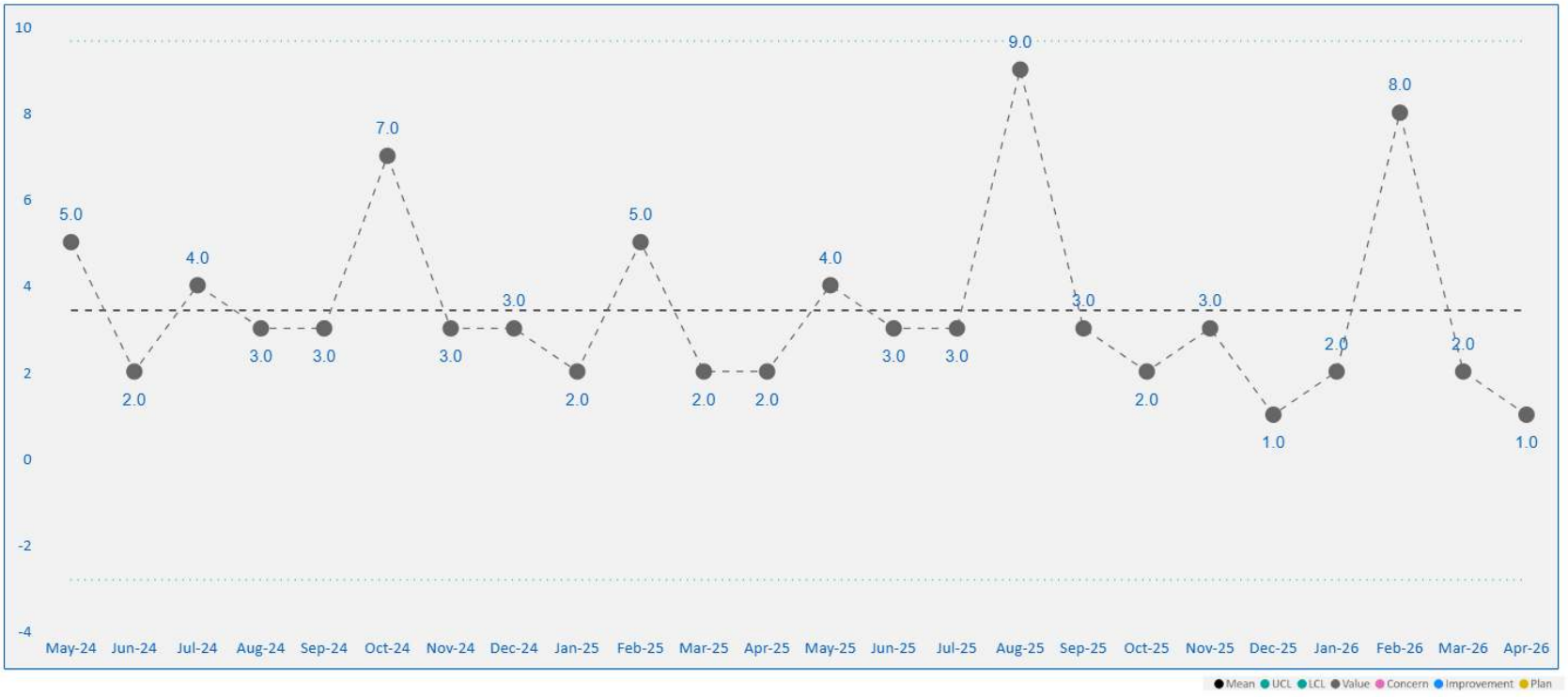

Question	Answers
A: What has happened?	Random variation in the data but an improvement on month. 1 prolonged restraint incident for the month of April, 25 mins duration. Service user in SCOH was managed by staff and had the Soft Restraint System (mechanical restraint) applied to assist with relocation to a purpose built seclusion facility and to prevent the need for further prolonged prone intervention.
B: Why has it happened?	Escalating situation where staff were attempting to prevent a service user from self harming.
C: What are the implications and consequences?	If staff hadn't intervened the service user may have been successful in their attempts to self-injure. SRS was utilised in an attempt to reduce the length of time prone holding was utilised. The situation was an exceptional emergency event where the use of prone was unavoidable and the application of MR was justified. The incident should be discussed and reviewed in local patient safety panels to see if there is any learning to be shared and disseminated and appropriate preventative strategies identifed to prevent future incidents.
D: What are we doing about it?	Changes to AVERTS training and philosophy supporting Restrictive physical interventions. Review of incidents in local RRP meetings. Escalations through RRPSG. Identified workstreams for reduction of prone interventions. Deep dive into prolonged prone interventions. Looking at Trustwide PBS strategy.
E: What do we expect to happen?	Prolonged incidents should be an exceptional emergency event that are reviewed in local patient Safety panel meetings and where approipriate subject to PSIRF review. The number of prolonged incidents should reduce over time as RRP strategies and oversight are implemented across the organisation.
F: How will we know when we have addressed issues?	Improved incident data detailing sustained improvement. Improvement in service user and staff experience. Improvements in friends and family feedback, staff survey results and restraint related injuries.

Safeguarding Incidents

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

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Trust

Divisions

Services

Commentary

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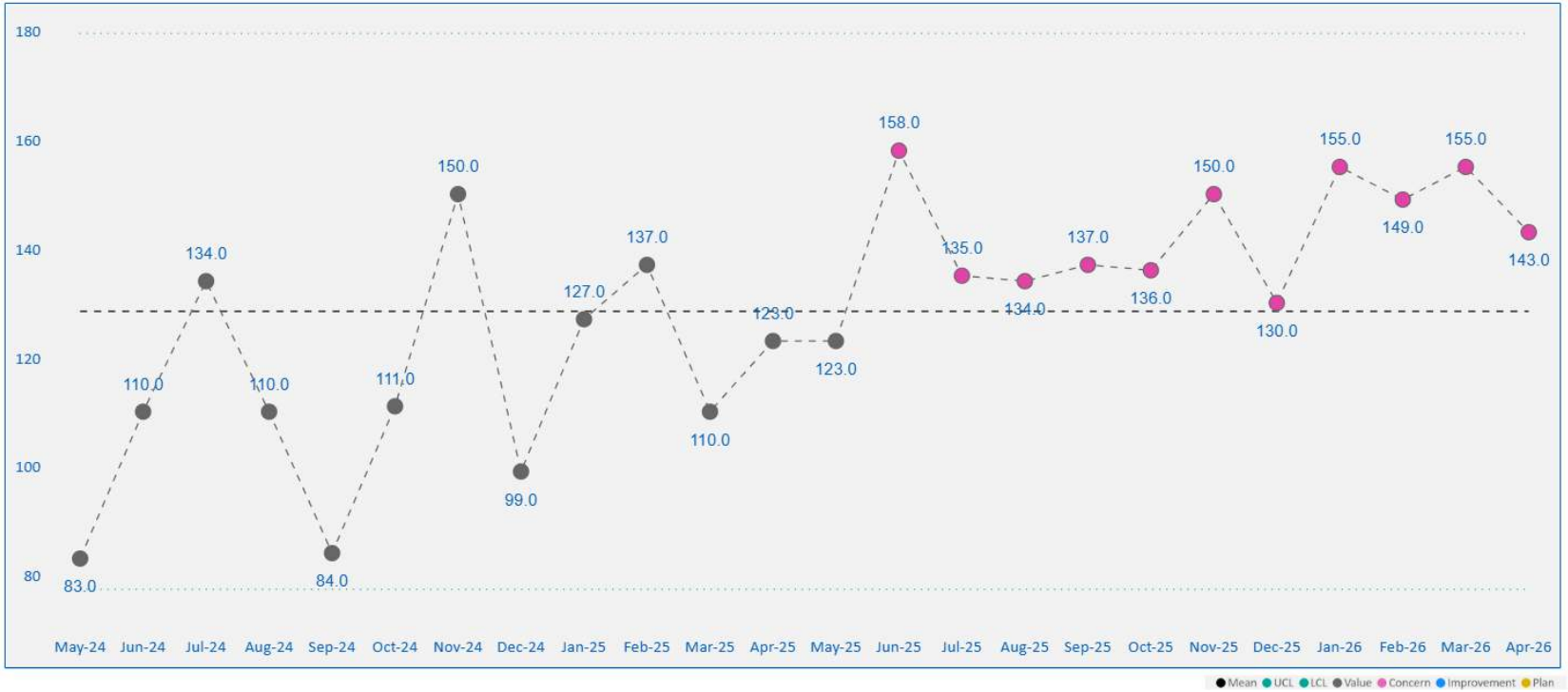


Safeguarding Incidents

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

All commentary is for Trust-level only

Question	Answers
A: What has happened?	Of the incidents evaluated, 51% related to staff making a safeguarding referral (26 children, 31 adults). Form the incident narratives this demonstrates good practice by staff in identifying and responding to safeguarding concerns. There were no incidents that referenced organisational abuse or acts of omission. There were no incidents reported indicating there would be an external safeguarding review. (1) There was one tissue viability incident but no incitation of any care delivery problem. There was a patient o patient sexual assault incident on an inpatient ward. This occurred in the shower and both were on hourly observations at the time. This was reported to the police and an adult safeguarding sexual assault referral made. There has been a follow up support from the BSMHFT Safeguarding Team and a sexual safety workshop arranged. (2) There was a serious sexual and physical assault of a 64 year old woman (open to CMHT). A 12 year old boy was charged with this offence (previously open to CYP, then FTB, proceeding as a criminal matter. Child now classed as Child in Care. No multi-agency review will be called. An update on this incident isn't needed in the sections below.
B: Why has it happened?	Re sexual assault on Larimar: service user's mental state was really poor at the time. Now moved to Eden PICU. Awaiting incident investigation findings of whether risk was being managed (eg right observation level, did their mental state require move to PICU earlier, risk assessment to disinhibited behaviour) or evaluation that this wasn't something that could have been prevented.
C: What are the implications and consequences?	Implication of a vulnerable service user exposed to abuse because of failure to safety plan (if incident investigation findings indicate this).
D: What are we doing about it?	Awaiting outcome of adult safeguarding referral. Request update when investigation is completed to provide assurance and identify any wider learning.
E: What do we expect to happen?	incident investigated by Patient Safety Team. Provide safeguarding assurance or request table-top review.
F: How will we know when we have addressed issues?	When the investigation and assurance process is completed.

Harm-free Days

April 2026

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME PERFORMANCE PEOPLE QUALITY SUSTAINABILITY

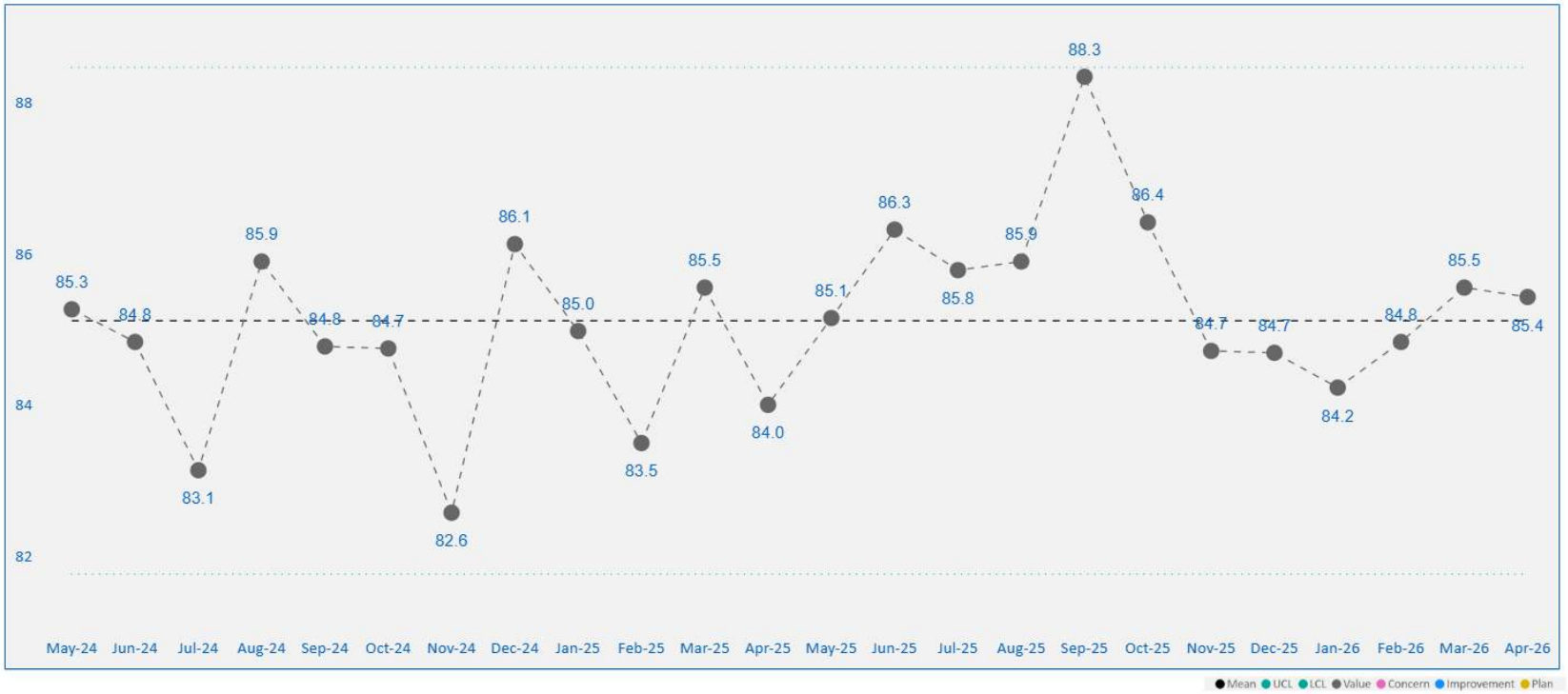
Trust

Divisions

Services

Commentary

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



Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix I FPPC 21st May 2026

NHSE 2026/27 Draft National Oversight Framework

Recommended Draft MH metrics for 2026/27

Draft Metrics in NOF 2026/27	level	Type	Status	Initial Assessment
CQC community mental health survey satisfaction rate	MH trust	Scoring	Existing	
Mean length of stay for adult acute and PICU discharges	MH trust	Scoring	Revised	Improvement plans in place
Mean length of stay for older adult acute discharges	MH trust	Scoring	Revised	Improvement plans in place
Proportion of urgent referrals to Crisis Services with first face to face contact within 24 hours	MH trust	Scoring	Existing	Improvement plans in place
Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages)	MH trust	Scoring	New	TBC
Proportion of total open CYP MH related waits that are over 104 weeks (help-based clock stop and referral spells methodology)	MH trust	Scoring	New	Currently at 29% based on local data
Proportion of adult acute discharges followed up within 72 hours	MH trust	Scoring	New	Consistent performance over the 80% national quality standard
Crude rate of MHLDA restrictive interventions per 1,000 occupied bed days (all ages)	MH trust	Contextual	Existing	TBC
Proportion of discharges with rapid readmission (within 14 days) to adult acute beds	MH trust	Scoring	New	2025/26 performance - 0%
Percentage of NHS talking therapies patients completing a course of treatment and achieving Reliable Recovery	ICB	Scoring	Existing	TBC need to have a combined view BHM at 46% in March 2026
All adult inappropriate OAP bed days as a proportion of all bed days (PICU, adult and older adult acute, rehabilitation inpatient care, Acute Mental Health Unit for Adults with a Learning Disability and/or Autism and Adult Neuro-Psychiatry / Acquired Brain Injury)	ICB	Scoring	Revised	TBC CYP data will be included with a combined trust view
The percentage of people on the General Practice (GP) SMI register receiving a full physical health check in the preceding 12 months	ICB	Scoring	Existing	Taken from GP systems
Adult acute admissions with no contact with mental health services in the prior year	ICB	System performance	New	Rolling quarter to Jan 2026 at 12%

2026/27 NOF – summary of key changes

Trust internal focus on following 5 MH Provider metrics as these can be influenced by in year action:

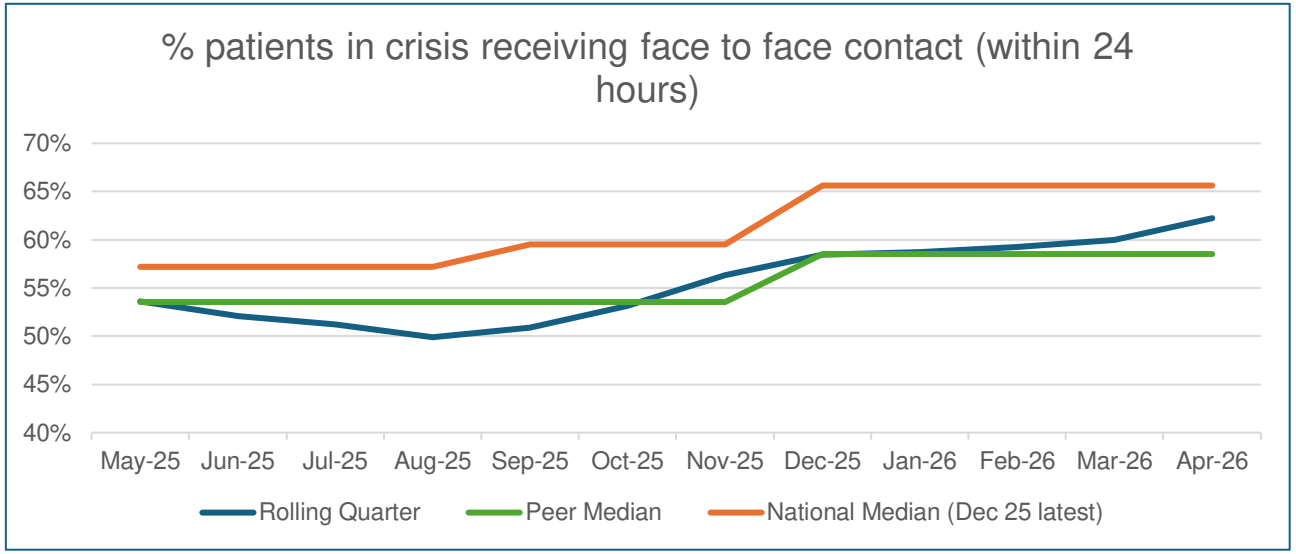
- Adult Average Length of stay on discharge
- Older Adult Average Length of Stay on discharge
- Percentage of patients in crisis to receive face-to-face contact within 24 hours
- Proportion % of total open CYP MH related waits that are over 104 weeks (help - intervention based clock stop and referral spells methodology)
- Proportion of adult acute discharges followed up within 72 hours

Confirmation of the NOF methodology for the following metrics has yet to be confirmed:

- Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages)
- All adult inappropriate OAP bed days as a proportion of all bed days (PICU, adult and older adult acute, rehabilitation inpatient care, Acute Mental Health Unit for Adults with a Learning Disability and/or Autism and Adult Neuro-Psychiatry / Acquired Brain Injury)

Recent confirmation of a national webinar on 21st May to discuss the metric specifications. There maybe updates that will lead to reviewing our current understanding on performance thresholds.

Patients in crisis receiving face to face contact in 24 hours



- Internal local Trust data shows continued improvement, with performance at 62% as at April, placing the Trust in Band 2.
- Each Trust service contributing to this measure has confirmed an improvement trajectory to be achieved by the end of Q1 2026/27 as follows:
  - CYP division 85%
  - Adult HTT to 70%
  - Combined effect of moving the Trust to 70%.
- A review of action plans will be undertaken in June to confirm the improvement trajectories from July to end March 2027 with a view to achieving Band 1 performance.
- Local granular level data reports available to teams and clinicians to enable proactive action.
- Data quality work continues to be a focus.

Performance band	4	3	2	1
Thresholds	0-46%	47-59%	60-76%	77-100%

Crisis Care 24 hour metric – Summary of CYP action plan

- Practise changes – a review of how teams respond to urgent referrals and planned visits across the day and across the city, attending visits in order from south to north to effectively manage demand and capacity. Review of practise within the CAMHS team together with impact of managing high caseload levels.
- Learning from breaches - Reasons for breach to be tracked in detail, clinical lead discussion and common themes to be circulated to teams, identify training needs/support to address gaps.
- Referral management process – further work within the teams on clarifying responsibilities for starting the internal team allocation process eg: Shift Coordinators: Record the time of referral on the crisis board and include it in the allocation sent to the crisis nurse, maintain visibility of the 24-hour timeframe, Duty/Shift Coordinator: Add a RIO entry documenting the time referral was received and Crisis Nurse to ensure the diary outcome reflects the actual time of the assessment, not the time the entry is recorded. Reemphasise that all contacts such as Trust cancellations/Patient Declines are recorded to identify why appointments did not take place.
- Accurate and timely recording of activity on RIO – i) data quality improvement plan eg ensure use of correct crisis 24 referral, outcoming activity contacts on RIO, updating referrals to capture correct date/time recorded. ii) Bank staff unable to outcome activity due to not having access to teams caseload on RIO. Validation to be undertaken to ensure activity is outcomed. iii) Weekly validation processes established.

Crisis Care 24 hour metric – Summary of Adult HTT action plan

Detailed review of 132 cases in February that did not meet the 24hour crisis timeline undertaken. Thematic patterns and systemic barriers requiring further assessment as follows:

Patient Choice: patients actively choosing appointments outside the 24 hour timeframe for reasons, in line with adopting the least restrictive approach, and in situations where risk was manageable, HTT appropriately respected patient choice. The national metric does not distinguish between patient-led delays and service-led delays.

Roles and Responsibilities: Clinical Input Requirements and Resource Availability

- Out of hours impact, doctor availability, prioritisation of urgent tasks to undertake assessments.
- Nursing assessments - caseload demands for planned and unplanned visits, travel plans across the city from base locations requiring logistical time efficient route and need to respond to emerging risk in the community.

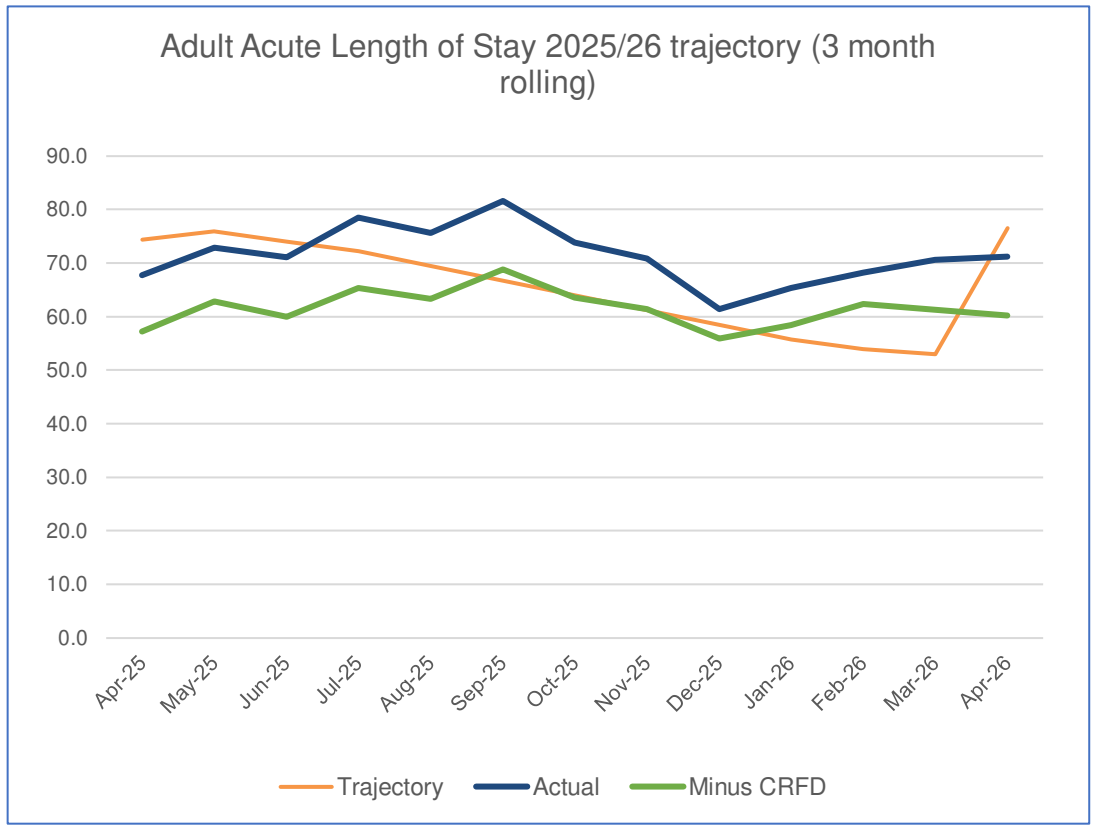
National Benchmarking – Lower Staffing Levels, Business case

Known staffing capacity challenges limiting ability to reorganise schedules at short notice, redeploy clinicians to meet revised 24hour clock times and maintain pace during high-demand periods.

Balancing acute risk with continuing care obligations, operational complexity reducing flexibility in managing available staff capacity to support delivery.

Q1 action focusing on accurate and timely recording of activity on RIO – routine validation process established, correct errors in referral urgency; and assign referrals to a 24–72 hour urgency in line with the national urgency classification after full screening.

Mean length of stay for adult acute and PICU discharges – based on Planning submission metric



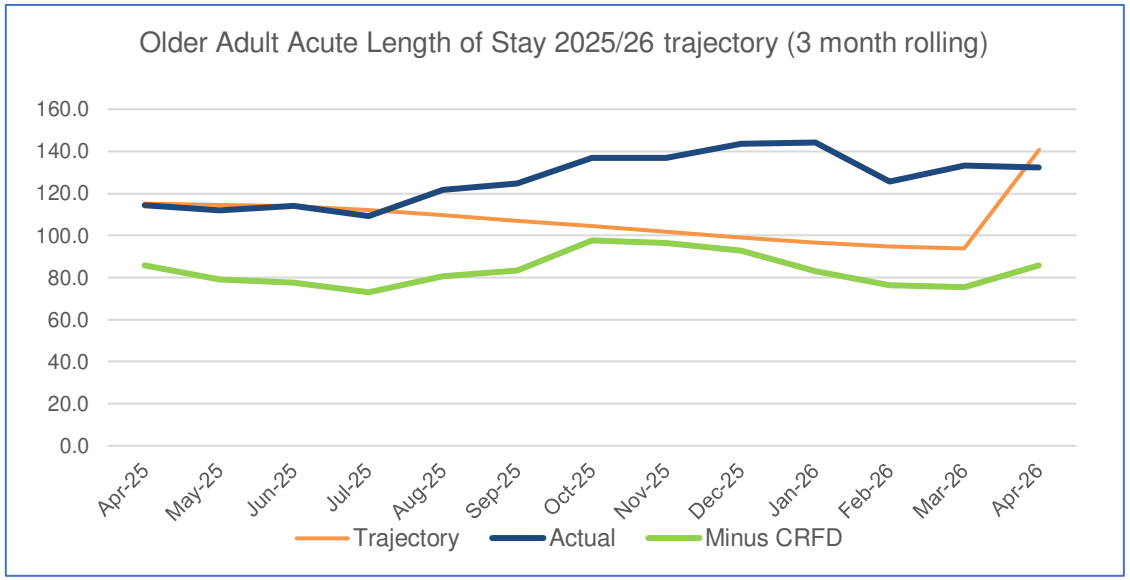
- As at April 2026, the 3-month rolling average for LOS is at 71.2 days, below the trajectory
- CRFD impact on LOS remains a continuing challenge - see chart.
- Regular tracking of progress of actions being managed by the weekly Patient Flow LOS Steering Group chaired by the AD for Acute & Urgent Care.
- Includes ward level deep dives on individual patient LOS to enable escalation where appropriate.
- Granular level patient data provided to support operational and clinical oversight.
- Forecast for Q1 – Trust will remain in performance band 4 without a step change including a reduction in CRFDs.

Performance band	4	3	2	1
Length of Stay thresholds	66+	50-65	37-49	0-36

% Adult (18-64 yrs) Acute discharges with LoS >60 days – key actions

- An action plan has been developed by the Acute and Urgent Care Service and includes pathway-based actions of support from CMHTs and Rehabilitation services.
- A weekly Patient Flow Group is in place including clinical and operational leads to review detail plans at ward level including deep dives in to long stay patients at ward level.
- Trust Leads including the Director of Operations and the Medical Director met with Birmingham Local Authority Social Care leads on the 13th April 2026 to discuss the impact of LA delays on patient experience with the extended length of stay also impacting on reducing Trust capacity resulting in out of area placements and challenges in meeting national length of stay targets for adult and older adult acute inpatient services.
- Action agreed includes escalation of patient details where Birmingham Local Authority action is required to support discharge.

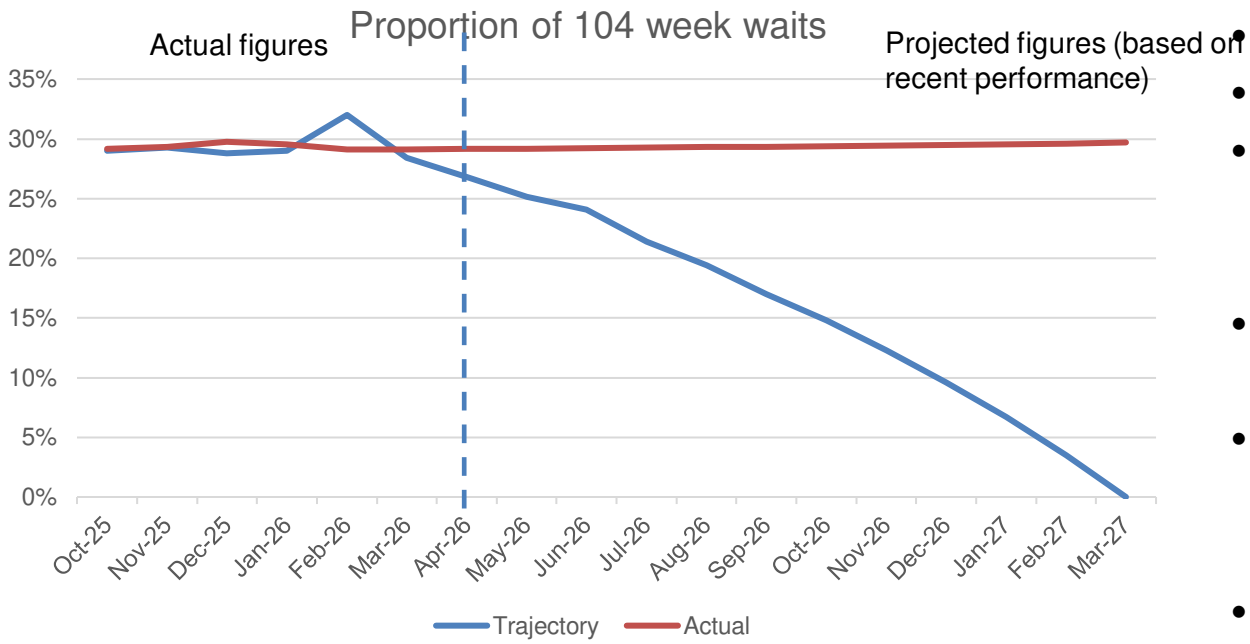
Mean length of stay for older adult acute discharges – based on Planning submission metric



- As at April 2026, the 3-month rolling average for LOS is at 132.4 days, below the trajectory.
- CRFD impact on LOS remains a significant challenge - see chart, the majority of the CRFD patients are waiting for a bed within a care home.
- A regular list of the CRFD patients is being shared with the Local Authority to support discharge discussions.
- Granular level patient data provided to support operational and clinical oversight.
- Forecast for Q1 – Trust will remain in performance band 4 without a step change including a reduction in CRFDs.

Performance band	4	3	2	1
Length of Stay thresholds	126	94-125	68-93	0-67

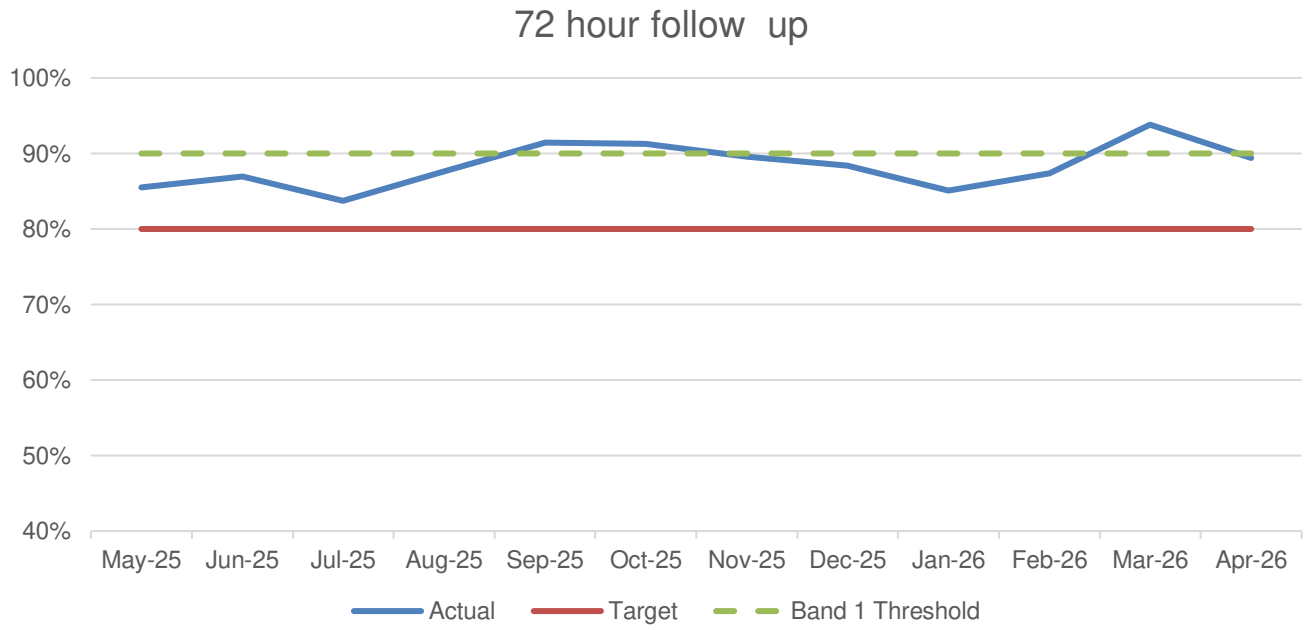
Proportion % of total open CYP MH related waits that are over 104 weeks (help -intervention based clock stop and referral spells methodology)



Performance band	4	3	2	1
Thresholds	30%+	12-29%	6-11%	0-5%

- The planning guidance methodology is based on achieving a reduction in numbers waiting over 104 weeks and the NOF metric is based on the proportion.
- 2025/26 baseline position of 1085 service users.
- BSMHFT target is to achieve 0 by end March 2027.
- As at April, we have 941 patients waiting over 104 weeks (CYP at 703 and Solar at 238), representing 29% of all waits placing the Trust in band 3.
- Regular patient level reports are shared with services to support operational planning and oversight.
- CYP division have regular meetings with managers to review the lists outstanding and to highlight any issues preventing improvement.
- National reporting on this metric will be affected by non inclusion of data prior to the CYP transfer in July 2025 due to the break in MHSDS submissions. The impact will reduce over time.

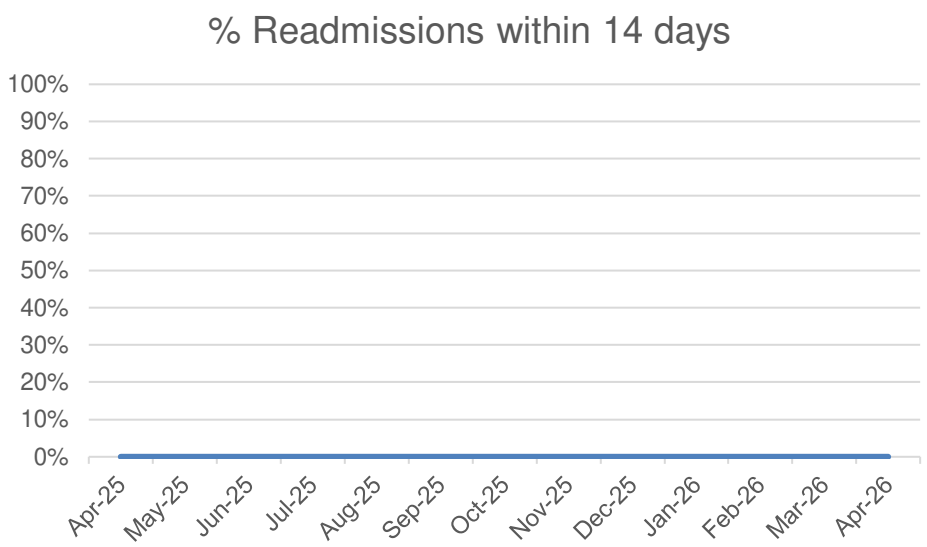
Proportion of adult acute discharges followed up within 72 hours – based on Local data



Performance band	4	3	2	1
Thresholds	0-69%	79-79%	80-89%	90+%

- Daily automated reminders are sent to services to highlight patients who have been discharged to support proactive planning of diaries to see patients.
- The Information Team routinely supports operational teams with addressing data quality and recording issues in RIO. Incorrect recording adversely impacts on percentage compliance figures.
- Supporting guidance on completing the recording of 3 day follow up has been produced and shared with teams and is also accessible via the Intranet.
- Compliance has been consistently in the 80-89% bracket – Band 2 level.
- Forecast performance for Q1 is band 2.

Proportion of discharges with rapid readmission (within 14 days) to adult acute beds



- The chart shows that the Trust maintains a high level of compliance with this measure, with zero readmissions in 2025/26 maintained for April 2026.
- Current Forecast Trust performance - band 1

Performance band	4	3	2	1
Thresholds	16-100%	11-15%	6-10%	0-5%

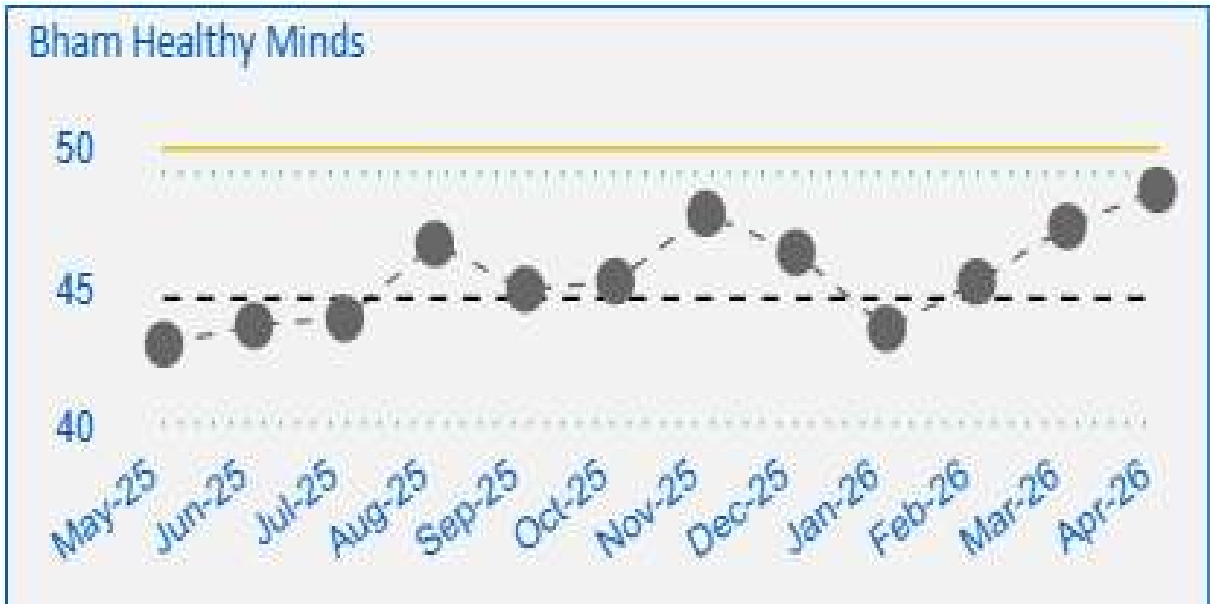
Draft ICB level MH metrics

1. Percentage of NHS talking therapies patients completing a course of treatment and achieving Reliable Recovery
2. Adult acute admissions with no contact with mental health services in the prior year
3. All adult inappropriate OAP bed days as a proportion of all bed days (PICU, adult and older adult acute, rehabilitation inpatient care, Acute Mental Health Unit for Adults with a Learning Disability and/or Autism and Adult Neuro-Psychiatry / Acquired Brain Injury) ***NOTE – methodology TBC***
4. The percentage of people on the General Practice (GP) SMI register receiving a full physical health check in the preceding 12 months

- For metrics 1 to 3, BSMHFT activity performance will contribute to the ICS position and will also be reviewed internally for progress and action planning to support the ICB position.
- For metric 3 the national methodology has yet to be confirmed.
- For metrics 1 and 2 above, Trust performance is outlined in slide 14 and 15 below.

Birmingham and Solihull Mental Health NHS Foundation Trust

ICB metric - Percentage of NHS talking therapies patients completing a course of treatment and achieving Reliable Recovery

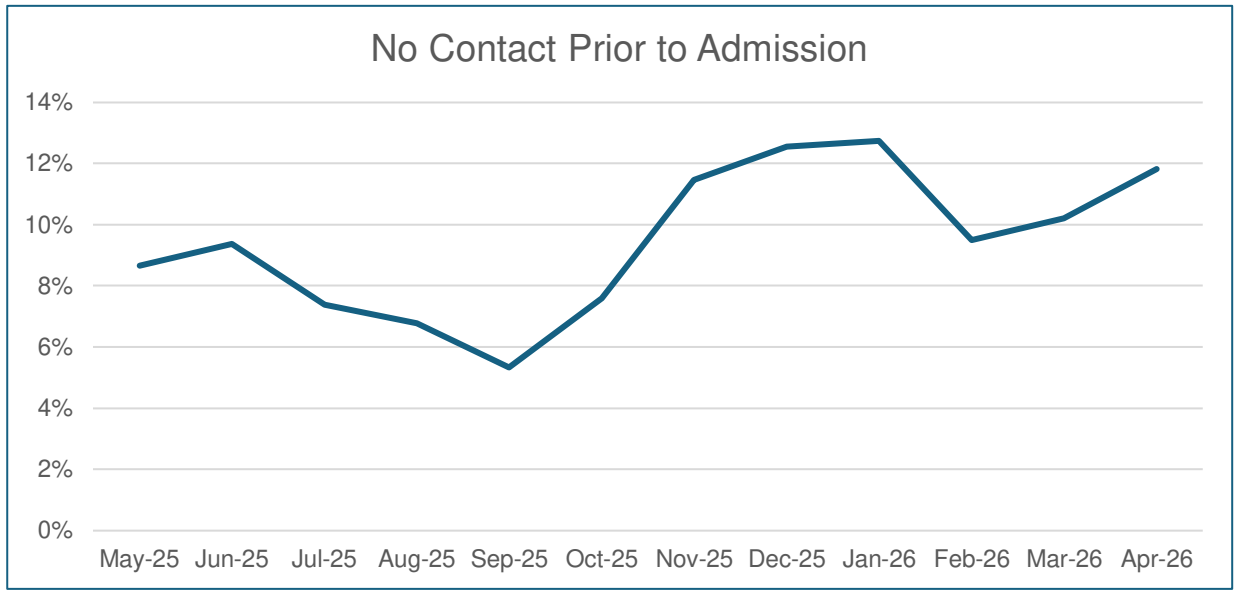


Performance Band	4	3	2	1
Thresholds	Below 48%	48-50%	50-51%	>51%

BSMHFT position:

- The national standard is 51%.
- Since January Trust performance has been on an improving trend but April 2026 performance at 44.8% remains below the national standard.
- FPPC is aware that a recovery action plan is in place to address shortfall in overall performance.
- Current Trust performance forecast - band 4.

ICB MH metric - Adult acute admissions with no contact with mental health services in the prior year



Performance band	4	3	2	1
Thresholds	16-100%	11-15%	6-10%	0-5%

Methodology:

- Denominator based on admissions to adult acute, PICU or older adult beds
- Numerator based on patients who did not have an appointment with BSMHFT in the 12 months prior to admission
- Rolling 3 month view.
- BSMHFT performance - Rolling quarter to April 2026 at 12%.
- Forecast Trust performance - band 3

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix III - FPPC 21st May 2026

2026/27 Performance metrics Improvement Trajectory updates

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

The 2026/27 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 3 year improvement trajectories commencing 2026/27 using previous years as a baseline for improvement. The same methodology is planned to be used in the NOF assessment for 2026/27 on these measures.

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

Adults

- 5% improvement (on average across the year) by the end of the year compared with the NHSEs June - August 2025 national baseline data.

Older Adults

- 12% improvement (on average across the year) by the end of March 2027.

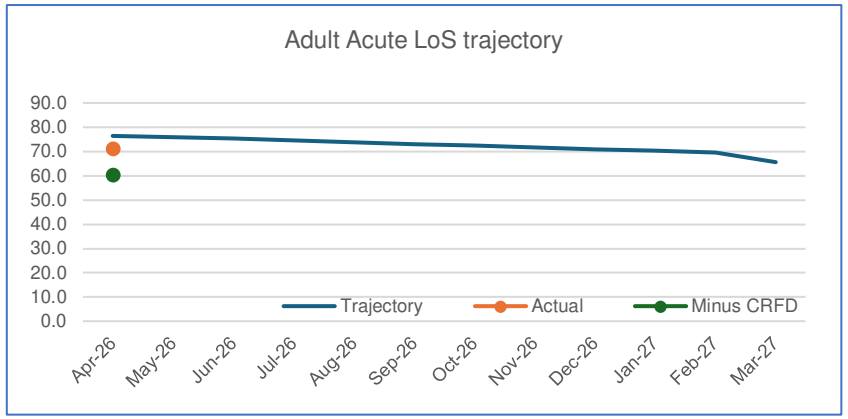
NHSE methodology – Factors to note:

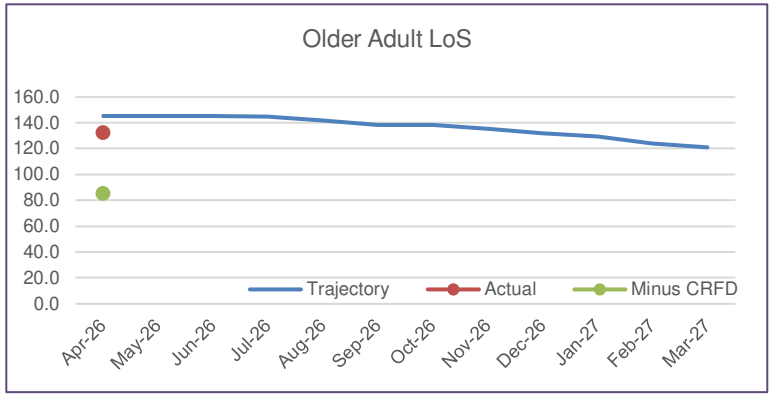
- As the methodology is based on discharge, discharging service users with long lengths of stay will have a negative impact on performance against trajectory.
- Achieving significant length of stay reductions on this methodology will require more discharges of people with longer lengths of stay during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

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 2026/27 Length of Stay Reduction Trajectories



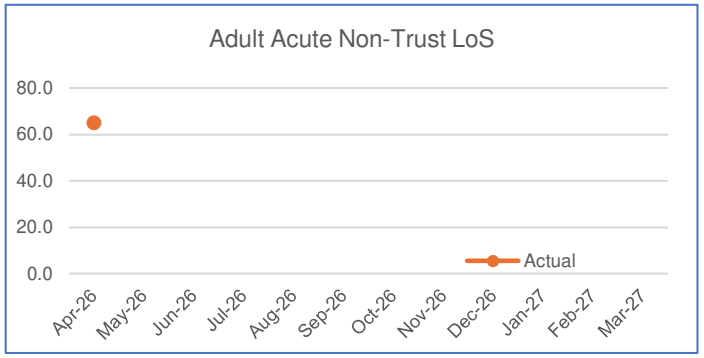


The Trust's 3-month rolling length of stay against the 2026/27 Planning submission trajectories show that both service areas are below April's trajectory. Factoring in the impact of CRFD indicates that Trust performance would see a greater improvement and reduction in LOS in both services.

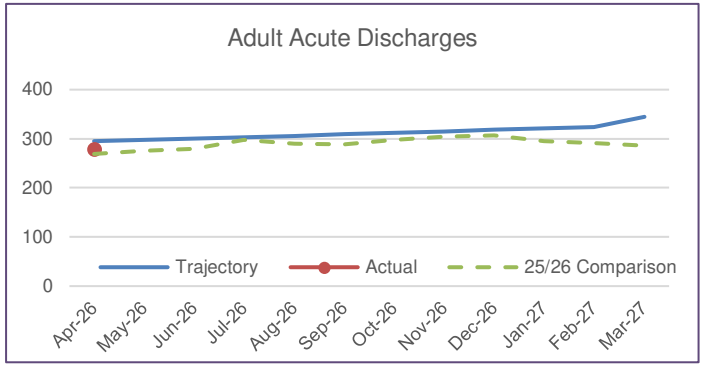
NHSE Methodology: Based on:
- Discharged patients
- Rolling 3 month view
- Entire inpatient spell
- Adult, older adult, CYP and BSMHFT non-Trust spells are separate
- Includes leave

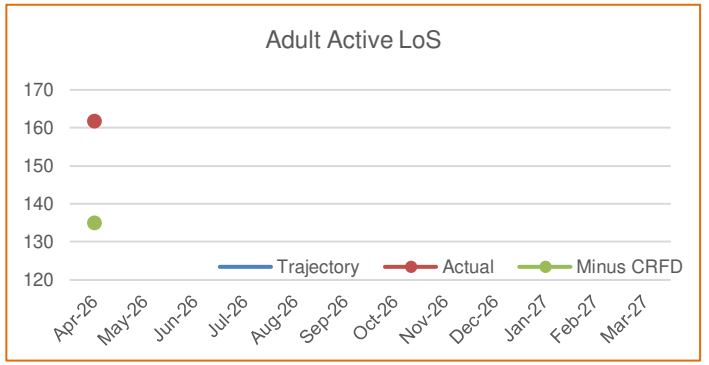
On NHSE measure, discharge of long stay patients will impact negatively on the agreed trajectories in the short to medium term and once LOS improvements are achieved routinely with a reduction in longer lengths of stay, this impact will reduce over time.

Adults/ Older Adult LOS – additional views

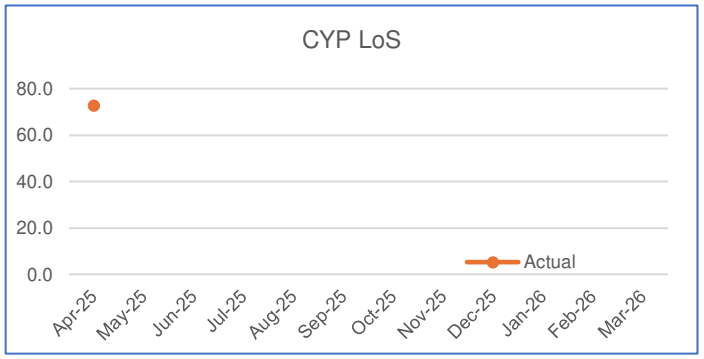


length of Stay- 3 month rolling based on discharge

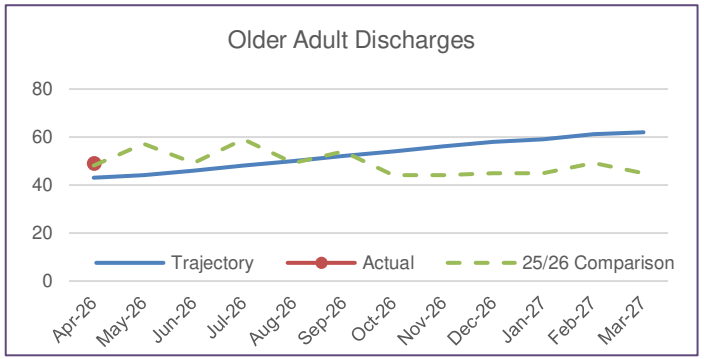


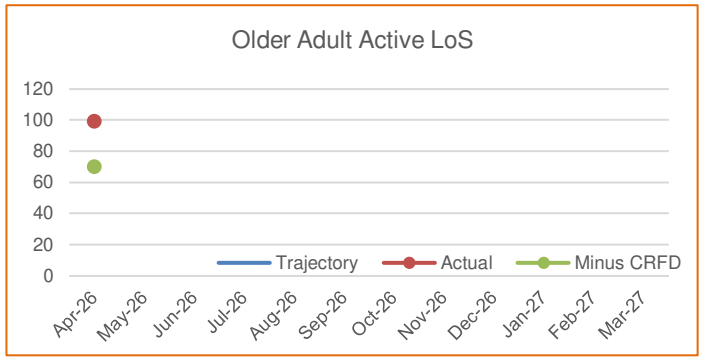


Current length of Stay- month end figures



length of Stay- 3 month rolling based on discharge





Current length of Stay- month end figures

CYP LOS data is based on private beds only.

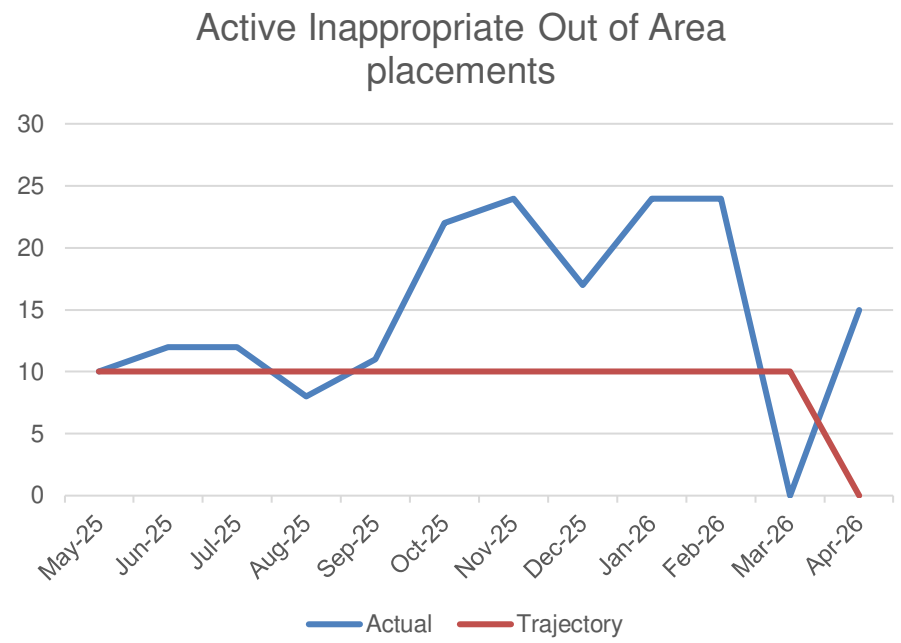
'Active' Current LOS based on entire inpatient spell, including leave, at each month end.

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Action plan updates and trajectories for improvement in 2026/27 have been provided by the relevant KPI owners. Please see below.

Active Inappropriate Out of Area Placements



The Trust trajectory agreed with NHSE as part of the 2026/27 national planning requirements are to maintain zero acute and PICU inappropriate 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) has been finalised and agreed on the 30th March 2026 by NHSE to support the classification of these placements as being 'appropriate'.

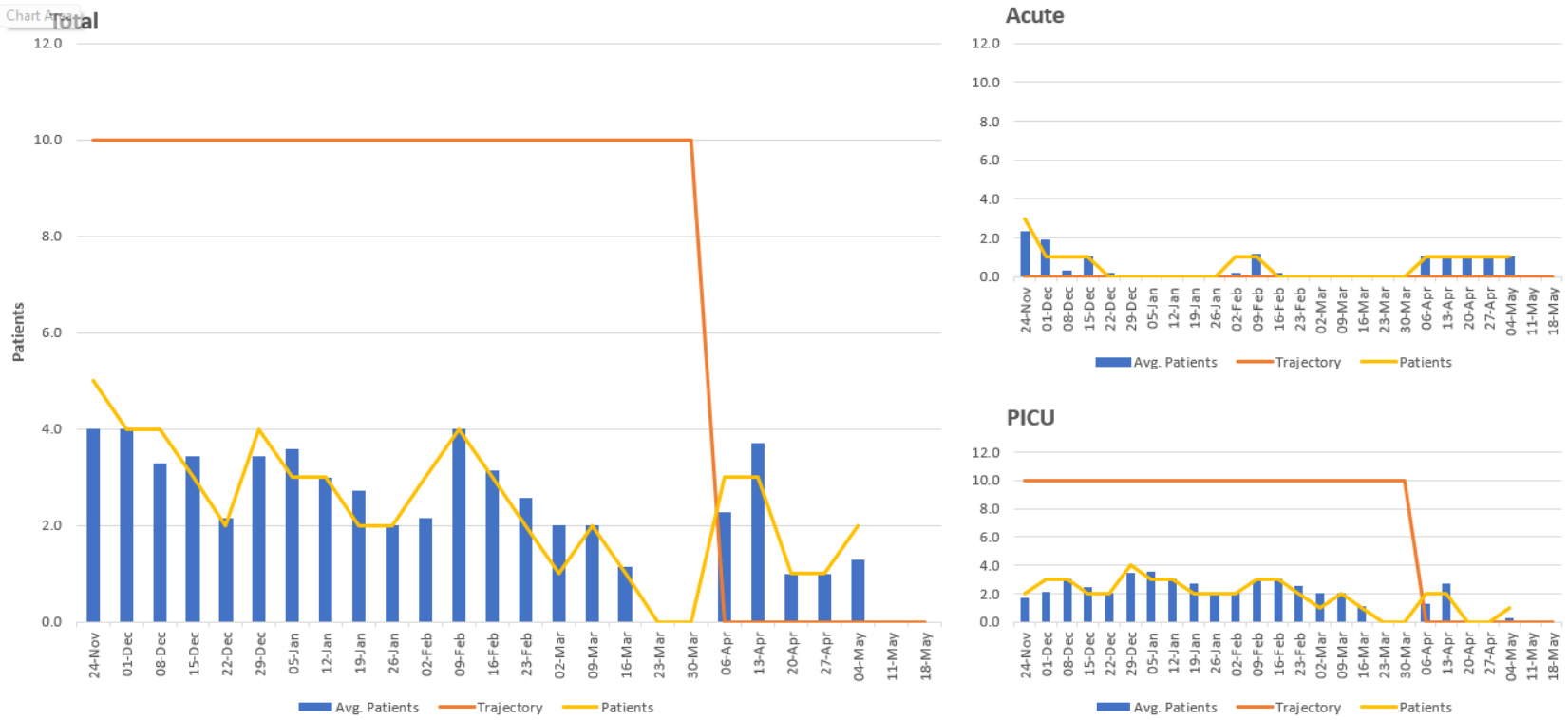
April 2026 position

At the end of April there were 15 'inappropriate' out of area placements above the NHSE agreed target of 0. **Adults** – 1 acute and 2 PICU, **CYP** 12 acute. Plans are in place to discharge or repatriate a number of the 'inappropriate placements'

The Trust's productivity action plan continues to focus on reducing all out of area placements with workstreams focusing on demand management, reducing CRFD patients, optimising services within available resources and positively impacting on patient experience as an outcome.

Slide 7 and 8 below highlights the weekly progress being achieved, being 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, and overall CRFDs have increased to 14.13% (from 13.2%) reducing overall flow within adult acute beds.

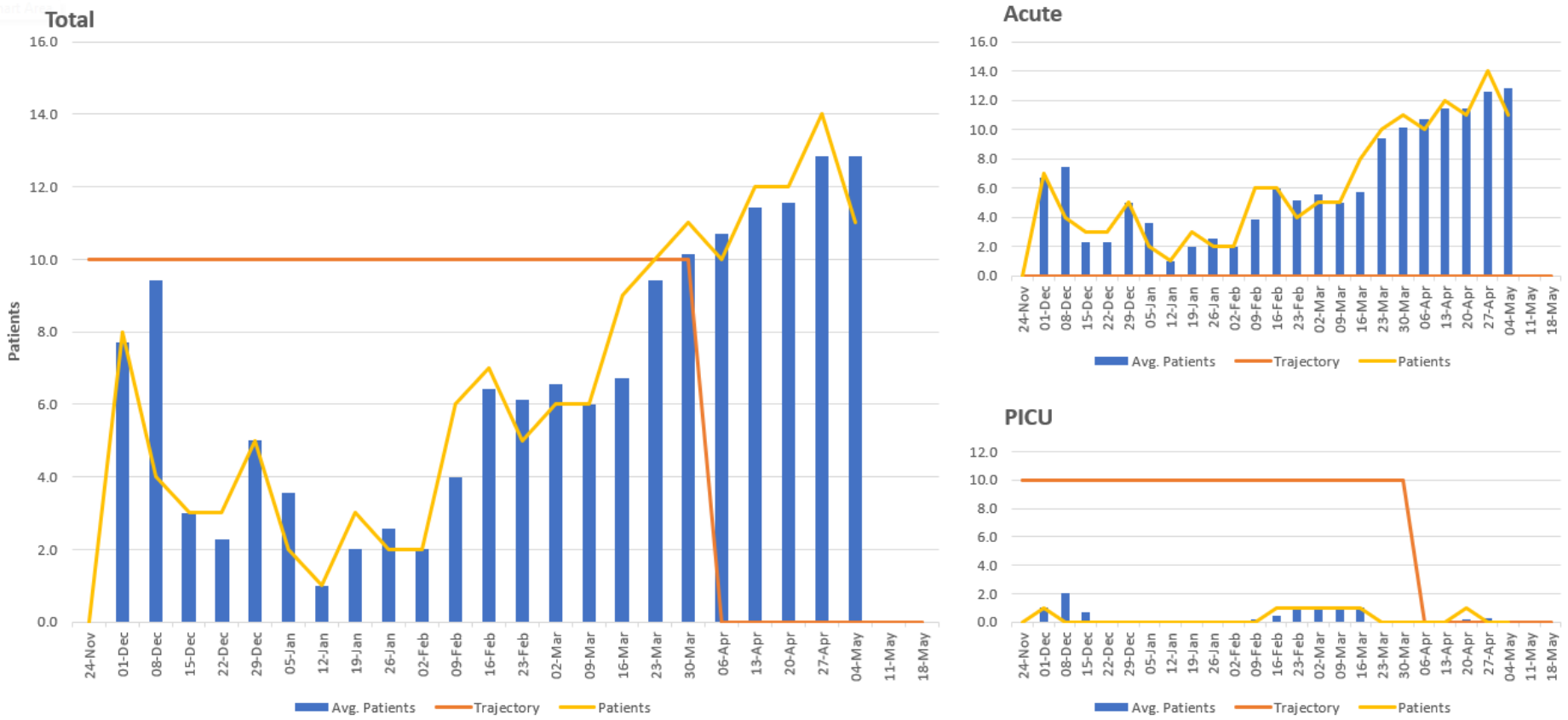
Inappropriate Out of Area Placements - Adults



Admissions to Cygnet hospitals are now being classified as ‘appropriate’ in line with the SOP which has been approved by the Mental Health Provider Collaborative.

Slides 9 below outlines a summary of key actions from the Adult Acute & Urgent Care productivity plan for Q1.

Inappropriate Out of Area Placements - CYP



CYP had a sudden increase in admissions in March which remained in April and resulted in people being placed out of area especially for female beds.

Q1 2026/27 Productivity Plan Update

Admission avoidance

Goal: Ensure admissions are appropriate and alternatives are considered.

- Deep Dive on Early Intervention Admissions: Conduct a deep dive analysis on all early intervention admissions to understand why more first episode patients are being admitted.
- Convene a discussion with Responsible Clinicians and relevant medical colleagues to review/ address the use of Section 17 leave versus Community Treatment Orders (CTOs)—particularly the impact on length of stay data, recall/admissions.

Inpatient Care & Reducing Length of Stay

Goal : Increase timely discharges and reduce delays in discharge

- Pilot Red2Green Model on 2 wards – to drive daily progress towards discharge- extend to a further 2 wards
- Compare and align CRFD (Clinically Ready for Discharge) lists for learning disability and autism patients.

Discharge Planning and Support

Goal : Increase timely discharges and reduce delays in discharge and active use of data to inform reporting and decision making

- Audit of estimated Discharge date to ensure accurate and timely recording to inform proactive discharge planning
- Review MDT discharge decision timing and work jointly with pharmacy to establish an escalation or fast-track process for same-day TTOs, particularly where discharge decisions or medication changes occur late in the day, with the aim of reducing avoidable next-day discharge delays.

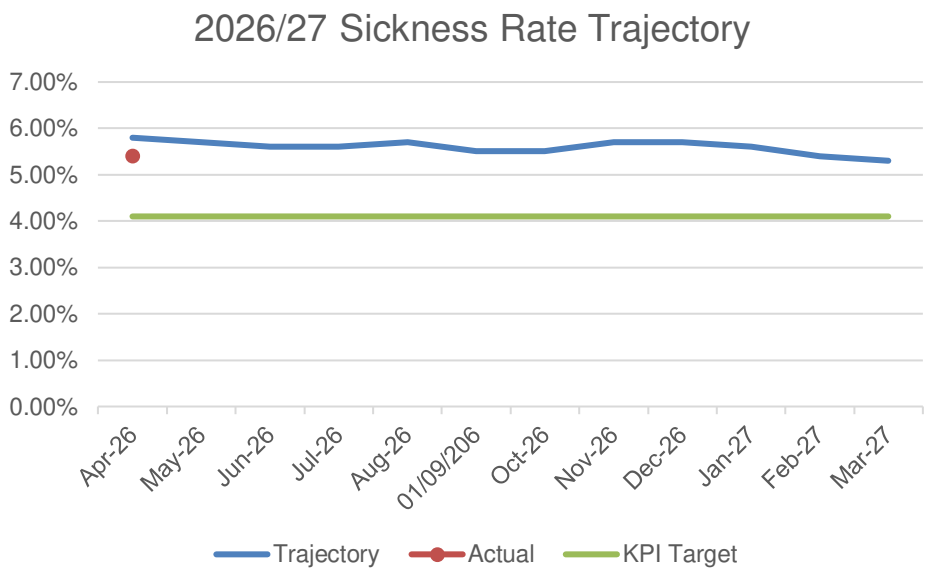
NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce trajectories – 2026/27 update.

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

Sickness Absence

Updated 2026/27 Sickness trajectory in line with the workforce plan



The 2026/27 Trust trajectory is to reduce sickness levels by 0.5% reaching 5.3% by March 2027.

April 2026 at 5.4% a reduction from last month of 5.9%, below the trajectory of 5.8% for April

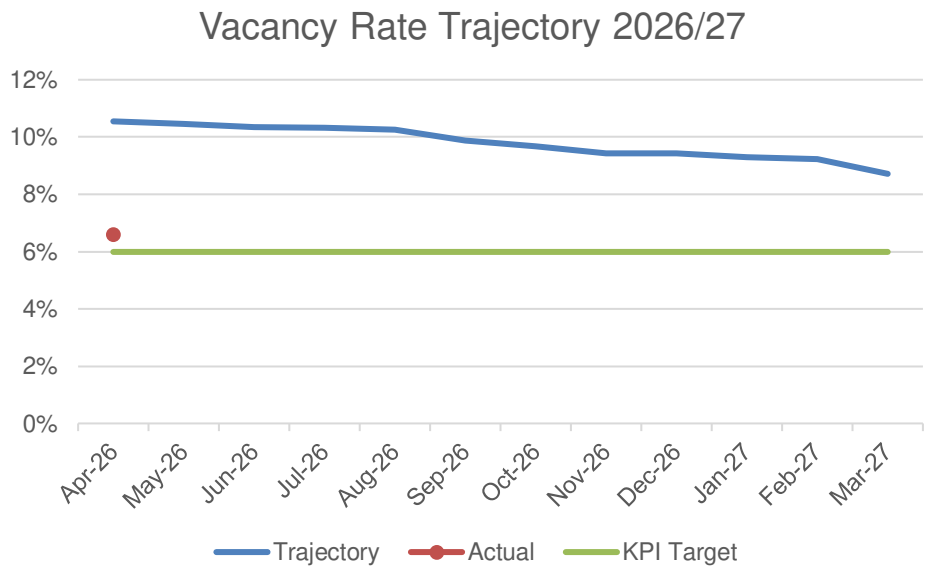
Action Plan:

- Return-to-Work (RTW) meetings after every sickness episode (recorded on the RTW form) within 7 calendar days, with OH referral considered for long-term absence, >28 days.
- Growing use of trigger/insight views to spot repeat short-term absence (e.g., 3+ episodes/12 months; 8+ days/12 months) and focus on hotspots, reasons, and missing RTWs.
- Targeted support and action planning in place to prioritise mental wellbeing support and early muscular skeletal intervention /ergonomics to reduce long-term cases.

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

Vacancies

Updated 2026/27 vacancy trajectory in line with the workforce plan



The target to reduce the vacancy rate for 2026/26 is based on a reduction of 1.8% to reach 8.71% by March 2027. The KPI target is 6%.
April at 6.6% below the April trajectory of 10.55%

The Directorates Projects team and Recruitment team have been working together to improve the trust's overall time to hire (measuring from vacancy approved until all recruitment checks complete). This timeframe to completion has dropped significantly from approaching 100 working days at the start of the 2025/26 financial year to 54.7 working days currently, enabling vacancies to be filled more quickly and creating safer staffing levels. As a result, the target has been reduced going forwards to between 40-50 working days. Within the current 57.3 working days taken to complete the overall time to hire, time taken to complete shortlisting (in working days) has reduced from 12 to 7.1 and the time to complete Occupational Health checks has reduced from 23.5 to 14.9 working days – these have been the 2 areas of the teams' focus since November 2025 to date.

Note – 2026/27 trajectory approved by People Committee and commentary provided by People team

Vacancies

Action Plan update cont:

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 (no international recruitment in 2025/26), multiple offers have been made, again with them being manoeuvred into our vacancies successfully.

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.

Vacancies

Action Plan update cont:

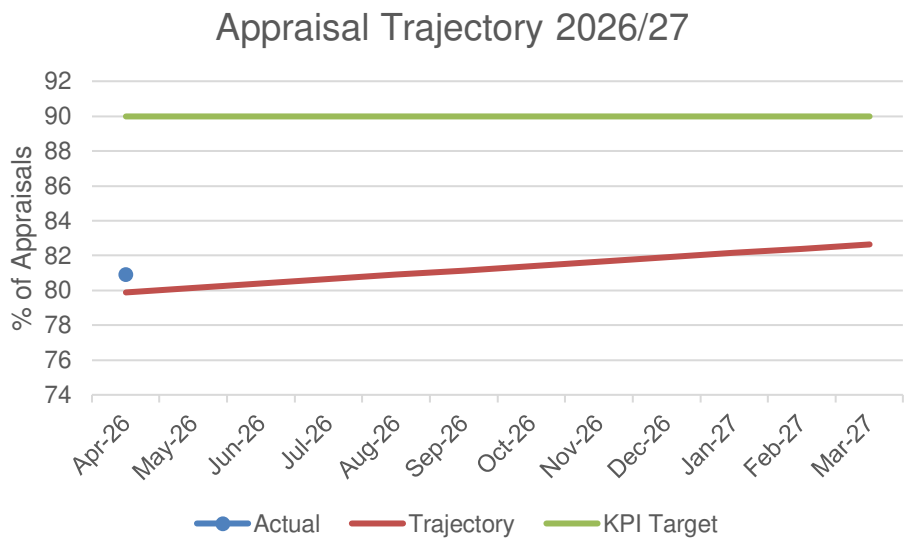
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- 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 May 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 2026/27 Appraisal trajectory



The 2026/27 trajectory is to increase appraisal performance as a minimum by 2.75% moving from 79.9% in April 2026 to 82.65% by March 2027.

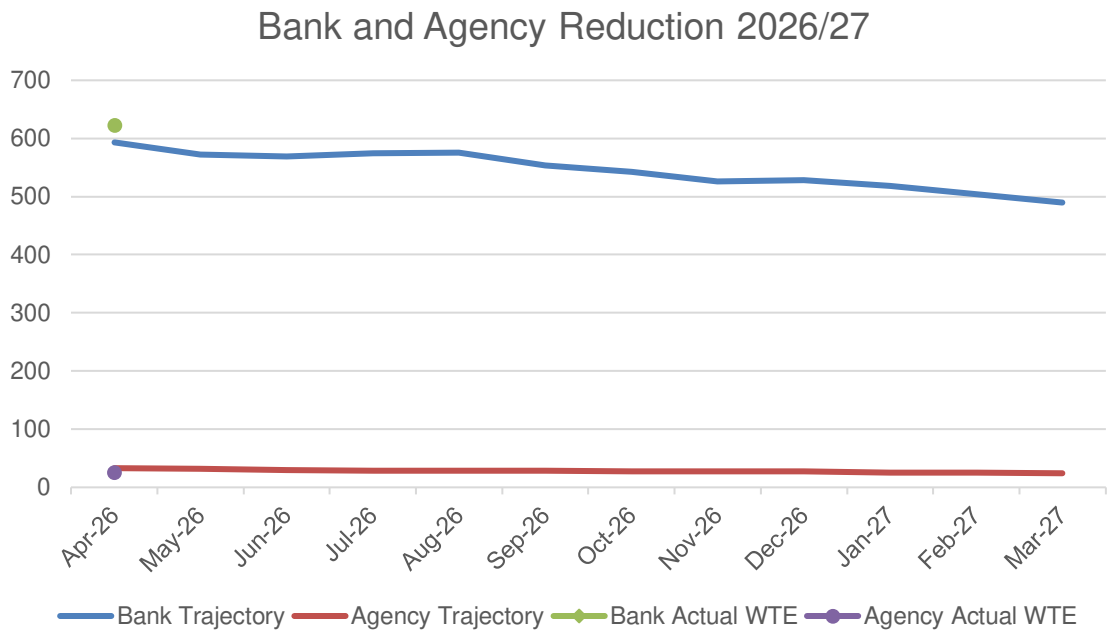
April 2026 at 80.9% above the trajectory of 79.9% for April.

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

- Continuing current practice to raise compliance and Monitoring.
- Additional VBA training dates scheduled.
- we continue with targeted to work with those teams with low compliance.

Note - Trajectory agreed by people team Leads and TBC by the People committee . commentary provided by People team leads

Bank and Agency Reduction



The focus for 2026/27 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 103 WTE and 8.5 WTE in agency workers by March 2027.

Bank at 622.9 WTE in April above the trajectory of 592.9 WTE for April
Agency at 24.8 WTE below the trajectory of 32.96 WTE for April

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability

Monthly Agency costs

- A detailed agency reduction programme mentioned above is in progress working in conjunction with ICB / NHSE policies and restrictions and the Midlands and Lancashire CSU. Two areas of renewed focus are the expediating of the TSS bank workers to substantive process and the finishing of agency block bookings. Currently all HCA agency requests require Exec approval. The NHSE Midlands above cap improvement workgroup requirements ensured that all agency standard nursing bookings were fully compliant with cap rates as at the end of January 2025.
- As mentioned above, the TSS function has gone live with NHS Professionals – who have considerably less charge rates than agency – and are transferring over high cost and long-term block bookings, which can be recorded as bank spend, rather than agency. A deadline of the end of March 2025 was given to areas to transfer over their non-medical agency block bookings and regulars to NHSP otherwise they would not be able to use them in their areas. This has also stimulated the areas to organise and put out any vacancies (either perm or fixed term) that were outstanding, plus encourage the updating of their rota's long-term, which is of course the preferred option than simply transferring agency block booking's over to NHSP.

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

- In April 10 bank workers started with the trust, helping to alleviate the need for agency.

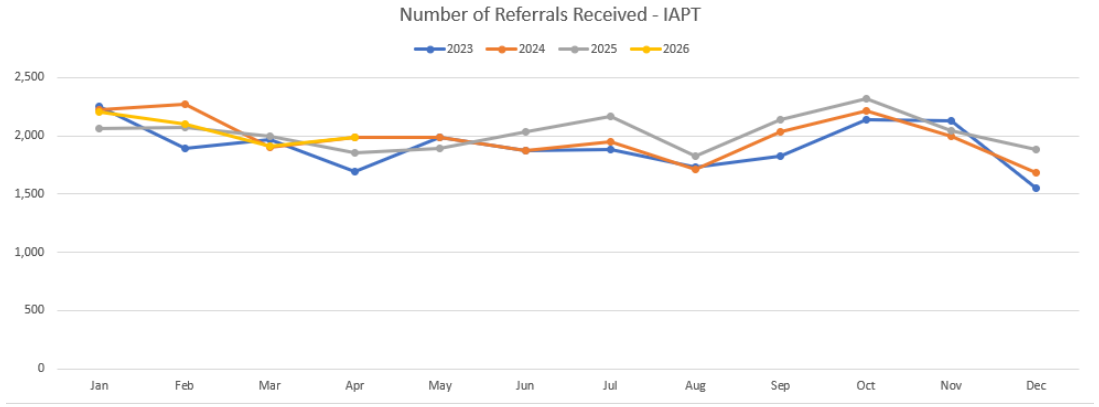
Birmingham and Solihull Mental Health NHS Foundation Trust

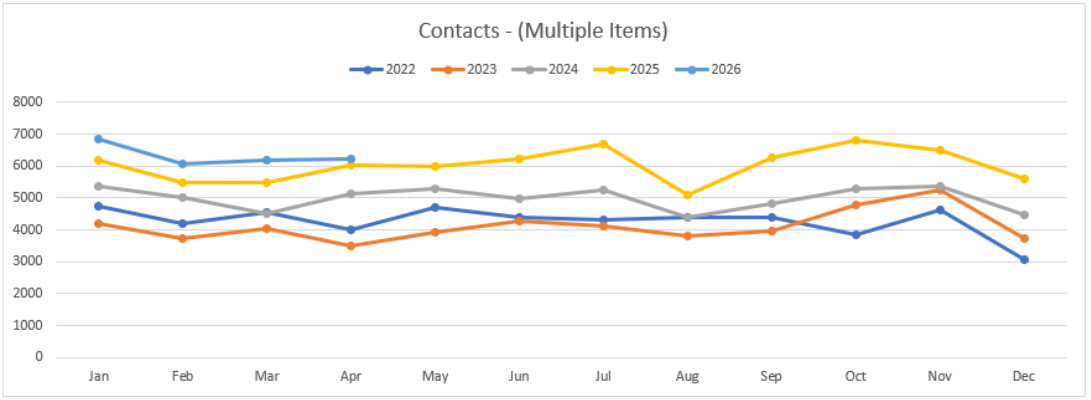
- BHM are under achieving its KPIs relating to activity and outcomes.
- Financial risks remain due to underperformance against KPI's. Placed on risk register as likely occurrence.
- Reputational risk due to non-achievement of reliable recovery target

BIRMINGHAM HEALTHY MINDS

KPI's	Mar-26	Apr-26
Completed Treatment	719	730
Completed Treatment Trajectory	811	800
Reliable Recovery Rate	47.50%	48.5%
Reliable Recovery Rate shortfall to meet 50% (51% from April 2026)	17 (patients)	18 (patients)
Reliable Improvement Rate	68.40%	69.50%
Reliable Improivement Rate shortfall to meet 68% (69% from April 2026)	0	0

NHS TALKING THERAPIES – REFERRALS AND CONTACTS

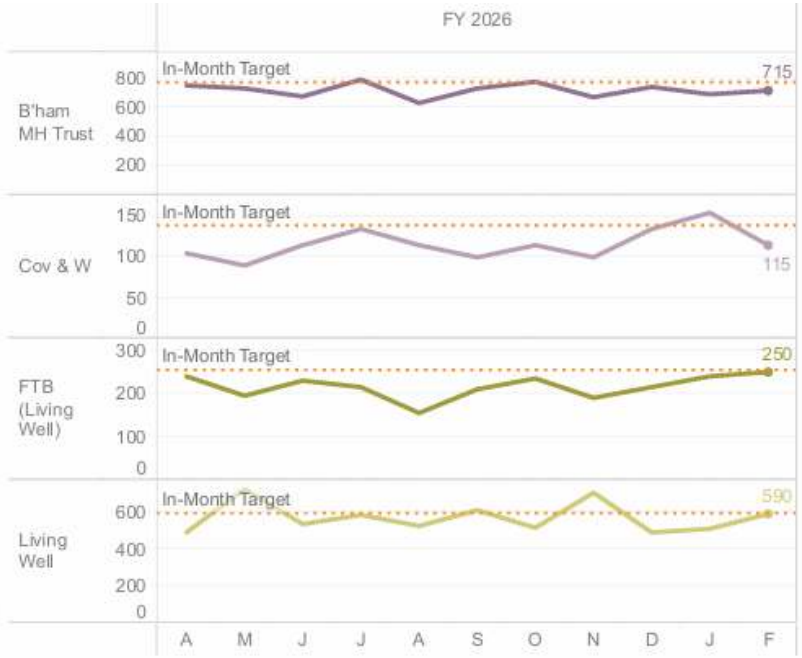




RISK AND CHALLENGES	KEY ACTIONS	LEVELS OF IMPROVEMENT
• 13 staff on improvement plans • Digital front door proposal • Recruitment underway • Team managers are managing significantly large teams • Commissioner modelling inconsistent with national tool which states that we are significantly understaffed. • 3 PWP vacancies • High level of neurodivergent and long term health issues within the team • Single Therapy Session discharges – 42.7% in November 2025- reductions in last 2 months	• 8a Locality Clinical Leads to be recruited – Paper submitted to ICB • Align teams to localities • Address performance issues by working closely with HR and Organisational Development team • Recruitment to all vacancies	• Reduced activity level agreed for 2026/27 • Referrals averaged 2,025 in 2025. April 2026 at 1,988 below last years average • Contacts averaged 6,028 in 2025. April 2026 at 6,228 above 2025 average • Improving Access for Black Men 18-month project - successful bid and funding • Health Inequalities dashboard which BHM senior team worked with informatics to develop. • Power BI data tool developed to better display performance data – both manager and clinicians have access. • Temporary part time practitioner for 12-week period to focus on quality and risk until clinical lead posts progressed

NHS TALKING THERAPIES – SEEN IN 6/18 WEEKS AND ACCESS TARGET

6 – weeks –96.45% in April 2026 (currently XX%) - 18 weeks – 99.9% in April 2026 (currently XX%) - Both above trajectory and national target



2025/26
February BSMHFT (national) – YTD 86.2% of 25/26 target.
March Internal data YTD – 93.7% of target

2026/27
April internal data YTD 7.7% of target

RISK AND CHALLENGES	KEY ACTIONS
• Consistent achievement of both 6 and 18 weeks target.	• Triage process to be streamlined further

DNA RATES
April – April 2026

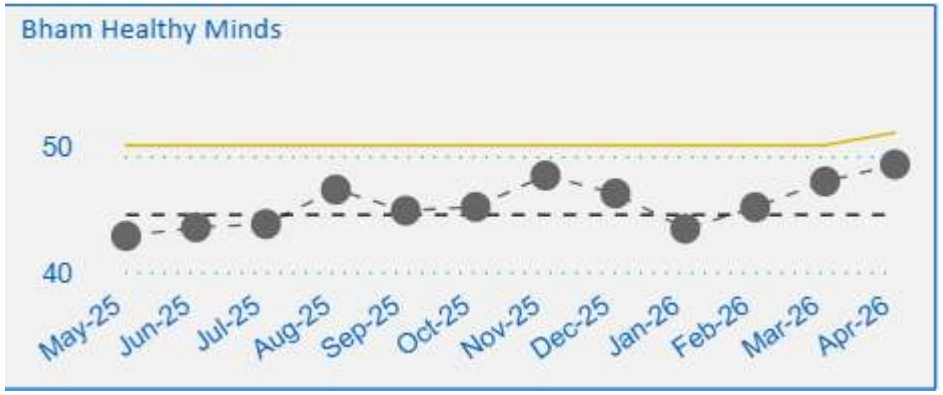
DNA rate by step

Step\	April 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
1	15%	17%	17%	16%	16%	14%	15%	13%	14%	14%	15%	14%	14%
2	14%	13%	15%	15%	12%	18%	13%	15%	14%	17%	12%	11%	12%
3	8%	9%	10%	8%	7%	9%	8%	8%	7%	11%	6%	6%	6%
Overall	12%	12%	13%	12%	11%	13%	11%	11%	10%	11%	10%	10%	10%

RISK AND CHALLENGES	KEY ACTIONS	LEVELS OF IMPROVEMENT
• Ability to achieve a 10% DNA rate • High level of patient cancellations	• Sharing DNA data as a standing agenda item within team meeting. • The use of Automated Booking System (ABS). • The use of automated text message service. • Providing link for Telephone Triage "choose and book". • DNA/cancellation policy reviewed. • Ensuring new starters have the policy as part of local induction. • Contract of expectations for therapy. Documenting this conversation on IAPTus. • Clinical contact hours – reviewing staff with a high DNA rate. • Clinicians to over book appointments where high DNA rates have been identified. • Discussion in regular management supervision about MTR rate, and DNA rate. • Use of Power BI to monitor clinicians' individual DNA rate.	• Step 3 DNA rates remain consistently low.

NHS TALKING THERAPIES RECOVERY RATES

Reliable Recovery rate [Target 51%] 48.5%



Reliable Improvement rate [Target 69%] 69.5%

RISK AND CHALLENGES	KEY ACTIONS	LEVELS OF IMPROVEMENT
• The Reliable Recovery Rate target has increased to 51% in April 2026 • Further recovery training for the whole service took place in Jan 2026. • Case management supervision to be introduced at Step 3. • 55% of our referrals are from deprived areas in Birmingham (Decile 1 and Decile 2) • Significant increase in trauma representations	• Review impact of employment advisers • Address working relationship with 24/7 • Consider which VCSFE partners we can work more closely with • Enhance older adult clinics • Review outstanding training needs for the whole service • Review the presenting complaints for all patients • Review which service can accommodate patients with significant trauma needs	• The service has consistently met the target for reliable improvement

NHS TALKING THERAPIES
IN TREATMENT PATHWAY WAITS – February 2026

Talking Therapies In-treatment Pathway Waits

Return to Contents

BSOL ICB

% of referrals with In-Treatment Waits of over 90 days

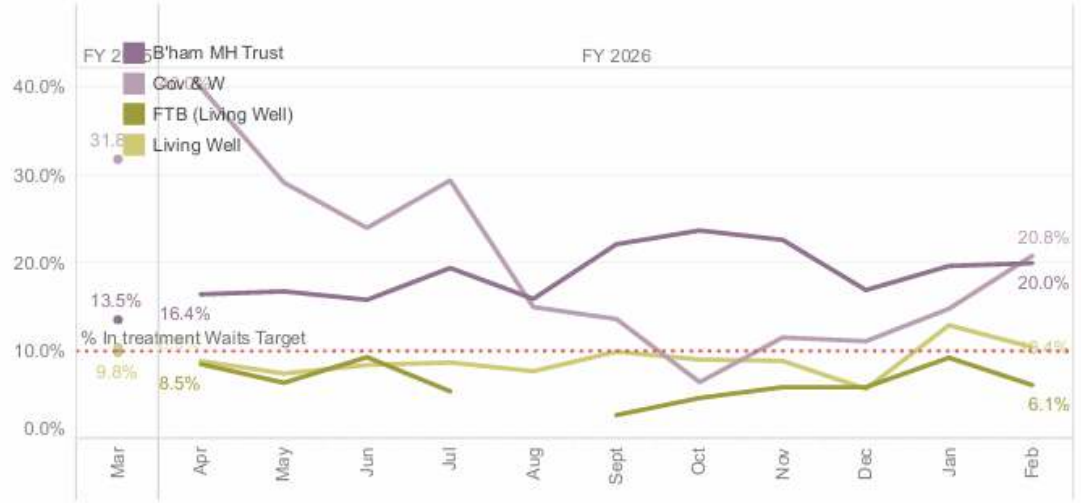
		Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
BSOL ICB	% In Treatment Waits over 90 days	13.1%	13.6%	13.3%	13.3%	15.3%	11.9%	15.2%	15.1%	14.9%	11.3%	16.0%	14.4%
BSOL ICB	1st to 2nd Treatment 90+ Days	215	225	225	230	255	160	260	275	270	150	315	235
	Second Treatment Contacts	1,635	1,650	1,695	1,730	1,670	1,340	1,710	1,825	1,815	1,330	1,965	1,635

National Standard: Less than 10% of referrals wait 90 days or more between first and second treatment

Measure Description: Proportion of people who wait +90 days first to second appointments. There should be no in-treatment pathway waits.

Methodology: [metric ID 047 count first to second treatment over 90 days] / [metric ID 184 count second treatment]. Both metrics count referrals in the month that the second contact is reached.

Source: NHS Digital, IAPT Monthly



RISK AND CHALLENGES	KEY ACTIONS	LEVELS OF IMPROVEMENT
• Internal data shows increase over last 3 months from 20% to February, to 22% in April 2026	• Offer groups while clients are waiting a specific intervention • Offer self-help guides/material whiles waiting a specific intervention • Offer CBT to clients while waiting a specific intervention • Timely review of effectiveness of group/intervention • Utilising Employment Advisors as required	• In treatment wait times have deteriorated in the last 12 months • Deep dive to be completed to understand and address issues.

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 June 2026**
Date(s) of Committee Meeting(s) reported	**20 May 2026**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Board Assurance Framework Risks • Corporate Risk Register • Patient Safety Report • Safe Care Today Dashboard and Bronze, Silver, Gold Updates • Regulatory Compliance Report • Clinical Governance Committee Assurance Report • Quality Day process • Customer Relations Report • Mental Health Legislation Committee Assurance report inc. AMHP review • Nigel's Plan Assurance Report • Health Inequalities and PCREF Project Board • Staff Support Assurance Report • Reducing Restrictive Practice Report • Quality Account
Alert:	• There has been a notable increase in staff and patient assaults, particularly within Acute and Urgent Care settings, with associated impacts on staff wellbeing, morale and workforce retention. Concerns were also raised regarding the variability and timeliness of police response, which continues to affect staff confidence and organisational risk management. • Workforce pressures remain a key concern across multiple areas, including high sickness absence rates linked to mental health, ongoing staff harm incidents, and capacity challenges in key services such as Crisis and Home Treatment Teams. • Significant system flow risks were highlighted in relation to the Approved Mental Health Professional (AMHP) service, including a substantial reduction in workforce capacity and delays in access. This is contributing to extended patient length of stay, delays in treatment, and risks to legal compliance, compounded by further delays in SOAD reviews and tribunal processes.
Assure:	• The Committee received assurance that robust governance arrangements are in place, with the Board Assurance Framework and Corporate Risk Register operating effectively and subject to ongoing refinement to strengthen alignment with strategic priorities. • Patient safety performance remains stable overall, with incident levels and harm rates within expected variation and no evidence of special cause

	variation. Established governance mechanisms, including weekly safety huddles and PSIRF processes, are supporting timely escalation, learning and improvement. • Actions are in place to address staff safety concerns, including enhanced post-incident support arrangements, improved escalation processes, and rollout of training in de-escalation, psychological first aid and bystander intervention. Early indications suggest improved timeliness in staff accessing support. • The Committee was assured that restrictive practice is subject to strengthened oversight, with bedroom lock use under active review, clearer escalation requirements, and a focus on reducing restrictive interventions through preventative and therapeutic approaches. • Progress was noted in a number of regulatory and quality areas, including fire safety improvements, positive engagement with the CQC, and examples of good practice in service delivery and quality improvement. • The Committee were assured there is strong organisational progress in health inequalities, including integration of PCREF into governance and recognition through national award, alongside improved staff engagement in quality improvement initiatives.	
Advise:	The Board is asked to note the approval of the Quality Account 2025/26, which has been recommended by the Committee.	
Reducing Health Inequalities impact:	The Committee reviewed all papers through a Health Inequalities Impact lens and agreed for a number of deep dives into areas for reflection going forward.	
Board Assurance Framework	The Committee recognised the significant ongoing development of the Board Assurance Framework. The Committee requested the Board Assurance Framework is inclusive of evidence-based impacts for further assurances going forward. Overall, the Committee were assured.	
	New risks identified: None.	
Report compiled by:	Nick Moor Non- Executive Director	**Minutes available from:** Hannah Sullivan Corporate Governance and Membership Manager

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**4 June 2026**
Date(s) of Committee Meeting(s) reported	**22 April 2026**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Patient Safety Report • Safe Care Today Dashboard and Bronze, Silver, Gold Updates • Regulatory Compliance Report • Clinical Governance Committee Assurance Report • Patient Experience and Recovery (PEAR) Group Assurance Report • Customer Relations Report • PLACE 2025 Results • Nigel's Plan Assurance Report • Health Inequalities and PCREF Project Board • Clinical Effectiveness Advisory Group Assurance Report • Reducing Restrictive Practice Report • Year-End Strategy Goals Report 2025/26
Alert:	• The Committee noted high caseloads in community mental health teams, noting that many patients would be managed in primary care elsewhere, and emphasized the need to stratify caseloads and shift stable patients to less intensive care.
Assure:	• The Committee were assured the Board Assurance Framework continues to be developed. The Committee noted the importance of providing clear evidence and rationale for any proposed risk score reductions, suggesting that improvements in outcomes should be demonstrated alongside the implementation of initiatives. • The Committee received Nigel's Plan noting the focus on improving assurance and risk management across community services, with ongoing work to achieve consistent assurance. Work is underway to reduce caseloads, with regular reporting to the Mental Health Provider Collaborative and the development of an audit and assurance framework to track progress. • The Committee were assured that Trust executive leads, alongside the Provider Collaborative, have met the Director of Social Services for Birmingham City Council to agree an action plan to respond to the shortage of AMHPs which is affecting both inpatient and community services. • The Committee received the Health Inequalities and PCREF Project Board report and were assured efforts are underway to streamline community engagement, particularly with Somali and Caribbean communities, and to

	develop clear pathways for supporting individuals with no recourse to public funds. • The Committee received the PLACE assessment outcomes, noting good results and ongoing work to make assessments more mental health-friendly, with action logs generated for all findings and regular monitoring of progress. Survey results showed areas for improvement, particularly in community support for finance and recovery, with action plans being developed and a focus on addressing low response rates and meaningful feedback. • The Committee were assured improvements in Dialogue Plus and safety planning compliance across most directorates continue, with some variability in community teams and ongoing efforts to address gaps in specialties.	
Advise:	The Committee were advised processes have been developed and implemented to support the improvements for complaint responses in CYP and ICCR divisions, including revising communication with families, offering support forums, and addressing recurring themes such as staff attitude and missed appointments.	
Reducing Health Inequalities impact:	The Committee reviewed all papers through a Health Inequalities Impact lens and agreed for a number of deep dives into areas for reflection going forward.	
Board Assurance Framework	The Committee recognised the significant ongoing development of the Board Assurance Framework. The Committee requested the Board Assurance Framework is inclusive of evidence-based impacts for further assurances going forward. Overall, the Committee were assured.	
	New risks identified: None.	
Report compiled by:	Nick Moor Non- Executive Director	**Minutes available from:** Hannah Sullivan Corporate Governance and Membership Manager

Report to Public Board of Directors							
Agenda item:	**11**						
Date	3 June 2026						
Title	Quality and Safety Report, inc Safer Staffing						
Author/Presenter	Lisa Stalley-Green, Executive Chief Nurse						
Executive Director	Lisa Stalley-Green, Executive Chief Nurse	**Approved**	**Y**	✓	**N**		

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

Summary of Report					
Alert		**Advise**		**Assure**	✓

Introduction
This report provides a report on Quality and Safety for Birmingham and Solihull Mental Health Foundation Trust to the Public Board of Directors Meeting being held 03 June 2026.

Purpose
This report provides the Public Board meeting with an update on the quality metrics and associated activity for the month ending April 2026; members will note the following:

- Safeguarding highlights and an increase in effective completion of Eclipse forms related to domestic abuse providing assurance on training and practice.
- Key incidents and learning from incidents and response to a Prevention of Future Deaths report received in respect of care for a patient with complex physical health needs.
- A summary of the findings from the 2025/2026 Care Quality Commission Community Survey and plans to extend the scope for our Recovery College.
- Progress on Bronze, Silver, Gold escalations including Larimar improvements, development and use of SafeCare Dashboard and Customer Relations.
- Culture of Care assurance on progress and sharing good practice outside the Trust.
- Safer Staffing; Right People, Right Place, Right time Assurance.

Executive Summary

Safeguarding - Safeguarding referrals from teams are demonstrating the impact of the Trust priority focus on identification and support for people experiencing domestic abuse.

Incidents and preventing future deaths report – the Trust has received a report from the Birmingham Coroners Office identifying concerns about contemporaneous observation recording due to WiFi fluctuation and the translation of physical health care pans into practice, assurance is provided on the Trust response.

The Care Quality Commission Community Survey has been published and disappointingly shows no progress on

the previous year with similar themes continuing to concern service users. Plans are in place to address the areas of concern through the provision of additional information and support in accessing crisis services and the development and implementation of a Charter for Families and Carers.

Recovery College - Plans are being established to implement a Recovery College in each locality; this approach will permit modules to allow Recovery College modules to reflect specific needs of local populations and reduce health inequalities.

Bronze, Silver, Gold - The Children & Young People's Division Urgent Care Pathway remains under this framework with developments underway. The Learning Disabilities and Autism team and Referral Management Team have both requested support via this pathway to address increased wait times.

Larimar Ward – monitoring by the Integrated Care Board and NHS England has formally been closed following demonstration of improvements by the Trust. Continuous embedding of the learning is being led through the framework through a monthly meeting and assurance into the Clinical Governance Group.

Customer Relations – a thematic review has been completed into complaints received by the Trust Community services. Actions are in place to improve early contact with service users and families and ongoing support whilst they are waiting for assessment or treatment.

Culture of Care – The Trust Culture of Care framework is now in place across Acute Services, Integrated Community Care and Recovery, Secure Care and Offender Health, and Specialist Services. During quarter one all teams will complete their bronze silver gold self-assessment against the twelve standards, and care informed by trauma, learning disability and autism and anti-racist practice. The Trust has been asked to share the framework and is hosting visits for Derbyshire Trust and Cygnet Group in the near future.

Safe staffing assurance – The Trust has increased registrant staffing levels across the Trust in the last six month. There are very few Registered Nurse or Healthcare Support Worker Vacancies and there are a number of vacancies at Senior Staff Nurse Level in Urgent Care and Community Services. There are now three registered nurses rostered on each ward shift, and this has seen a significant increase in registrant workforce on night shifts, improving quality and therapeutic interaction. There is an effective graduate pipeline in place and nurses who joined the Trust from abroad in the last two years are now experienced and committing to stay with the Trust.

Development programmes are in place to train staff nurses to the level required to fill the remaining senior staff nurse vacancies.

Regular management supervision continues to fluctuate and is being addressed with divisions through the Trust Performance Panel.

Utilization of temporary staffing continues to reduce across all areas, notably Specialist and Older People's Services. There are now three areas for further focus at the monthly Bank Gold to ensure temporary staffing utlization meets the required reductions for 2026/27, these are;
E-roster compliance
Improving the prescription and practice for Enhanced Therapeutic Observations of Care
Planning annual leave and compliance with Trust policy

Recommendation
The Board is asked to receive assurance from this report.
Enclosures

- Quality and Safety Report
- Safer Staffing Assurance Report

Safeguarding

The Trust Safeguarding Team has identified a sustained increase in the reporting of domestic abuse and sexual safety incidents via Eclipse, alongside a growing volume of complex cases requiring multi-layered, risk-informed responses. This trend highlights both increased recognition of safeguarding concerns and the need for consistent, high-quality professional judgement in managing them.

The Safeguarding Team's Domestic Abuse and Sexual Safety workstream continues to deliver a targeted programme of support, focusing on high-risk and high-demand services including Home Treatment Teams, Assertive Outreach Teams, Neighbourhood Mental Health Teams, and Community Mental Health Teams. This includes the provision of structured safeguarding supervision to strengthen practitioner decision-making, alongside tailored, locality-based "bite-size" training.

Current training priorities include domestic abuse and older adults, delivered in partnership with the Trust Independent Domestic Violence Advisor service from Birmingham and Solihull Women's Aid. Improved safeguarding practice has been identified within Eclipse reporting, particularly among Home Treatment Teams. This improvement appears to correlate with strengthened engagement in safeguarding supervision, with practitioners demonstrating increased confidence in identifying and responding to indicators of risk, most notably in relation to domestic abuse, which remains the predominant safeguarding theme. Furthermore, teams where leadership actively engages in supervision, or where Team Managers maintain strong safeguarding oversight, consistently demonstrate more robust and timely safeguarding responses.

This safeguarding priority stems from Learning from Deaths and Homicides related to incidents of abuse and harm from adult children to parents, in particular female parents or carers. Building on this priority the Trust is further developing a Charter for Parents and Carers and aiming to reduce abuse and harm for women and girls.

Patient Safety

Incident reporting and harm levels remain stable, with Statistical Process Control analysis showing no cause variation. Self-harm incidents continue to reduce while restrictive practice and violence and aggression remain with previous ranges. The Trust is continuing to embed the Patient Safety Incident Response Framework, promoting a systems-based approach to learning, compassionate engagement, and service improvement. Learning from Structured Judgement Reviews, After Action Reviews, Patient Safety Incident Investigations and thematic reviews is being triangulated to identify recurring themes and opportunities for organisational learning.

Key themes include transitions of care, communication across services, therapeutic engagement, risk escalation, and operational consistency, which are informing both local and Trust-wide improvements. Assurance activity is increasingly focused on evidencing real changes in operational practice and safety systems through audits, thematic reviews, observations, governance oversight, and SPC trend analysis, rather than relying only on completion of actions.

The Trust is also consulting on its Patient Safety Incident Response Framework priorities with internal and external stakeholders to ensure learning activity targets areas with the greatest improvement potential. Additional work includes commissioning Patient Safety Incident Response Framework oversight training, establishing a Community of Practice for review leads, and auditing compassionate engagement and use of Systems Engineering for Patient Safety methodology within completed Patient Safety Incident Investigations.

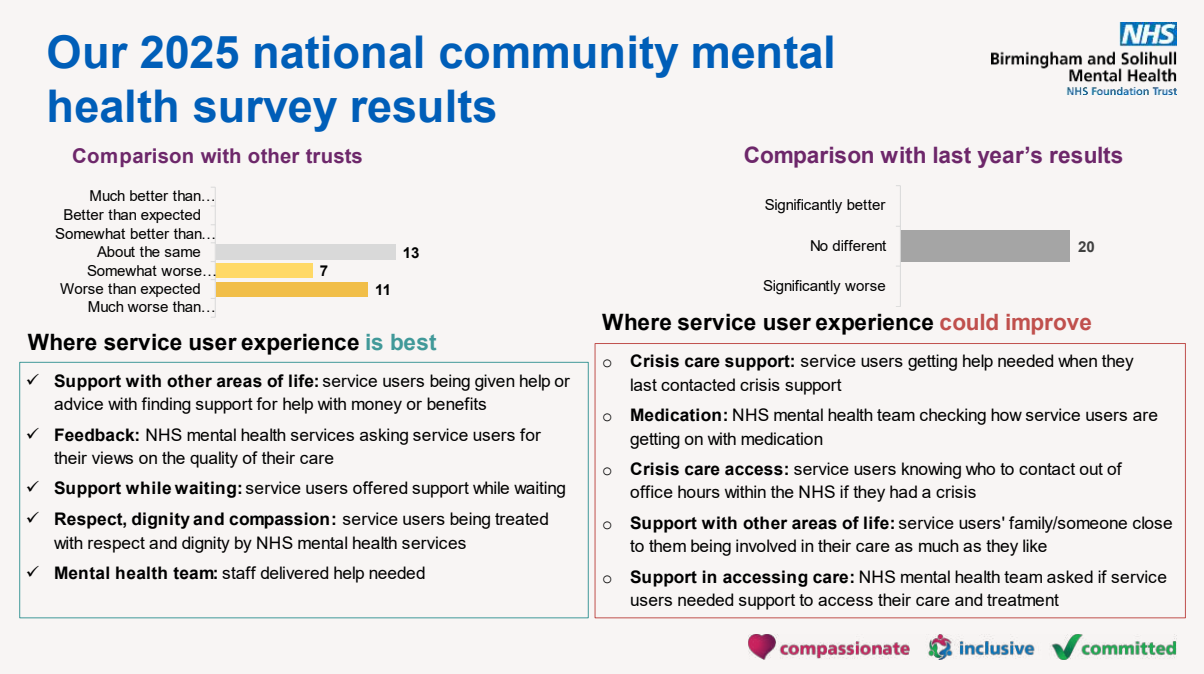
During April the Trust received a Prevention of Future Deaths report which identified concerns regarding the reliability of Wi-Fi connectivity on inpatient wards, which impacted staff ability to contemporaneously record therapeutic observations on handheld devices, creating a risk that observations may not be accurately documented. In addition, the Coroner identified concerns regarding the absence of explicit care plans for patients with significant physical health conditions associated with long-term psychotropic medication use, including obesity, sleep apnoea and positional asphyxia risks.

In response, the Trust has undertaken Wi-Fi surveys across acute wards and is working with Information and Technology colleagues to identify and test clinically safe solutions that improve signal reliability whilst mitigating environmental ligature risks. Current continuity measures remain in place,

including access to ward-based desktops and laptops and reinforcement with staff regarding the importance of timely documentation.

The Trust has responded to confirm that the patient did have an appropriate care plan in place but has developed a Physical Health Strategy in recognition of variation in staff understanding of some complex physical health conditions and have strengthened arrangements for physical health care planning through the implementation of Dialog+ across inpatient services, ensuring physical health risks are explicitly identified, documented and reviewed within care plans. This is supported by enhanced ward-level audit and assurance processes to provide oversight that identified risks are translated into clear actions and follow-up arrangements. A meeting held with Acute Consultants in May identified a need for more consistent leadership in Multi-Disciplinary Ward Round Meetings for the Ward Managers or their Deputy, ensuring greater consistency in translating care plans into consistent individualised practice on the wards.

Care Quality Commission Community Survey 2025/2026



The 2025 National Community Mental Health Survey results show that service user experience within Birmingham and Solihull Mental Health NHS Foundation Trust is broadly comparable with other Trusts, with most areas rated as "about the same." However, there were slightly more areas rated "worse than expected" (11) and "somewhat worse" (7) compared with peer organisations. Compared with last year's results, the majority of responses showed no significant difference.

Key strengths identified by service users included support with wider life issues, opportunities to provide feedback, support while waiting for services, respectful and compassionate care, and positive support from mental health teams. Areas highlighted for improvement included crisis care support and access, medication reviews and support, greater involvement of families and carers, and improving support for accessing care and treatment.

In response to the findings there are a number of actions being taken by the Patient Experience Team and monitored through Service User Led Assurance Group. These include developing information for patients on who to contact in the event of a crisis, a welcome booklet for all service users, families and carers on admission to an Acute Wards and a commitment to work with the Care Quality Commission on increasing the uptake and value of feedback from our service users in the community.

Recovery College Plans

Following a review of the governance and delivery mechanisms for the Recovery College, plans are now in place to redesign the service to ensure that all elements of the Trust strategy are fully considered, with the voice of service users embedded throughout. In alignment with the Trust strategy and the NHS 10-Year Plan, there is recognition that our communities are best placed to support recovery.

In conjunction with the Integrated Community Care & Recovery Division, the Community Transformation Team, IMROC (a registered charity led by lived experience people and dedicated to improving the lives of people with mental health conditions, autistic and neurodivergent people and/or those with long term health and social charities), and the Recovery College team, plans are underway to embed a Recovery College within each locality, supported by a central team to ensure consistency in quality, educational input, governance, and delivery. This model will be further strengthened through collaboration with Peer Support Workers from the voluntary, community and social enterprise sectors, along with local educational providers.

By adopting a locality-focused approach, the Recovery College timetable will ensure that modules are tailored to the specific needs of each population, further supporting the reduction of health inequalities and ensuring that employment support is appropriately understood for our service users and integrated for local communities.

The Trust is holding a Strategy and Celebration event on the 25th June for Recovery College members and staff in recognition of their ten year anniversary and intentions for their future development.

Bronze, Silver, Gold Escalation and Improvement Framework

There are two areas of escalation within the Trust at present; Children & Young People's Division Child and Adolescent Urgent Care Pathway and Acute Inpatient Services Larimar Ward

The issues escalated within the Children and Young People's Service includes the following:

> Access and waiting times, medical capacity, increasing demand, referral management and bed management resilience and processes.

- The Children and Young People Transformation workstream is in place to review and integrate the referral management and bed management teams with the wider Trust teams to provide resilience and standardized processes and escalation for people waiting to access services. There are particular pathway challenges for young people with a Learning Disability or Autism, and young people between the ages of eighteen and twenty five.
- A draft psychiatric liaison team provision is being developed in partnership with local Acute Trust services following meetings with Birmingham Women's Hospital and University Hospital Birmingham to agree expectations, commissioning responsibilities and service capacity.
- Additional Matron and Advanced Clinical Practitioner posts have been authorized to strengthen leadership and quality improvement across the pathway. Further Advanced Clinical Practitioner roles are being considered to support the Medical workforce plan. The review of medical workforce is in implementation and has successfully completed stage one in terms of reducing agency contracts through negotiation of substantive contracts and recruitment is in place for vacant posts.
- Draft guidance has been developed to support oversight of caseloads and staffing levels in response to clinical demand and patient need.
- Long working devices have been issued and socialized with staff in the Division in support of their safety and good practice in community settings.
- Standard Operating Procedures (SOPs) and the audit programme will be aligned to Nigel's Plan implementation for June 2026.

Larimar Ward

Monthly monitoring by the Integrated Care Board and NHS England has now been concluded and ongoing reporting on progress and improvements will be reported through the regular Commissioning Quality Review Meetings with the Integrated Care Board. The Trust maintains a monthly Bronze, Silver, Gold structure to monitor and track areas which are not yet consistent and a monthly report will be submitted to Clinical Governance Committee. Priorities will focus on:

- Systematic gaps in autism appropriate care
- Care planning translating to day-day care
- Workforce and relational security
- Therapeutic observations being fully therapeutic
- Family involvement being fully embedded
- Safety governance and oversight improvements
- Searching and access to items

All areas are improving but still demonstrate some month on month variation, a new Ward Manager is in post and the team are actively engaging in the Divisional Culture of Care programme.

SafeCare Dashboard – strengthening use of data from Ward to Board

Work is currently being undertaken by the Informatics Team to replicate the comprehensive dashboards currently in place for Acute and Urgent Care and Community Services across all other Divisions. Specialist specific metrics are to be provided to the Information Team by June 2026. The databases are used within the current Divisions to support quality and safety progress and assurance which is triangulated at Trust level at Quality Assurance Group on the Quality Day.

Customer Relations

A thematic review of Quarter four for the period ending April 2026 has been undertaken and submitted to the Quality Patient Experience and Safety Committee. There is an outlying area identified following the number of open/live formal complaints increasing by 125% for this area in one calendar year. At the end of April 2026, the Adult Attention Deficit Hyperactive Disorder Service had 20 out of the 81 open complaints for Community Services (25%). A quality improvement workstream will focus on the emerging themes and trends across complaints received 2025-26 in relation to the comparative review. The review will inform the improvement work in access and waiting times in the developing neighbourhood teams model. The comparative review against the baseline population and demographic profile has highlighted areas of variation which may indicates health inequalities in patient experience and access.

Culture of Care – Progress to Date

Since April, the Culture of Care accreditation framework has been launched across Acute, Secure, Community, Children and Young People Services and specialist services, with all ward areas asked to undertake a structured self-assessment against the 12 Culture of Care standards. This has supported a shift from compliance-based assurance towards reflective, team-led quality improvement, with early feedback indicating strong engagement from ward teams and increased ownership of relational practice, safety and patient experience. The approach has also enabled triangulation of existing data such as audits, safety metrics and patient feedback, with local insight, strengthening understanding of variation in care and identifying priority areas such as relational security, care planning quality, and therapeutic activity.

The next phase will focus on validating self-assessment outcomes, supporting teams to develop targeted improvement plans, and embedding a consistent governance process to track progress. This will include strengthening clinical leadership capability, aligning accreditation with existing quality and safety reporting structures, and developing a systematic approach to evidencing impact over time. Plans are also underway to introduce peer review and shared learning opportunities across services to build consistency and spread improvement, alongside the development of a formal accreditation process to recognise sustained improvement and high-quality care environments. The accreditation process will include Bronze, Silver and Gold Awards for teams culminating in an annual Celebrate and Share event in September where Gold Awards will presented by the Chief Executive Officer.

Enabling the scale up and embedding of the Culture of Care Standards through the Culture of Care Excellence Programme has been recognised and the Trust invited to present at National events.

Safer Staffing

This item is available as Agenda item 12.3 in the reading room, Safer Staffing Update, expanding on:

- Staffing
- Current position
- Temporary Staffing Solutions (TSS)
- Skilled workforce
- Training requirements
- Regular management supervision
- Nursing education
- Rostering
- Professional standards and fitness to practice
- Future planning

1. Introduction

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

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

1.3 The National Quality Board guidance (2026) outlines responsibility that we ensure that the staff working in our clinical areas are providing safe and effective care to all our service users.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Right Staff

2. Staffing

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

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

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

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

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

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

2.6 Table 1 and Table 2 show us the actual staffing levels that we achieved across our 48 inpatient wards between April 2025 and April 2026.

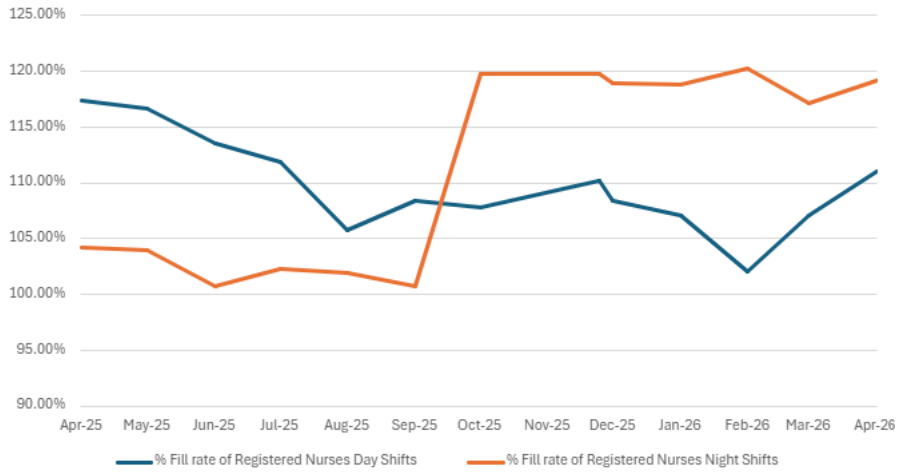
2.7 Table 1 shows us that we have been able to consistently work towards having adequate registered nurses on the inpatient wards. Where there has been spikes in the registered nurses this is where we were over recruited with our registered nurse workforce.

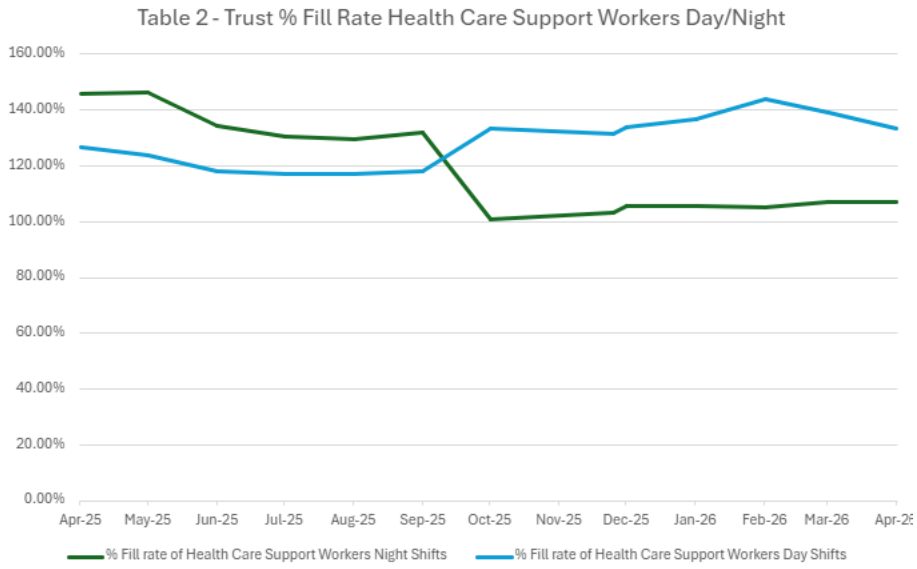
2.8 Table 2 shows we have had a consistent percentage fill rate for our healthcare support workers (HCSW).

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

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

Table 1 - Trust % Fill Rate Registered Staff Day/Night





3. Current Position

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

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

3.3 The Trust process currently is to review establishments, TSS deployment and workforce data through our monthly Quality Assurance Day, we have a dedicated table to discuss:

- Staffing
- Workforce Key Performance Indicators (KPI)
- Roster Compliance
- Training
- Temporary Staffing Solutions Spend

This is chaired by our Chief Nurse/ Executive Director of Quality and Safety.

3.4 Table 3 shows our current registered nurse vacancy position across the Trust. Our predominant nurse vacancies are the Band 6 (B6) role. To mitigate any gaps, we use Temporary Staffing Solutions colleagues to provide consistency in care to our service users, this is often done on a block booking.

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

3.6 Where there are B5 vacancies we have a healthy pipeline of newly qualified nurses to go straight into those posts following being successful at interview.

3.7 We are interviewing 160 + student nurses who are due to qualify in September 2026.

3.8 To increase our graduate pipeline we will need to do the following.

- No band 5 roles are advertised externally unless approved at senior level
- All band 6 roles are advertised internally only in first instance to try and encourage band 5 to 6 movement
- Review of band 6 roles and skill mix for band 5 roles
- Getting managers to consider band 5 to 6 development roles
- Offering preceptorship to NQNs who join TSS as band 5s

3.9 Table 4 shows our current HCSW position across the organisation. We have seen a reduction in our HCSW vacancies.

3.10 The vacancy data is reflective of the clinical workforce only.

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

3.12 We have completed a significant piece of work where we have seen a £3.5 million uplift in our Acute division of nursing. This has supported with moving TSS workforce moving into substantive posts. The recruitment process is due to start to recruit to the remainder of the posts.

3.13 We have completed a piece of work to support with creating an additional Home Treatment Team in Solihull.

3.14 We have now started to review our community staffing levels in our Older Adults Community Teams.

Table 3 - Registered Nurse Vacancy

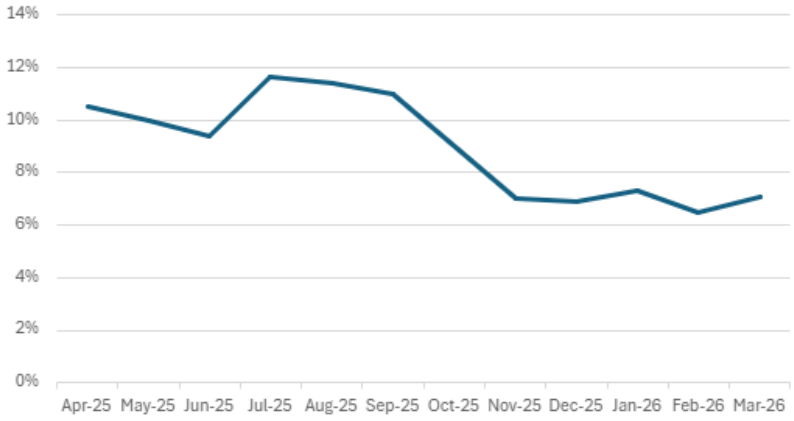
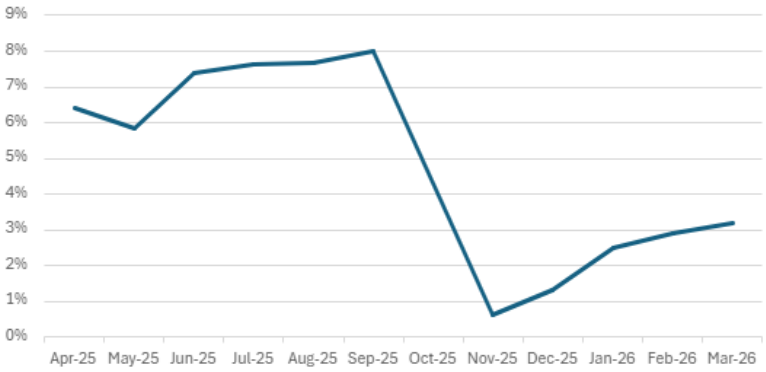


Table 4 - Health Care Support Worker Vacancy



4. Temporary Staffing Solutions

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

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

4.3 We saw an increase in agency spend when the Children's and Young People (CYP) Division of Nursing joined us in July 2025. We are supporting them with the reduction in the agency spend. It is anticipated there will be no agency staff working in CYP by end of June 2026.

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

4.5 The Trust has established a working project group to support with the reduction in bank spend across the organisation. Key dependencies to reduce bank spend are:

- Enhanced Therapeutic Observations of Care Quality Improvement Project
- Introduction of 'Plan the Day and Night' Workstreams.
- Effective Rostering across Inpatient Wards
- Introduction of Community Rostering
- Reduction in Bank Booking Reasons
- Effective Workforce Planning
- Recruiting into Vacancies

Right Skills

5. Skilled Workforce

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

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

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

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

6. Training Requirements

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

6.2 The Trust position for those who are currently in a substantive position in a clinical division is at 95% compliancy. This is above our 90% target.

6.3 The Trust position for those who are in TSS only position is 93%. This is above our 90% target.

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

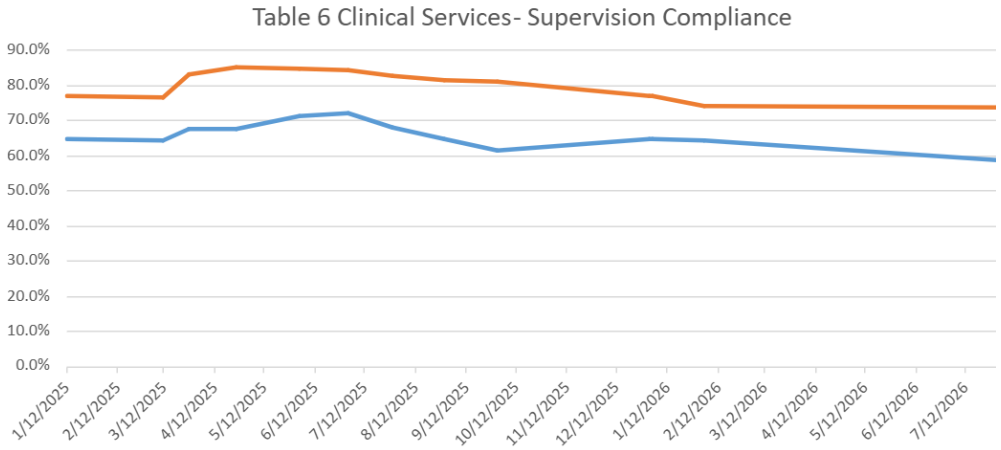
6.5 Statutory and Mandatory training for those in a TSS only position is reviewed by the TSS team and emails are sent to the individual recommending training must be completed within a period that is set out. TSS staff are informed that they could be restricted from working until training is seen.

7. Regular Management and Clinical Supervision.

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

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

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



8. Nursing Education

8.1 Clinical Education – Core Offer (Registered Nurses)
The Clinical Educator Core Programme for registered nurses continues to be well received across services. A clear process for clinical education requests is in place. Alongside the core programme, there has been a strong focus on developing specialist education offers in response to identified clinical need. Discussions underway with subject matter experts on topics inclusive of: Disordered eating, substance misuse and strengthening the carers voice sessions.

8.2 Clinical Education – Healthcare Assistants (HCAs)

A core clinical education offer for Healthcare Assistants has been developed and delivered across acute services. This includes:

- Delivering person cantered care
- Communication, information sharing, escalation, and reporting
- Teamwork, expectations and responsibilities
- Mood disorders.
- Engaging and proactive observations

The programme has been well received, with early engagement and a clear appetite from clinical services for ongoing delivery. While the current team capacity is limited, there is optimism that this offer can be further expanded over time to support workforce capability.

8.3 Continuing Professional Development (CPD)
Nursing and AHP staff continue to access CPD to support both service development and individual professional growth. We are currently delivering an accredited 20-credit flexible based learning module in collaboration with Birmingham City University on medicines management and are at an early stage of working with the Head of Patient Safety who will be leading on developing a flexible based learning module on patient safety for our clinical workforce.

Right Place

9. Rostering

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

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

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

9.4 Our Key Performance Indicators are.

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

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

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

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

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

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

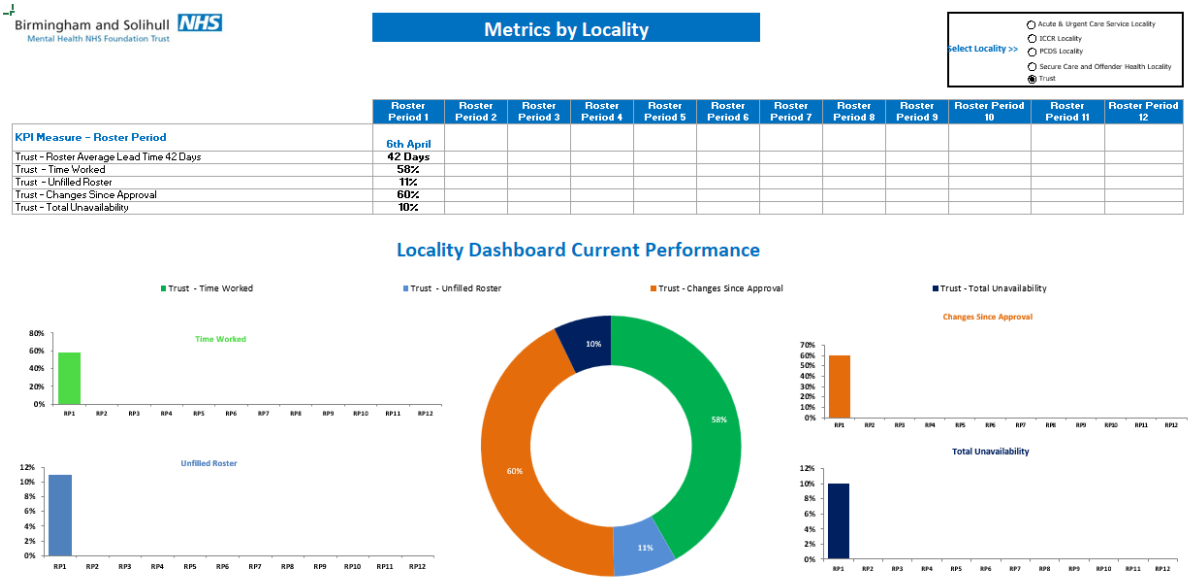
9.5 Table 6 shows are current compliancy with rostering, as a Trust we are committed to improve our compliancy to ensure that we have rosters ahead of schedule with staff who are in right place at the right time with the right skills. There is limited information in this table due to being in a new financial year.

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

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

9.8 We are currently socialising auto rostering and electronic community rostering. It is anticipated that that will support with giving a manager the essential clinical/operational time back to continue providing quality care to service users.

Table 6



KPI Measure – Roster Period	Roster Period 1	Roster Period 2	Roster Period 3	Roster Period 4	Roster Period 5	Roster Period 6	Roster Period 7	Roster Period 8	Roster Period 9	Roster Period 10	Roster Period 11	Roster Period 12
	6th April											
Trust – Roster Average Lead Time 42 Days	42 Days											
Trust – Time Worked	58%											
Trust – Unfilled Roster	11%											
Trust – Changes Since Approval	60%											
Trust – Total Unavailability	10%											

Professional Standards and Fitness to Practise.

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

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

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

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

10.4 As a Trust we have made none of these of referrals

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

Table 7

Cases	Screening Stage	Awaiting Case Manager	Investigation Stage	Final Stage

13	7	6	0	0

Future Planning for BSMHFT

11. Advanced Practice for our Nursing Workforce

11.1 Governance
11.1.1 The organisation has now established a comprehensive advanced practice training framework, designed to underpin the training, education, and operational development of advanced clinical practice roles. With the new release of HCPC guidance this training framework will be updated to reflect their guidance to prevent differing levels of advanced practice across the professions.

11.1.2 This framework provides clear guidance regarding the expected standards of practice for advanced clinical practitioners, ensuring alignment with national benchmarks and incorporates the NMC principles. Standardised both qualified and trainee job descriptions, person specifications and training contracts are currently going through the HR process. Thereby addressing role variability, ensuring that practitioners operate across all pillars of advanced practice and to ensure the financial impact to the organisation is minimal with trainees.

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

11.1.4 These measures are expected to enhance the overall quality and consistency of the workforce, leading to improved standards of patient care and more effective service delivery. The next step in this process will be the development of an advanced practice policy, E-Portfolios, and job planning. These next governance steps will begin once the workforce review has been completed. This will give us a clear strategic direction with all divisions on board with one approach to advanced level practice.

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

11.1.6 The Advanced Clinical Practice Forum is going to be re launched in the next coming months, the current ACP workforce has developed a rolling programme where there are sessions on each pillar of practice. This will be open trust wide to anyone who wishes to learn more about advanced practice. We will also provide trust and national updates within this forum.

11.1.7 Building a connect page is underway for advanced practice on the trust intranet, so we can advertise the success, create more understanding and awareness, educate around advanced practice roles which is supported by the three shifts.

11.1.8 Working with local Health Education Institutes (HEI) Birmingham City University (BCU) to develop a mental health advanced practice pathway.

12. <u>Celebrating our Achievements</u>

12.1 We have a substantive Matron in post to support the Temporary Staffing Solutions Workforce.

12.2 The Pre Registration Clinical Education Team continue to demonstrate innovation in practice. They have won a Nursing Times Award 2026 in the category of Student Placement of the Year: Hospital, for the Applied Theory and Practice Pathway. This pre-registration clinical education programme is a core offer for all pre-registration nursing students undertaking placements within the Trust. The programme supports students to effectively translate theory into practice and demonstrates the Trust's commitment

to developing its future nursing workforce. This national recognition highlights the programme's impact on learning quality and workforce development.

12.3 Due to the success of the Matron's Training Development Days we are future planning our Ward/Team Managers Training Day's, it is expected these will be launched in September 2026.

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	12					
Date	3 June 2026					
Title	BSMHFT Quality Account 2025/26					
Author/Presenter	Lisa Stalley-Green, Executive Director for Quality & Safety					
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**	✓

Executive Summary

The Quality Account for BSMHFT provides a look back on the achievement of quality priorities for 2025/26 and a proposal for priorities for 2026/27

The account provides mandated compliance information for publication on the Trust Website and gives an opportunity for key stakeholders to provide feedback on the progress of the Trust.

The account is presented to the Council of Governors, Trust Quality Committee and Trust Board during the first quarter of 2026/27 for assurance and sign off prior to publication.

There has been good progress during 2025/26 on improving quality outcomes for service users and has seen the Trust identify the National Culture of Care standards as the framework for our improvement ambitions, investment and quality governance excellence.

The Trust continues to build on the principles of co-production with service users and families, trauma and autism informed care and well supported, highly capable staff.

Recommendation

The Committee/Board is asked to: Discuss and approve the Quality Account for publication

Enclosures

BSMHFT Quality Account Report 2026/27

Birmingham and Solihull Mental Health NHS Foundation Trust

Quality Account Report 2025/2026

Quality Account Report

Contents

Performance against local strategic priorities

The Friends and Family Test

Reducing Health Inequalities

Care for People with a Learning Disability or Autism

Staff Survey

Guardian of Safe Working Hours

Freedom to Speak Up

Statement of Directors' responsibilities

Statements from key stakeholders

Birmingham and Solihull Mental Health NHS Foundation Trust would like to thank those who contributed to the development and publication of this Quality Account.

How to provide feedback on this Quality Account

If you would like to provide feedback on this quality account, or would like to make suggestions for content for future accounts, please email lisa.stalley-green@nhs.net

Or write to

Company Secretary
Birmingham and Solihull Mental Health NHS Foundation Trust
Uffculme Centre
52 Queensbridge Road
Birmingham B13 8 QY

PART 1 – Statement On Quality

CHIEF EXECUTIVES'S STATEMENT ON QUALITY

Foreword from the Chief Executive Officer

As we present the Quality Account for 2025/26, we reflect on a period of continued challenge, learning and progress across our organisation, our commitment to delivering safe, effective and compassionate care remains at the heart of everything we do, and this report demonstrates the steps we have taken to improve outcomes and experiences for the communities we serve.

Over the past year, our teams have worked with dedication and resilience and led many improvements in care models and personalised care for individuals. The Culture of Care Framework has empowered clinical and support staff and increased the involvement of service users in understanding and meeting their needs. Investment in environments, staffing and training, alongside improvements in patient safety, strengthened clinical governance and use of data.

The Trust has focussed on transformation which has led to improving waiting times in key crisis and acute services, establishment of the 24/7 Mental Health Neighbourhood Centre in East Birmingham and the transfer of colleagues providing services for Children and Young People in Birmingham to deliver mental health services across the life-course from pre-birth to end of life, enhancing service user outcomes and embedding a culture of continuous learning and innovation.

We are proud of the progress made in areas such as patient safety, staff development, complaints handling and partnership working. At the same time, we recognise that there is more to do. Health inequalities, workforce pressures and increasing demand continue to present significant challenges and we are committed to addressing these with transparency and determination through new models of integrated care in community settings.

We have continued to grow our Teams with more substantive registered staff joining the Trust and competition for Consultant posts resulting in further development and promotion of internal candidates who have grown from our local communities and into clinical leadership roles in the NHS. As a result of this the Trust has reduced reliance on temporary staffing and rarely uses staff engaged through agencies. Listening to our service users, families, carers and staff has been central to shaping our priorities. Their feedback has informed service improvements and helped ensure that care is responsive, inclusive and person centred. We remain committed to working collaboratively with service users and families to ensure we meet all the requirements of the personalised care framework and new Mental Health Act.

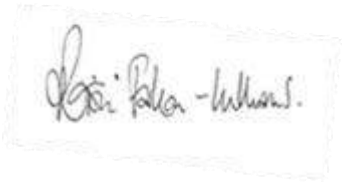
A number of services have been inspected by the Care Quality Commission in the reporting period and the Trust no longer has any regulatory sanctions in place or areas that are inadequate, a number of services have been recognised as Good. Through effective use of the Patient Safety Investigation and Response Framework we have seen a significant reduction in Preventing Future Deaths Reports following inquests, demonstrating the Trust as focussed on learning and just culture.

Looking ahead we will continue to focus on improving quality, reducing variation and ensuring that every service user receives the highest standard of care. We are grateful to our staff for their unwavering dedication and to our patients and partners for their ongoing trust and support.

This Quality Account provides an honest assessment of our performance and sets out our priorities for the year ahead. We are committed to building on our progress and delivering meaningful improvements that make a difference to the lives of those who live or work in the communities we serve.

To the best of my knowledge, the information contained in the Quality Account is accurate.

Roísìn Fallon-Williams
Chief Executive Officer



Phil Gayle
Chair

Background

Once a year, every NHS Trust produces a Quality Account Report. This report on behalf of Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) includes information about the services we deliver, how well we deliver them and our plans for the following year.

Our aim in this Quality Account Report is to make sure that everyone who wants to know about what we do, can access that information. All Quality Account Reports are stored on the Trust website and available at NHS providers – quality-accounts@nhs.net

What the Quality Report includes:

- How we performed last year (2025/26), including where our services improved.
- What we plan to do next year (2026/27), what our priorities are, and how we intend to address them.
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS Trusts
- Stakeholder and external assurance statements.

Purpose and Activities of our Trust

BSMHFT provides comprehensive mental healthcare services for the residents of Birmingham and Solihull and to communities in the West Midlands and beyond.

With more than 40 sites, we serve a culturally diverse population of 1.3 million, spread out over 172 square miles. We have a dedicated workforce of around 6,000 staff and a range of local and regional partnerships, making us one of the most complex and specialist mental health foundation trusts in the country. Our catchment population is ethnically diverse and characterised in places by high levels of deprivation, low earnings, and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas.

One Vision

We have a vision to continually **improve mental health wellbeing** which is underpinned by three core values.

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

Compassionate	Inclusive	Committed
• Supporting recovery for all and maintaining hope for the future. • Being kind to ourselves and others. • Showing empathy for others and appreciating vulnerability in each of us.	• Treating people fairly, with dignity and respect. • Challenging all forms of discrimination. • Valuing all voices so we all feel we belong.	• Striving to deliver the best work and keeping service users at the heart. • Taking responsibility for our work and doing what we say we will. • Courage to question to help learn, improve and grow together.

We continue to be ambitious about the quality of care that we provide, that we have developed in partnership with our Experts by Experience and our colleagues.

Our Ambition

To deliver the highest quality services in a safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve.

Our Aims

- A focus on a positive service user experience
- A focus on preventing harm.
- A focus on a positive safety culture
- A focus on quality assurance
- A focus on using our time more effectively.

PART 2: Priorities for Improvement and Statements of Assurance from the Board.

2025/26 Quality Improvement Priorities – Progress on the priorities

Continuous quality improvement is of paramount importance to BSMHFT, and we have strived over the last year to deliver on the Quality Priorities we set in our Quality Account 2024/25. This section of the report describes the progress we have made in these areas.

In creating our quality priorities and goals, we have considered the aspirations in the NHS 10 year Plan and consulted with stakeholders on what matters to them locally.

Quality Goal Priority 1: Service User Experience

Why is this a priority?

To improve our services, we must collaborate with the people who use them through meaningful partnership working. We must be able to listen to, learn from and empower the people and communities we serve to ensure that the best standards of care are provided. To do this we must continue to engage with our Experts by Experience and increase the opportunities for people to participate in shared decision making in both treatment and care and service improvement.

Through strong engagement with our populations, we will enable the voice of individuals that are in contact with our services to be heard leading to enhancements in our services in line with expectations and need. Engagement processes and improvement plans will enable us to drive system change to address health inequalities and deliver the most appropriate responses to the care required.

Service User Experience	
Why is this important? Shared decision making with service users and families about their treatment and care to aid their recovery.	**Measures of success:** • Implement the actions following the endorsement of the HOPE Strategy delivering the outcomes with patients, service users and families. • Co-produce with Experts by Experience the implementation of a plan including goals and

	outcomes against national frameworks to identify and address health inequalities, such as Patient and Carer Race Equality Framework (PCREF), Equality Diversity System 2022, the Accessible Information Standard and Patient Led Assessments of Care Environments. • Co-produce with service user networks plans and goals to strengthen involvement for people who identify with a protected characteristic as per the Equality Act 2020 • Identify and measure quality improvement projects with service users/carers and co-produce measurable outcomes to deliver against plans.

What we achieved…

The Experts by Experience (EBE) Programme -The Experts by Experience (EBE) Programme continues to play a central role in ensuring that service users and carers are meaningfully involved in shaping Trust services. The programme supports our duties under the NHS Constitution by enabling direct participation in service planning, improvement, and decision-making.

The programme is built on a rights-based and inclusive approach, offering flexible, accessible involvement opportunities aligned with individual preferences and lived experience.

Participation is founded on the following principles:

- Every service user, family member, and carer has the right to be involved in decisions about their care.
- They also have the right to contribute to Trust-wide initiatives through the EBE programme.
- Individuals can select co-production activities that reflect their interests and lived experiences.

The HOPE Strategy (Health through Opportunities, Participation and Experience), developed collaboratively with EBEs, continues to guide this work and is embedded within the Trust's Culture of Care Framework. Current EBE Involvement Opportunities Included:

- Recruitment and selection panels
- Membership of the PEAR Group
- Co-delivery of the Recovery for All Forum
- Co-facilitation within the Recovery College
- Quality improvement advisers
- Educators and induction facilitators
- Lived Experience Action Research (LEAR) contributors
- Safety partners
- Policy and procedure review
- Patient Council co-facilitation
- AVERTS training co-delivery

The monthly HOPE Action Group continues to provide a structured forum for co-production between EBEs and staff.

Recent achievements include:

- Development of a new accessible information and communication policy
- Review of multiple Trust policies
- Contribution to the Estates Strategy review
- Co-production of an EBE service evaluation

Collectively, EBEs have contributed over 2,519 hours this year.

The EBE Programme continues to strengthen service user and carer involvement across the Trust, contributing directly to quality improvement, strategic development, and cultural change. The programme's expansion and planned developments provide clear assurance that participation will remain a core organisational priority.

Quality Goal Priority 2: Preventing Harm

Why is this a priority?

Working within the Patient Safety Incident Framework we will learn from events/incidents to achieve person-centred, safe quality care and meet regulatory compliance to prevent harm.

Learning from incidents under PSIRF is crucial for several reasons. PSIRF provides a structured approach to investigating and responding to patient safety incidents, ensuring that healthcare organizations systematically identify the root causes of errors and adverse events. This process is essential for understanding not only what went wrong, but also why it happened, enabling the development of targeted interventions to prevent recurrence. By analyzing incidents thoroughly, PSIRF fosters a culture of transparency and continuous improvement within healthcare settings, where staff feel encouraged to report and learn from mistakes without fear of blame. This openness is fundamental to building trust among healthcare professionals and patients alike.

Additionally, learning from incidents helps to identify systemic issues and inefficiencies that may compromise patient safety, leading to organisational changes that enhance overall care quality. It also provides valuable insights that can inform policy decisions, clinical guidelines, and training programs, ultimately contributing to safer healthcare environments. Embracing the principles of PSIRF ensures that lessons learned from incidents are effectively integrated into practice, promoting resilience and adaptability in healthcare systems.

Preventing Harm	
Why this is important? A quality assurance framework will underpin and give assurance of the quality of our services and care on a continual basis.	**Measures of success:** • Use data to understand outcomes and develop opportunities for improvement. Though the development of data dashboards progress will be monitored in real time. • Provide evidence that all teams across the Trust have systems of audit and assurance in place. And can provide evidence that improvements are being made. • Ensure that there is equality and inclusion within our system through data dashboards. • Implement the Trust Quality Management System

What we achieved…

Quality and safety dashboards for the Acute & Urgent Care and Integrated Community Care & Recovery divisions are now established, with a structured programme in place to expand development across additional areas. These dashboards provide real-time feedback to support continuous monitoring and improvement.

A real-time dashboard for Reducing Restrictive Practice is also in place, enabling teams to access up-to-date data to enhance quality and safety outcomes. This tool is actively used within Reducing Restrictive Practice and Quality Assurance Group to drive quality improvement initiatives and to identify and respond to areas of potential risk.

In addition, the Physical Health Team is developing a real-time dashboard focused on physical health metrics and benchmarking. This work will enable the integration of physical health data into divisional quality and safety dashboards, strengthening oversight and supporting improved patient outcomes.

A Culture of Care QI programme dashboard is in place for all divisions to monitor service delivery and enable data-driven decision making at leadership and ward/service levels. It will be reported via the Trust Culture of Care Programme Group.

All directorates undertake structured audits within the AmaT system. In addition, specialist services carry out targeted audits across all divisions using AmaT, with specialties being the only division to consistently undertake this level of cross-divisional review. Audit data is reviewed within the Quality Assurance Group to monitor trends and identify areas of concern relating to quality and compliance.

There are 102 quality audits running on AMaT, across all 5 directorates. Monthly reporting of compliance percentages on all quality audits via Quality Assurance Group. Monthly reporting of outstanding and overdue actions of all quality audits via Quality Assurance Group.

In the last year the Trust conducted 117 quality audits across multiple service areas, reflecting a strong commitment to quality assurance, safety, and compliance. Audit coverage spans clinical, operational, and specialist domains, with focused attention on Community Services, Children and Young People, Mental

Health Legislation/Community Treatment Order compliance, and Acute Care. This marks a substantial increase from the 47 audits reported to the Trust CGC in October 2025, underscoring the extensive engagement of ward teams in system integration.

In specialised sectors such as Acute Care, quality audits encompass systematic evaluation of ward management, clinical procedures, patient documentation, risk assessments, and physical health, thereby underpinning assurance at both local and organisational levels.

The implementation of AMaT has significantly enhanced audit completion and oversight by providing a centralised, user-friendly platform with comprehensive analytics. This advancement has optimised efficiency, accuracy, and transparency of the Trust's audit processes.

Audits are now conducted within AMaT, facilitating instant visibility, efficient monitoring, and reduced administrative burden compared to previous manual approaches. The system minimises errors—including incorrect or incomplete submissions—by displaying only relevant, active proformas, and supports collaborative audit creation and supervision among staff members. Reporting time has been notably reduced from over one day to mere minutes; real-time quantitative data and trend analysis further reinforce assurance and improve service user experience.

There were 65 local clinical audit projects registered in 2025/26. 15 of those have been closed with completed actions. Another 13 have been completed with open actions. The remaining projects have ongoing data collection or are due to start this quarter (as were registered in the last two months). All Clinical Audits are reported via Clinical Effectiveness Assurance Group and cascade of learning is shared with members and Local Clinical Governance Forums.

A proforma to support delivery of the 15 Steps Challenge has been developed, alongside a structured programme of Non-Executive Director visits. A defined information pack will be provided in advance to support the visits and strengthen the feedback loop. Experts by Experience (EBEs) are contributing questions to help ensure visits are meaningful and provide valuable insight. Visits take place on the same day at Trust quality Committee to support triangulation of assurance.

Quality Goal priority 3: Patient Safety Culture

Why is this a priority?

To ensure that the organisation meets internal and external requirements to deliver the highest standards of care. A robust patient safety culture is vital because it underpins the entire framework of healthcare delivery, ensuring that safety is prioritised at all levels of our organisation. A strong patient safety culture promotes an environment where healthcare professionals feel empowered and obligated to report errors, near misses, and potential hazards without fear of retribution. This transparency is essential for identifying and addressing issues before they result in harm. In such a culture, safety is seen as a collective responsibility, fostering collaboration and communication across multidisciplinary teams. It encourages continuous learning and improvement, where the focus is on understanding and mitigating risks rather than assigning blame. By prioritising patient safety, healthcare organisations can reduce the incidence of adverse events, enhance the quality of care, and build trust with patients and their families. Moreover, a positive safety culture supports staff well-being by reducing the stress and burnout associated with working in environments where mistakes are hidden or ignored.

Patient Safety Culture	
Why is this important? A patient safety culture will strengthen the confidence to speak up and promote learning and will enhance the values, beliefs and behaviours that support patient safety.	**Measures of success:** • Identification and response to the Measurement of compassionate engagement with those affected by patient safety incidents • Uptake of training provided by the Freedom to Speak Up Guardian Team to ensure managers and staff have greater confidence in speaking up and resolving issues • Complete the co-production and implementation of the Staff Safety Strategy. • Strengthen the approach to raising awareness and taking actions in support of service users, families, carers and staff who experience domestic abuse . • Further development of the role of Expert By Experience Safety Specialists in Clinical Governance Committees • Develop a framework for reporting the outcomes from Dialogue+

What we achieved…

The patient safety team in partnership with the Trust Chief Psychologist implemented an enhanced staff support framework that is offered to all staff following an incident. The psychological impact of incidents on staff is reported through the eclipse system and feature in discussion and assurance through the Trust Health & Safety Committee and the Quality Committee.

The Trust has coproduced a Staff Safety Strategy which has been launched through the Culture of Care Programme and is monitored through the Health & Safety Committee. As a result the Trust has put more focus on insuring that incidents of harm to staff are appropriately reported to the police, that staff have access to and know how to use the sky guard personal safety equipment, and increases actions to address racist abuse experienced by staff from patients and service users.

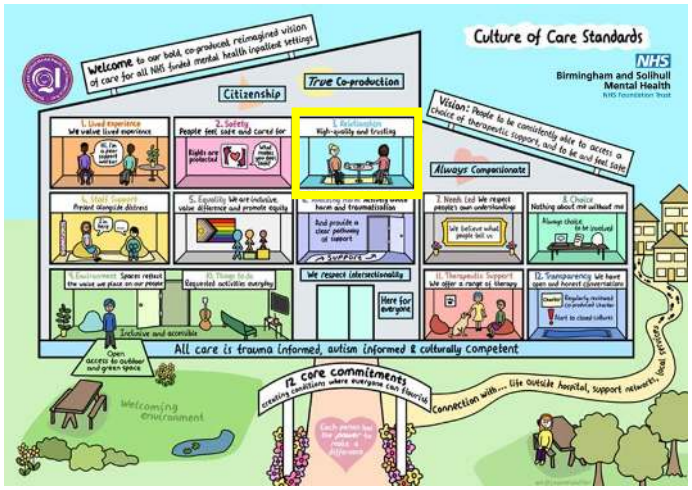
Through the 'Think Family' programme the team have completed work on reducing adult(child) domestic abuse to parents/carers, actions taken included; reviewing and analysing eclipses in relation to Adult Child Parent Abuse and identified hot spot areas, designed bitesize training which is co-delivered by the Birmingham Solihull Women's Aid Independent Domestic Violence Advocate and a safeguarding facilitator to teams across the Trust and developed a 7 min briefing on Adult Child Parental Abuse.

In Memory of Mustak a valued and loved Trust Governor who passed away, the Trust implemented a model for 15 Steps Visits at his request. The model has been embedded in the Culture of Care approach and ensures there is visible and intentional leadership supporting clinical teams and giving the time and space to listen to their challenges and celebrate their successes.

15 Steps Visits

In Memory of Mustak

BSMHFT



Quality Goal Priority 4: Quality Assurance

Why is this a priority?

As an organisation we want to ensure that we meet fundamental standards of quality and safety and meet the needs of our population. Quality assurance is critically important to our organisation as it ensures that our services consistently meet established standards and deliver safe, effective, and patient-centred care. By systematically monitoring, evaluating, and improving processes, quality assurance helps identify areas where care may fall short of guidelines or expectations, enabling timely interventions to rectify deficiencies. This continuous cycle of assessment and improvement fosters a culture of excellence and accountability, where staff are committed to maintaining high standards and continuously seeking ways to enhance care delivery. Effective quality assurance processes protect patients from harm by reducing variability in care practices, ensuring adherence to evidence-based protocols, and promptly addressing potential safety issues. Additionally, it supports organisational learning by providing data-driven insights that inform strategic decisions, resource allocation, and staff training programs. Quality assurance is essential for optimising efficiency and ensuring that our service users receive the highest standard of care possible. Ultimately, robust quality assurance mechanisms contribute to improved patient outcomes, increased patient satisfaction, and trust in our services.

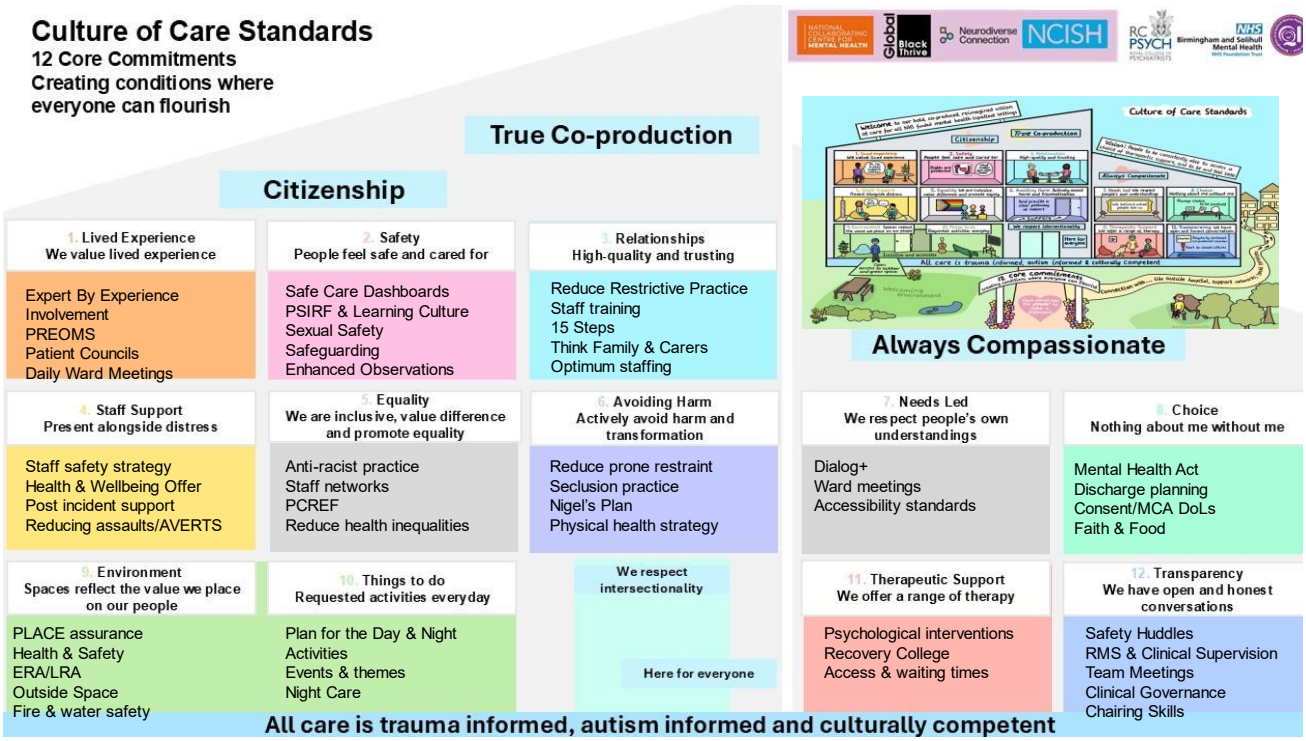
Quality Assurance	
Why is this important? It will give clarity in relation to how we monitor and evaluate service delivery.	**Measures of success:** • Implementation of dashboard for Quality & Patient experience committee to utilize data and understand outcomes in care for service users. • Evidence that pathways in Locality Delivery Areas have been created to meet the needs of service users and communities • Utilization of AMAT through the Clinical Effectiveness Group to provide assurance for services and Quality & Patient Experience Committee. • Implement 15 Steps visits and provide feedback for services and reporting for the Quality & Patient Experience Committee. • Align the 12 Culture of Care standards with the CQC I Statements ensuring a joined up approach to evidencing outstanding care.

Culture of Care Programme

Adopting the coproduced twelve National standards the Trust has now engaged all clinical services in signing up to the Culture of Care Standards and developed a Trust Culture of Care Excellence Framework to improve care, develop teams, share and celebrate positive achievements, the framework brings together tools and resources for teams and allows for self assessment to progress through to Bronze, Silver or Gold Accreditation.

Starting with four national pilot sites the Trust has now aligned all patient safety and quality work to the twelve standards, aligned them with the CQC I statements and rolled out the framework to ensure the right resources, focus and support for patient, service users and their families over the next two years.

The progress made by the Trust and approach to innovation in Governance has been recognized by the National Leads, including the fantastic progress at Reaside Clinic highlighted below.



Reaside - Live Love Life

What's worked well

- Clean up week: Was a resounding success with the support of all leads, staff and service users.
- Sustainable community initiatives started at Reaside including employability sessions.
- Staff QI training uptake in May exceeded previous numbers
- CQC notice lifted
- EBEs involved in the recruitment of staff through a unique speed dating approach. EBE's have also reviewed PICU care, and with Psychology and OT.
- The OT Team have developed and implemented a learning style survey for service users to help with levels of engagement in the current group programme.
- Reach Out have attended Reaside EBE suppers and have asked to cite the EBE work as best practice in their upcoming workshops.
- The Resident's Council has stabilised and working better with an EBE co-chair to be elected soon.

Quality Goal Priority 5: Using Our Time More Effectively

Why is this a priority?

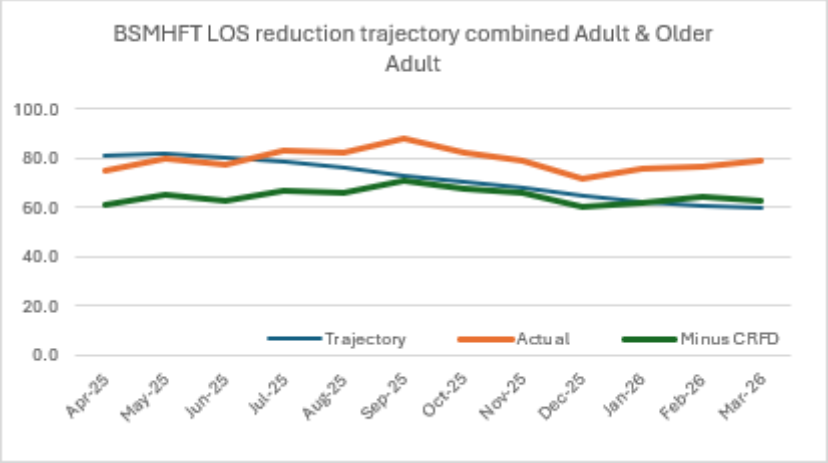
To maximise the quality and standard of care provided. To ensure that individuals within our care pathways feel listened to, valued, and receive appropriate care at the right time. Using time effectively is crucial in our organisation due to the high demand for our services. Efficient time management ensures that healthcare professionals can maximize the quality of care provided to our service users while minimising delays and wait times. By prioritising tasks, streamlining workstreams, and reducing unnecessary administrative burdens, we can devote more time to direct patient care, enhancing the patient experience and improving overall health outcomes. Effective time management also helps in managing workloads more sustainably, reducing stress and burnout among staff, which is essential for maintaining a motivated and resilient workforce. Furthermore, when time is used efficiently, it supports better utilisation of resources, including facilities, equipment, and personnel, leading to cost savings and more effective allocation of NHS funds. This optimisation of time and resources not only improves operational efficiency but also supports strategic planning and the ability to respond swiftly to emerging challenges. Ultimately, effective time management in our organisation is fundamental to delivering high-quality, patient-centred care in a timely and resource-efficient manner, contributing to the overall sustainability and effectiveness of the healthcare system.

Managing our Time Effectively	
Why is this important? To enhance patient care and staff satisfaction.	**Measures of success:** • Demonstrate outcomes against Quality Improvement Programmes that demonstrate improvement in the Culture of Care in Inpatient Settings. • Outcomes that demonstrate that evidence-based practice and research are a routine way to inform transformation of care and services. • Evidence related to the reduction in waiting lists and length of stay. • Better use of service user's time (less waiting) including; Children, people accessing talking therapies and people returning to the community from inpatient settings.

What we achieved…

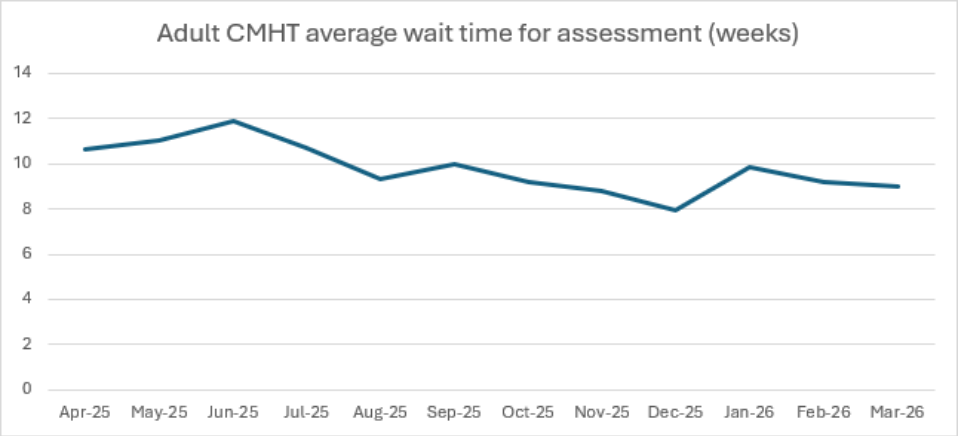
Reducing length of stay

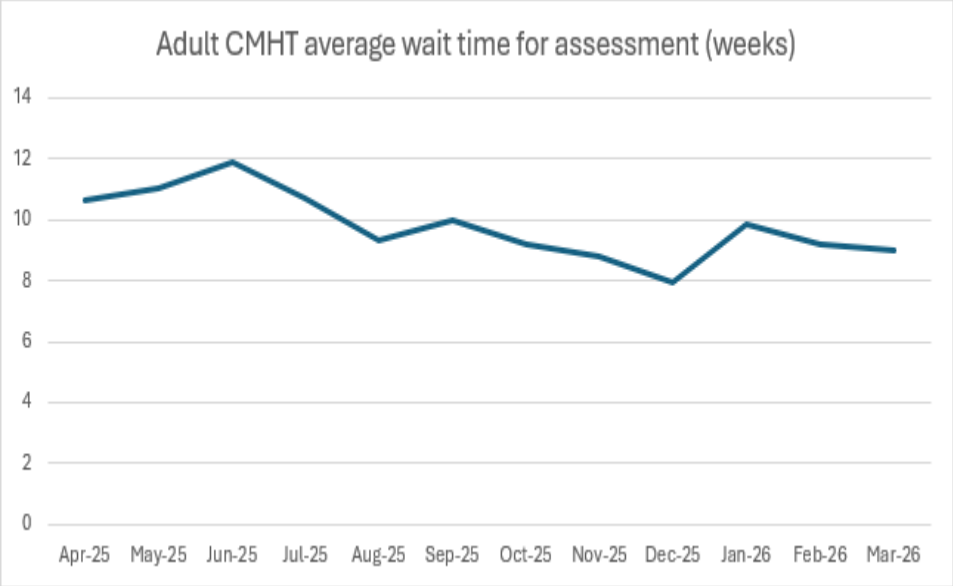
As part of the national planning submission requirements for 2025/6, the Trust submitted a combined adult and older adult acute inpatient services trajectory focusing on reducing length of stay. Actions have been in place supported by a productivity plan in adult acute services. The key areas of focus include, admission avoidance, discharge planning and support working with partner organisations to support with care packages as required in the community to facilitate discharge when service users are clinically ready with routine ward level actions to progress and minimise delays. As the chart below highlights, the Trust's ability to meet the 2025/26 trajectory was impacted by the proportion of service users in both adult and older adult acute inpatient services who are clinically ready for discharge due to delays outside of Trust's control with service users experiencing delay in discharge resulting in extended stay in hospital and impacting the Trust's length of stay position. Partnership working continues with aim of supporting a reduction in such delays enabling the trust to use the beds more effectively.



Reducing waiting times in community teams

There has been a continued focus on reducing longer waiting times within community services with reductions in adult and older adult CMHTs. The graph below shows a reduction in the average waiting times within adult CMHTs for assessment. In terms of adult CMHT waits, the length of time patients are waiting for an assessment is showing gradual reduction.





The Trust also continues to meet the following national waiting time access standards:

- 95% national standard for routine and urgent care access to the Trust's Eating Disorder service.
- 60% national standard for service users experiencing first episode of psychosis.
- 75% national standard for service users seen within 6 weeks of referral to the Trust's Talking Therapy service.
- 95% national standard for service users seen within 18 weeks of referral to the Trust's Talking Therapy service.

2025/26 also saw the introduction of a new model of care, a 24/7 community service being part of a national pilot programme which aims to see people in a timely way according to their needs. The model allows flexibility for service users to access services without making formal appointments and to receive enhanced support when required to maintain continuity of care.

Quality Improvement Priorities for 2026/27

7. Our refreshed strategic priorities

As part of the refresh of our Trust Strategy for 2026 -31 we have reviewed our strategic priorities and aims. Our new strategic priorities, the '4Cs', are **Care**, **Communities**, **Culture** and **Creativity**.

Care brings together the previous Clinical Services and Quality priorities, and includes:

Transforming services
- Adopting a life course approach
- Strengthening how we provide services in the community
- Enhancing urgent and emergency care
- Reducing inpatient length of stay
- Implementing a new model of care for children and young people

Focusing on service user, family and carer experience
- Using service user and carer experience to drive improvements in care
- Valuing lived experience
- Being recovery and outcomes focused
- Improving the experience of families and carers

Creating a culture of care
- Celebrating high-quality care through our Culture of Care programme
- Creating the right therapeutic environments
- Ensuring people feel safe and cared for and that we actively avoid harm
- Care led by the individual needs of our service users

The professional skills and standards elements of quality are included in the **Culture** priority and research is included in **Creativity**

Priority One – Transforming Services

Improve the safety of transitions in care between Services and Teams for people on a mental health or learning disability &/or autism pathway by removing referral barriers and reducing waiting times.

Achieve learning Disability and Autism Accreditation in Acute Services, improving patient reported outcomes and family feedback about our care for people with a learning disability and/or autism.

Priority Two - Focusing on service user, family and carer experience

Implement Patient Reported Outcome and Experience Measures across all services ensuring the feedback drives improvement priorities and provides assurance on progress. Involve patient councils and experts by experience in the processes for assuring that the voice of services users drives their care.

Coproduce and implement a Family & Carer Charter with clearly defined standards that can be monitored and achieved. Engaging with communities, families and carers ensure their voice is captured through Dialog+ service user records and they are provided with support for their own mental wellbeing.

Priority Three - Creating a Culture of Care (Standards 10 and 11)

Coproduce and implement a model and standards for 'Night Time Care' for in-patient settings, recognising that the care provided for patients at present is very different between 'in-hours' and 'out of hours'. This priority comes directly from patient feedback and should include reporting through to patient councils on progress.

Increase the range and opportunities for access to a range of therapy and activities for patients and service users. For patients and services users in the community or in hospital there may be limited access to interesting and fulfilling exercise, hobbies, learning, work, activities and opportunities for creativity and fun. There is a direct correlation between access to activities and reduced restrictive practice, enhanced recovery and self-esteem. More focus on activities should enhance the health of service users and staff.

Statements of Assurance from the Board

This section of the report includes a series of statements of assurance from the Board of Directors. The exact form of the statements is prescribed and
specified by the 'quality account regulations' and as such the wording of these statements is statute and unable to be changed.

	Prescribed information	**Form of Statement**
1.0	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	During 2025/26 BSMHFT provided the following mental health services: A&E Liaison Adult Acute Ward Adult CMHT Adult Day Care AOT Child and Adolescent Mental Health Services (CAMHS) Deaf Inpatient Eating Disorders Community Eating Disorders Inpatient Early Intervention Forensic CAMHS Community Forensic CAMHS LOW SECURE Forensic CAMHS MEDIUM SECURE High Dependency Wards Home Treatment Homeless and addiction IAPT Justice Liaison Low Secure Perinatal Community Perinatal Inpatient Medium Secure Wards

		Neuropsychiatry Older Adult Acute Ward Older Adult Community Memory Services OPIP (Older Adult Day Care) Psychiatric Intensive Care Unit (PICU) Primary Care Prison Mental Health Care Rehabilitation Ward Substance Misuse Services Twenty Four Seven East Birmingham Mental Health Centre
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	BSMHFT has reviewed all the data available to them on the quality of care in these services.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2025/26 represents 91.8 % of the total income generated from the provision of relevant health services by BSMHFT for 2025/26.

Participation in National Clinical Audits and National Confidential Enquiries

	Prescribed information	**Form of statement**
2.0	The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period, and which covered the relevant health services that the provider provides or subcontracts.	All directorates undertake structured audits within the AmaT system. In addition, specialist services carry out targeted audits across all divisions using AmaT, with specialties being the only division to consistently undertake this level of cross-divisional review. Audit data is reviewed within the Quality Assurance Group to monitor trends and identify areas of concern relating to quality and compliance. There are 102 quality audits running on AMaT, across all 5 directorates. Monthly reporting of compliance percentages on all quality audits via Quality Assurance Group. Monthly reporting of outstanding and overdue actions of all quality audits via Quality Assurance Group.

		National - 7 of the 8 national projects available on AMaT (exception is the National Audit of Eating Disorders which has not begun it's service user-related data collection phase). All Prescribing Observatory of Mental Health National QIPs are available on AMaT. We are one of only two Trusts that work this way. It allows the Trust to conduct early reporting on results whilst the national report is prepared by POMH (which can take six months or more). Trustwide / High Priority – 10 clinical audit projects registered under this priority level, with two entering reaudit phase (second round).
2.1	The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period Birmingham and Solihull Mental Health NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in.	The national clinical audits and national confidential enquiries that the Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in during 2024/25 are as follows: • National Audit of Care at the End of Life (NACEL) – Mental Health Spotlight Audit • National Audit of Dementia (NAD) - Spotlight on Memory Assessment Services • National Audit of Eating Disorders (NAED) • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • POMH 16c: Rapid Tranquilisation • POMH 18c: The Use of Clozapine • POMH 21b: The Use of Melatonin • POMH 24a: Opioid Medications in Mental Health Services
2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in.	• National Audit of Care at the End of Life (NACEL) – Mental Health Spotlight Audit • National Audit of Dementia (NAD) - Spotlight on Memory Assessment Services • National Audit of Eating Disorders (NAED) • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • POMH 16c: Rapid Tranquilisation • POMH 18c: The Use of Clozapine • POMH 21b: The Use of Melatonin • POMH 24a: Opioid Medications in Mental Health Services
2.4	A list of each national clinical audit and national confidential enquiry that the	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health

	provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	NHS Foundation Trust participated in, and for which data collection was completed during April 2025 to March 2026 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Title of National Clinical Audit	Eligible	Participated	%*
LeDeR – Learning from Lives and Deaths – People with a Learning Disability and Autistic People	Yes	Yes	N/A
National Audit of Eating Disorders (NAED)	Yes	Yes	N/A
National Audit of Dementia (NAD) - Spotlight on Memory Assessment Services	Yes	Yes	100% (50)
National Clinical Audit of Psychosis (NCAP) – Early Intervention Services	Yes	Yes	100% (57)
POMH 16c: Rapid Tranquilisation	Yes	Yes	100% (50)
POMH 18c: The Use of Clozapine	Yes	Yes	100% (73)
POMH 21b: The Use of Melatonin	Yes	Yes	100% (41)
POMH 24a: Opioid Medications in Mental Health Services	Yes	Yes	100% (45)

2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of 7 national clinical audits were reviewed by the provider in 2025/26 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	
2.7	The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.	There were 65 local clinical audit projects registered in 2025/26. 15 of those have been closed with completed actions. Another 13 have been completed with open actions. The remaining projects have ongoing data collection or are due to start this quarter (as were registered in the last two months). All Clinical Audits are reported via Clinical Effectiveness Assurance Group and cascade of learning is shared with members and Local Clinical Governance Forums.
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	

Research

	Prescribed Information	Form of Statement
3.0	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	The number of patients receiving relevant health services provided or subcontracted by Birmingham and Solihull Mental Health NHS Foundation Trust in April 2025-March 2026 that were recruited during that period to participate in research approved by a research ethics committee is 402.

CQUIN

Prescribed Information	Form of Statement
Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement, or arrangement with for the provision of relevant health services.	BSMHFT income in 2025/26 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.
If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	
If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	

Care Quality Commission

Registration with the Care Quality Commission (CQC)

Prescribed Information	Form of Statement
Whether or not the provider is required to register with CQC under Section 10 of the Health and Social Care Act 2008.	Birmingham and Solihull Mental Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional. BSMHFT has the following conditions on registration – none. Birmingham and Solihull Mental Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional. BSMHFT has the following conditions on registration – none. Birmingham and Solihull Mental Health NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 1 April 2025 to 31 March 2026. Focused Inspections of: ○ Lavender and Saffron Wards at Zinnia Centre, Eden Acute, Eden Psychiatric Intensive Care Unit, George Ward, Endeavour House and Larimar (June 2025) ○ Healthcare Wards at HMP Birmingham (October 2025) ○ Home Treatment Teams, Psychiatric Liaison Teams, Psychiatric Decisions Unit and Health Based Place of Safety ○ Older Adults Community Mental Health Teams (February 2026) ○ Long Stay Rehabilitation Wards (March 2026). Birmingham and Solihull Mental Health NHS Foundation Trust has developed and submitted detailed action plans to the Care Quality Commission on the actions being taken to address the findings from each inspection and provide updates on progress at each Engagement Meeting for those inspections where the report has been received.

Data Submission

Prescribed Information	Form of Statement
Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider.	Birmingham and Solihull Mental Health NHS Foundation Trust did not submit records during 2025/26 the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's: (i) valid NHS number (ii) General Medical Practice Code (b) the percentage of records relating to outpatient care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code (c) the percentage of records relating to accident and emergency care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code.	

Information Governance

Prescribed Information	Form of Statement
The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.5	Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Assessment Report for 2025 / 2026 is not due to be submitted until the 30th June 2026 in line with national submission timescales relating to the Data Security and Protection Toolkit. At the time of writing, the Trust's 2024 / 2025 toolkit rating is 'approaching standards'. Subject to completion of the related action plan due by end March 2026, it is anticipated that the Trust's attainment rating will then be revised to 'standards met'. Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Assessment Report for 2025 / 2026 is not due to be submitted until the 30th June 2026 in line with national submission timescales relating to the Cyber

	Assurance Framework - Data Security and Protection Toolkit. The 2025/26 Cyber Assurance Framework - Data Security and Protection Toolkit attainment level for the Trust was 'approaching standards'. Based on this result the Trust submitted action plans to NHSE which were approved by NHSE, and progress continues against these actions.

Payment By Results

Prescribed Information	Form of Statement
Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.	Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2025/26.
If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider	

Data Quality

Prescribed Information	Form of Statement
The action taken by the provider to improve data quality.	Birmingham and Solihull Mental Health NHS Foundation Trust will be taking the following actions to improve data quality: • Maintaining regular assessment of the quality of data underlying all key performance measures so that any issues can be addressed. • Continuing detailed audit and review of the accuracy of clinical case classification, activity monitoring and clinical outcome measurement information • On-going comparison of service user contact and GP registration details with the national NHS Summary Care Record database to ensure information in our clinical systems stays up to date. • Close monitoring and continuous quality improvement work on a range of data quality performance indicators, with clinical and

	administrative staff using monitoring reports to identify and correct data errors. • Maintaining work on completeness and validity of Mental Health Services Data Set (MHSDS) submissions guided by the nationally defined Data Quality Maturity Index • Improving the completeness of Restrictive Interventions data submitted to the MHSDS • Maintaining work on completeness and validity of NHS Talking Therapies data submissions and the related experimental data set items added to the Data Quality Maturity Index • Active data quality support to operational services by service-aligned data analysts bringing any data issues forward for attention and supporting and monitoring improvement actions • A range of data quality audits covering key reporting data sets, with special in-depth audits and corrective work where data quality issues are identified. • Reviewing national methodologies for the new metrics included within NHSEs National Oversight Framework and the metrics submitted as part of the 2026/27 national Planning submission, identifying data quality improvement actions. • Programme of data quality work in place to support integration of reporting for Children and Young Peoples services following transfer to BSMHFT from Birmingham Women's and Children's Trust on 1st July 2025.

Learning from Deaths

The Trust is committed to learning from deaths to improve the quality and safety of care provided to patients and their families. Reviews of deaths provide an opportunity to understand how care is delivered in practice and to identify opportunities to strengthen systems of care.

The Trust undertakes reviews of deaths in line with national guidance published by NHS England.

Number of Deaths

During the reporting period 1093 patient deaths were recorded of which 809 were reported as expected and 284 unexpected.

This compromised of the following number of deaths which occurred in each quarter:

Q1 258 Q2 305 Q3 251 Q4 279

Of these deaths:

171 Structured Judgement Reviews (SJRs) were commissioned, the table below provides a breakdown per quarter:

Q1 35 Q2 39 Q3 37 Q4 60

Case record reviews were undertaken using the nationally recognised Structured Judgement Review methodology, which supports clinicians to review care and identify learning.

3 Patient Safety Investigations were commissioned, as they were adjudged to be more likely than not due to problems in the care provided

Learning Identified

Across investigations and learning responses, consistent themes emerging

• Increased vulnerability during discharge, leave, transfer and waiting periods.

• Risk building over time without always triggering timely senior review.

• Actions agreed not consistently tracked through.

• Safety plans present but not always guiding day to day care.

These themes are recurrent across pathways and show how risk develops and presents over time, particularly where care changes or need increase.

What Has Been Done in Response

In response to this learning, targeted improvement work is already underway across the Trust to strengthen how emerging and cumulative risk is recognised and responded to in practice.

This includes:

• A more consistent approach to follow-up and response where early warning signs of deterioration are identified (missed depot medication, repeated crisis contact, non-engagement).

• Improved identification of repeated or escalating presentations to support timely review of care.

• Earlier and more consistent senior clinical input where risk is increasing.

• Clearer translation of MDT and crisis decisions into ongoing care.

• Greater focus on review of risk at key transition points, including discharge, leave and transfer.

• Improvements to Duty and access systems to support timely response to risk at the point of contact.

Engagement with Families

Families are offered the opportunity to raise questions or concerns about the care provided to their relative. Learning from deaths reviews seek to ensure that family perspectives are considered wherever possible. Trust colleagues have met with a number of families to discuss incidents and support involvement in investigation; this is coordinated by a dedicated Family Liaison Officer.

Reporting Against Core Indicators

The Trust is required to provide performance details against a core set of quality indicators that were part of a new mandatory reporting requirement in the Quality Accounts from 2013 with the data being supplied by NHS Digital as follows:

- The percentage of patients on Care Programme Approach who were followed up within 7 days of discharge from psychiatric inpatient care during the reporting period.
- The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.
- Readmission to hospital within 28 days of discharge.

The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period

The percentage of service users being treated under the Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care is shown in the table below. This indicator identifies whether people with a mental illness discharged from our inpatient wards have a direct face-to-face or telephone follow-up contact with a member of clinical staff on at least one of the seven days following discharge. The measure aims to ensure that service users are protected at a time of significant vulnerability and appropriately supported through their transition back into day-to-day life outside hospital.

	Birmingham and Solihull Mental Health NHS Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2025-26	92.9%	*	*	*
2024-25	91.7%	*	*	*
2023-24	90.7%	*	*	*
2022-23	92.0%	*	*	*

Data Source: Rio - our internal clinical information system

** No national comparator figures have been collected or published since 2019-20.*

It should be noted that in addition, the Trust aims to follow up 80% of service users within 3 days of discharge in line with national good practise. This measure is routinely monitored, and same actions taken as with 7 day follow up to support staff in carrying out timely follow up.

Our local methodology excludes three groups of service users where the exclusion is not explicitly defined in national guidance, as follows:

- People discharged to non-NHS psychiatric hospitals, because they continue to be under the direct 24- hour care of qualified mental healthcare staff.
- People discharged to an overseas address are excluded from the indicator due to the challenge of contacting people outside the United Kingdom.
- People discharged from our neurological investigations unit because their admissions do not relate to acute psychiatric illness.

Birmingham and Solihull Mental Health NHS Foundation Trust consider that this data is as described for the following reasons:

• A process audit of the Trust's methodology has confirmed that our processes and calculations adhere to national reporting definitions.
• Regular samples of records are compared with clinical progress notes to ensure that they are being correctly included or excluded from indicator calculations.

Birmingham and Solihull Mental Health NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, monitoring adherence to our Trust's policy on community follow-up of inpatient discharge, undertaking regular sample audits and feeding back results to clinical teams, and by ensuring oversight of this process is maintained through circulation of daily reports to senior managers and review at regular divisional performance meetings.

The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

This indicator identifies whether crisis resolution or home treatment teams had assessed people admitted to hospital and been involved in the decision to admit and, therefore, measures our success in ensuring that people are not admitted to hospital where they could be more appropriately cared for in their own home or another community location. As such, it is a measure of both quality of care and efficiency of resource use. National definitions exclude transfers from other hospitals, including A&E Departments, so the measure is looking at people admitted from their own homes or other community locations. Our local definitions would also consider admissions as having been 'gate-kept' where there was involvement from an assertive outreach or Psychiatric liaison, as these teams also provide a crisis resolution service and consider alternatives to admission as part of their assessments.

	Birmingham and Solihull Mental Health Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2025-26	98.0%	*	*	*
2024-25	96.7%	*	*	*
2023-24	95.9%	*	*	*
2022-23	96.7%	*	*	*

Data Source: Rio - our internal clinical information system

* No national comparator figures have been collected or published since 2019-20.
Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:
• A process audit of the Trust's methodology has confirmed that our processes and calculations adhere to national reporting definitions.
• Regular samples of records are compared with clinical progress notes to ensure that they are being counted correctly in indicator calculations.
Birmingham and Solihull Mental Health NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by ensuring oversight of this process is maintained through regular review.

Readmissions to hospital within 28 days of discharge

The percentage of admissions to Trust hospitals of patients aged:
(i) 0 to 15 and
(ii) 16 or over

which were readmissions within 28 days of discharge from a hospital which forms part of the Trust. There is no national indicator meeting exactly this definition. Trust data is based on all readmissions happening on the same day as a discharge from Trust inpatient services or any of the following 27 days.
This indicator measures quality of inpatient care, discharge arrangements and ongoing community support by identifying the extent to which service users discharged from hospital need to be readmitted within 4 weeks, our Trust's aim being to keep early readmissions to a minimum. National comparison figures are not available.
There is no national data available for comparison for this indicator.

	Age 0-15	Age 16+
2025-26	0.0%	3.4%
2024-25	0.0%	4.52%
2023-24	0.0%	3.78%
2022-23	0.0%	3.9%

Data source: Rio – our internal clinical information system

Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:
• Admission and discharge dates, and service user dates of birth, are audited regularly as part of the Trust's routine data quality audit programme.
• Service user dates of birth are also subject to regular validation against information held on the NHS national Summary Care Record.
Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following action to improve these percentages and so the quality of its services, by ensuring oversight of this process is maintained by monthly reporting and review at service level meetings.

Performance against the relevant indicators and performance thresholds

The following indicators form part of the annexes to the NHS Oversight Framework and are required to be reported upon in this section of the report, unless they are referred to in section 2.
National mental health indicators

	NHSE/I Oversight Framework updated in November 2017: National Indicators – 2025/26	National Threshold	2025/26
1*	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	60%	65%
2	Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. within 18 weeks of referral	50% 75% 95%	48.2%** 94.8% 99.8%
3*	Inappropriate out-of-area placements for adult mental health services (average bed days per month) *	n/a	939***

4*	Admissions to adult facilities of patients under 16 years old	n/a	0

*Please note that from 1st July 2025, Birmingham Women's and Children's CYP mental health services were transferred to BSMHFT from Birmingham Women's and Children's Hospital. Data for this service has been included from 1st July 2025 to end of March 2026 for these metrics.
** For 2025/26, the Trust's 'Moving to Recovery' rate for service users accessing psychological talking therapies was 48.2% It should be noted that this metric is no longer the primary national focus for Talking Therapies with outcome measures focusing on improving 'Reliable Recovery Rate' and the 'Reliable Improvement Rate'. Service level improvement plans are in place.
** For 2025-26 the trajectories for reducing inappropriate out of area placements agreed with commissioners and submitted to NHSE were based on reducing and maintaining no more than 10 PICU active inappropriate placements each month and 0 Acute inappropriate out of area placements. A productivity improvement plan has been in place to support this action with a focus on the following key workstreams, to better manage demand, reduce inappropriate OOA placements and related costs, improve patient experience and optimise services within resources available. The workstreams include admission avoidance, reducing length of stay, including reducing those who are Clinically Ready for Discharge and earlier intervention actions on discharge planning and support.
It should be noted that the existing Standard Operating Protocol (SOP) agreed with commissioners specifying adherence to national qualitative and quantitative criteria that need to be met to classify out of area placements as 'appropriate' was further reviewed to confirm inclusion of additional contract beds commissioned out of area and was approved by commissioners at the end of March 2026.
It should also be noted as recognised by NHSE, that as the SOP includes locally agreed changes these are not reflected in national reporting. There will therefore be a lack of consistency between local and national data. It is recognised nationally that this impacts on all Mental Health Providers who have a SOP in place.

The Friends and Family Test

The Friends and Family Test (FFT) provides service users, carers, and family members with an opportunity to share feedback on their experiences of our services. Core questions include: "Overall, how was your experience of our service?", "Please tell us about anything that we could have done better", and a question selected by our Experts by Experience (EBE) team: "When you have spoken with us, did you feel that we have listened / you have been heard?" reflecting the fundamental importance of feeling heard.

FFT enables respondents to provide free-text comments, ensuring experiences are captured in their own words. The tool actively invites constructive feedback, particularly through the improvement-focused question, which supports ongoing service development and quality improvement.

In addition to traditional postcard and tablet-based collection methods, the Trust provides an online portal to improve accessibility and convenience: https://fftsurvey.bsmhft.nhs.uk/

During 2025, response rates have increased, with Quarter 3 achieving above-average participation and overall response levels remaining generally consistent.

Table 1 – FFT responses January – December 2025

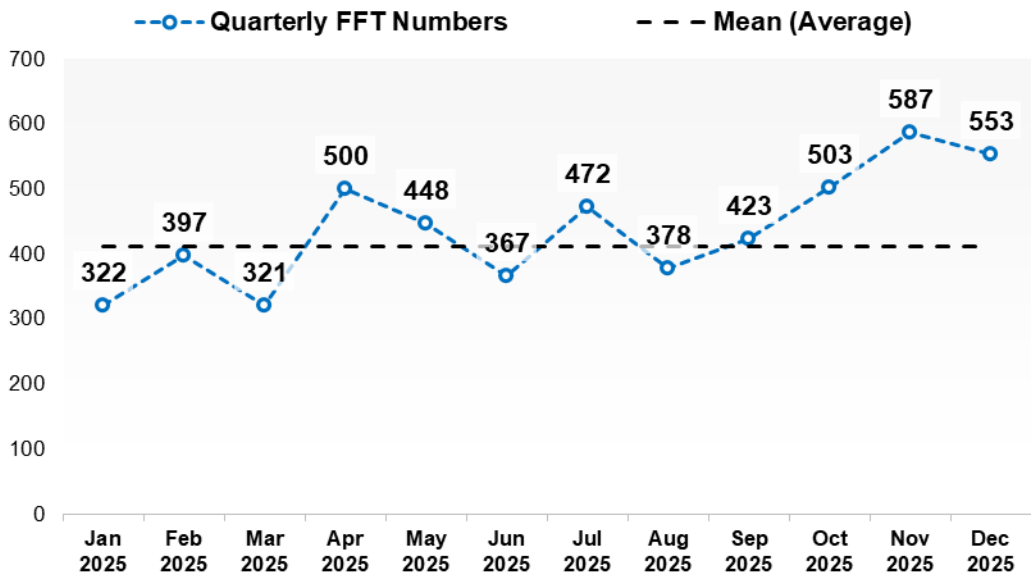
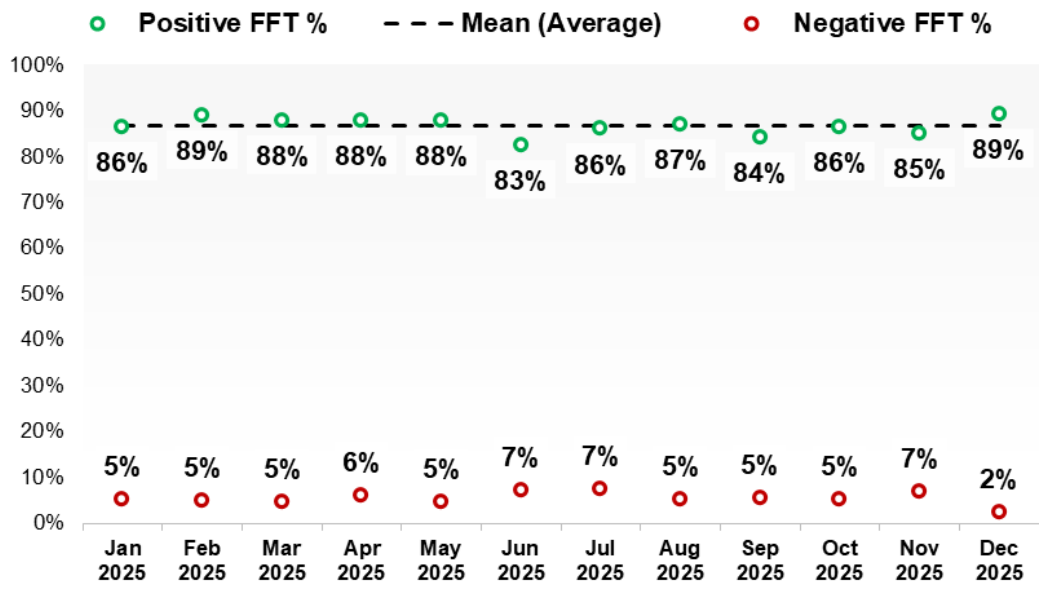


Table 2 – FFT positive and Negative response rate January – December 2025



Themed responses detail comments related to the highest scoring positive and improvement areas:

Staff Positive Theme Feedback indicates that staff are widely perceived as compassionate, caring, kind, helpful, and approachable. There is overlap with the Environment theme, as staff contribute significantly to individuals feeling safe. Similarly, crossover exists with Support and Information, as staff are described as knowledgeable, proactive, and willing to go above and beyond in providing advice. Staff efforts were also noted as making the Christmas period particularly meaningful.

Support Positive Theme Positive feedback highlights the importance of being listened to, understood, taken seriously, and given adequate time to talk. These factors have a substantial impact on individuals' health and overall wellbeing.

Waiting Times Improvement Theme Concerns relate to prolonged waiting times for initial appointments, extended gaps between appointments, delays when on-site (including waiting to be seen or receive medication), and slow communication from services. Long waiting times are particularly challenging for individuals in crisis or those with limited alternative support.

Support Improvement Theme Areas for improvement include individuals feeling unheard or not fully understood, the need for more timely access to support, longer-term support where required, and increased time during appointments to discuss concerns.

Activities Improvement Theme Feedback reflects a desire for a greater variety of structured indoor and outdoor activities, including access to gym equipment and exercise opportunities. A lack of meaningful activity contributes to boredom. There is also a need for activities to continue consistently, even when specific staff members are unavailable.

Information Improvement Theme Issues relate to both the timeliness and accuracy of information sharing. This includes delays in providing information to service users, lack of clarity in communication, incorrect recording of information, and inadequate information transfer between services and external agencies (e.g., GP practices).

Self-Harm Improvement Theme Concerns centre on insufficient follow-up, limiting opportunities to appropriately address self-harm.

Crisis Response Improvement Theme Feedback highlights slow response times for individuals in crisis, including delays when contacting the crisis line.

Security Improvement Theme Concerns relate to personal safety and privacy, particularly regarding contractors entering bedrooms and a perceived need for enhanced security measures

Table 3 FFT responses by clinical division April 2025-January 2026

Friends and Family Test (FFT)

Start Date : 01/Apr/2025
End Date : 16/Jan/2026

Birmingham and Solihull Mental Health NHS Foundation Trust

NHS England

Divisions	Positive	Negative	Other	Total	Positive	Negative	Other
Trust Wide	3774	238	348	4360	87%	5%	8%
Dementia & Frailty	338	5	23	366	92%	1%	6%
Specialities	228	5	9	242	94%	2%	4%
Primary Care	250	16	13	279	90%	6%	5%
Secure Care	30	5	11	46	65%	11%	24%
Offender Health					0%	0%	0%
Integrated Community Care	1783	153	163	2099	85%	7%	8%
Recovery	187	6	15	208	90%	3%	7%
Acute Care	435	24	70	529	82%	5%	13%
Urgent Care	115	2	15	132	87%	2%	11%
Corporate	84	5	10	99	85%	5%	10%
Children & Young People	324	17	19	360	90%	5%	5%

Given the results for Secure Care through FFT it has been pleasing to see the improvement in Service User involvement and voice started at Reaside clinic delivering the following results:

Culture of Care Service Users / EBE Involvement at Reaside

• Recovery Suppers in the restaurant

• PREOMS support, individual interviews with service users by EBEs

• Supported the Belgrade Theatre in Coventry

• EBEs were awarded with a certificate presentation for their contributions in empowering service users' voice.

• 45 EBEs have been trained over the last 12 months with about 30–35 actively working in the clinic.

• The Residents' Council has been transformed, which is now considered one of the strongest across secure services.

• Art Exhibition with invitations for members of the community

• Family visits on Christmas day for the first time

• Father's Day Fete and Games

• Revamped Roles

• Anti-racism stories that impact care

• Reaside Choir

• EBEs have also represented the service at events across the Trust, at the NHS Confederation, and with the CQC, sharing their experiences and journeys.

• Freedom to Speak Up and QI masterclass

• Incorporating service-user attendance and stories into governance

Outcome from the Care Quality Commission Community Survey 2025

- 211 respondents from Birmingham and Solihull Mental Health NHS Foundation Trust
- Survey period: April–May 2023
- Compares performance with 53 NHS mental health trusts
- Scores reported out of 10, with benchmarking against other trusts
- Overall experience score: 6.1 / 10
- Performance rating: Somewhat worse than expected compared with other trusts
- Indicates acceptable core care, but significant gaps in support and access impacting overall experience

Strengths:

Compassionate Care

- Most people felt treated with respect, dignity and compassion
- Score: 7.4 / 10 (about the same as other trusts)

Talking Therapies

- Users generally reported sufficient privacy during therapy sessions
- Score: 8.3 / 10 (about the same as other trusts)

Time with Clinicians

- People felt they were usually given enough time to discuss needs and treatment
- Mental health team score: 5.6 / 10 (about the same as other trusts)

Areas for improvement:

Support with Wider Life Needs

Lowest-scoring domain in the survey:

- Poor support for physical health, employment, benefits, financial advice, cost of living, and social participation
- Score: 2.7 / 10
- Rated worse than expected compared with other trusts Access to Care
- Many people were not asked whether they needed support to attend or access services
- Score: 3.5 / 10
- Worse than expected compared with other trusts

Medication Management

- Insufficient discussion about:
    - Purpose of medication
    - Benefits and side effects
    - Stopping medication
- Score: 6.1 / 10
- Worse than expected against national comparators

Crisis Care Access

- Difficulties knowing who to contact out of hours
- Delays getting through to crisis services
- Crisis access score: 6.0 / 10
- Worse than expected compared with other trusts

Involvement and Feedback

- Involvement in care: Average 5.3 / 10)
- Many felt families or carers were not involved as much as desired
- People were rarely asked for feedback on their care (2.0 / 10), though this mirrors national patterns

What's working

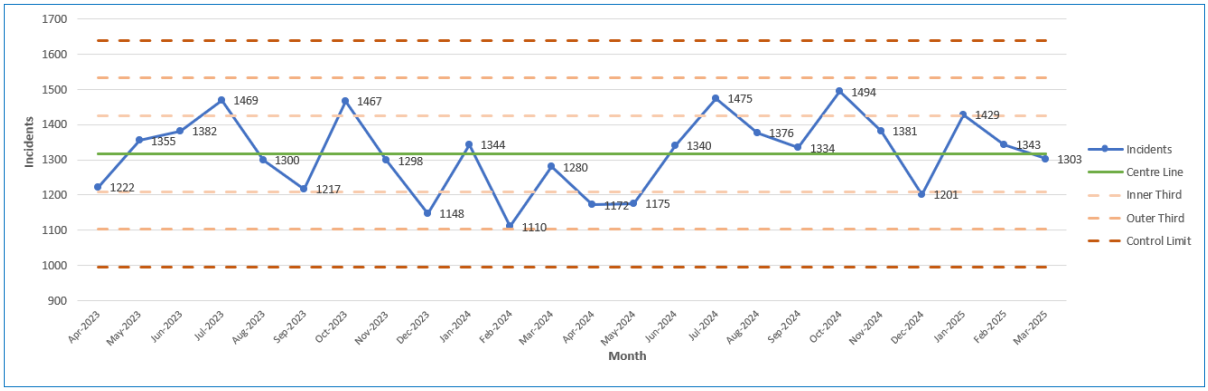
- Compassionate frontline staff
- Safe and private therapeutic environments

What needs attention

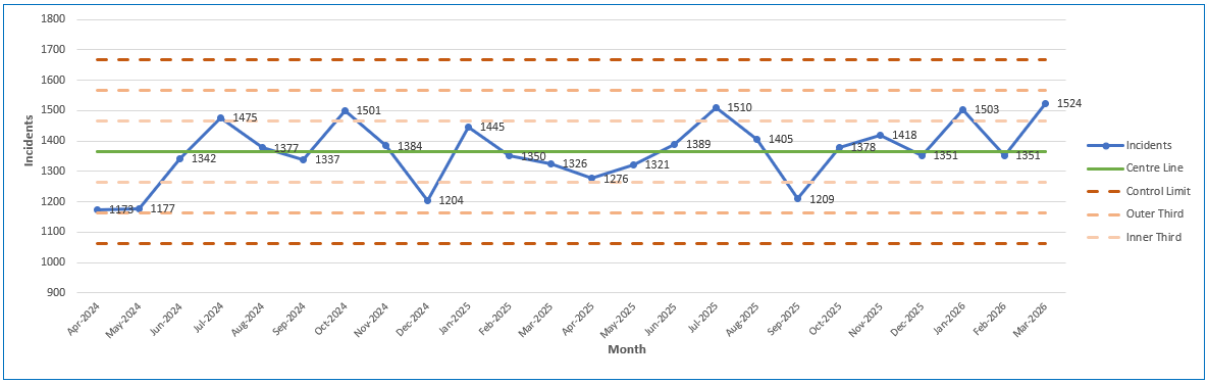
- Holistic support beyond clinical treatment
- Practical access support and crisis responsiveness
- Shared decision-making around medication
- Stronger links to social, physical health and financial support

Patient Safety Incidents 2024/25

Reported Patient Safety Incidents



Incidents resulting in severe harm



Birmingham and Solihull Mental Health NHS Foundation Trust encourages staff to report patient safety incidents so that we can learn and improve care. During the year, the number of incidents reported has remained broadly consistent. This reflects a positive reporting culture, where staff feel able to raise concerns and share learning.

Most reported incidents result in no or low harm to patients. Incidents that result in severe harm are rare. While there is some natural variation in these numbers due to the low volume, every incident is carefully reviewed to understand what happened and to identify any improvements needed.

Learning and Improving Care

We have continued to strengthen how we learn from incidents and use this learning to improve services. This includes:

- Reviewing incidents in detail to identify common themes and areas for improvement
- Carrying out focused reviews where patterns or risks are identified
- Using information from incidents to inform changes in practice and service delivery
- We have also improved how we record and categorize incidents to ensure we have a clearer understanding of the issues affecting patients.

Making Changes that Matter

Learning from incidents is shared across teams and services to support improvement. During the year we have:

- Continued to promote a culture of openness and learning
- Supported staff through training and development in patient safety and incident reporting
- Strengthened how we track actions from incidents to ensure improvements are implemented and sustained

Part three – Other Information

In this section of the report, we share other information relevant to the quality of the services we have provided during 2025/26 which together with sections 1 and 2 of this report, provide an overview of additional elements impacting the quality of care offered by our Trust during this period.

Improving quality and reducing health inequalities

Reducing health inequalities is fundamental to improving the quality and safety of the care we provide. Evidence consistently shows that people who experience disadvantage are more likely to experience poorer access, less positive care experiences and worse outcomes. For mental health services, these inequalities can be particularly pronounced for people from racialised communities and other groups facing structural barriers. Addressing inequality is therefore integral to delivering safe, effective, and person-centred care.

The Trust takes a coordinated approach to reducing health inequalities, focusing on improving equitable access to services, experience of care, and clinical outcomes. Key priority areas include ethnic disparities in Mental Health Act detention, access and experience in talking therapies, severe mental illness (SMI) physical health care, reducing restrictive practice, and adapting psychological service provision to better meet the needs of diverse communities.
Health inequalities are addressed as part of routine quality improvement rather than as a standalone programme. This enables services to focus on reducing unwarranted variation in care and outcomes, with learning embedded into everyday clinical and operational practice.

Each Operational Division owns delivery of health inequalities through a Divisional Health Inequalities plan, aligned to Trust priorities and informed by local population data and lived experience. These plans set out how Divisions will identify and address inequalities within their services, including actions linked to quality improvement, workforce development and partnership working.
Divisional ownership ensures that action is taken closest to patients and carers, where changes to pathways, practice and experience can have the greatest impact. Progress against Divisional plans is reviewed through established governance arrangements, enabling challenge, support and shared learning across services.

Quality oversight of health inequalities is provided through a combined Health Inequalities and Patient and Carer Race Equality Framework (PCREF) governance structure. This brings together Divisional leaders, quality, experience and workforce expertise, and lived experience insight to provide coordination, assurance and escalation.
Progress, risks and learning are reported through formal governance routes into Board-level committees responsible for quality, performance, experience and safety. This ensures that health inequalities are considered alongside other quality priorities and that the Board receives assurance on the impact of improvement activity.

The Patient and Carer Race Equality Framework is embedded as a core quality improvement framework within the Trust. PCREF supports services to identify and address racial inequalities in access, experience and outcomes in a structured and systematic way.
Rather than operating as a separate initiative, PCREF actions are incorporated into Divisional Health Inequalities plans and service improvement activity. This supports a consistent focus on reducing unjustified variation in care and improving safety and experience for patients and carers from racialised communities.
At service level, PCREF delivery includes the use of working groups to review data, listen to lived experience and test practical changes. This approach supports continuous learning and improvement rather than one-off interventions.

Improving quality and reducing inequalities requires a workforce that is confident and capable of delivering culturally responsive care. As part of our quality improvement approach, the Trust supports Divisions to embed Cultural Humility and Safety training, alongside community-led cultural awareness training.
Cultural Humility and Safety training focuses on reflective practice, power, bias and psychological safety. It supports staff to understand how clinical decisions, communication and systems can impact different groups of patients and carers, and to adapt practice to improve trust, safety and experience.
Community-led cultural awareness training complements this by drawing directly on the knowledge and experience of local communities. Delivered with community partners, this training helps staff better understand the context, needs and barriers faced by the populations they serve, supporting more effective and compassionate care.
Both approaches are embedded within Divisional plans to ensure that learning translates into changes in practice and contributes directly to improved quality and experience, rather than being treated as standalone training activity.

Improving how data and lived experience are used to drive quality improvement remains a key focus.
Services review access, experience and outcomes through an equality lens, supported by improved recording of ethnicity, language and accessibility needs.
Quantitative data is triangulated with qualitative insight from patient and carer feedback to identify inequalities, prioritise improvement activity and monitor progress. This approach supports services to move from understanding variation to taking action to improve quality and safety for all patients.

Through Divisional ownership, strong governance and an embedded approach to workforce development and co-production, the Trust continues to strengthen how health inequalities are addressed as a quality priority. While this is long-term work, it supports a culture of continuous learning and improvement, helping to ensure that care is increasingly equitable, safe and effective for the diverse communities we serve.

Care for People with a Learning Disability and/or Autism

Our Learning Disability and Autism work in 2025/26 has focused on strengthening community-based, preventative support, most notably through the introduction of Birmingham and Solihull's first Adult Autism Enhanced Support Team. This service has been purposefully designed to provide timely, specialist support to autistic people and their families, with the clear aim of preventing unnecessary hospital admissions and improving wellbeing in the community. The team continues to grow and brings together a highly skilled, multidisciplinary workforce including nursing, occupational therapy, and speech and language therapy. We are particularly proud of the strong partnership approach underpinning this work, with colleagues from BSMHFT, Autism West Midlands, and Birmingham and Solihull local authorities working collaboratively as one team. Crucially, the development of this service has been directly informed by what autistic people in Birmingham and Solihull have told us they need to stay well, safe, and supported, ensuring the model of care is purposeful, person-centred, and responsive to local need.

Other highlights include the continued strengthening of our Dynamic Support Register across Birmingham and Solihull mental health services, alongside the first trust-wide roll-out of the National Autism Trainer Programme, reinforcing our commitment to consistent, high-quality autism-informed practice. Looking ahead to 2026/27, our clear purpose is to build on this momentum through further investment in community-based support for people with a learning disability and autistic people, the continued growth of our skilled workforce within BSMHFT, and the delivery of a robust Autism Accreditation programme across our acute services to drive sustainable, system-wide improvement.

Trust Staff Survey 2025/26

The Trust recognises that w well supported and respected staff group who are empowered and resourced with the skills and tools to provide safe and effective care for patients will provide better care than those who may not be. Given this the Staff Survey continues to be an important part of our Quality System and important to reflect in our Quality Account. We continue to monitor and respond to staff concerns through the NHS People Pulse survey, the NHS National Staff Survey, and other local team surveys. The People Pulse survey is used quarterly to track changes in staff experience and engagement, with a particular focus on wellbeing. The annual NHS Staff Survey remains a key measure of progress against our People Goals and helps us identify priorities for improving staff experience at team level.

In 2025, 3,347 colleagues responded to the main staff survey at BSMHFT, compared with 2,650 in 2024. This total included 269 responses from the Children and Young People's Directorate, which was not part of BSMHFT in 2024. The overall response rate increased from 56.8% to 60.6%.

Our approach to improvement is centred on meaningful engagement with teams across every part of the Trust. Teams are supported to review and analyse their local results, identify areas of strength and opportunities for improvement, and co-produce changes to working practices in response. Survey findings also help shape the priorities of our corporate teams. In 2025, 140 teams received localised reports, compared with 130 in 2024.

A summary of our 2025 results is set out below:

Our key People Goal measure, whether colleagues would recommend BSMHFT as a place to work to friends and family, remained at 65.7%, unchanged from 2024. This is above the mental health sector average of 64.0% and represents an improvement of 8.8 percentage points since 2022 (56.9%).

We scored above the mental health average in four themes of We are always learning, Morale, We each have a voice that counts, and Staff Engagement.

We were at the mental health average in four further themes but remained below average in the Compassionate and Inclusive theme (7.52 v 7.61).

Negative behaviours from service users, carers and families towards colleagues remain a concern. In the Negative Experiences sub-theme, BSMHFT scored 7.87 compared with 8.05 across other mental health trusts.

Question-level analysis shows a particular strength in staff involvement. The percentage of staff who feel involved in deciding changes that affect their work was 56.8%, above the mental health average of 52.4%. Our score for the statement "My immediate manager asks for my opinion before making decisions that affect my work" was 71.48%, the highest among mental health trusts.

The percentage of colleagues who said they would be happy with the standard of care provided by the organisation if a friend or relative needed treatment was 59.07% at BSMHFT, compared with 64.45% across other mental health and learning disability trusts.

Each year, we use staff survey data to inform continuous improvement both locally and across the organisation. This year's results highlight areas where further action is needed. We remain committed to becoming a truly inclusive, anti-racist and anti-discriminatory organisation. Although we have narrowed the gap with other trusts this year, these areas remain a key focus, alongside strengthening psychological safety and helping colleagues feel more confident to speak up.

In response, we will move into the second year of our Authentic Leader Programme, which represents a refreshed approach to leadership development. We will also continue to strengthen the ways in which colleagues can raise concerns and share their experiences, supported by a new communications strategy aligned to our new Five-Year Trust Strategy.

Guardian of Safe Working Hours

This section provides assurance that doctors in training are safely rostered and that their working hours are compliant with the terms and condition of their contract.

The Guardian of Safe Working Hours (GSWH) has been introduced to protect patients and doctors by making sure doctors and dentists are not working unsafe hours.

A Consultant Psychiatrist undertakes this role for the Trust and is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of service for doctors in training. It is a role intended to be undertaken by a consultant or someone of equivalent seniority. The Guardian reports directly to the Trust Board and is independent of the management structure within the organisation.

To fulfil this role, The GSWH:

- Acts as a champion of safe working hours.
- Receives exception reports and records and monitors compliance against terms and conditions.
- Escalates issues to the relevant executive director, or equivalent for decision and action.
- Intervenes to reduce any identified risks to doctors or to patient safety.
- Undertakes work schedule reviews where there are regular or persistent breaches in safe working hours; and
- Distributes monies received as a consequence of financial penalties, to improve training and service experience.
- Meets with the Deputy Medical Director for Medical Workforce, Associate Medical Director for Medical Education and Senior Human Resource Business Partner for medical staffing, as well as with all of the postgraduate doctors in training to receive direct information about the rotas and working conditions.

Freedom to Speak Up Guardian

The Freedom to Speak Up Guardians in partnership with the Trust are taking action to promote the following:

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

· Speaking up policies and processes are effective and constantly improved

· Senior leaders role model effective speaking up

· All colleagues are encouraged to speak up

· Individuals are supported when they speak up

· Barriers to speaking up are identified and tackled

· Information provided by speaking up is used to learn and improve

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

The Trust's FTSU service was established in 2019 and has expanded to become a team of 3 guardians (2 WTE; 1 .6 WTE) a team administrator and is supported by a growing network of 30 Champions working across the organisation. For the period 1 April 2025- 31 March 2026 there were 482 contacts. These provide an opportunity for the Trust to learn from these speakers who may not have otherwise been heard. The FTSU Guardians are in place as an alternative route to speaking up with many other options embedded and available to staff.

Workers from a range of professional groups spoke to the guardians, with Nurses accounting for the biggest portion (29%). Of those concerns, 23 per cent of cases included an element of patient safety and quality (compared to the national average of 17.8%). Twelve per cent of cases reported an element of bullying or harassment (national average of 18.4%); and Worker Safety and Wellbeing was the most reported theme featuring in 1/3 or one- in -three cases. Inappropriate attitudes and behaviours was a theme in 2/5 or two-in- five cases with the percentage of cases that were raised anonymously at 2 per cent against the national average of 2.9 per cent.

High level themes are routinely shared in reports and with leaders across the organisation enabling them to act, learn and improve. Behind these themes are the human experiences of workers wanting to do their best for their patients and colleagues.

In 2025 the Trust accepted our recommendations and proposals for the "All our Voices" communication and engagement initiative which is led by the Chief Executive Operations (CEO). Staff not feeling involved and listened to by senior leaders is a persistent theme in our NHS Staff Survey and Pulse data. This project seeks to connect the CEO directly with frontline clinicians providing an opportunity for listening, sharing of good practice, and ideas for improvement. Any wider feedback from these sessions is directly shared with the team reinforcing the values of a listening and responsive organisation.

We have made a significant contribution to the cultural change work at Reaside, supporting the leadership to develop and improve the speak up culture. We have hosted numerous listening events, surgeries, and drop ins. This is reflected in February's CQC inspection which has led to improved ratings in Caring, Responsive and Well-led. Similarly, in June/July 2025 a CQC inspection of the Trust's acute and psychiatric intensive care (PICU) services at Northcroft Hospital, the Zinnia Centre and Ardenleigh scored FTSU in the service area as a 3, demonstrating a good standard with most staff confident their voices would be listened to.

The work of the guardians and the wider cultural speak up listen up follow up work is embedded for the first time in the Trust's Five -Year Strategy 2026-2031 and is fundamental in achieving our goal of becoming an organisation that listens, acts and learns. This years' Quality Goal objectives are largely achieved; we have

socialised the Listen Up e-learning module for the senior leadership team supporting them to respond confidently and consistently when concerns are raised; the commissioned Courage to speak Up leadership programme is shortly concluding and will have strengthened leadership and conflict resolution skills across key professional roles; and our toolkits for managers and staff will be launched later this year.

We have updated the Trust's Freedom-to-Speak-Up-Policy which incorporates the latest guardian network guidance Detriment-guidance.docx for organisations and their leadership. This sets out guiding principles in the prevention of disadvantageous treatment or detriment from speaking up, the critical role that managers and leaders play in safeguarding against this and ensuring we have clear and effective processes in place to address it.

This year we saw an increase in cases where disadvantageous and or demeaning treatment was indicated. Separate from the guardian's function, and building on organisational progress to date, we are working with our Equality Diversity Inclusion /Organisational Development partners and other stakeholders to produce a comprehensive corporate programme response to making speaking up business as usual in a compassionate and inclusive culture that communicates a zero tolerance of detriment.

The guardians do not work in isolation; they are supported by a growing Champion network consisting of 30 fully trained champions who work in all areas across the Trust. Champions do not handle cases but listen, signpost and role model the values and principles of a positive speak up culture. They take on these roles in addition to their substantive jobs and are also visible across our staff networks. They are committed, passionate and uphold our values in driving behavioural change, and empowering their colleagues. Nearly half of our network has one or more protected characteristics (Global Majority, LGBTQ and Disability and Neurodiversity).

Our Ward Managers and Deputy Ward Managers are often the 'go to' people when it comes to raising frontline clinical concerns. Equipping them with the knowledge and skills to do this consistently and confidently is a key objective of the Culture of Care Masterclass 'Conversations that Matter' programme. After a successful pilot at Reaside, this is now being rolled out across all divisions. Divisional quality plans will include this training as part of an accredited quality assurance programme linking it to 'Transparency' one of the 12 Culture of Care standards. Candidate evaluation is through pre and post confidence ratings which measures behavioural change and manager's confidence in creating psychological safety within their teams.

In November 2025 we made representations to the national CQC policy team for their work on the development of the new regulatory platform and well led inspection framework for FTSU. The team have also contributed to NHS E proposals for the National Guardian's Office replacement NHS England » Future of Freedom to Speak Up: engagement pack

STATEMENT OF DIRECTORS' RESPONSIBILITIES

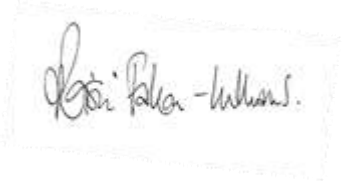
The Board of Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011). In preparing the Quality Account, the Board of Directors are required to take steps to satisfy themselves that:

- The Quality Account presents an open and balanced picture of the Trust's performance over the period covered;

- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review, and;
- The Quality Account has been prepared in accordance with Department of Health guidance. The Board of Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By Order of the Board of Directors:

Roísìn Fallon-Williams
Chief Executive Officer



Phil Gayle
Chair

Annex 1: Stakeholder Statements

To be collated from stakeholders and added prior to publication on the Trust website

BSMHFT Council of Governors Statement on the Quality Account

Birmingham & Solihull Black Country Integrated Care Board

Birmingham Health and Social Care Scrutiny Committee – Chair's response

Solihull Health and Adult Social Care Scrutiny Board – Chair's Response

Healthwatch response

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 June 2026**
Date(s) of Committee Meeting(s) reported	**19 May 2026**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered the following items on the agenda: • Board Assurance Framework Risks • People Dashboard • People Strategic Goals 2025/26 Year-End Report • Workforce Plan • Transforming People Services Report • Shaping our Future Workforce Committee Assurance Report • Transforming our Culture and Staff Experience Group Assurance Report • Health Inequalities Report • LGBTQ+ Staff Network Report • Multi-Professional, Education and Training Group Assurance Report • Medical Directorate Quarterly Report • Safer Staffing Report • Internal audit review progress and assurance: Medical Job Planning, Appraisals Process, Temporary Staffing, Counter Fraud Recruitment Process • Corporate Risk Register
Alert:	• Workforce pressures in critical services continued, particularly within liaison psychiatry and CYP urgent care, with vacancy levels and skill-mix gaps impacting resilience. • Data quality issues were highlighted, with differing data points in reports reducing confidence in workforce metrics. The Committee noted that this issue had been raised previously, and that further work was needed to reach a consistent position. • A key challenge remained across the organisation to release staff for development activities and to take part in groups and networks.
Assure:	• The Committee was assured by an improving workforce position, including decreasing vacancy rates, growth in substantive staffing and a significant reduction in agency reliance. • A positive year-end report into the Trust Strategy highlighted strong delivery of the People goals, with continued progress across workforce, culture and development programmes. • Training, recruitment and workforce development remained areas of strength, including high compliance levels, active recruitment pipelines and positive feedback on leadership development programmes.

	• The Committee celebrated the recent HSJ Digital award that the Trust had received for its Equality, Diversity and Inclusion dashboard.
Advise:	The Committee was advised that the Trust was preparing for the NHSE Transforming People Services programme, which would introduce a digital-first, standardised regional operating model. This would include ESR replacement, staff app functionality and enhanced data platforms. The Committee noted that key performance indicators were being reviewed into areas such as return-to-work and bank usage to ensure focus on staff experience, safety and outcomes rather than purely compliance. Ongoing development of culture and leadership interventions, including the Authentic Leadership programme and embedding of health inequalities within roles and job planning, was supporting delivery of the new strategy. The Committee was advised on some prioritisation and review of activity that could be stopped in response to capacity pressures, to maintain delivery of core objectives and avoid overextension.
Reducing Health Inequalities impact:	Reducing health inequalities was becoming more embedded within core service delivery rather than treated as a standalone initiative. There was increasing alignment between workforce, culture and patient care approaches, including integration with patient safety frameworks and PCREF. Co-produced interventions, such as work to reduce restrictive practices, were beginning to demonstrate tangible impact on addressing disproportionate outcomes, while improvements in day-to-day communication, e.g. appropriate use of translation tools, were supporting more equitable access for service users. There was also growing use of workforce data (WRES/WDES) and lived experience from staff networks to better understand inequalities and inform action. However, the Committee noted that impact remained variable across the organisation, driven in part by differences in the maturity of local health inequalities planning and confidence in applying health equity principles, highlighting a need for continued focus on capability and consistency.
Board Assurance Framework	The Committee reviewed the risks, which had been reframed to align to the new Strategy: • Failure to create and sustain an inclusive, psychologically safe, anti-discriminatory and anti-racist organisational culture that enables equitable staff experience, effective speaking up, workforce wellbeing and high-quality care outcomes. • Failure to develop, transform and sustain a future-ready workforce with the capacity, capability, diversity and leadership required to meet changing population needs, service transformation and long-term organisational resilience. The Committee was assured by the ongoing work to align the BAF to the new Strategy and commended the refined process.
	New risks identified: No additional risks were identified.
Report compiled by:	Sue Bedward, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 June 2026**
Date(s) of Committee Meeting(s) reported	**21 April 2026**
Quoracy	**Membership quorate: Y**
Agenda	The Committee held a strategy session which focused on the Staff Survey Results.
Alert:	• The Committee highlighted that violence towards staff remained high. Around one in six staff reported experiencing physical violence from patients, service users or carers in the last twelve months, despite some long-term improvement. This continued to present a significant workforce safety risk. • The Trust remained below the mental health average on all four staff survey questions relating to raising concerns, particularly *confidence that concerns will be addressed*. Scores in this area were broadly unchanged since 2020, indicating a persistent gap. • The Committee highlighted some significant variation of staff experience, particularly around flexible working and psychological safety, across local teams.
Assure:	• The Trust's overall staff survey response rate had increased to 60.6%, with participation from 155 teams. The Committee noted the increased local ownership and visible action at team level, which had improved trust and engagement in the survey process. • Scores remained stable or improved compared to previous years, with the Trust now above the mental health trust average on four of the national themes, including *We are always learning*, *Morale*, *Employee engagement* and *We are a team*. • The question "My manager asks my opinion before making decisions that affect my work" achieved the highest score of any mental health trust nationally, reflecting progress in compassionate and inclusive leadership and staff involvement in change. • The Committee noted that long-term trends showed a sustained reduction in reported bullying by colleagues since 2019, linked to values-based behaviours and leadership interventions.
Advise:	The Committee was advised that continued prioritisation was required to build confidence that concerns were acted upon and outcomes communicated, including visible learning and feedback loops, to address the persistent gap in raising concerns.
Reducing Health Inequalities impact:	The Trust continued to score below average on the compassionate and inclusive theme, driven primarily by poorer scores on diversity and equality. This included experiences of discrimination from both colleagues and service users.

	The Committee highlighted that inclusion, anti-racism, and discrimination would remain a strategic workforce priority, with assurance sought on delivery and impact of active bystander training, anti-racist supervision and related QI initiatives.	
Board Assurance Framework	The Committee scrutinised the following risks: • Failure to create a positive working culture that is anti-racist and anti-discriminatory. • Inability to attract, retain or transform our workforce in response to the needs of our communities.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Sue Bedward, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	**14**					
Date	3 June 2026					
Title	Health Inequalities Report					
Author/Presenter	Jas Kaur, Associate Director of EDI and OD					
Executive Director	Patrick Nyarumbu, Deputy 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**	

The Trust has made strong progress in reducing health and workforce inequalities, including embedding PCREF into organisational objectives, delivering key service improvements, and achieving significant reductions in disproportionate disciplinary outcomes. Quality improvement initiatives have improved access, reduced delays and strengthened culturally responsive care.
However, widening racial disparities in Mental Health Act detentions, inconsistent divisional reporting, variable data quality and a widening gender pay gap remain key risks. A new Health Equality Dashboard will support improved oversight. Continued focus on leadership accountability, data quality, and embedding inequality objectives across roles is required to sustain progress.

Risks Identified

- **Inconsistent divisional reporting** on health inequalities.
- **Variable data quality** across services.
- **Low health inequality literacy** among staff.
- **High levels of discrimination, bullying and harassment** from service users.
- **Health inequalities not embedded** in job plans.
- **Limited community representation** in governance structures.

Recommendation

The Board is asked to receive the report for assurance.

Enclosures

Health Inequalities Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Board report
May 2026

Health and Workforce Inequalities

Birmingham and Solihull Mental Health NHS Foundation Trust

What are Health Inequalities

Health inequalities are **unfair** and **avoidable** differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

-Kingsfund

Birmingham and Solihull Mental Health NHS Foundation Trust

The BIGGER Why…

To enable the right ingredients for an

Inclusive culture

which is…

Anti racist

and

Anti discriminatory for **all**

to

Improve access, experience

and

outcomes

for

our people

Birmingham and Solihull Mental Health NHS Foundation Trust

Value Me to Reduce Inequality

What..

Every person to be valued and understood

Why...

So that I have a fair opportunity to take the next step-*whatever that looks like for me*

https://www.etransx.com/wellbeing-care-community-addressing-social-determinants/

Current Position

Initiative	Impact
All priority workstreams have milestone plans.	Improved accountability, tracking and consistent delivery of service improvements
PCREF is integrated into refreshed organisational objectives and divisional inequality plans.	Strengthened action to reduce racial disparities in access, experience and outcomes.
Culture of care is being socialised across services.	Supported compassionate environments, improved staff wellbeing and better patient experience.
Application for national Triangle of care programme has been successful, with specific focus on racialised carer's experience to begin	Improved carer involvement, communication and culturally responsive support.
BSMHFT site for BCC Cultural Humility, Safety and Competence Pilot with external evaluation.	Enhanced culturally responsive care and providing measurable learning for service improvement.
New service model pilot 24/7 (featured as spotlight)	Improved access to support outside standard hours and helping prevent crisis escalation.

Key Achievements in reducing Health Inequalities

- Focussed interventions relating to DNA's across the Specialties Division
- Active engagement with eclipse data to support and respond to colleagues experiencing discrimination from service users
- This is Me' tool developed in ICCR being rolled out pan Trust within Rio, emphasising identity and culture
- Physical Health Insight Dashboard Development with Integration of Health Inequalities
- Integration of physical health training into multi-professional education committee.

- Deep-dive review on prone restraint and Rapid Tranquillisation led to training advances reducing prone use.
- ‘Quality Improvement Programmes
  - **Project Aim:** To reduce to zero the percentage of patients waiting over 40 weeks for High Intensity Cognitive Behavioural Therapy (HI CBT) by the end of March 2024 (from joining the waiting list to being allocated a clinician)- completed.
  - **Project Aim:** To develop a discharge process which reduces delays in discharge referrals for Solihull Early Intervention Psychosis service users by 20% from January to May 2024. (completed)
  - Readmission rates in FIRST Team, ensuring the continuity of appropriate care in the community to decrease readmissions
  - **Environments which meet sensory needs of people who are neurodiverse:**QI Project at Forward House which is part of the Culture of Care RCPysch QI programme.

Alert	Advise
Variability in divisional progress on reporting health inequalities creates inconsistency in oversight, limits the ability to compare performance, and risks gaps in identifying and addressing disparities across the Trust	Provide targeted support to divisions, including guidance, tools, and training to improve reporting capability. Triangulate data from multiple sources (quantitative metrics, patient and staff feedback, workforce insights) to ensure gaps are identified and addressed. Regularly review divisional reports in governance forums, escalate risks where reporting is incomplete, and share best practice from divisions demonstrating strong progress. Encourage peer support and knowledge-sharing between divisions to standardise approaches and improve consistency
Variable data quality across services.	Provide targeted support and guidance to services with poorer data quality, rather than a one size fits all approach and use triangulation of qualitative insight, staff experience, and patient feedback alongside quantitative data to inform decision making while data quality improves.
Low levels of health inequality literacy	Embed health inequalities content into existing training, supervision, and leadership development programmes rather than creating standalone offers and use real case examples from Trust services to build confidence and relevance

High levels of discrimination, bullying, harassment, and victimisation from service users.	Expand access to Active Bystander training and support for teams experiencing higher levels of abuse and provide confidential support spaces for staff affected and ensure consistent use of incident reporting and follow up processes. QI Project
Health inequalities not explicitly included in job plans.	Encourage inclusion of health inequality objectives within leadership, clinical and managerial job plans where appropriate and provide practical examples of how health inequalities work can be incorporated into existing roles without increasing workload.
Representation of community assets in governance not fully embedded.	Review governance structures to identify opportunities for meaningful involvement of community partners and lived experience voices

Key Achievements in reducing Health Inequalities-PCREF Focus

PSIRF & PCREF marrying

RRP training materials revised to focus on disproportionate impact

Google translate endorsed as a legitimate tool in improving everyday communication

Trauma informed care training actively incorporates racism as trauma

2 Fairer Futures Fund projects with a focus on improving access for racialised communities

Application for national Triangle of care programme has been successful, with specific focus on racialised carer's experience to begin

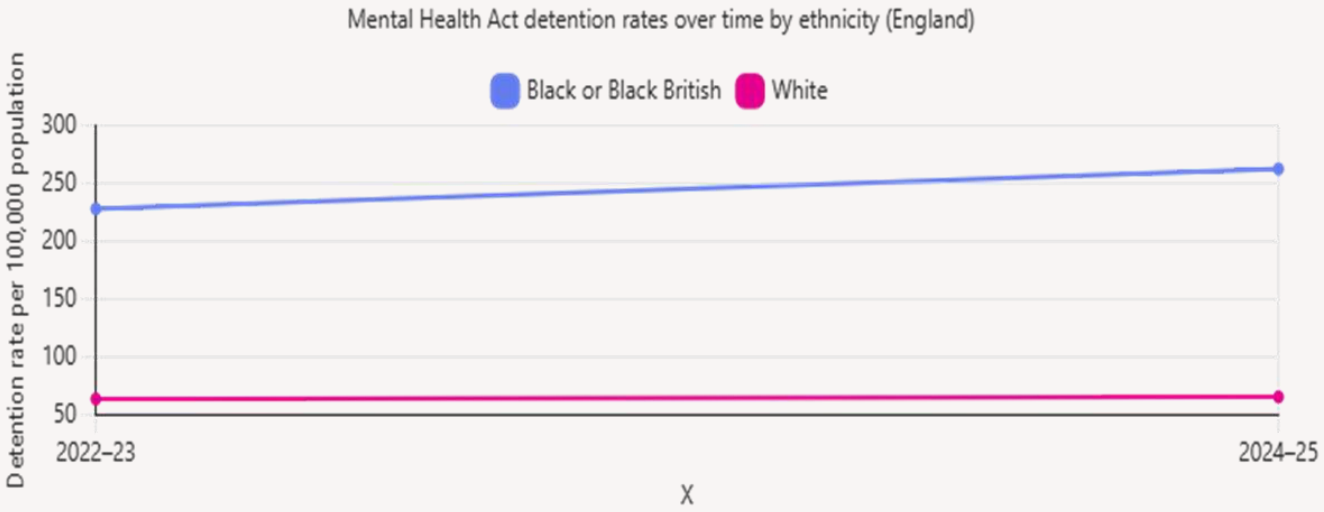
- **ICCR** - Engagement with 40+ community organisations across nine POAPs (plans on a page)
  - Trauma-informed workforce development (SWAN) Engagement Training pack for Professionals working with Sex Workers. Domestic Abuse Peer Support Workers and Train the Trainer Training supporting DASSC(Domestic Abuse Suicide Screening Conversation)
- **Specialites** - Dementia and Frailty ‘no borders, no bias’ working group completing a number of projects and focusing on improving access with the Somalian community
- **SCOH -** Protocol for Prolonged Seclusion Clinical Inequalities Audit
  - Sustainable community initiatives programme with community partners delivering sessions on wards
- **AC&U –** Culture of care project that focuses on reducing prone restraints and better use of the safety pod to administer deltoid injections

Birmingham and Solihull Mental Health NHS Foundation Trust

HI Metrics

- **Trends and Inequalities in MHA detentions**

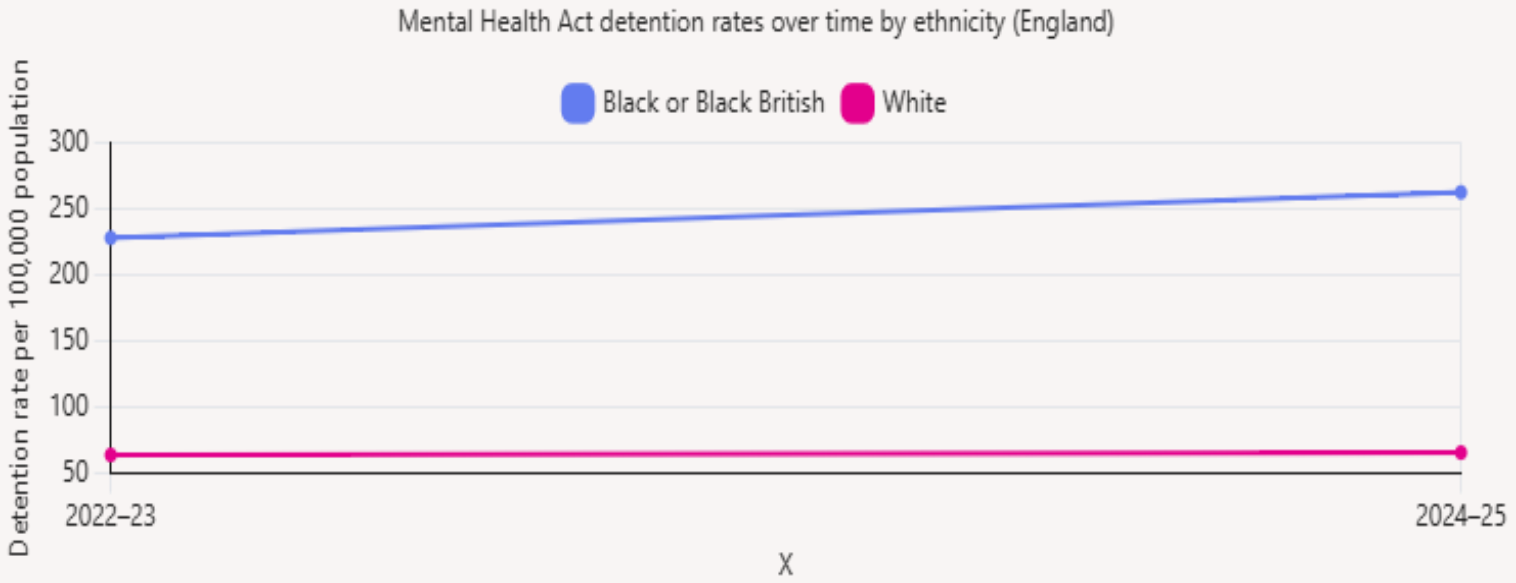
- Racial disparities are widening, with Black people detained at 4× the rate of White people in 2024–25, up from 3.5× the previous year. (262 per 100,000 Black people vs 66 per 100,000 White people).



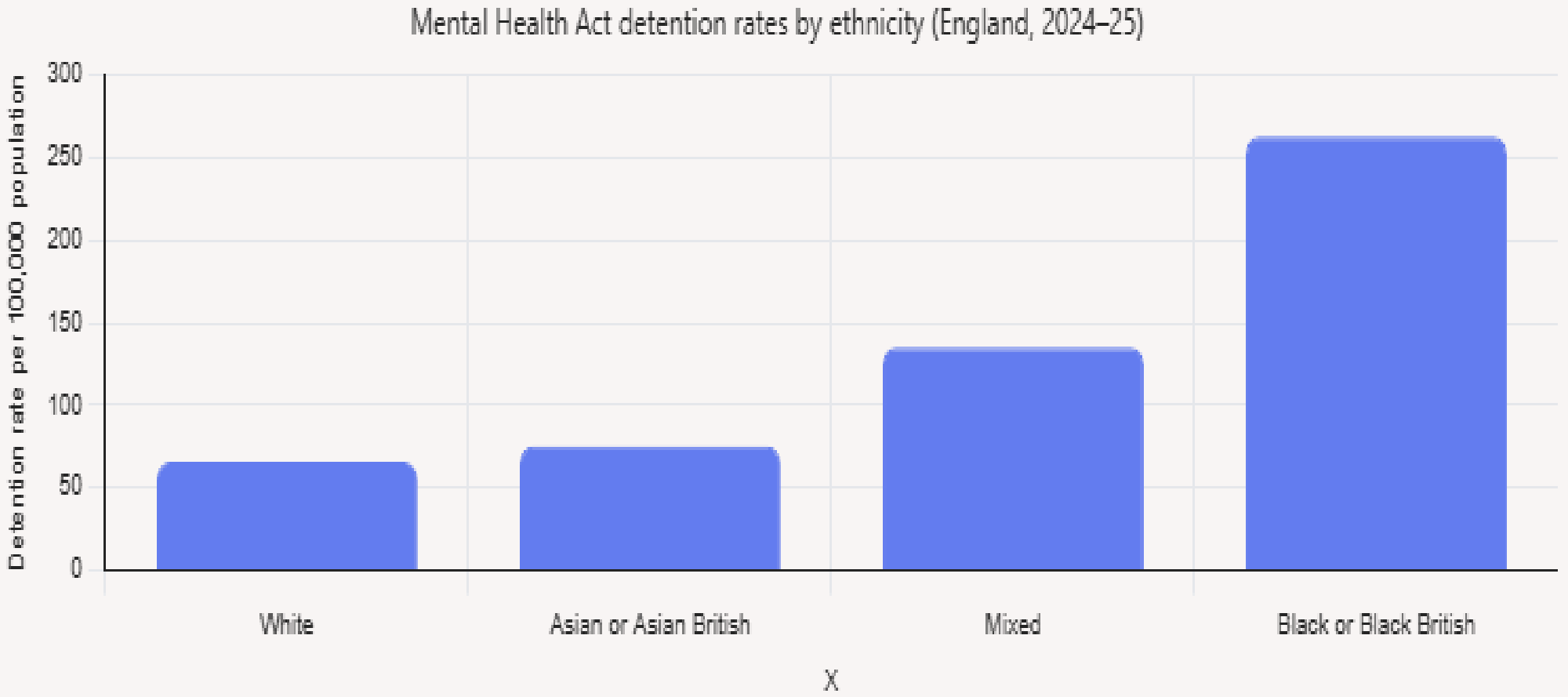
- Community Treatment Orders (CTOs) also show disproportionate use: Black people are issued CTOs over 8.5× more often than White people.

Trends and Inequalities

- Racial disparities are widening, with Black people detained at 4× the rate of White people in 2024–25, up from 3.5× the previous year. (262 per 100,000 Black people vs 66 per 100,000 White people).



- Community Treatment Orders (CTOs) also show disproportionate use: Black people are issued CTOs over 8.5× more often than White people.


Mental Health Act detention rates by ethnicity (England, 2024–25)
Detention rate per 100,000 population
300
250
200
150
100
50
0
White
Asian or Asian British
Mixed
Black or Black British
X

Birmingham and Solihull Mental Health NHS Foundation Trust

Table 1: Gender breakdown of CTOs, sections 2 and 3

Section		Q3 – average per month	Q4 – average per month
17A (CTO)	Male	74%	74%
	Female	26%	26%
	Total average	**295**	**301**
S2	Female	56%	50%
	Male	44%	50%
	Total average	**126**	**120**
S3	Male	62%	62%
	Female	38%	38%
	Non-Binary	0.03%	0.03%
	Total average	**343**	**324**

Table 2: Ethnicity breakdown of CTOs, sections 2 and 3

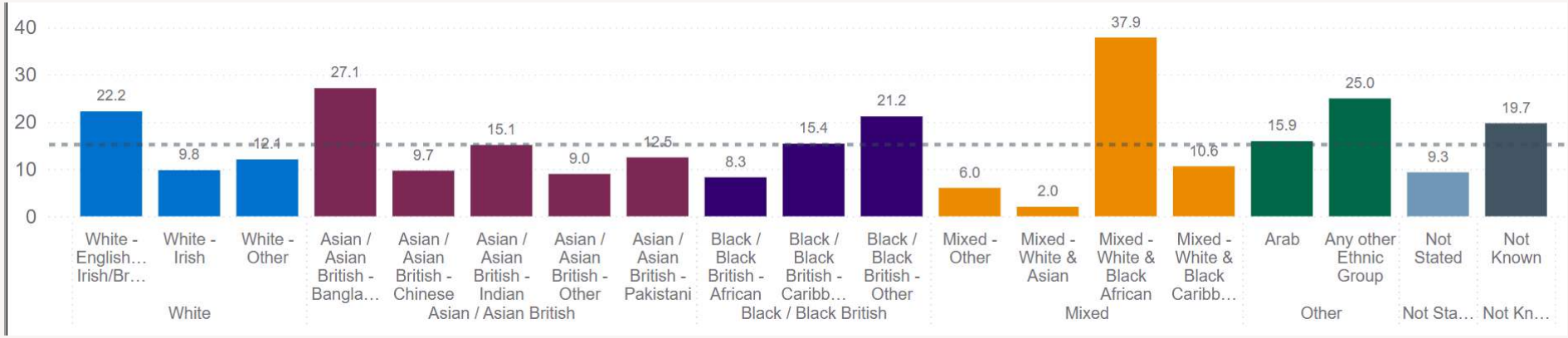
Section	Ethnicity Category	Q3 – average per month	Q4 – average per month
17A (CTO)	Black	38%	37%
	White British	24%	24%
	Asian	21%	23%
	Total average	**295**	**301**
S2	White British	44%	46%
	Asian	19%	23%
	Black	18%	12%
	Total average	**126**	**120**
S3	White British	40%	42%
	Black	24%	24%
	Asian	18%	17%
	Total average	**343**	**324**

Table 3: Age breakdown of CTOs, sections 2 and 3

Section	Age Category	Q3 – average per month	Q4 – average per month
S17A CTO	41-65	49%	51%
	26-40	37%	35%
	0-25	7%	8%
	65+	7%	7%
	Total average	**295**	**301**
S2	26-40	43%	45%
	41-65	34%	34%
	65+	18%	11%
	0-25	7%	9%
	Total average	**126**	**120**
S3	41-65	46%	49%
	26-40	33%	31%
	65+	14%	14%
	0-25	6%	8%
	Total average	**343**	**324**

Birmingham and Solihull Mental Health NHS Foundation Trust

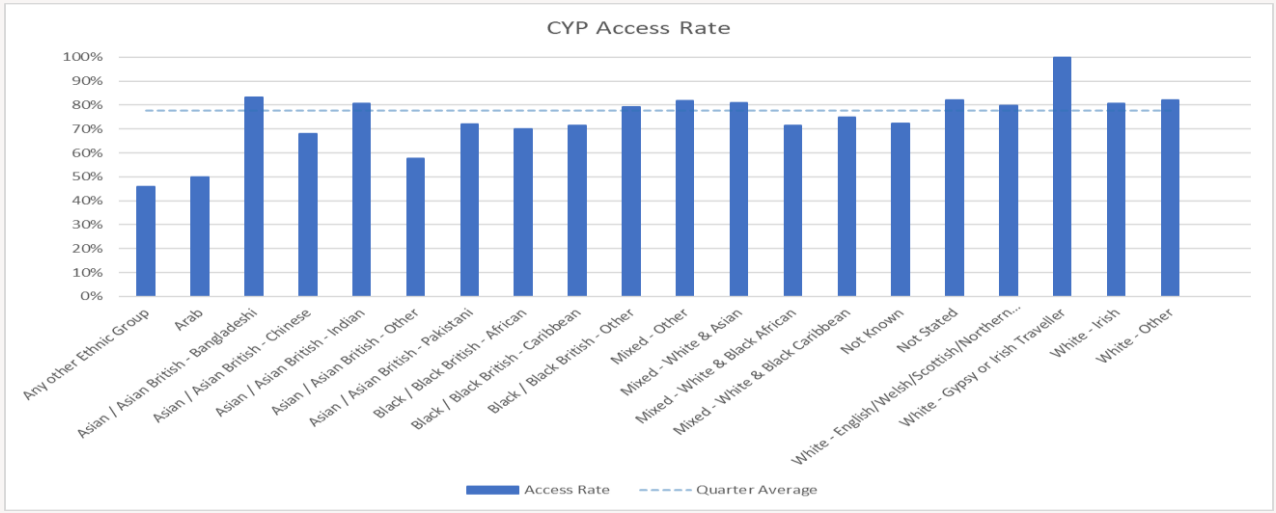
Restrictive interventions



The Restrictive Interventions Dashboard is reviewed on a monthly basis in the Reducing Restrictive Practice Steering Group Meeting and also more regulalry by individual directorates and service areas in their local RRP meetings. The Dashboard does provide a breakdown using multiple parameters eg. Age, gender, ethnicity, deprivation index and the trends are regularly discussed. Service User feedback provided as part of the Inpatient Survey has been used to inform the 2025 workplan priorities for service areas and work is being done on reviewing Communication Training videos for wider rollout.

Birmingham and Solihull Mental Health NHS Foundation Trust

Evidence CYP access rates by ethnicity/race



- Demonstrate the access rates to Children and Young Person (CYP) services by service users of different ethnicities. CYP access is defined as the proportion of referrals with at least one attended contact. While access rates vary across different ethnic categories, the majority of groups lie close to the overall average (78%). There has been continued improvement in the access rate for 'Black / Black British Caribbean' patients (from 64% to 71%). While this suggests disparity is still present, sustained progress is being made to reduce disparity.

Birmingham and Solihull Mental Health NHS Foundation Trust

Evidence death in mental health inpatients data by ethnicity/race (reported to CQC)

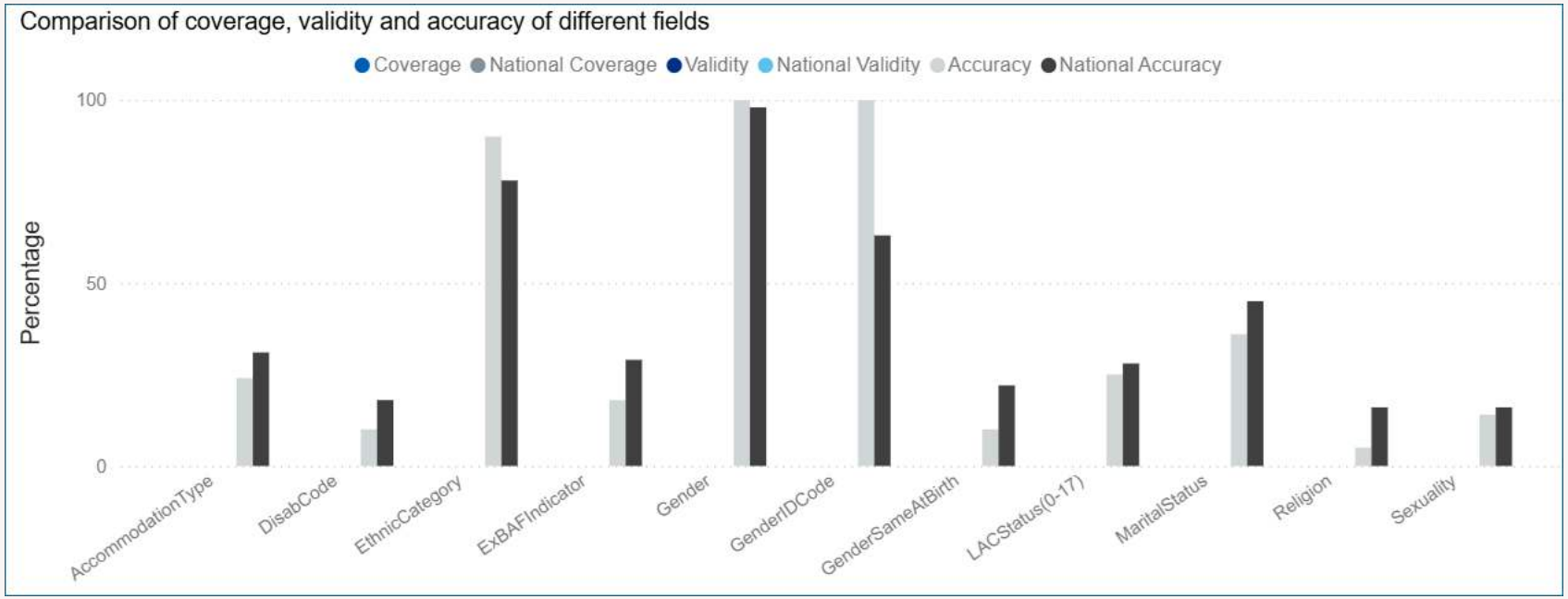
Ethnic Group	Trust Population %	Number of Deaths Q4 [Jan 2025 to Mar 2025]	% of total Deaths Q4 [Jan 2025 to Mar 2025]
Any other Ethnic Group	2.76%	7	1.85%
Any other mixed / multiple ethnic background	1.67%	5	1.32%
Arab	0.49%	1	0.26%
Asian / Asian British - Chinese	0.45%	1	0.26%
Asian / Asian British - Indian	3.94%	14	3.70%
Asian or Asian British - Any other background	2.03%	5	1.32%
Asian or Asian British - Bangladeshi	1.82%	3	0.79%
Asian or Asian British - Pakistani	9.64%	7	1.85%
Black / Black British - African	1.88%	0	0.00%
Black / Black British - Caribbean	4.79%	18	4.76%
Black / Black British - Other	0.80%	4	1.06%
Mixed - White & Asian	0.64%	0	0.00%
Mixed - White & Black African	0.29%	0	0.00%
Mixed - White & Black Caribbean	2.36%	4	1.06%
Not Recorded	8.62%	28	7.41%
White - English/Welsh/Scottish/Northern Irish/British	53.80%	265	70.11%
White - Gypsy or Irish Traveller	0.04%	0	0.00%
White - Irish	1.22%	9	2.38%
White - Other	2.77%	7	1.85%

During the quarter there were 393 deaths recorded of which 2 were inpatient and both unexpected deaths. Both deaths will have an inquest where their cause of death will be determined.

Both service users were White/British which accounts for over 50% of the trust population

Birmingham and Solihull Mental Health NHS Foundation Trust

NHSE dashboard



This chart comes from an NHSE dashboard on protected characteristics (Microsoft Power BI). The chart compares the accuracy of our data (light grey) to national data (dark grey). Accuracy means having a valid data which isn't 'Not Known', 'Unknown'. It shows there are a number of patient characteristics we need to improve collecting, which are reflected nationally.

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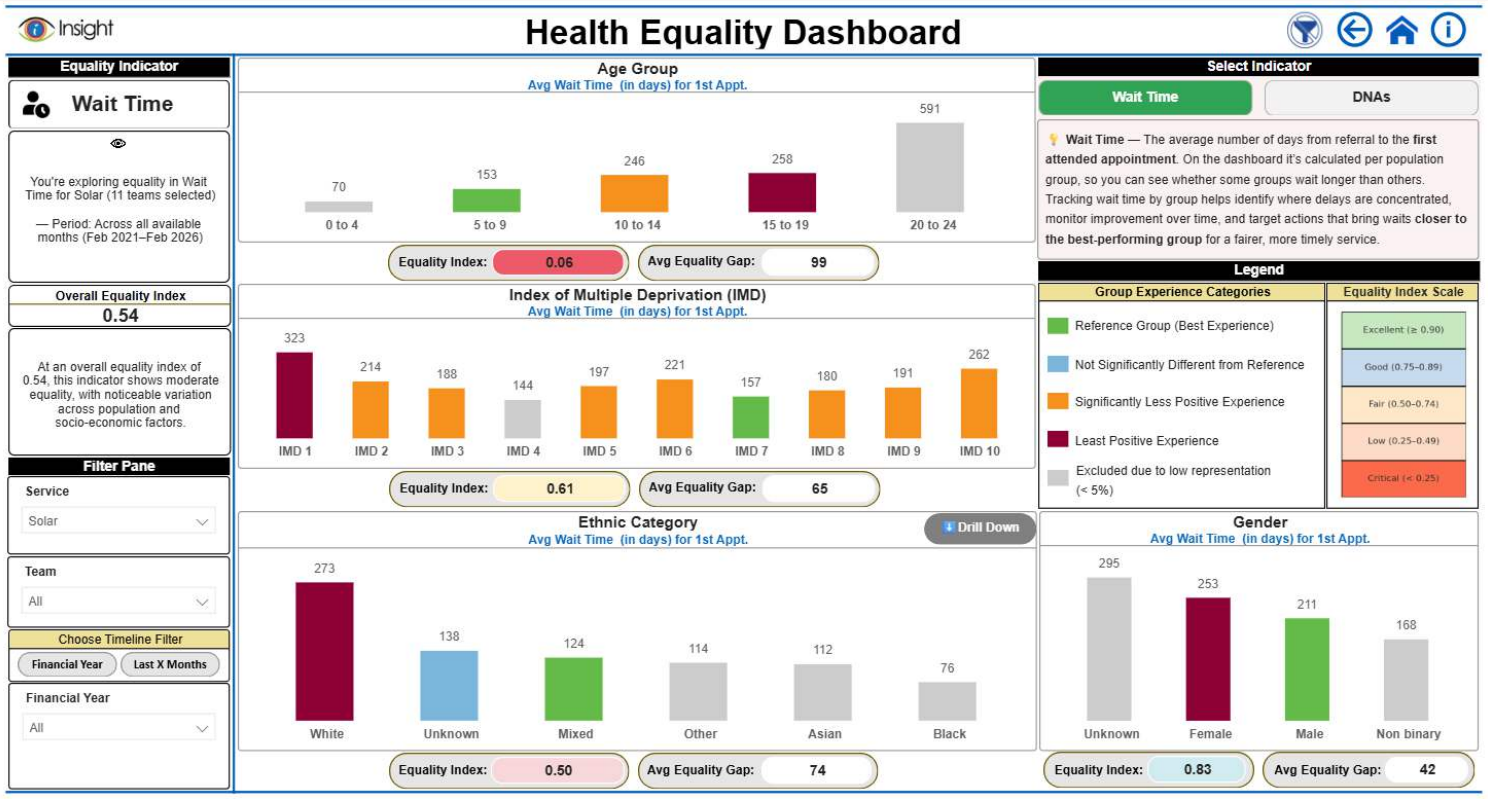
New health inequalities dashboard



- The Informatics team aim to publish a ‘Health Equality Dashboard’ (sample above). This will look to explore access, experience and outcome for different patient groups within team and services to help identify possible areas of inequality. This is due to be launched in the coming quarter.

Workforce inequalities

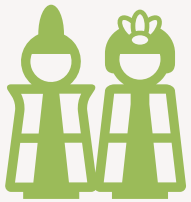
Birmingham and Solihull Mental Health NHS Foundation Trust

Race Equality: WRES 2025 Overview

Improved measures from 2024

Shortlisting - White colleagues are 0.7 times more likely to be appointed from shortlisting. In 2025 we have decreased the gap on the 1.7 reported in 2024. **(+ive)**

Disciplinary Investigation - Global Majority colleagues are 0.82 times more likely to enter formal disciplinary process than white colleagues. In 2024 it was reported at 1.86 **(+ive)**



Bullying and Harassment - 22.8% Global Majority colleagues compared to 21.7% white colleagues experienced discrimination at work from manager/team leaders (the gap has decreased from previous year, with the experience of all colleagues improving) **(+ive)**

Birmingham and Solihull Mental Health NHS Foundation Trust

Disability Equality: WDES 2025 Overview

01

Colleagues with long-term condition or illness are - The likelihood of non-disabled colleagues being appointed from shortlist compared to colleagues with disabilities is 0.92 compared to 1.28 in 2024 **(+ive)**

02

Colleagues with disabilities are 3.28 times likely to enter the capability process then those without. (Last year 5.33) **(+ive)**

03

Colleagues with long-term condition or illness are more likely to experience harassment, bullying and abuse from patients or relatives – this has numerically decreased to 35.9% since last year 36.1% **(+ive)**

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Gender Pay Gap

In terms of the overall gender pay gap figures, a mean gap of **9.29%** **(**Increase from 7.87% in 2024) was calculated, alongside a median of 0.61% (increase from 0.56% in 2024). The figures show that men earn more than women overall, indicating a widening gap driven by higher-paid roles **(negative)**

The bonus gender pay gap has remains equitable **(positive)**

The mean ethnicity pay gap has decreased from 8.49% in 2024 to 8.15% in 2025 **(positive**

How this links to Workforce Inequalities?

- A diverse and inclusive workforce is better able to understand and respond to the needs of different communities.
- Staff who feel valued, supported and treated fairly are more likely to provide high quality care, remain engaged and stay in their roles.
- The EDI Improvement Plan aims to improve staff experience and address inequalities in areas such as recruitment, career progression and disciplinary processes.
- The document references the Core20PLUS5 approach, focusing on tackling health inequalities and ensuring leadership teams can demonstrate how disparities are being addressed for both staff and service users.

How this links to Workforce Inequalities?

- The approach is informed by triangulated data from several sources, including:
  - population and service data
  - patient outcomes and access rates
  - patient and carer feedback
  - workforce metrics such as representation, pay gaps, staff survey results and career progression

- Combining these data sources helps organisations identify where workforce inequalities overlap with patient and population disparities, highlight barriers to access and care, and prioritise interventions with the greatest impact.

- The final section stresses that reducing health inequalities requires understanding who is being left behind, both in patient care and within the workforce itself, and that equitable services cannot be achieved without addressing internal inequalities.

Birmingham and Solihull Mental Health NHS Foundation Trust

Thank you

Committee Escalation and Assurance Report

Name of Committee	**Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 June 2026**
Date(s) of Committee Meeting(s) reported	**21 May 2026**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework • Corporate Risk Register • Integrated Performance Report • Health Inequalities Report • Finance Report • Clinically Ready for Discharge Report • Capital Review Group Assurance Report • Planning and Delivery Subcommittee Assurance Report
Alert:	• Clinical Ready for Discharge (CRFD) remained a significant operational and financial risk. Whilst the Committee was assured by the mitigation plans in place, it was noted that there was no clear trajectory for improvement, reflecting heavy reliance on external partners. Delays in decision-making and approvals continued to affect patient flow and prolong length of stay, with acknowledged impact on patient outcomes and system capacity. • Inconsistent data was highlighted, which affected assurance and triangulation across committees. • Key safety indicators were highlighted in relation to safeguarding and absent without leave patients, which required triangulation with Quality, Patient Experience and Safety Committee. • The Committee received the Health Inequalities report (see summary below). The gender pay gap was highlighted as a key alert, with progress not being sustained and further focused action required to understand and address the underlying causes. • The Month 1 position was a reported £600k deficit, mainly driven by unresolved CYP income and continued system dependency to resolve funding. Whilst Bank spend showed an improvement from this time last year, the delivery of the Trust's financial plan remains high risk. • Emerging drug cost pressures were identified as a financial risk, with an overspend reported at Month 1 that, if sustained, could result in a significant year-end pressure (c£3.6m). The increase was understood to be partly driven by areas such as ADHD prescribing, and work was underway with clinical and pharmacy leads to better understand the drivers and identify opportunities for cost mitigation. • The National Oversight Framework uncertainty remained, with final metrics and expectations still evolving, but the Committee noted this would continue to mature over time.

Assure:	• The Committee was assured by improving workforce metrics, including positive trends in appraisal rates, sickness levels and reductions in temporary staffing reliance, indicating strengthened workforce management and operational grip. • The Committee was assured by positive performance in Talking Therapies, with noted improvements in key indicators and trajectories, demonstrating effective delivery and progression within this service area. • There was increased scrutiny of divisional performance and transformational outcomes against the Trust's strategy through Performance Assurance Panels and subcommittee structures. • The Committee noted early indications of positive impact from transformation initiatives, although financial benefits were not yet fully realised. • The Committee celebrated the recent HSJ Digital award that the Trust had received for its Equality, Diversity and Inclusion dashboard.	
Advise:	The approach to CRFD improvement would continue, with strengthened system focus to maintain escalation and engagement with local authority and system partners and utilise national leverage where available. The Committee was advised of the need to balance operational grip with system-level intervention.	
Reducing Health Inequalities impact:	The Committee noted that persistent inequalities in patient outcomes remained, despite improvements in workforce-related indicators, highlighting the complexity and long-term nature of addressing disparities. Wider system factors, particularly delays in social care, housing availability, discharge pathways and partnership working, were recognised as key contributors, reinforcing that many determinants of inequality sit beyond the Trust's direct control. Whilst data quality and analytical capability had significantly improved, enabling better identification of disparities, the Committee emphasised the need to move from insight to measurable improvement in outcomes, with clearer prioritisation of actions and greater clarity on what could be influenced directly by the Trust and what could be improved through system collaboration. The gender pay gap was identified as a key concern, with the Committee noting that, despite previous improvement, progress had not been sustained and the position had deteriorated. This raised concerns that existing interventions may not be sufficiently targeted or effective, and that there was a need for a more detailed understanding of the underlying drivers; particularly whether inequalities were linked to recruitment practices, progression opportunities, or structural workforce factors, to inform more robust and sustained action.	
Board Assurance Framework	The Committee considered the three risks: • Failure to maintain a long-term, sustainable financial position • Failure to maintain acceptable governance and national standards • Failure to deliver optimal outcomes with available resources The Committee discussed the alignment to the new Strategy, with suggested revisions around transformation, digital/AI and system dependency. This would be discussed at the Board strategy session in May.	
	New risks identified: no new risks were identified.	
Report compiled by:	Bal Claire, Non-Executive Director	**Minutes available from:** **Kat Cleverley, Company Secretary**

Committee Escalation and Assurance Report

Name of Committee	**Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 June 2026**
Date(s) of Committee Meeting(s) reported	**23 April 2026**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework • Integrated Performance Report • Emergency Preparedness, Resilience and Response Report • Finance Report • Year-End Strategic Goals 2025/26 Report • Capital Review Group Assurance Report • Planning and Delivery Subcommittee Assurance Report
Alert:	• The Month 12 position was a surplus of £9.1m. This was £4.9m adverse to original plan and forecast financial recovery trajectory, attributable to recognition of £4.9m unearned Deficit Support Funding. • The full-year 2025/26 bank expenditure was a reported £32m (£4m overspend). A £9m reduction was required in 2026/27. • The Committee considered the Secure Patient Transport Contract award, and requested further assurance on quality elements and the procurement process prior to formal approval at the Board of Directors.
Assure:	• The Committee was pleased to note that the Trust was classified in Segment 1 of the National Oversight Framework (NOF) for finances, recognising compliance and delivery. • The Committee was assured by the positive year-end position and thanked all teams in the Trust for the achievement. • The Committee was assured by the Year-End Strategic Goals 2025/26 Report and thanked the team for their hard work in closing the previous strategy in such a positive way.
Advise:	The Committee was advised of ongoing challenges in relation to Clinically Ready for Discharge (CRFD), as there was limited evidence of improvement in this area. An action plan and timeline would be developed for discussion at May's Committee meeting. The Committee requested a deep dive into bank spend to understand the impact of controls in place, as there had not been as much improvement reported in this area. An action plan and timeline would be developed for discussion at May's Committee meeting. Additional clarity on mitigations, controls and outcomes was requested in relation not future Emergency Preparedness, Resilience and Response reports to provide assurance on plans in place to meet full compliance.

Reducing Health Inequalities impact:	The Committee identified several areas with direct relevance to reducing health inequalities. These included the significant AMHP workforce gap (approximately 15 posts), ongoing pressures on community capacity, and variation in CRFD processes which constrained the organisation's ability to systematically identify and address inequitable outcomes. Wider determinants of health, particularly housing, were highlighted as a material barrier requiring coordinated action with system partners. The Committee emphasised that the planned transformation to locality-based models of care, alongside the implementation of the new NOF mental health metrics, would be critical to improving equity of access, outcomes and experience across the population.	
Board Assurance Framework	The Committee considered the three risks: • Failure to maintain a long-term, sustainable financial position • Failure to maintain acceptable governance and national standards • Failure to deliver optimal outcomes with available resources	
	New risks identified: no new risks were identified.	
Report compiled by:	Bal Claire, Non-Executive Director	**Minutes available from:** **Kat Cleverley, Company Secretary**

Report to Board of Directors						
Agenda item:	**16**					
Date	3 June 2026					
Title	Month 1 2026/27 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 month 1 2026/27 Group financial position.

Introduction

The month 1 2026/27 consolidated Group position is a deficit of £0.6m. This is £0.6m adverse to the break-even plan. The variance to plan is predominantly driven by £0.3m year to date share of Children and Young People's (CYP) income shortfall (related to CYP service transfer) and £0.3m bank overspend. Other savings shortfall and medication overspend is offset by underspends, mainly related to substantive pay. Total agency and non-trust bed expenditure are in line with plan for month 1.

Key Issues and Risks

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

- **CYP income shortfall** – There is a £4m recurrent income shortfall related to the transfer of the CYP service from BWCH to BSMHFT which took place on 1 July 2025. This forms £4m of the 2026/27 savings target. The BSOL ICB Chief Finance Officer is leading on the resolution of this issue. The year to date impact of the shortfall is £0.3m variance to plan.

- **Bank expenditure** - The 2026/27 bank budget has been set in line with the NHSE limit of £23.4m. This is £9m less than the 2025/26 actual expenditure. Month 1 bank expenditure is £0.3m above plan. If monthly spend were to continue at this level for the full year, bank would be £3.6m overspent. The Bank Reduction Gold project is ongoing, led by the Chief Nurse.

- **Savings** – The 2026/27 Group savings plan is £40.3m (£29.5m recurrent and £10.8m non- recurrent). As at month 1, £1.8m savings have been achieved (£1.4m recurrent) which is £21.6m full year effect. This is a shortfall of £1.6m against plan. In month 1, this shortfall has been offset by current underspends, predominantly substantive pay.

- **Medication expenditure -** The 2026/27 medication budget is £7.8m. Month 1 expenditure is £0.3m adverse to plan. If monthly spend were to continue at this level for the full year, medication expenditure would be £3.6m overspent.

Advise:

- **2026/27 Pay Award –** The month 1 financial position includes the impact of the 2026/27 agenda for change pay award of 3.3% paid from April 2026. Income has been calculated based on the interim indicative net cost uplift factor (CUF) of 0.73% which is 0.7% above original CUF per annual plan.

Capital position:

The month 1 Group capital expenditure is £0.6m, this is £0.6m less than plan.

Cash position:

The Group cash position at the end of month 1 is £73m.

Recommendation

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

Enclosures

Month 1 2026/27 finance report

NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2026 to 30th April 2026

Group financial position
£0.6m deficit

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Annual Budget	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Patient Care Activities	720,197	60,016	60,502	486
Other Income	36,377	3,031	2,817	(214)
Total Income	**756,574**	**63,047**	**63,319**	**272**
Expenditure				
Pay	(372,161)	(31,013)	(30,278)	735
Other Non Pay Expenditure	(343,704)	(28,634)	(30,022)	(1,388)
Drugs	(7,776)	(648)	(950)	(302)
Clinical Supplies	(857)	(72)	(24)	48
PFI	(14,550)	(1,213)	(1,243)	(30)
EBITDA	**17,525**	**1,468**	**803**	**(665)**
Capital Financing				
Depreciation	(9,505)	(792)	(780)	12
PDC Dividend	(500)	(42)	(42)	-
Finance Lease	(7,263)	(3,342)	(3,385)	(43)
Loan Interest Payable	(1,275)	(107)	(70)	36
Loan Interest Receivable	3,063	256	282	27
Surplus / (Deficit) before taxation	**2,046**	**(2,558)**	**(3,192)**	**(634)**
Impairment	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-
Taxation	(380)	(32)	(32)	0
Surplus / (Deficit)	**1,666**	**(2,590)**	**(3,224)**	**(634)**
Adjusted Financial Performance:				
Remove capital donations/grants/peppercorn lease I&E impact	78	6	6	-
Adjust PFI revenue costs to UK GAAP basis	(1,743)	2,588	2,588	-
Adjusted financial performance Surplus / (Deficit)	**0**	**4**	**(629)**	**(634)**

The Group position is driven by a £658k deficit for the Provider, £66k surplus for Summerhill Services Limited (SSL), break even position for the Mental Health Provider Collaborative (MHPC) and a surplus of £21k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

Month 1 2026/27 Group Financial Position

The month 1 2026/27 consolidated Group position is a deficit of £0.6m. This is after adjusting for the year to date revenue impact of the PFI liability remeasurement under IFRS 16 to UK GAAP basis.

The month 1 performance is in line with the financial strategy as set out previously at FPP Committee. The position is £0.6m adverse to the break even plan. This is predominantly driven by £0.3m year to date share of CYP income shortfall (related to CYP service transfer) and £0.3m bank overspend.

Other savings shortfall of £1.6m and medication overspend of £0.3m is offset by underspends, mainly related to substantive pay. Total agency and non-trust bed expenditure are in line with plan for month 1.

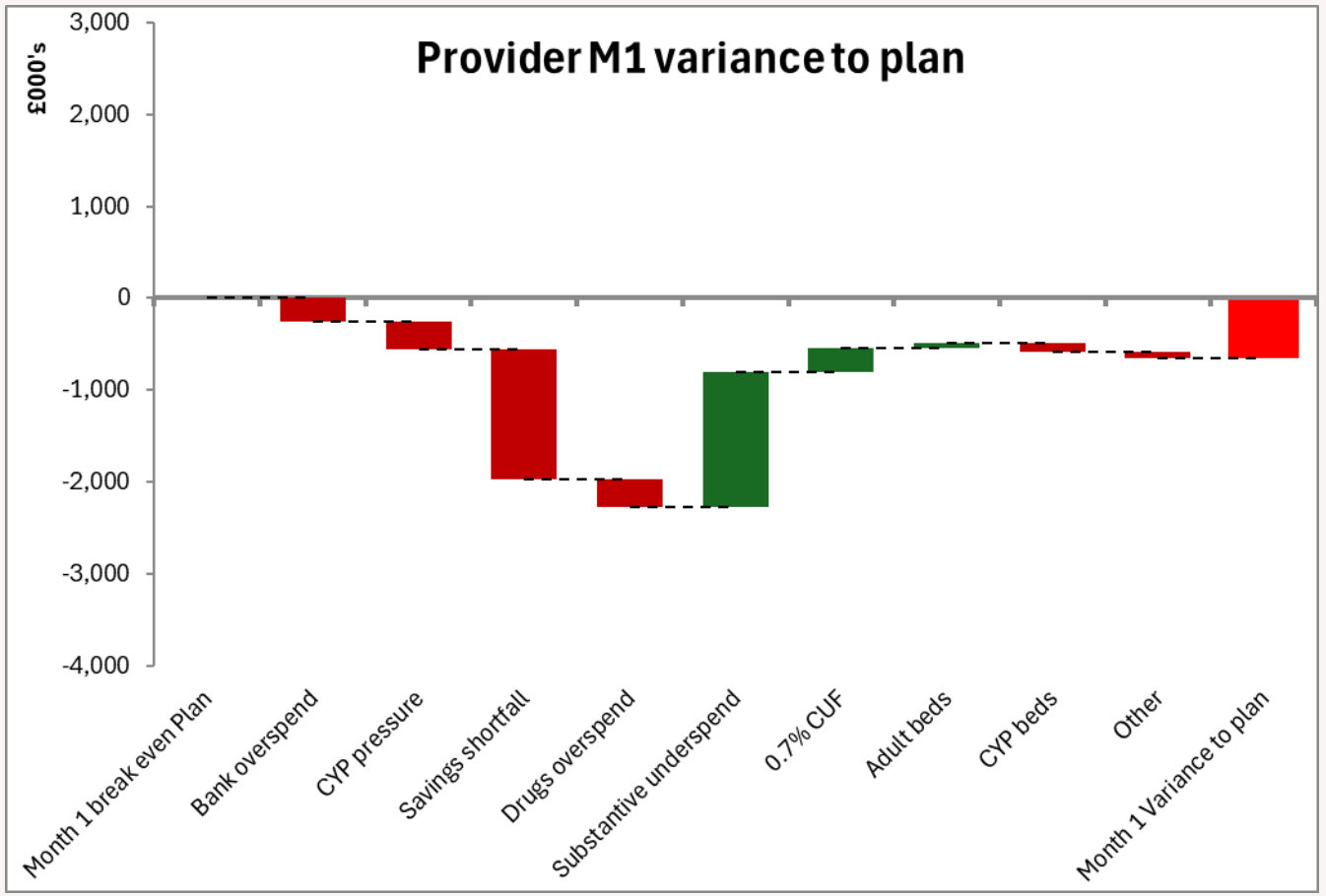
The financial position includes the impact of the 2026/27 agenda for change pay award of 3.3% paid from April 2026. Patient care income has been calculated based on the interim indicative net cost uplift factor (CUF) of 0.73% advised by NHSE, which is 0.7% above original CUF per annual plan.

National Oversight Framework	YTD Actual
	M1
NOF - Finance	
NOF variance YTD to plan score	4
NOF plan surplus/deficit score	1
NOF combined finance score	3

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	37,865	-	15,321	41,089	(33,774)	60,502
Other Income	2,831	2,524	-	(29)	(2,508)	2,817
Total Income	**40,696**	**2,524**	**15,321**	**41,060**	**(36,282)**	**63,319**
Expenditure						
Pay	(28,604)	(1,130)	(205)	(364)	25	(30,278)
Other Non Pay Expenditure	(9,380)	(601)	(15,145)	(40,809)	35,912	(30,022)
Drugs	(994)	(270)	-	-	314	(950)
Clinical Supplies	(24)	-	-	-	-	(24)
PFI	(1,243)	-	-	-	-	(1,243)
EBITDA	**451**	**523**	**(29)**	**(112)**	**(30)**	**803**
Capital Financing						
Depreciation	(498)	(227)	-	-	(54)	(780)
PDC Dividend	(42)	-	-	-	-	(42)
Finance Lease	(3,384)	(29)	-	-	27	(3,385)
Loan Interest Payable	(70)	(176)	-	-	176	(70)
Loan Interest Receivable	291	6	49	112	(176)	282
Surplus / (Deficit) before Taxation	**(3,253)**	**97**	**21**	**0**	**(57)**	**(3,192)**
Taxation	-	(32)	-	-	-	(32)
Surplus / (Deficit)	**(3,253)**	**66**	**21**	**0**	**(57)**	**(3,224)**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	6	-	-	-	-	6
Adjust PFI revenue costs to UK GAAP basis	2,588					2,588
Adjusted financial performance Surplus / (Deficit)	**(658)**	**66**	**21**	**0**	**(57)**	**(629)**

Month 1 Provider variance to plan



National Oversight Framework (NOF)

	YTD Actual
	M1
YTD actual	(629)
YTD plan	4
YTD variance to plan	**(634)**
YTD income	63,362
YTD variance to plan as % of YTD income	-1.00%

National Oversight Framework	YTD Actual
	M1
NOF - Finance	
NOF variance YTD to plan score	4
NOF plan surplus/deficit score	1
NOF combined finance score	3
NOF - Productivity	
Relative difference in costs score	1.6
NOF Finance & productivity domain score	2

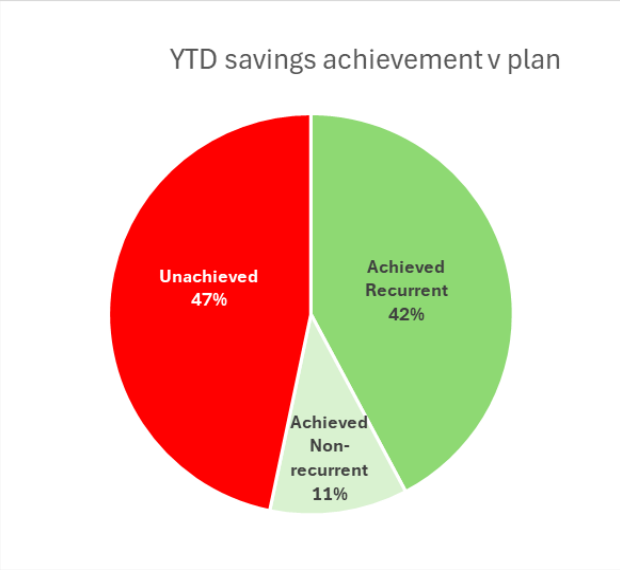
Efficiencies

Birmingham and Solihull Mental Health NHS Foundation Trust

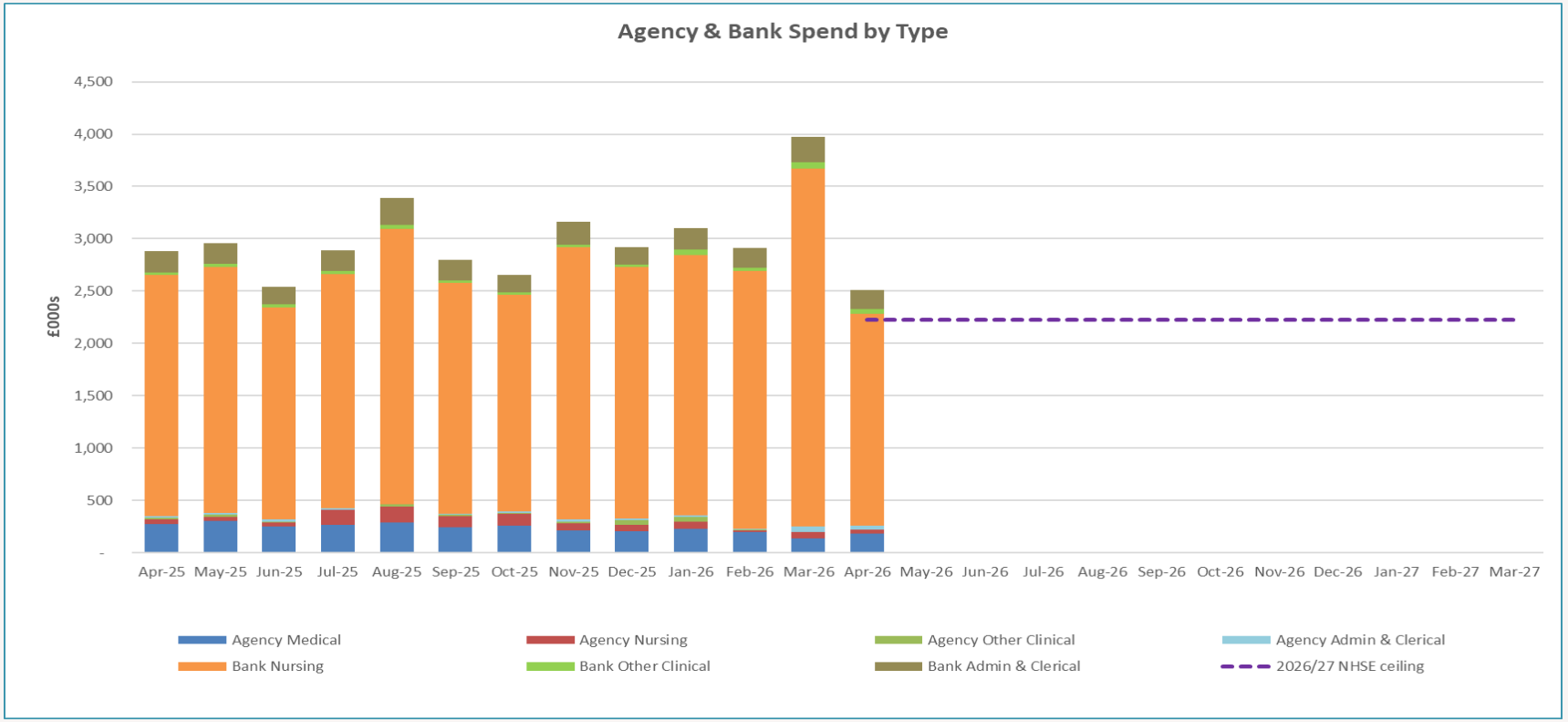
Efficiency status	Original plan £'000	Forecast £'000
Fully developed	18,675	28,639
Plans in Progress	3,714	6,802
Opportunity	13,133	4,889
Unidentified	4,808	-
Total	**40,330**	**40,330**

- The 2026/27 Group savings plan is £40.3m (£29.5m recurrent and £10.8m non- recurrent).
- At the time of plan submission, £4.8m of plans were unidentified. Following discussions at Executive Team meeting and Planning and Delivery sub committee, at the end of April, it has been approved that £4.8m stretch savings target will be allocated against inpatient beds with a focus on length of stay and clinically ready for discharge (adult/CYP split to be agreed). This will take the total inpatient beds savings target to £11.6m.
- As at month 1, £1.8m savings have been achieved (£1.4m recurrent) which is £21.6m full year effect. The year to date delivery is a shortfall of £1.6m against plan. The key drivers are: £0.3m CYP income shortfall, £0.4m inpatient beds, £0.2m transformation, £0.2m vacancy factor. Internal validation exercise underway to determine whether performance is better than reported because of the vacancy factor scheme.

Row Labels	Original Plan £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
Recurrent	**29,510**	**2,457**	**1,419**	**(1,038)**
ACUC	5,365	447	447	-
ICCR	1,010	84	51	(33)
SCOH	2,216	187	-	(187)
SPEC	1,380	118	-	(118)
SPP	156	13	13	0
CYP	3,150	263	206	(57)
CORP	2,343	197	112	(85)
Trustwide	8,687	725	167	(558)
PC'S	5,203	423	423	-
Non-Recurrent	**10,820**	**903**	**370**	**(533)**
ICCR	2,343	195	68	(127)
CYP	58	5	-	(5)
Trustwide	8,419	703	302	(401)
Grand Total	**40,330**	**3,360**	**1,790**	**(1,570)**



Temporary staffing expenditure

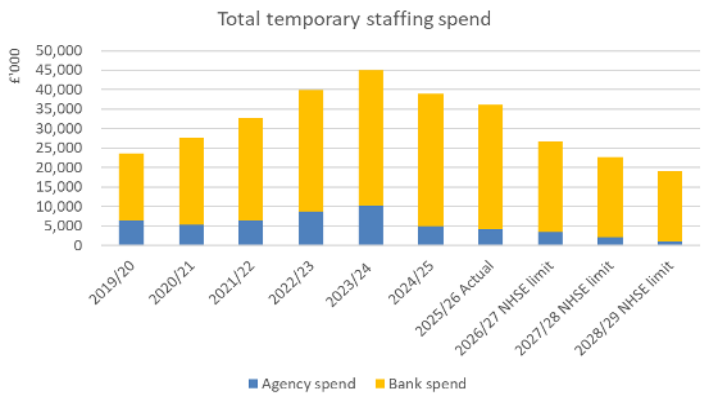


The 2026/27 temporary staffing budget has been set in line with the NHSE limit of £27m (£23.4m bank and £3.4m agency).

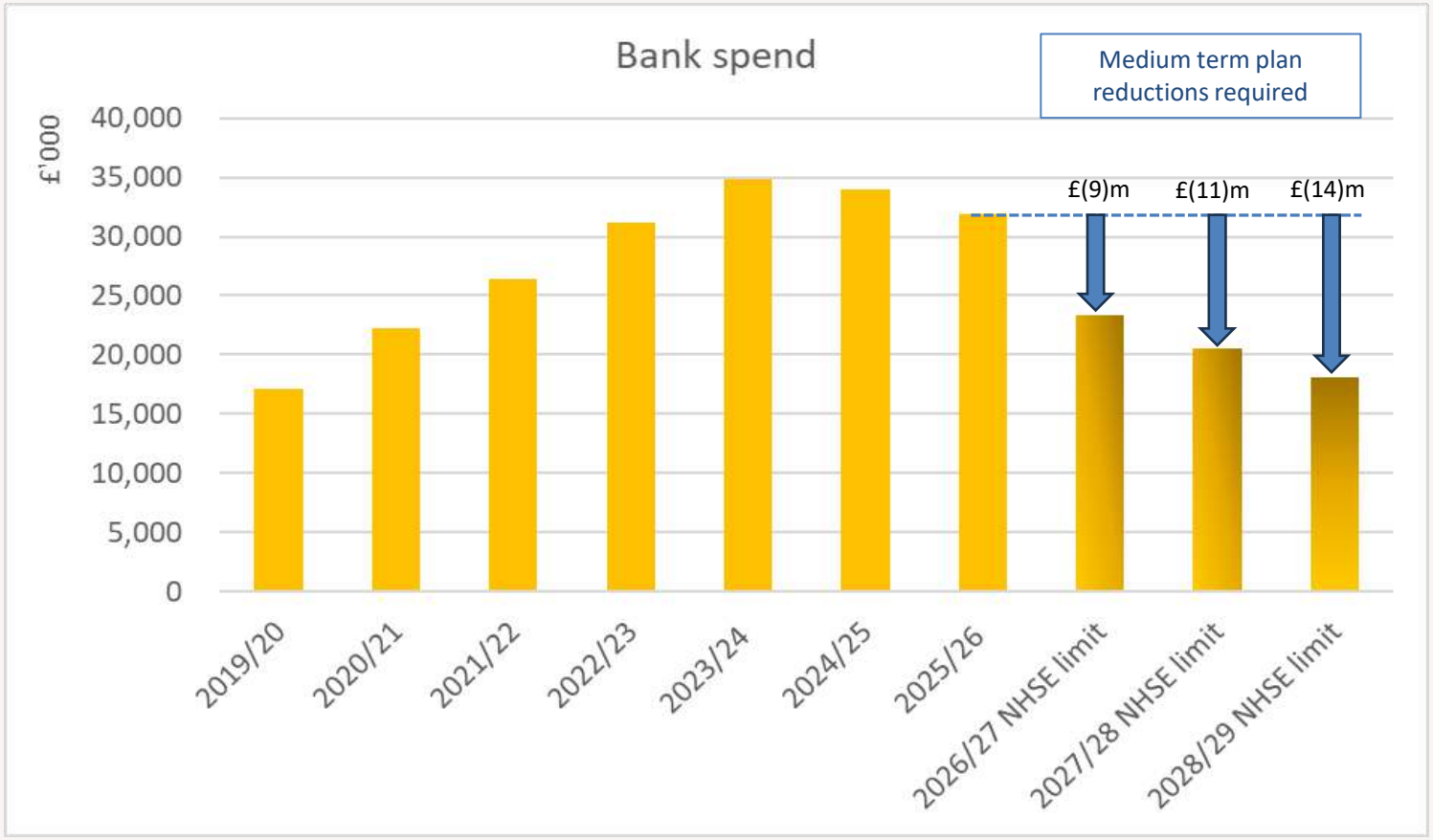
Temporary staffing spend in April is £2.5m, this is £0.3m above the NHSE limit (driven by bank). April spend is £0.5m less than the 2025/26 average.

Bank expenditure £2.3m (90%) – the majority of bank expenditure relates to nursing bank shifts - £2m

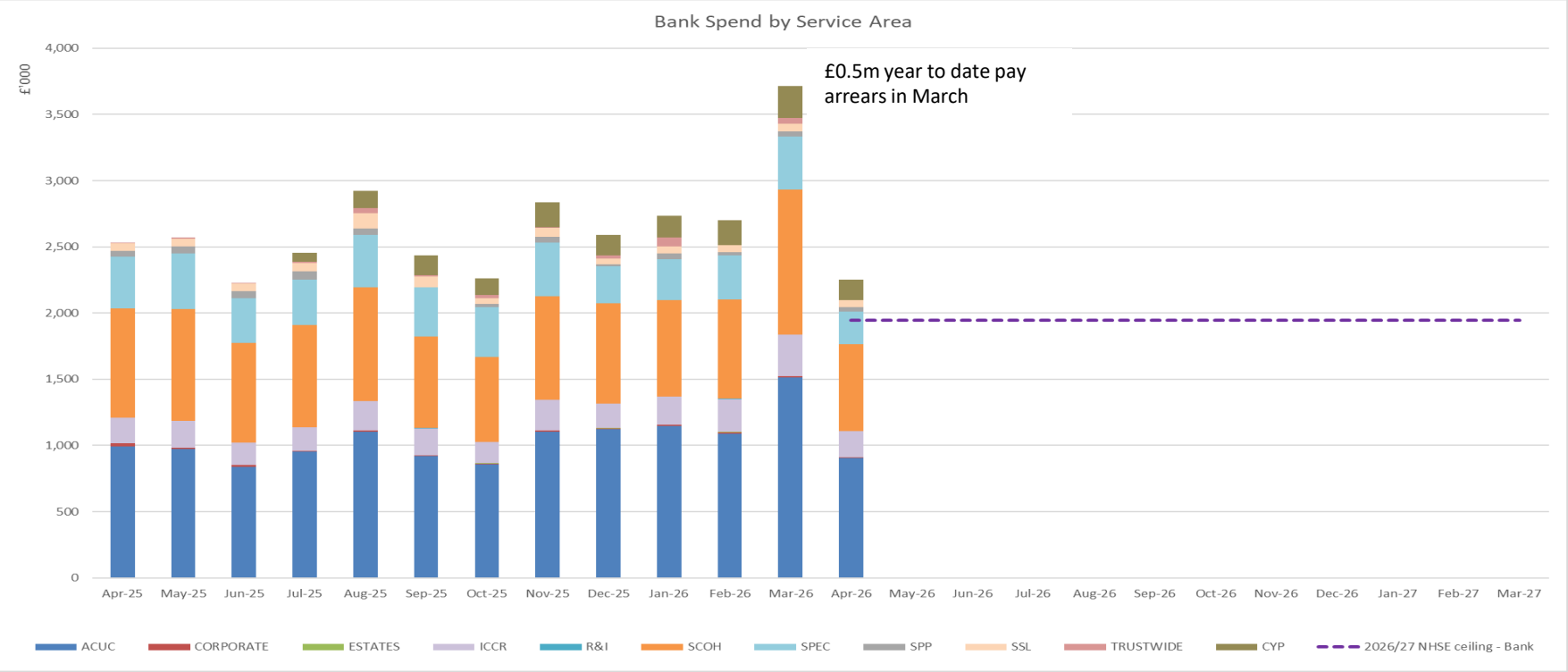
Agency expenditure £0.3m (10%) – the majority of agency expenditure relates to medical agency - £0.2m.



Bank medium term plan reduction requirements



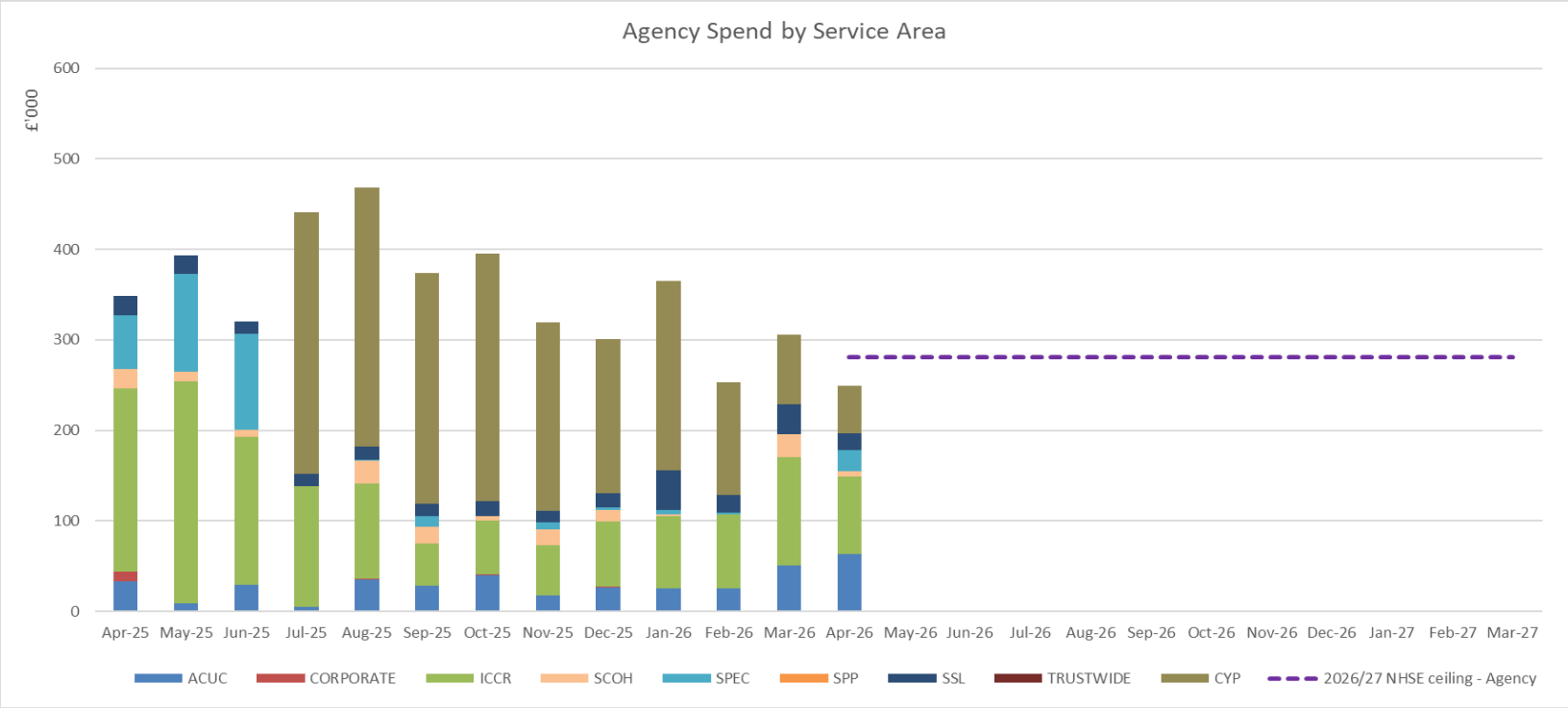
Bank expenditure



Bank expenditure

- The 2026/27 bank budget has been set in line with the NHSE limit of £23.4m which equates to £1.95m per month.
- April bank expenditure is £2.25m which is £0.3m above plan. If monthly spend were to continue at this level for the full year, bank would be £3.6m overspent. The Bank Reduction Gold project is ongoing, led by the Chief Nurse. An updated project plan has been agreed for the next 12 months. There is also a piece of work ongoing to establish real time bank reporting.
- The bank expenditure in April is £0.4m less than the 2025/26 average and is in line with the 2 lowest spend months of 2025/26. TSS shift data for bank suggests 11,500 bank shifts were filled in April which is 3,500 less than March. Given pay award and the two bank holidays in April, additional validation is underway to check all expenditure is accounted for.

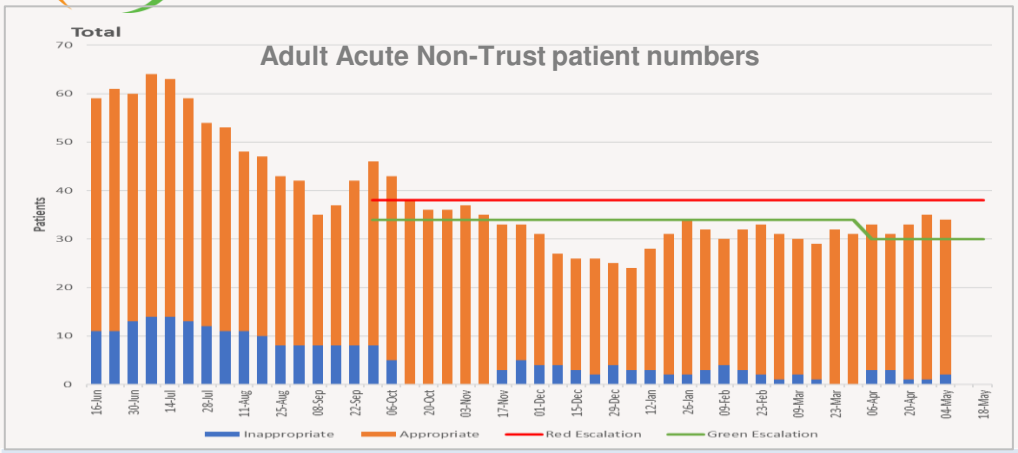
Agency expenditure

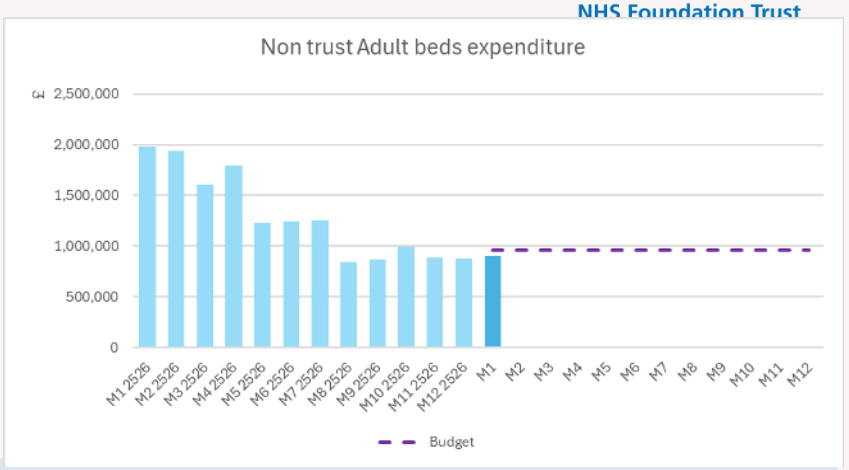


Agency expenditure

- The 2026/27 agency budget has been set in line with the NHSE limit of £3.4m which equates to £281k per month.
- April agency expenditure is £262k which is £19k less than plan. If monthly spend were to continue at this level for the full year, agency would be £0.2m below the NHSE limit.
- Agency spend in April is the lowest of the previous 12 months and is £86k below the July 2025 to March 2026 average, predominantly due to the work to reduce CYP agency expenditure since the CYP service was transferred to BSMHFT on 1 July 2025.

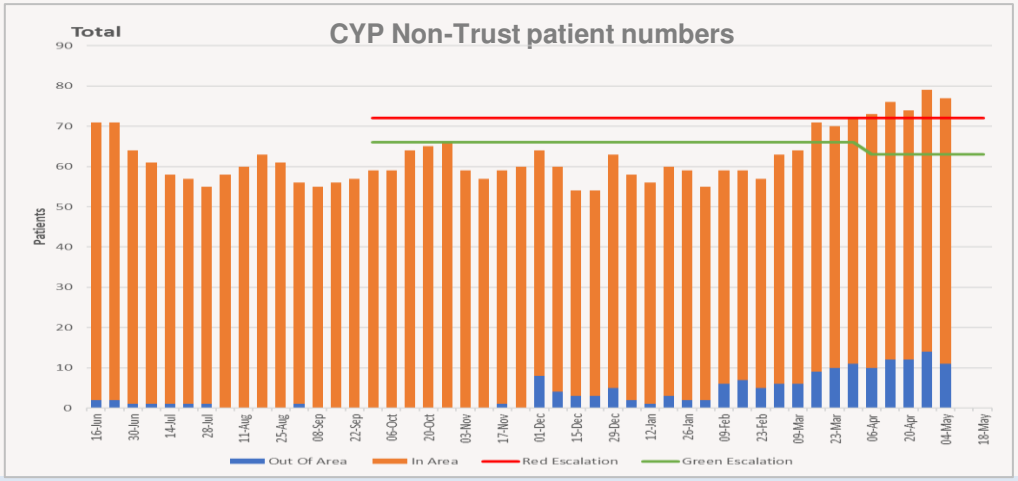
Non-Trust Inpatient Beds

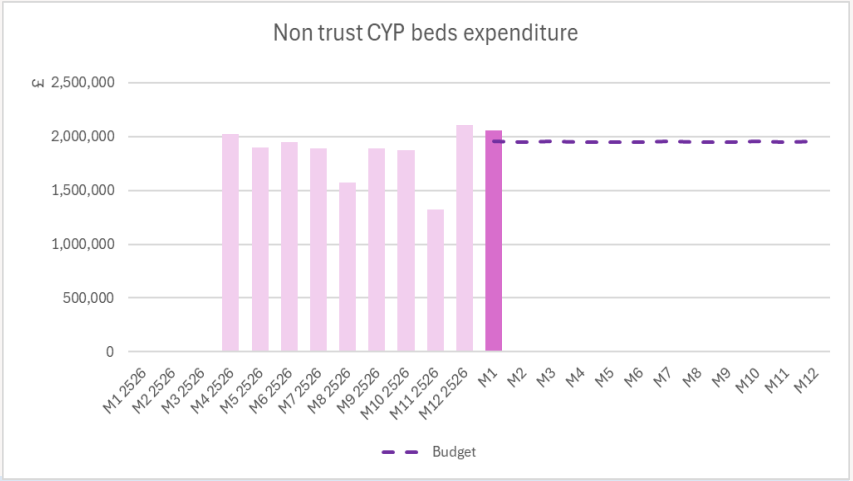




Adult non-Trust beds

- The 2026/27 non-Trust Adult bed budget is currently £11.5m (including £5.4m savings target). Share of additional stretch target still to be allocated.
- The month 1 expenditure of £0.9m is £56k below plan and just below the 2025/26 quarter 4 average.



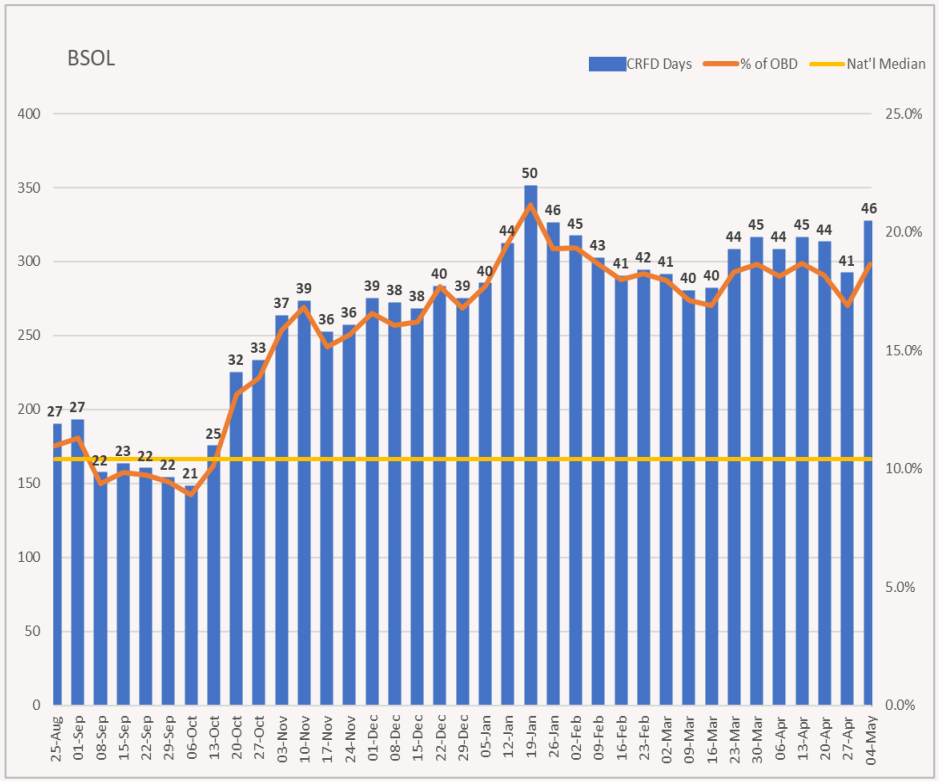


Children and Young People's (CYP) non-Trust beds

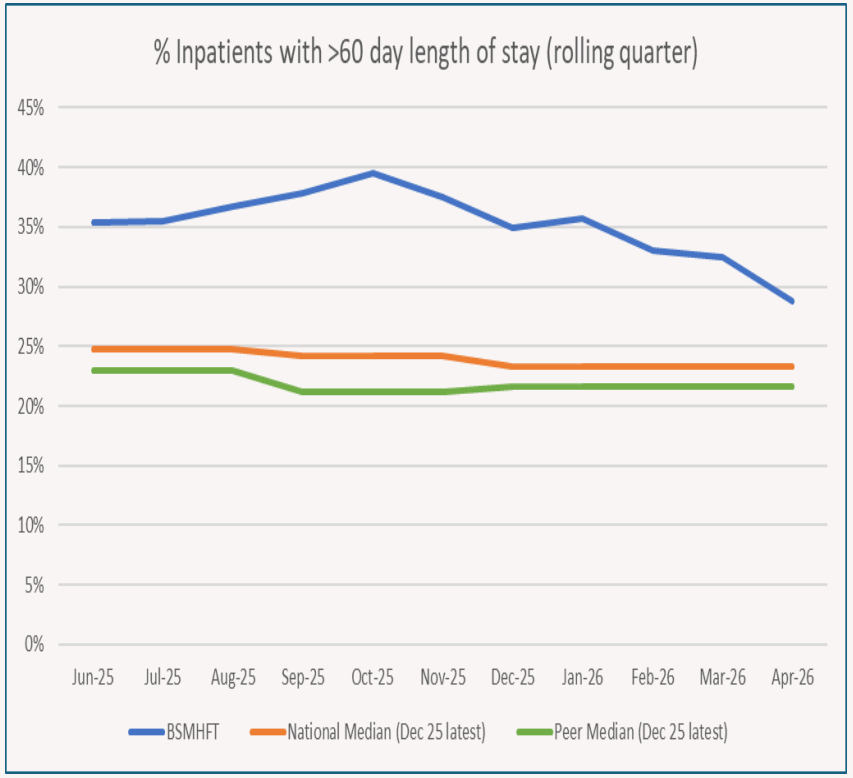
- The 2026/27 non-Trust CYP bed budget is currently £23.5m (including £1.5m savings target). Share of additional stretch target still to be allocated
- The month 1 expenditure of £2m is £97k above plan and £0.2m above the 2025/26 quarter 4 average.

Clinically Ready for Discharge and Length of Stay

Clinically Ready for Discharge

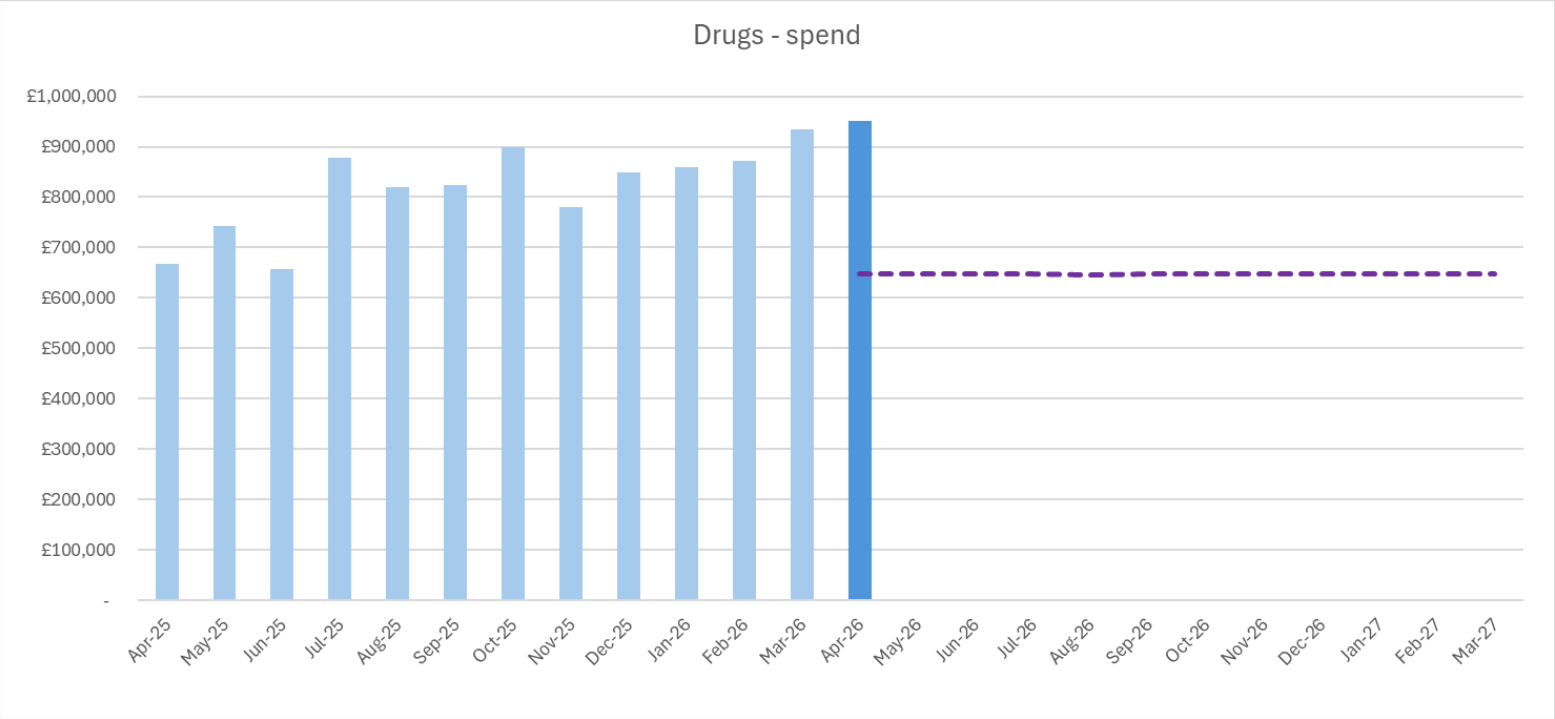


Average length of stay



An additional inpatient bed stretch savings target of £4.8m was approved at the end of April with a focus on reducing clinically ready for discharge and length of stay – adult/CYP savings target split to be agreed (page 6).

Medication expenditure



Medication expenditure

- The 2026/27 medication budget is £7.8m which equates to £650k per month.
- April expenditure is £950k which is £0.3m adverse to plan. The expenditure in April is £93k above the July 2025 to March 2026 average. If monthly spend were to continue at this level for the full year, medication expenditure would be £3.6m overspent.
- 71% of the overspend is in the ICCR service area and predominantly relates to expenditure on aripiprazole, respiredone and clozapine.

Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - 'Draft' 31-Mar-26 £m's	NHSI Plan YTD 30-Apr-26 £m's	Actual YTD 30-Apr-26 £m's	NHSI Plan Forecast 31-Mar-27 £m's
Non-Current Assets				
Property, plant and equipment	228.8	241.3	228.6	252.5
Prepayments PFI	1.0	2.3	1.3	2.3
Finance Lease Receivable	0.0	-	(0.0)	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	229.8	243.6	229.9	254.8
Current assets				
Inventories	0.7	0.9	0.5	0.9
Trade and Other Receivables	34.9	27.7	34.6	27.7
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	67.6	81.2	73.3	72.8
Total Curent Assets	103.2	109.9	108.4	101.4
Current liabilities				
Trade and other payables	(70.0)	(76.9)	(72.7)	(76.9)
Tax payable	(9.3)	(8.9)	(9.6)	(8.9)
Loan and Borrowings	(2.5)	(2.5)	(2.3)	(2.5)
Finance Lease, current	(1.3)	(1.3)	(1.3)	(1.3)
Provisions	(0.8)	(0.9)	(0.8)	(0.9)
Deferred income	(35.1)	(46.1)	(39.3)	(46.1)
Total Current Liabilities	(119.0)	(136.6)	(126.0)	(136.5)
Non-current liabilities				
Deferred Tax Liability	0.3	0.2	0.3	0.2
Loan and Borrowings	(18.6)	(16.8)	(17.9)	(16.4)
PFI lease	(78.9)	(80.5)	(81.7)	(79.4)
Finance Lease, non current	(5.3)	(5.4)	(5.3)	(5.1)
Provisions	(2.3)	(2.3)	(1.7)	(2.3)
Total non-current liabilities	(104.9)	(104.7)	(106.4)	(103.0)
Total assets employed	109.2	112.2	105.9	116.7
Financed by (taxpayers' equity)				
Public Dividend Capital	122.7	125.9	122.7	128.5
Revaluation reserve	46.7	49.1	46.7	49.1
Income and expenditure reserve	(60.2)	(62.8)	(63.5)	(60.9)
Total taxpayers' equity	109.2	112.2	105.9	116.7

SOFP Highlights

The Group cash position at the end of April 2026 is £73.3m.

For further detail on the current month cash position and movement of trade receivables and trade payables see pages 15 to 16.

Current Assets & Current Liabilities

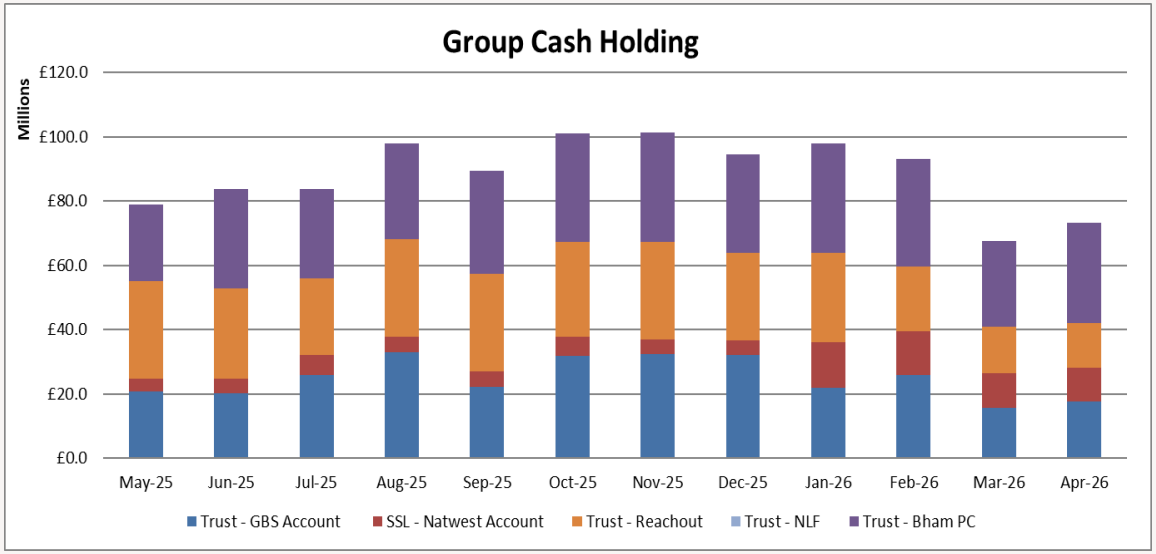
Ratios

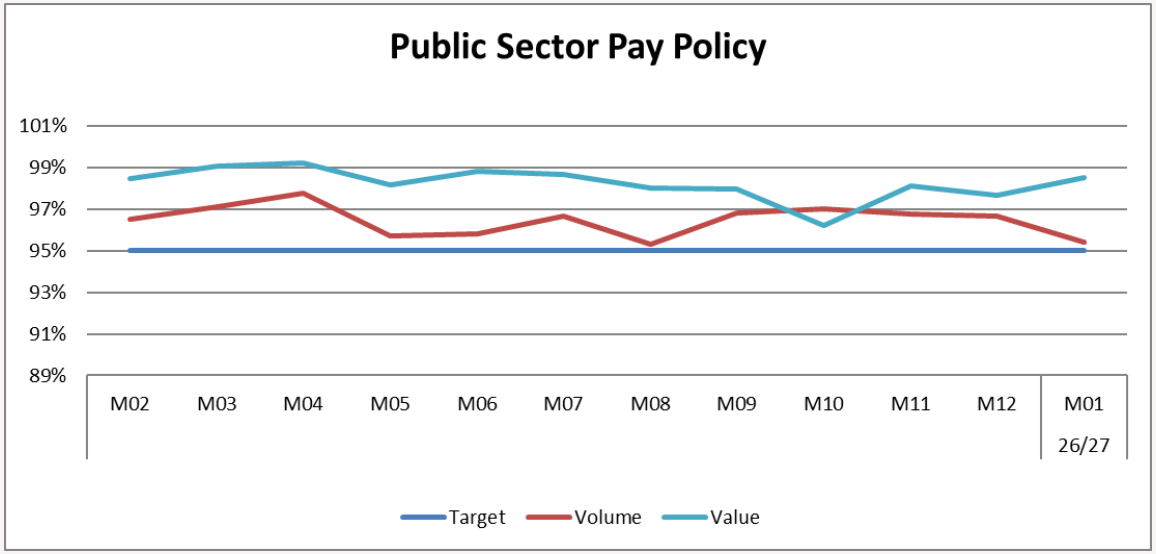
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	£m's
Current Assets	108.4
Current Liabilities	-126.0
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 April 2026 is £73.3m. This comprises of Trust £17.7m, SSL £10.5m, Reach Out Provider Collaborative £13.9m and Mental Health Provider Collaborative £31.2m.

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

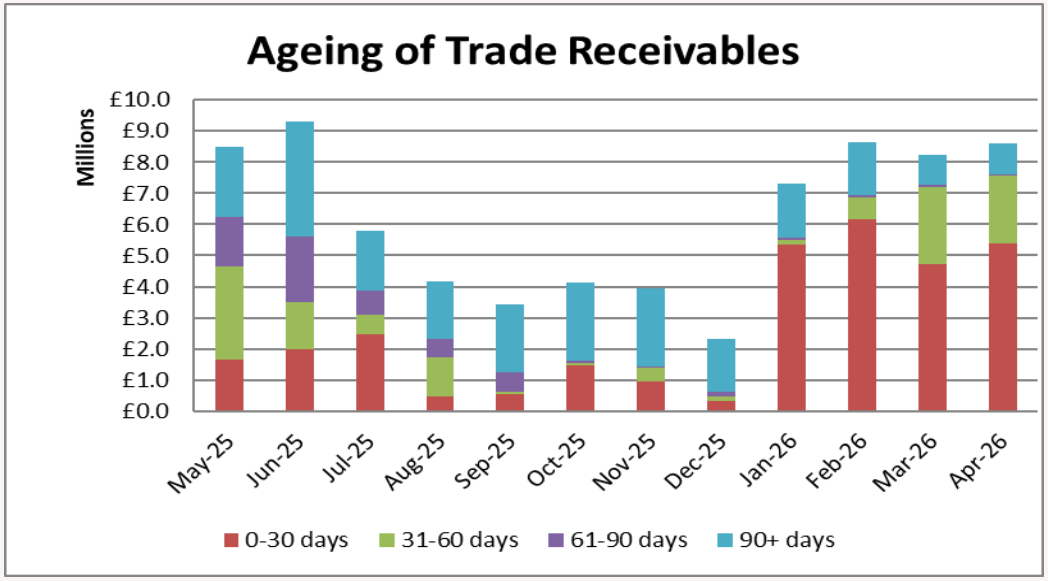
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

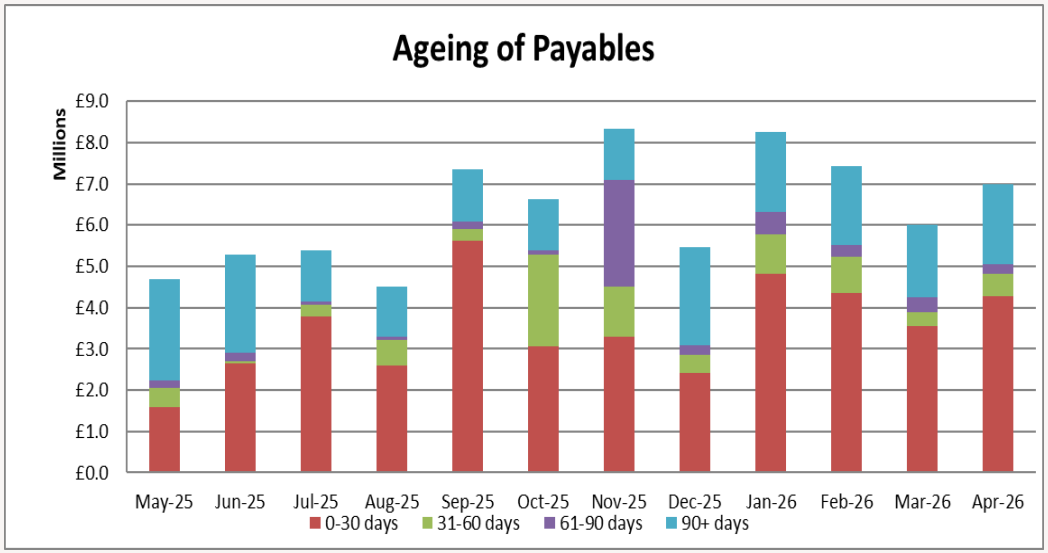
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	96%	✓	99%	✓
Non - NHS Creditors within 30 Days	95%	✓	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 £5.4m- increase in balance. Balance consists of monthly/daily ad hoc invoices waiting to be advised if approved or in query. Some balances are awaiting approval/payment or have been settled in May 2026.

- **31-60 days-** Overall Balance £2.2m – decrease in balance. Several debts are awaiting approval/payment or have been settled in May 2026. Remaining balance mainly staff overpayments (on payment plans).

- **61-90 days-** Overall Balance £41k- decrease in balance. Several debts are awaiting approval/payment or have been settled in May 2026. Remaining balance mainly staff overpayments (on payment plans).

- **Over 90+ days-** Overall Balance £969k–decrease in balance. *Awaiting authorisation:* UHB - £142k, UofB - £119k, ATW - £22k, Parexel Inc Ltd - £16k, SDSmy HC - £52k, Mecury Pharma - £79k. Remaining balance mainly staff overpayments (on payment plans).

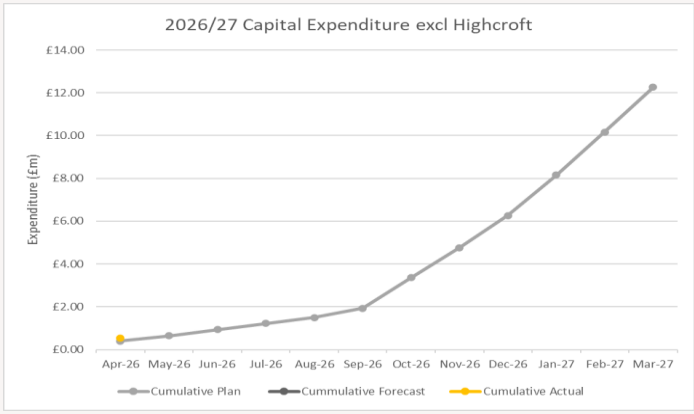
Trade Payables-Over 90 days:

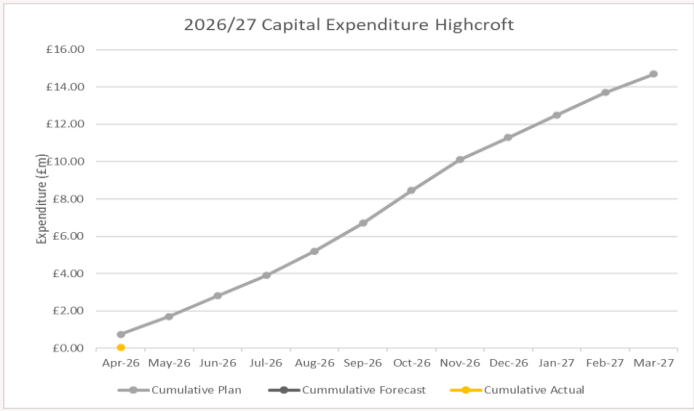
NHS Suppliers £99k: CNWL £55k in query, Nottinghamshire £52k, other small balances in query

Non-NHS Suppliers (55+) £1.8m mainly bed/out of area fees invoices in query/awaiting approval, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in May 2026.

2026/27 Capital Expenditure

Capital schemes	Annual Plan	Annual Forecast	New annual plan	YTD Plan	YTD Actual	YTD Variance to Plan
	£'m					£'m
Approved Schemes:						
Ardenleigh - Extension and Refurbishment of Production Kitchen	0.5	0.5	0.5	0.0	0.0	0.0
Children & Young People - Works to properties	0.5	0.5	0.5	0.0	0.0	(0.0)
Trustwide Decarbonisation Works	0.5	0.5	0.5	0.0	0.0	0.0
SSBM Works	2.0	2.0	2.0	0.1	0.1	0.0
Medical Devices	0.1	0.1	0.2	0.0	0.2	(0.2)
Lease Vehicles	0.6	0.6	0.8	0.2	0.0	0.2
Recognition of IFRS 16 Leases	0.1	0.1	0.1	0.0	0.0	0.0
ICT	0.1	0.1	0.3	0.0	0.0	0.0
Minor Works	1.8	1.8	1.2	0.1	0.3	(0.2)
2025/26 Estates Safety	0.6	0.6	0.6	0.0	0.0	0.0
24/7	4.6	4.6	4.6	0.0	0.0	0.0
MH Emergency Department	1.0	1.0	1.0	0.0	0.0	0.0
Digital Transformation to support MH ED	0.0	0.0	0.0	0.0	0.0	0.0
Total	12.3	12.3	12.3	0.4	0.5	(0.1)
Highcroft New Build	14.7	14.7	14.7	0.8	0.0	0.7
Total	26.9	26.9	26.9	1.2	0.6	0.6





Current Capital plan for 2026/27

The total planned capital for 2026/27 is £26.9m, this includes:

BAU Capital	£6.1m
Highcroft New Build	£14.7m
CIR Estates Risk	£0.6m
24/7 Neighbourhood MH Centre	£4.6m
MH ED/Crisis Assessment Centre	£1.0m
Digital Transformation to support MH ED	£0.02m

Group Capital Expenditure

Total capital expenditure for month 1 is £0.6m, this is a £0.6m underspend against a £1.2m plan.

The monthly Capital Review Group meeting ensures review of the capital plan and approval of any changes, including new schemes. The finance team meet regularly with the ICT team and estates and capital team to ensure a joint understanding of the position.

Committee Escalation and Assurance Report

Name of Committee	**Audit Committee**
Report presented at	**Board of Directors**
Date of meeting	**3 June 2026**
Date(s) of Committee Meeting(s) reported	**29 April 2026**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework • Corporate Risk Register • External Risk Factors Report • Draft Annual Governance Statement • Draft Annual Report 2025/26 • Draft Annual Accounts 2025/26 • Internal Audit Progress Report • Draft Head of Internal Audit Opinion 2025/26 • Internal Audit Plan 2026/27 • Internal Audit Review: BAF and Risk Management • Internal Audit Review: Key Financial Controls • Internal Audit Review Assurance and Progress: Medical Job Planning; Appraisals Process; e-Rostering and Temporary Staffing • Local Counter Fraud Annual Report 2025/26 • Draft Local Counter Fraud Workplan 2026/27 • Recruitment Local Proactive Exercise Report • Conflicts of Interest Local Proactive Exercise Report • External Audit Strategy Memorandum • Single Tender Waivers Report • Risk Management Group Assurance Report
Alert:	The Committee commented on the positive meeting held, with no alerts to report.
Assure:	The Committee was assured on the following areas: • The Committee was assured that the Annual Report and Accounts 2025/26 were on track to be completed in line with national timescales. • A positive draft Head of Internal Audit Opinion was received, confirming adequate and effective governance arrangements, risk management and internal controls.

	• The Committee was assured by the Reasonable Assurance rating given to the BAF and Risk Management internal audit review, noting some minor housekeeping recommendations. • The Committee was assured by the Reasonable Assurance rating given to the Key Financial Controls internal audit review. • The external audit was progressing according to plan, with no emerging issues likely to impact delivery of final audit. • Counter Fraud activities had been diverse and positive throughout the year, reflecting proactiveness and maturity. The Committee approved the workplan for 2026/27. • The Committee received assurance on actions and progress from internal audit reviews into Medical Job Planning, Appraisals Process and e-Rostering/Temporary Staffing.	
Advise:	The Committee discussed that the use of technology and AI presented both opportunity and risk, and that clear governance, controls and awareness were required to manage information governance, fraud and assurance risks while supporting innovation and productivity. The Committee highlighted recurring themes around data quality, consistency and system integration, particularly in relation to CYP services and assurance reporting.	
Board Assurance Framework	The Committee reviewed the Board Assurance Framework and was satisfied with the management of the strategic risks, noting that a review was underway to align the BAF to the refreshed Trust Strategy. The Corporate Risk Register was received. The Committee discussed the emergence and review of several high-scoring and developing risks, including temporary staffing pressures, financial delivery, capital availability, secure bed capacity and workforce constraints. These risks were being actively reviewed through the Risk Management Group. The Committee discussed the treatment of external risks (including geopolitical and system-wide issues), noting that they would be framed by operational impact on the Trust where possible, to strengthen Board-level assurance.	
	New risks identified: The Committee explored the balance and distribution of risks across People, Quality and Finance domains, noting differences in scoring and risk appetite between committees. Continued challenge and moderation were important to ensure a consistent and transparent view of organisational risk.	
Report compiled by:	Winston Weir Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary