

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST				
Board of Directors Public Meeting, 10.15, Wednesday 7 October 2026, Uffculme Centre				
AGENDA				
Ref	Item	Purpose	Report type	Time
Service User Talk 10.15-10.30				
1	Chair's Welcome and Introduction			10.30
2	Apologies for absence			
3	Declarations of interest			
4	Minutes of meeting held on 5 August 2026	Approval	Enc	10.35
5	Matters arising from meeting held on 5 August 2026	Assurance	Enc	
6	Chair's Report <i>Phil Gayle, Chair</i>	Assurance	Enc	10.40
7	Chief Executive and Director of Operations Report <i>Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Executive Director of Operations</i>	Assurance	Enc	10.45
8	Board Assurance Framework <i>Kat Cleverley, Company Secretary</i>	Assurance	Enc	10.55
9	Integrated Performance Report <i>Dave Tomlinson, Executive Director of Finance</i>	Assurance	Enc	11.00
Care and Communities				
10	Quality, Patient Experience and Safety Committee Report <i>Nick Moor, Non-Executive Director</i>	Assurance	Enc	11.05
11	Quality and Safety Report <i>Lisa Stalley-Green, Chief Nurse</i>	Assurance	Enc	11.10
12	Safeguarding Annual Report and Assurance Statement <i>Mel Yates, Head of Safeguarding</i>	Approval	Enc	11.20
Culture				
13	People Committee Report <i>Sue Bedward, Non-Executive Director</i>	Assurance	Enc	11.30
14	Medical Directorate Annual Report <i>Fabida Aria, Executive Medical Director</i>	Approval	Enc	11.35
15	Freedom to Speak Up Guardian Quarterly Report <i>Kirsten Jones, Chief AHP/Interim Deputy Director of Quality, Safety and Experience*</i>	Assurance	Enc	11.40
Creativity				
16	Finance, Performance and Productivity Committee Report <i>Bal Claire, Non-Executive Director</i>	Assurance	Enc	11.50
17	Finance Report <i>Dave Tomlinson, Executive Director of Finance</i>	Assurance	Enc	11.55
18	Winter Plan <i>Vanessa Devlin, Executive Director of Operations</i>	Approval	Enc	12.00
19	Audit Committee Report <i>Winston Weir, Non-Executive Director</i>	Assurance	Enc	12.10
20	Caring Minds Committee Report <i>Monica Shafaq, Non-Executive Director</i>	Assurance	Enc	12.15
21	Risk Appetite Framework <i>Kat Cleverley, Company Secretary</i>	Approval	Enc	12.20
22	Risk Management Policy <i>Kat Cleverley, Company Secretary</i>	Approval	Enc	12.25
Reflections				
23	Living the Trust Values <i>Sue Bedward, Non-Executive Director</i>		Verbal	12.30
24	Board Assurance Framework reflections		Verbal	12.35
25	Any other business		Verbal	12.40
26	Questions from Governors and members of the public			
Close by 12.45				
Date and Time of Next Meeting: Wednesday 2 December 2026, 10.15				

*Note: Emma Randle, Lead Freedom to Speak Up Guardian, is on annual leave



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BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Minutes of the Public Board of Directors Meeting
Wednesday 5 August 2026, 10.30,
Uffculme Centre

Members	Phil Gayle	PG	Chair
	Fabida Aria	FA	Executive Medical Director
	Nick Moor	NM	Non-Executive Director
	Sue Bedward	SB	Non-Executive Director
	Bal Claire	BC	Non-Executive Director/Deputy Chair
	Vanessa Devlin	VD	Executive Director of Operations
	Roisin Fallon-Williams	RFW	Chief Executive Officer
	Patrick Nyarumbu	PN	Deputy CEO/Executive Director of Strategy, People and Partnerships
	Lisa Stalley- Green	LSG	Executive Director of Quality and Safety/Chief Nurse
	Dave Tomlinson	DT	Executive Director of Finance
	Winston Weir	WW	Non-Executive Director
Attending	Hannah Sullivan	HS	Corporate Governance Manager (minutes)
	Zalika Geohaghon	ZG	Lead Nurse Consultant/Deputy Director for Infection Prevention and Control (Item 12 only)
	Emma Patterson	EP	Head of Research and Development (item 13 only)
	Alex Copello	AC	Associate Director of Research and Development (item 13 only)
	Hari Shanmugaratnam	HSh	Guardian of Safe Working Hours (item 15 only)
	Jas Kaur	JK	Head of EDI
Observers	There were no observers at the meeting.		
Ref	Item		
0	The Board of Directors were joined by Charlotte Tolley, Advanced Nurse Practitioner and Family and Carer Inclusion and Engagement Lead, and Richard Taylor, Digital Transformation Specialist who shared their story focussing on making carer involvement more visible through the development of a co-produced Carer Check-in Tool and a redesign of RiO to improve the identification of carers, strengthen engagement, support safe information sharing and enable more meaningful reporting. CT highlighted the current challenges in consistently identifying carers, evidencing meaningful engagement, recording decisions around information sharing and reporting the support offered to carers. It was highlighted that key information relating to carers is often fragmented across patient records, which can make it difficult for staff to identify carers consistently, understand their role, evidence engagement or ensure that appropriate support has been offered. CT and RT advised the Board that the co-produced Carer Check-in Tool had been developed to provide a structured and consistent approach to engaging with carers. The tool is intended to support collaborative conversations, improve documentation, strengthen the recording of carer involvement and generate more consistent data to inform service evaluation, quality improvement and organisational learning. It was noted that Version 13 of the tool was nearing completion and was ready for final refinement prior to implementation. RT led a discussion regarding the proposed redesign of RiO and the importance of ensuring that carers have a dedicated and visible space within the electronic patient record. The Board recognised that, without a clear and structured section for carer information, the carers' voice risked being diluted within wider clinical documentation. This could limit the visibility of carers' contributions, reduce the ability of staff to record and access key information consistently, and make it more difficult to demonstrate the support provided to carers across services. CT highlighted that the current recording arrangements do not sufficiently showcase the significant and positive work undertaken by the Trust with families and carers. It was acknowledged that staff across the organisation undertake valuable engagement and support work with carers, but that this is not always visible, reportable or		



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easy to evidence within existing systems. The redesign of RiO was therefore viewed as an important opportunity to strengthen the Trust's ability to demonstrate the impact of its work with carers, improve accountability and support a more consistent approach to carer involvement across services.

RT noted that the RiO redesign would support a safer, more streamlined and reportable system for recording carer information. This would help ensure that carer involvement, information-sharing decisions, support offered and key engagement activity are recorded in a more consistent and accessible way. It was further noted that introducing a structured approach to recording carer information would support safer information sharing, improve the quality and consistency of care, strengthen accountability and enable more meaningful reporting and service improvement.

The Board recognised the importance of ensuring that the redesign is not solely a technical change but also a cultural and practice-based improvement. Members noted that embedding a dedicated carer space within RiO would help reinforce the Trust's commitment to families and carers, support staff to do the right thing more easily, and ensure that carer involvement becomes more visible and embedded within routine clinical practice. This was considered particularly important in supporting the Trust's ambition to move from good individual examples of carer engagement to a more consistent, Trust-wide approach.

CT noted that the Carer Check-in Tool was initially being developed within FIRST, with the opportunity for wider organisational adoption across the Trust. The Board discussed the potential benefits of implementing the tool beyond FIRST and recognised the need to consider the appropriate level of ambition for wider Trust-wide implementation.

RT confirmed that the redesign of RiO was planned for January/February 2027, with a further review to be brought back to the Trust Board in April 2027. This would provide the Board with an opportunity to review progress, consider the impact of the redesign and receive assurance on implementation, visibility of carer information, reporting arrangements and the continued development of the Carer Check-in Tool.

PG welcomed the development of the Carer Check-in Tool and highlighted the benefits of a structured carer care plan. He noted that the approach would help staff better understand and respond to the complexities often experienced within family relationships and would strengthen carer involvement within care planning.

DET queried how the proposed tool aligned with local authority carer assessments and whether opportunities existed to strengthen links between the Trust and local authority assessment processes.

CT advised that there are three categories of local authority carer assessments and that the proposed care plan aligned well with the principles underpinning these arrangements. She noted the Trust's responsibility to offer support to carers and explained that the tool was being developed as a directory of resources. CT highlighted the benefits of the approach not being clinician-led, creating greater opportunity to establish rapport with carers and enabling more meaningful engagement.

FA welcomed the inclusion of an "I want help" option within the tool, describing it as a clear and accessible function that would make it easier for carers to identify and request support. She also recognised the significant commitment and dedication demonstrated by RT in supporting the development of the tool.

BC commended the work undertaken to date and sought assurance regarding any barriers that could impact delivery and implementation.

CT acknowledged that working within the current RiO system remained challenging and advised that successful implementation would depend upon securing staff engagement and buy-in to ensure the tool was adopted and used consistently across services.

RFW expressed confidence that staff would support the initiative once they became aware of its benefits and highlighted the need for effective promotion and communication to support implementation. She suggested that any resource concerns could be partially addressed through professional development opportunities and emphasised that listening to and supporting carers is the responsibility of all staff across the organisation.

	CT informed the Board that the RiO redesign team meets regularly and that a number of creative design sessions had taken place. These discussions had highlighted the importance of ensuring that the tool supports the Trust's culture of care and aligns with both the Patient and Carer Race Equality Framework (PCREF) and the Trust Strategy. A broader discussion then focused on the redesign of RiO and the opportunity to strengthen the visibility of carers within the electronic patient record. Members recognised that the current system does not provide a dedicated space for carer information, resulting in information often being fragmented across records and the carer voice becoming diluted within wider clinical documentation. The Board noted that this can make it difficult to evidence meaningful engagement with carers, record information-sharing decisions and demonstrate the support provided to carers in a consistent and measurable way. It was further acknowledged that the current system does not effectively showcase the significant amount of positive work undertaken by the Trust with families and carers. The Board strongly supported the proposal to create a dedicated area within RiO for carers and carer engagement information. Members agreed that a more visible and structured approach would improve the identification of carers, strengthen accountability, support safer information sharing and provide meaningful reporting on carer involvement and support. The redesign was viewed as a key opportunity to ensure that the contribution and experiences of carers are more visible within clinical systems and organisational reporting. VJD welcomed the data-driven approach being taken and emphasised the importance of maintaining a service user and carer-led co-production model throughout the development process. She highlighted the importance of ensuring that carers are listened to, valued and appropriately supported. SB sought clarification regarding the extent to which the tool would link with partner organisation systems and how relevant information could be shared appropriately across organisational boundaries. CT advised that the intention was to create a seamless approach to information sharing, supported by high-quality and consistent data. She noted that the NHS number may provide opportunities to facilitate information sharing and reduce duplication, although willingness from carers to share personal information and consent to information sharing may present challenges that would need to be carefully considered as the work progresses. The Board noted that development of the Carer Check-in Tool was approaching completion and that work on the redesign of RiO would continue through the established design and development process. It was confirmed that the RiO redesign is planned for implementation during January/February 2027, with a further progress review and update to be presented to the Trust Board in April 2027. Members agreed that this would provide an opportunity to assess the effectiveness of the redesign, the visibility of carer information within the record and the Trust's ability to evidence and showcase its work with carers. Overall, the Board was highly supportive of the initiative and recognised the Carer Check-in Tool and proposed RiO redesign as significant developments in strengthening carer involvement across the Trust. Members welcomed the co-produced approach to development and acknowledged the potential benefits of a structured tool to improve identification, engagement, information sharing and support for carers. The Board recognised that current arrangements can result in carer information being fragmented across records, leading to the carer voice being diluted within wider clinical documentation and limiting the Trust's ability to evidence and report on engagement with carers. The Board therefore strongly supported the creation of a dedicated space within RiO for carers, enabling more consistent recording, greater visibility of carers' contributions and more meaningful reporting of outcomes and support provided. The Board thanked CT and RT for their continued hard work and dedication.
1	Chair's Welcome and Introduction PG welcomed everyone to the meeting.
2	Apologies for absence Kat Cleverley, Company Secretary Peter Axon, Non- Executive Director



	Monica Shafaq, Non- Executive Director
3	Declarations of interest None.
4	Minutes of meeting held on 3 June 2026 The minutes were agreed as a true and accurate record.
5	Matters arising from meeting held on 3 June 2026 There were no matters arising.
6	Chair's Report The Board received the Chair's Report. PG highlighted recent engagement activity undertaken and reflected positively on the commitment, innovation and professionalism demonstrated by staff across services visited: • Board approval and submission of the Annual Report and Accounts, providing assurance of the Trust's commitment to transparency, accountability and good governance. • Completion of annual Non-Executive Director appraisals, with positive feedback and no significant concerns identified regarding Board effectiveness. • Positive Chair's visit to the Lyndon Centre, providing assurance regarding service quality and highlighting the dedication and professionalism of staff. • Continued engagement in regional and national NHS forums, strengthening the Trust's influence within the wider health and care system and supporting strategic partnerships. • Ongoing focus on stakeholder engagement, workforce culture, quality and staff experience through Council of Governors activities, Board Strategy Sessions and Freedom to Speak Up assurance discussions. • Governor engagement remains challenging, the Corporate Governance Team continue to work hard to engage Governors meaningfully. The Board was assured by the update provided with no further comments.
7	Chief Executive and Director of Operations Report The Board received the report and noted the following key points: • Workforce remains stable with strong recruitment, reduced agency usage and continued investment in digital, AI and workforce development. • The West Midlands Mental Health, Learning Disability and Autism Provider Collaborative, continues to support coordinated, system-wide action across partner Trusts to address shared workforce, quality and sustainability challenges. A full report was included in the report. The new Secretary of State met with all Chief Executives this week to confirm there will be no large scale change and to reiterate their passion and dedication for improving mental health services. • Birmingham Healthy Minds continues to exceed activity targets, whilst urgent care services are progressing patient flow improvements and development of a dedicated Mental Health Emergency Department model. • Positive progress across community and children's services, including recruitment improvements, service transformation and pathway redesign initiatives. • Older Adult Community Mental Health Teams received an overall CQC rating of Good, with ongoing quality improvement activity across the Trust. • FIRST has successfully relocated to Main House. The move has gone well overall, with the team now using the space effectively for meetings, supervision and quieter working. • Progress is being made against the Remedial Action Plan in SOLAR. • Financial pressures remain significant, with continued focus on delivering efficiencies and reducing temporary staffing and non-contracted bed expenditure.

	• More than 30,000 patients have enrolled in the new shared patient portal, supporting improved digital access to services. • The report highlights ongoing engagement with major NHS reforms, including NHS Staff Standards, the proposed Health Bill, ICB mergers and development of a new national Mental Health Strategy. WW queried the Combined Authority's commitment to health and social care following the appointment of the new Health Secretary. He also sought clarification regarding the future role of NHS England, including whether it would continue to operate in its current form or be subject to further organisational change. RFW advised that NHS England would continue to operate within the Department of Health and Social Care, although the future operating structure remained under development. RFW further confirmed that the Combined Authority had reaffirmed its commitment to neighbourhood health centres and had committed funding to support mental health provision. The Board heard that planning was underway for a model comprising both bed-based and non-bed-based services, with full support and commitment from the Integrated Care Board (ICB). The West Midlands Major has reinforced the importance of delivering mental health services within community settings and noted that positive relationships continued to be developed with key partners to support this ambition. PG highlighted concerns that reductions in agency and bank workforce usage had not yet been sustained and sought assurance regarding the actions being taken to address the gap. He requested assurance that there was a clear plan in place to improve performance and queried whether the associated trajectory would be reviewed. RFW advised that a range of actions had been implemented and that progress continued to be reported through the Financial Performance Programme (FPP). She confirmed that Executive Directors were due to undertake a detailed review of performance and delivery plans and continued to work closely with divisional teams to support implementation and delivery of agreed actions. PG also queried the ongoing Children's and Young People's (CYP) sickness risk and sought assurance regarding actions being taken to address underlying workforce wellbeing concerns. RFW confirmed that she had met with the divisional team and that work was underway to develop and implement cultural improvement plans, alongside wider workforce support initiatives, aimed at improving staff wellbeing and reducing sickness levels. PG sought an update regarding system-wide discharge arrangements, noting that approximately 30% of older adult patients were affected by discharge-related challenges. VJD advised that transformation work was progressing in relation to patients who were clinically ready for discharge. She confirmed that Jenny Watson was leading this work and was working collaboratively with local authorities and system partners to improve discharge pathways, strengthen partnership working and support timely discharge arrangements across the system. Overall, the Board received assurance regarding the continued development of system partnerships and transformation programmes across health and social care. Members noted the ongoing work to reduce agency and bank workforce usage, address workforce wellbeing challenges and improve discharge pathways for older adults. The Board welcomed the commitment from the Combined Authority and ICB towards neighbourhood health provision and recognised the importance of maintaining strong partnership arrangements to support the delivery of integrated mental health services across the region.
8	Board Assurance Framework The Board received an update on the development of the Board Assurance Framework (BAF) and noted that the Framework continues to provide a structured approach to identifying, monitoring and gaining assurance over the key strategic risks that could impact delivery of the Trust's objectives. DET highlighted that the current draft BAF risks have been realigned to the Trust's new strategy and revised following feedback received through Board Committees during July.

	The Board was advised that further work is required to refine Strategic Risk 8 relating to digital infrastructure, systems, cyber security and innovation, alongside continued development of the remaining risks to ensure risk descriptions and scoring are fully aligned. The Board noted that a broader discussion on the BAF, risk management arrangements and the Trust's risk appetite would take place at the Board Strategy Session in September. The Board acknowledged that the BAF process is well embedded across the organisation and supported the continued development of the strategic risks aligned to the new Trust strategy.
9	Integrated Performance Report The Board received the Integrated Performance Report and noted the introduction of new Mental Health Chief Executive Officer Improvement Metrics and the National Oversight Framework (NOF) 2026/27 measures, with executive and operational leads identified for all indicators and improvement plans in place where required. The Board was advised that challenges remained in relation to inappropriate out of area placements, clinically ready for discharge delays, CYP Eating Disorders waiting times, sickness absence, appraisals and selected NOF metrics. Positive progress was noted in reducing overall out of area placements, improving clinically ready for discharge performance, achieving planned length of stay trajectories, maintaining vacancy rates below target and reducing agency use. The Board also reviewed quality indicators, noting improvements in AWOL incidents resulting in harm, post-discharge deaths, episodes of rapid tranquillisation and restrictive practice measures, whilst recognising increases in incidents of moderate harm and safeguarding incidents. PG queried the trajectory for the four-week wait performance standard and sought assurance regarding delivery against planned performance levels. He questioned whether the current trajectory remained achievable and whether it would require revision. RFW confirmed that the trajectory would be reconsidered to ensure it remained realistic and reflected current performance and operational challenges. PG also queried progress with e-rostering and sought assurance that implementation challenges were being addressed. RFW advised that pressures associated with e-rostering remained, however improvements continued to be seen across services as implementation matured and teams became more familiar with the system. DET reported that MHOST was operating effectively and delivering benefits across services. He advised that further work was underway to improve local knowledge and understanding of the system to maximise its use and effectiveness. DET noted that utilisation of bank staff remained variable across some areas, reflecting mixed levels of engagement with roster management processes. RFW highlighted the significant investment that had been made in MHOST and associated staffing resources. She advised that Acute and Urgent Care services were successfully utilising auto-rostering functionality and that this was working well, providing greater efficiency and supporting workforce planning and deployment. Overall, the Board received assurance that progress continued to be made in relation to workforce systems and operational performance. Members noted that work was ongoing to refine the four-week wait trajectory, further embed e-rostering arrangements and maximise the benefits of MHOST across the organisation. The Board welcomed the positive progress reported within Acute and Urgent Care services and noted the continued focus on improving workforce utilisation, roster management and system adoption across all divisions.
10	Quality, Patient Experience and Safety Committee Report The Board received reports from June and July's meetings, noting the following key points: Workforce and capacity pressures continue across CYP, community and specialist services.

	• Ongoing concerns regarding delayed discharges, waiting times, rising demand and pathway flow. • Health inequalities remain a significant concern, particularly for deprived communities. • IPC and Occupational Health (Optima) risks require continued oversight. • Strengthened Board Assurance Framework aligned to the Trust Strategy. • Continued progress in patient safety, PSIRF implementation, Culture of Care and Nigel's Plan. • Positive developments in governance, regulatory compliance, patient experience, co-production and reducing restrictive practice. • Improvement plans are in place to address workforce, community service and CYP pressures. • Ensure community, access, patient safety and CYP risks remain reflected within the BAF. • Maintain focus on workforce sustainability, organisational learning, partnership working and reducing health inequalities. • Further refinement of strategic risks aligned to the Trust Strategy was supported. The Board thanked NM for the comprehensive report.
11	Quality and Safety Report, including Safer Staffing The Board received the Quality and Safety Report and received assurance regarding progress against key quality, safety and patient experience priorities aligned to the Trust Strategy and Board Assurance Framework. The Board noted continued strengthening of safeguarding practice, particularly in relation to domestic abuse, alongside positive examples of multi-agency working and workforce development initiatives. LSG highlighted the learning arising from national inquiries and prevention of future deaths reports, which highlighted the importance of risk ownership, information sharing, listening to families and carers, and maintaining strong governance and assurance arrangements. She confirmed the Trust have responded to the relevant requirements. LSG highlighted a regional analysis of mental health homicide incidents across the Midlands has recently been shared by the Midlands Independent Investigation Team. The review examined incidents occurring between 2015 and 2024 and compared population-adjusted incidence rates across Midlands' systems. The analysis found no clear regional outliers, with the Trusts position appearing broadly consistent with comparable systems across the region. The Board received an update on the delivery of Nigel's Plan, noting progress in strengthening care for complex and high-risk patients through improved governance, multidisciplinary working, neighbourhood-based models, enhanced community pathways and strengthened partnership arrangements. Members noted further work to reduce variation across services, improve continuity of care and address risks associated with housing provision, discharge pathways and workforce experience gaps. The Board welcomed improvements in complaints management, the development of a refreshed Recovery College model focused on reducing health inequalities, progress in consultant caseload and demand management, and the implementation of the Culture of Care Excellence Framework. Assurance was also received regarding the successful implementation of Dialog+, supporting personalised and collaborative care planning across services, and the positive regulatory position following the publication of a 'Good' rating for Older Adult Community Mental Health Teams by the Care Quality Commission.
12	Infection Prevention and Control Annual Report 2025/26 ZG presented the Infection Prevention and Control Annual Report 2025/26 and noted the significant progress made in infection prevention and control during 2025/26. The Board received assurance that infection rates remained low, no Trust-attributable MRSA bacteraemia cases were reported, cleaning standards and IPC audit compliance remained consistently high, and infection outbreaks reduced by 76.3% compared with the previous year. The Board also noted the strengthening of governance arrangements, staff training, surveillance processes and co-production activity with service users.



	The Board noted a number of ongoing risks requiring attention, including the absence of a microbiology support contract, a decontamination officer and an air safety group, alongside concerns regarding occupational health support and FFP3 fit-testing compliance. ZG highlighted the recommendation for the Trust to acquire IPC systems such as ICNet to ensure IPC can monitor microbiology results and follow up on support given as well as being able to audit IPC work. PG queried the costs associated with ICNet and sought assurance regarding the procurement approach being taken. LSG confirmed that procurement options were currently being reviewed to identify the most appropriate route forward and ensure value for money. BC queried whether any additional support was required to enable the successful delivery and implementation of the programme. ZG advised that good progress was being made against all recommendations and that work remained on track to address the actions identified. RFW confirmed that risks associated with ICNet were being actively reviewed and monitored to ensure appropriate oversight and mitigation arrangements remained in place. RFW thanked ZG for her leadership of the programme, recognising her contribution in establishing a team that is working effectively and maintaining momentum against the improvement programme. PN confirmed that he would work with Human Resources colleagues to address the concerns that had been raised in relation to Optima and to identify any further actions required. The Board supported the proposed priorities for 2026/27, including strengthening microbiology arrangements, reviewing occupational health provision, establishing an air safety group and improving compliance with statutory infection prevention and control requirements. The Board thanks ZG and colleagues for the comprehensive report.
13	Research and Development Annual Report 2025/26 EP and AC presented the Research and Development Annual Report 2025/26 and noted significant progress in strengthening the Trust's position as a research-active organisation. The Board received assurance that research activity has continued to support innovation, service improvement, workforce development and improved patient outcomes, with increases in research income, commercial research activity, research capacity and academic partnerships. The Board noted the achievement of a breakeven financial position, strong research governance performance, 100% compliance with national study set-up requirements, and continued growth in research participation and grant funding. The Board welcomed the impact of research across a wide range of clinical services, including mood disorders, addictions, neuropsychiatry, perinatal mental health and children and young people's services, alongside continued investment in research leadership, lived experience involvement and workforce development. EP and AC noted that priorities for 2026/27 include further strengthening recruitment performance, expanding research opportunities across services, increasing commercial research activity and embedding research-led innovation within routine service delivery. EP highlighted the consolidation of Children's and Young People's (CYP) services remained challenging. The Board discussed the operational and workforce complexities associated with the programme and recognised the need to maintain a clear focus on service quality, staff engagement and the delivery of safe and sustainable services throughout the transition process. No significant risks were reported.



	BC commented that it had been a privilege to attend the recent Medical Celebration event and noted with pride that the Trust is home to the largest psychiatric unit in Europe. BC suggested that the Trust should consider exploring the possibility of applying for Teaching Trust status to further strengthen its reputation and support workforce development opportunities. EP thanked BC for the suggestion and acknowledged the potential benefits of Teaching Trust status. However, he highlighted the significant governance requirements associated with such an application, together with the considerable costs that may arise from any rebranding and implementation requirements. RFW agreed that there were opportunities to further promote the Trust's achievements and profile and confirmed that options to support this would continue to be explored. FA thanked EP and AC for their work and highlighted the recruitment trials being undertaken through the NOF programme. She noted that the work was progressing well and required only finalisation before implementation. PN noted that there may be an opportunity to scale the initiative across the wider organisation and suggested that associated costs and benefits be reviewed and incorporated into a future report for Board consideration. The Board welcomed the positive discussion regarding the Trust's profile, reputation and future development opportunities. Members recognised the strengths of the organisation, including its scale and expertise, and supported further exploration of opportunities to promote the Trust, enhance recruitment initiatives and consider the potential benefits and implications of Teaching Trust status. Overall, the Board was encouraged by the breadth and impact of research activity across the Trust and recognised the important contribution of research and innovation in improving care, reducing inequalities, enhancing staff development and strengthening the Trust's regional and national profile. Members supported the continued focus on expanding research opportunities, increasing research participation and embedding research-led innovation into routine service delivery. The Board thanked EP and AC for their continued dedication.
14	People Committee Report The Board received reports from June and July's meetings, noting the following key points: • Workforce inequalities and disproportionate employee relations outcomes remain a concern. • Bank staffing levels and complex employee relations casework continue to pose risks. • Ongoing concerns regarding discrimination, staff safety and management capability. • Continued improvements in recruitment, vacancy reduction, safer staffing, training compliance and reduced agency spend. • Improved oversight and timeliness of employee relations case management. • Positive progress in Freedom to Speak Up, equality and inclusion initiatives. • Maintain focus on leadership and management capability to improve staff experience and resolve issues earlier. • Continue strengthening the use of workforce, equality and speaking up intelligence to identify emerging risks. • Strategic workforce risks have been refreshed and aligned to the new Trust Strategy. No new strategic risks were identified. The Board thanked SB for the comprehensive report.
15	Guardian of Safe Working Hours Report HSh presented the Guardian of Safe Working Hours Annual Report 2025/26 and noted assurance regarding the oversight of junior doctor vacancies and rota gaps across the Trust. The Board noted that 1,542 vacant shifts were recorded during 2025/26, representing an increase compared to the previous year, with vacancies, doctors being off rota and sickness identified as the principal drivers of rota gaps. The Board was advised that although rota gaps continued to be actively managed, increasing workforce



	pressures and changing workforce patterns, including a growing proportion of less than full-time trainees, may present challenges to future rota stability. NM queried how the number of uncovered shifts translates into whole-time equivalent (WTE) staffing, seeking greater understanding of the workforce impact reflected within the report. HSh confirmed that the uncovered shifts referenced predominantly related to out-of-hours on-call arrangements rather than substantive vacant posts. RFW thanked HSh for the Annual Report and acknowledged the impact that Children and Young People's (CYP) services were having on the position reported. She queried whether the increasing number of requests for exemption from on-call duties was having an operational impact and sought assurance that a fair and consistent process was being applied? HSh confirmed that there had been a notable increase in exemption requests over a relatively short period and that this was having an impact on workforce planning and rota management. FA provided assurance that each exemption request is reviewed and assessed on an individual basis. She confirmed that Dr Imran Waheed was supporting the process and noted that challenges relating to out-of-hours cover and exemptions were being experienced nationally. SB queried how issues relating to locum bookings, vacancies and sickness absence were being addressed and sought assurance as to whether any identifiable patterns were emerging? HSh advised that reliance on locum staffing remained a national challenge. He confirmed that vacancies had been filled and that active measures continued to be taken to support workforce stability. FA acknowledged that some patterns had been identified through the review process; however, she noted that improvements had been observed following the actions implemented and that overall rates had reduced. BC highlighted the significant variation in locum expenditure and activity between April and May and sought clarification regarding the reason for the change. HSh confirmed that the difference reflected the allocation of funding through the national programme, which had influenced locum activity and expenditure during the reporting period. Overall the Board received assurance regarding the management of the medical workforce, noting the increasing impact of on-call exemption requests, the continued national challenges associated with locum staffing, and the actions being taken to address vacancies and workforce pressures. Members welcomed the progress made in reducing overall rates and noted the ongoing monitoring of trends and workforce risks. The Board thanked HSh for the comprehensive report.
16	WRES/WDES Annual Report 2025/26 The Board received the WRES/WDES Annual Report 2025/26 and noted progress in a number of workforce equality indicators, including increased Global Majority workforce representation, improved access to professional development opportunities, reductions in bullying and harassment, improved disability-related recruitment outcomes, increased reporting of concerns, improved staff engagement and greater access to reasonable workplace adjustments. The Board also noted a number of continuing challenges, including widening inequalities in recruitment outcomes, career progression, disciplinary processes and experiences of discrimination for Global Majority colleagues, together with a significant increase in the likelihood of disabled colleagues entering formal capability processes. The Board was advised that targeted actions and organisational improvement programmes are in place to address these disparities, strengthen inclusion and reduce workforce inequalities. JK highlighted that a detailed review of shortlisting practices had been undertaken across divisions and services using the Race Metric Scorecard. The work had provided greater insight into recruitment processes and supported efforts to improve equity and inclusion within recruitment practices.



	PN noted that the data reflected the ongoing work to improve organisational culture and highlighted the importance of exploring mediation and informal resolution approaches before progressing to formal HR processes. He acknowledged the need to continue raising the profile of this work across the organisation. JK highlighted the positive progress being made in relation to reasonable adjustments, noting that reported figures relating to disability had doubled. She also referenced the Resource Bank and Access to Work arrangements as important mechanisms for supporting staff. LSG queried whether neurodiversity was a contributing factor within the data and trends being reported. PN confirmed that some intelligence relating to neurodiversity had been identified. He advised that the Trust's Staff Networks were developing practical toolkits to support managers and staff and to improve awareness and understanding of neurodiversity across the organisation. SB queried whether information relating to staff leaving the organisation was being routinely captured and analysed? JK confirmed that leaver data is captured through a number of different mechanisms, enabling the Trust to monitor trends and better understand workforce experiences. PN confirmed that changes within the Band 8a workforce profile were expected and reflected an overall increase in staffing numbers rather than an area of concern. Overall, the Board welcomed the Trust's continued commitment to equity, diversity and inclusion and received assurance that robust governance, monitoring and improvement arrangements are in place to support delivery of the Trust's equality objectives and reduce health inequalities. The Board thanked JK for her contribution and support to the organisation, noting that this would be her final Board meeting. Members expressed their appreciation for her work and wished her every success in her new role.
17	Finance, Performance and Productivity Committee Report The Board received reports from June and July's meetings, noting the following key points: • Financial deficit remains a significant concern, driven by savings delivery shortfalls, bank spend, non-contracted beds, medicines expenditure and wider cost pressures. • High bed occupancy, discharge delays and ongoing demand pressures continue to impact operational and financial performance. • Performance concerns were highlighted in CYP services, including waiting times, workforce capacity and access performance. • Community service caseloads, performance and outcome reporting require continued oversight. • Strengthened governance and oversight arrangements are in place for transformation, bank reduction and clinically ready for discharge programmes. • Positive assurance was received regarding information governance, cyber compliance and statutory information request performance. • Clear delivery plans, monitoring arrangements and executive accountability are in place across key transformation programmes. • Continue to strengthen reporting on transformation delivery, risks, outcomes and benefits realisation. • Maintain close monitoring of financial performance, CYP access, community service pressures, medicines expenditure and safeguarding trends. • Strategic risks relating to financial sustainability, governance, transformation, digital infrastructure and AI were reviewed and aligned to the new Trust Strategy. No new strategic risks were identified. BC challenged the need for the Board to receive greater assurance regarding the delivery of transformational programmes through the FPP. He emphasised the importance of clearly articulating plans relating to Children and



	Young People's (CYP) services, workforce resourcing models, inpatient flow and service redesign, and understanding the associated financial implications of reshaping services. VJD confirmed that detailed work plans were in place and that appropriate governance and oversight arrangements existed to provide assurance regarding delivery and progress against transformational priorities. SB highlighted the importance of demonstrating a clear link between financial savings initiatives and Quality Improvement (QI) projects, ensuring that efficiency plans are aligned to improvements in patient care and service delivery. BC noted the importance of being able to clearly demonstrate and measure the benefits arising from transformational programmes and financial improvement initiatives, enabling the Board to assess the impact and value delivered. WW welcomed the emerging work relating to artificial intelligence (AI) and digital innovation, emphasising the importance of linking digital developments to wider productivity improvements and transformational objectives. BC expressed caution regarding the use of AI, particularly in relation to the management of personal and confidential data, and highlighted the need for appropriate safeguards and controls. RFW acknowledged the associated risks but noted that there was also a risk in failing to embrace AI as a tool to support productivity and transformation. She confirmed that guidance was being developed to support staff in using AI appropriately, safely and effectively. Overall, the Board supported the continued focus on transformation, productivity and financial sustainability, emphasising the importance of clear assurance, measurable benefits and strong governance arrangements. Members recognised the opportunities presented by digital innovation and AI while highlighting the need to balance these with appropriate risk management, particularly in relation to data protection, information governance and workforce adoption. The Board thanked BC for the comprehensive report.
18	Finance Report The Board received the Month 3 2026/27 Finance Report and noted the Quarter 1 consolidated Group financial position of a £1.9m deficit against the planned break-even position. Members noted that the position was primarily driven by overspends relating to bank staffing, non-Trust inpatient beds, medication expenditure and a shortfall in savings delivery, partially offset by substantive pay underspends and confirmation of recurrent funding for CYP services. The Board noted ongoing financial risks associated with bank expenditure, non-Trust bed utilisation, medication costs and delivery of the £40.3m savings programme, together with the need to sustain improvements in clinically ready for discharge performance and productivity. Assurance was received that agency expenditure remained below the NHS England limit, improvement programmes were in place to reduce bank spend, and the Trust's National Oversight Framework finance rating had improved. The Board further noted the Group cash position of £64m and progress against the capital programme, whilst recognising that capital expenditure remained behind plan, largely due to the Highcroft New Build programme. WW commended the progress being made but queried the underlying financial deficit and sought assurance regarding the sustainability of the financial position and planned recovery trajectory. DET reported that a sustained reduction was being achieved and highlighted the importance of reducing reliance on non-contracted beds as a key component of the Trust's savings and financial recovery plans. DET acknowledged that July had been particularly challenging, with operational pressures impacting performance. However, he confirmed that work continued to focus on delivering planned improvements and supporting the achievement of financial objectives.



	The Board welcomed the progress reported and noted the importance of continuing to reduce the use of non-contracted beds to support financial sustainability. Members received assurance that recovery plans remained in place, whilst acknowledging the challenges experienced during July and the need for continued monitoring of the underlying financial position. Overall, the Board acknowledged the challenging financial environment and the significant savings requirements facing the Trust, but was assured that robust financial oversight, improvement programmes and recovery actions were in place to address key risks and support delivery of the Trust's financial and operational objectives.
19	Audit Committee Report The Board received reports from July's meeting, noting the following key points: • Progress against the BAF was noted. The Board welcomed the improvements made to date and noted that a dedicated Board Development Session had been scheduled for September to undertake a comprehensive review of the framework. • The Board challenged a number of long-standing risks that have remained rated above 16 since 2024 and emphasised the importance of ensuring mitigating actions are delivering the intended reduction in risk exposure. • The Board received a positive Internal Audit update and welcomed the good level of assurance provided regarding the effectiveness of the Trust's governance, risk management and control arrangements. • The Board noted the reasonable assurance assessment received and welcomed the positive findings. Members acknowledged the recommendations arising from the review and supported the proposed actions to address these. • The Board welcomed a positive Counter Fraud report and received assurance regarding the effectiveness of arrangements in place to prevent, detect and respond to fraud risks. • The Board noted the positive External Audit findings and welcomed the assurances provided regarding the Trust's financial reporting and governance arrangements. • Board members were reminded of the requirement to review and update their Declarations of Interest, ensuring all records remain accurate and up to date. Overall, the Board welcomed the positive assurance received across the audit, governance and risk agenda, whilst emphasising the importance of maintaining oversight of long-standing high-rated risks and continuing to strengthen the Trust's assurance arrangements.
20	Trust Seal Report The Board received the Trust Seal Report and noted the use of the Trust Seal in accordance with the Trust's constitutional requirements. The Board noted that the Seal had been applied to a number of legal agreements during 2025/26, including lease, license reassignment, Land Registry and warranty agreements relating to properties at 109 Golden Hillock Road, Washwood Heath Health and Wellbeing Centre and Finch Road Primary Care Centre. The Board approved the application of the Seal.
21	Living the Trust Values FA reflected on her recent experiences of observing the Trust values being demonstrated across the organisation and highlighted the following examples: Compassion: FA recognised examples of compassionate practice across both clinical and non-clinical services. She specifically reflected on the Board Story presented earlier in the meeting by CT and RT, which demonstrated the Trust's commitment to supporting families and carers through the co-produced Carer Check-in Tool and the proposed redesign of RiO. Inclusion: FA highlighted the range of community events that had taken place throughout the summer, where Trust staff had engaged alongside service users, carers, families and members of the local community. She noted



	that these events demonstrated the organisation's commitment to inclusion, partnership working and meaningful community engagement. Committed: FA reflected on the continued focus on patient flow across the organisation and recognised the commitment shown by staff in supporting effective care pathways, timely access to services and improved patient experience.
22	Board Assurance Framework reflections The Board welcomed the positive progress being made in the further development and maturity of the Board Assurance Framework (BAF). Members noted the improvements made to date in strengthening the alignment between strategic objectives, principal risks and assurance arrangements, and recognised the BAF as an important tool in supporting effective Board oversight and risk management. The Board noted that a dedicated Board Development Session had been scheduled for September to undertake a comprehensive review of the BAF. Members agreed that the session would provide an opportunity to review the framework in detail, assess the adequacy of current assurances and controls, and ensure that principal risks remain appropriately aligned to the Trust's strategic priorities.
223	Any other business None.
24	Questions from Governors and members of the public There were no questions.
Close	

Actions/Decisions			
Item	Action	Lead/ Due Date	Update
None			

Report to the Board of Directors

Agenda item:	6				
Date	7 October 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 covers a period of continued strategic development for the Trust. Our particular focus has been on embedding our new Trust Strategy for 2026 to 2031, strengthening our governance arrangements and maintaining a visible programme of engagement with colleagues, service users, carers and partners. The period has provided valuable opportunities to see at first-hand how our strategic priorities are being translated into practice across our services and communities.

Since the launch of our strategy earlier this year, there has been a sustained focus on turning our ambitions into meaningful action. Care, Communities, Culture and Creativity remain at the heart of our approach. Together they provide a clear framework for improving the quality, accessibility and experience of our services over the next five years. It is particularly encouraging to see colleagues across the Trust connecting these priorities with practical improvements in the way care is delivered and with the experiences of the people who use and provide our services. Our programme of transformation continues to progress across several important areas. These include strengthening care in the community, developing more integrated and personalised models of support, improving urgent and emergency mental health pathways and enhancing inpatient flow. The continued development of our Culture of Care programme is also helping to embed coproduction, quality improvement and compassionate practice across the organisation. Service users, carers and colleagues are working together to identify and deliver meaningful improvements.

The wider NHS environment continues to present both opportunities and challenges. These include significant national changes to the delivery of mental health services, sustained workforce pressures and the ongoing reform of the NHS. Against this backdrop, the Board remains focused on ensuring that the Trust is well positioned to respond to these changes while maintaining a clear focus on quality, safety, experience and the wellbeing of our people.

I am grateful to colleagues, service users, carers and our partners for their continued commitment and contribution to the Trust. Their insight, challenge and collaboration remain essential as we move from developing our strategy to delivering it. Together we continue to build an organisation that provides compassionate care of the highest quality for the communities we serve.

Governance Matters

Effective governance continues to underpin the Trust's ability to deliver safe mental health services of the highest quality 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. This remains particularly important as the wider health and care system experiences sustained operational and financial pressures.

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 acknowledge the valuable scrutiny and constructive challenge provided by our Non-Executive Directors throughout this period. Their engagement plays a central role in strengthening accountability, supporting robust decision making and ensuring that the Board discharges its governance responsibilities with rigour and integrity.

BSMHFT Annual General Meeting

Our Trust Annual General Meeting (AGM) was held on 29 September 2026 at our Headquarters. It provided an important opportunity to reflect on the progress made over the past year while setting out the challenges and opportunities that lie ahead. Attendance was exceptional. For the first time, some colleagues initially had to stand because every seat had been taken. The market stalls showcasing services from across the Trust were busy throughout, giving attendees valuable insight into the support each service provides. Beautiful artwork was also displayed at the back of the hall.

The AGM brought together members, governors, service users, carers, partners and colleagues from across the organisation. The meeting opened with three powerful stories from service users, each of which received a standing ovation and rapturous applause. Attendees heard updates on the Trust's performance, quality and safety priorities, financial position and strategic ambitions. They also heard examples of the outstanding work delivered every day by our staff and volunteers. The event highlighted the significant progress made in improving services, strengthening workforce sustainability, advancing digital transformation and delivering our wider strategic objectives. It also provided an opportunity to recognise the commitment, compassion and professionalism of colleagues across the Trust, whose dedication continues to make a positive difference to the people and communities we serve.

Members and stakeholders took part in a constructive discussion, raising questions and sharing views on the future direction of the Trust. These contributions are invaluable in helping us maintain openness, transparency and accountability. They also help to ensure that our plans continue to reflect the needs and expectations of those we serve. The AGM remains a key element of our commitment to engagement and public accountability. It provided a valuable opportunity to celebrate achievements, reflect on learning and reaffirm our collective commitment to delivering compassionate care of the highest quality for the people of Birmingham and Solihull.

Pull Up a Chair with the Chair

I am pleased that Pull Up a Chair will return this month as part of our continued commitment to listening to and engaging with colleagues across the Trust. These informal and confidential individual sessions give colleagues the opportunity to speak with me directly about their experience of working at BSMHFT. Colleagues can share something they are proud of, suggest ideas for improvement, raise concerns or simply talk about what matters to them. I greatly value these conversations, which help me to understand the experiences of colleagues across our services.

Dates have now been set for the remainder of 2026, with sessions taking place across Birmingham and Solihull so that colleagues from all parts of the Trust can take part. I look forward to continuing these conversations and ensuring that the voice and experience of our colleagues remain central to our Culture of Care. Colleagues wishing to book a session are invited to email Paige Harrison at paige.harrison2@nhs.net.

Service Visits

Service visits remain one of the most important and valued elements of my role as Chair and of our wider Board and Council of Governors engagement programme. Non-Executive Directors and Governors are continuing their programme of site visits over the coming months. These visits provide direct and irreplaceable insight into the experiences of staff, patients and service users. They help the Board to understand both areas of genuine strength and those where further support, investment or improvement is needed. This direct engagement keeps the voices of those delivering and receiving care central to our governance and strategic leadership. It also ensures that Board discussions remain grounded in the lived reality of our services rather than in written reports alone.

Visit to Ardenleigh Hospital and Eden PICU, Northcroft, with Danielle Oum, ICB Chair

I was pleased to visit Eden PICU and Ardenleigh Hospital with Danielle Oum, Chair of Birmingham and Solihull Integrated Care Board. The visit provided direct insight into the experiences of women accessing our specialist mental health services and of the colleagues who deliver them. Danielle was pleased to hear how we have embedded our experts by experience in the decisions and operation of both services. She also remarked on the improvement she had noticed in both services since her previous visits.

The visit included tours of Eden PICU and Ardenleigh alongside discussions with colleagues and



service users about recovery, patient experience and involvement in shaping services. At Eden PICU, discussions focused on inequalities in women's mental health, the Trust's Culture of Care approach and innovation in the delivery of inpatient care. At Ardenleigh, we explored specialist inpatient provision for women, carer involvement, partnership working and the interface between mental health and criminal justice pathways.

The Chair and Danielle Oum, Chair of Birmingham and Solihull Integrated Care Board, with colleagues during the visit to Eden PICU

Several important themes emerged. These included the need to address inequalities in women's mental health and to strengthen support for people affected by domestic abuse or violence. There was also a shared emphasis on care that is personalised, focused on recovery and responsive to individual needs. The visit highlighted the importance of strong partnership working across health, social care and criminal justice services, together with our continued ambition to provide care closer to home wherever possible. Hearing directly from staff and service users was particularly valuable. It reinforced the importance of coproduction and lived experience in shaping service improvement. The visit also offered a timely opportunity to reflect on the Trust's strategic priorities and the practical impact of our Culture of Care programme while strengthening our relationship with system partners.

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. It supports the development of strong and productive relationships with partners and stakeholders across the health and care system. These activities provide the Board with assurance that the Trust is well positioned within the regional landscape. The Trust is actively contributing to the development of integrated mental health services while promoting innovation and inclusion. Throughout, it maintains a clear focus on improving outcomes for the communities we serve. I will continue to report significant developments from these forums at future Board meetings.

Stakeholder Engagement

Stakeholder engagement remains an important element of my role as Chair. I continue to focus on maintaining strong links with our governors, colleagues, service users, carers and wider partners. I also continue to chair meetings of the Council of Governors, which provide an important forum for engagement, assurance and constructive challenge.

Recent meetings have included focused assurance from Non-Executive Directors on key areas of Trust performance and governance. They have also included discussion of issues relevant to our communities and the delivery of our strategic priorities. The Council of Governors continues to provide an important link between the Board and the communities we serve, supporting transparency, accountability and effective stakeholder engagement.

People and 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 strategic direction of the Trust. They also provide assurance to the Board that quality, safety and workforce considerations are integral to our decision making rather than treated as separate or secondary concerns.

I hold regular individual meetings with our Chief Executive and with each Non-Executive Director 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 confidently to emerging challenges. I also continue to meet with Staff Side representatives and Trade Union colleagues. These discussions provide an important opportunity to hear directly about workforce concerns, industrial relations matters and the experiences of staff across the organisation. They support constructive partnership working, strengthen mutual understanding and help to ensure that workforce perspectives are reflected in Board discussions and decision making.

I meet monthly with our Freedom to Speak Up Guardians, which is 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 help the Board to maintain a clear and continuous line of sight to workforce risks and the actions being taken in response. In doing so, they reinforce 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	7 October 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

Strategic Headlines

People Performance

Performance is improving across key operational areas, reflected in reductions in formal employee relations caseloads, improved job evaluation performance, and strong service delivery through First Line Support despite rising demand. Challenges remain in relation to sickness absence, appraisal compliance and some complex employee relations cases, these are understood and are being actively addressed through targeted improvement activity.

Workforce Sustainability

Workforce sustainability continues to strengthen, with a significant reduction in agency locum usage, progress in reducing Band 5 nursing vacancies, stable workforce capacity, and increased utilisation of apprenticeship funding.

Leadership and Workforce Capability

Investment in leadership, management and workforce capability remains a priority, supported by the First Line Manager Programme, management development, coaching, wellbeing initiatives, and alignment with emerging national NHS standards.

Digital Transformation

Digital solutions are beginning to deliver tangible benefits through greater automation, AI-enabled support, enhanced workforce analytics, and improved oversight and accountability.

Learning and Development

Performance remains strong, with statutory and mandatory training compliance close to target and a growing focus on measuring the impact of learning on capability, behaviours, and organisational outcomes.

Workforce Intelligence and Analytics

Analytical capability continues to mature, enabling a more integrated understanding of workforce performance and supporting earlier identification of risks and opportunities.

Strategic Priorities

Improving Workforce Health and Performance

Reducing sickness absence, improving appraisal compliance, and strengthening the timeliness and effectiveness of workforce case management to support workforce wellbeing, productivity, and performance.

Strengthening Leadership and Workforce Capability

Embedding national leadership and management standards while continuing to invest in leadership, management, and professional development across the organisation.

Accelerating Digital and Analytical Maturity

Expanding digital and Artificial Intelligence (AI)-enabled solutions and further developing workforce intelligence to support more efficient, evidence-based decision-making.

Delivering a Sustainable Workforce

Strengthening recruitment, reducing reliance on temporary staffing, and delivering workforce transformation programmes that enhance capacity, capability, and long-term sustainability.

Celebration**Award**

Our work on EDI has been shortlisted again this year for an HSJ Award.

CARE – Delivery**Primary Care, Dementia Services & Specialties**

Older Adults Inpatient – We continue to evaluate the impact on flow and admissions of the interim short-term closure of Bermondsey ward, with staff temporarily redeployed across the other three inpatient wards and Reservoir Court has transitioned to a mixed-gender ward to improve bed flexibility. Clinically ready for discharge numbers remain high due to limited placement availability and the complexity of patient needs, work continues to explore step down options. Culture of Care work continues across all inpatient wards with positive feedback. Following a recent CQC (Care Quality Commission) inspection, local feedback has been reviewed and actions implemented where required. We are awaiting the final CQC report.

Community Mental Health Teams

The Memory Matters programme continues to deliver positive progress across Birmingham and Solihull, supporting earlier dementia diagnosis, reducing health inequalities and improving access to post-diagnostic support. Three Primary Care Networks are involved, with two actively delivering the model and a third currently onboarding. Early outcomes indicate improvements in access to assessment, diagnosis and treatment, with patients benefiting from shorter waiting times and more timely support through primary care services. Strategic partnerships with Alzheimer's Society and Age Connects West Midlands have strengthened community outreach, helping to raise awareness, promote earlier discussions about brain health and improve access to support for diverse communities. The programme remains focused on delivering accessible, community-based dementia care pathways and improving outcomes and experiences for both patients and carers.

Birmingham Healthy Minds

The current year 2025/26 cohort of High and Low Intensity trainees are nearing qualification, with all trainees securing substantive posts within the service. Recruitment and preparation for the next trainee intake is underway. Performance challenges remain against recovery targets; however, an improvement plan is in place, and positive progress continues to be monitored through regular review meetings with the Mental Health Provider Collaborative.

Perinatal

A recent Care Quality Commission inspection of both the Mother and Baby Unit and Perinatal Community Service provided positive feedback, highlighting the commitment and compassion of staff. Areas for improvement were identified within community services in relation to documentation and governance processes, and actions are being progressed. Recruitment to the Community Matron post is underway, with the successful candidate expected to address identified assurance gaps.

Bipolar

The service continues to generate income through the marketing of Mood on Track courses to other organisations. Research activity remains a significant strength. Dr Angela Foster has secured funding to progress Compassion Focused Therapy for Bipolar Disorder research and support a future National Institute for Health and Care Research funding application. The team's chapter on Compassion Focused Therapy for Bipolar Disorder has recently been published in *Treating Complex Mental Health Conditions with Mindfulness, Acceptance, and Compassion*.

Meriden

The Family work manual has been rewritten, including significant improvements to its layout and content. Work is currently underway to explore options for accrediting family intervention training, while discussions continue regarding future training arrangements and the longer-term position of the training contract with NHS England.

Acute and Urgent Care

The Recovery House, delivered with Birmingham Mind, supports admission avoidance and step-down through stays of up to seven nights. Relocation from Highfield Road to Sycamore Lodge, in the north of the city, is planned for late November 2026, subject to confirmation of the accommodation layout and service commencement date. Joint mobilisation arrangements are overseeing operational readiness, workforce engagement, safety and transition planning.

Development of the 32-bed Highcroft site remains on track for end of 2027. Following engagement with service users and Experts by Experience, the unit will be named Rowan House, comprising of Willow Ward and Birch Ward. Operational planning continues alongside construction, supported by engagement with service users, carers, staff and the local community.

Midlands Learning Improvement Network funding has supported inpatient ward videos and welcome packs for patients, families and carers. The resources aim to reduce uncertainty, improve access to information and provide a more consistent, compassionate admission experience. Impact will be assessed through patient, carer and staff feedback.

A Clinically Ready for Discharge workstream has been established. A Trust-wide event in August 2026 identified priorities including earlier care-coordinator involvement, clearer admission rationale, earlier identification of funding barriers, stronger accountability and review of safeguarding processes. These will inform a prioritised improvement plan with named owners, milestones and outcome measures.

Urgent and crisis pathway transformation is progressing through a review of NHS 111 mental health access, the mental health helpline, Call Before Convey, Street Triage, Home Treatment Teams and community interfaces. The focus is on reducing fragmentation, strengthening clinical triage and improving access. Development of the Mental Health Emergency Department model also continues with system partners to improve assessment, reduce avoidable Emergency Department attendance and strengthen onward flow. The joint service provided with British Transport Police is having a positive

impact on 136 prevention through more appropriate interventions and onward care and early support to individuals in distress, this pilot continues to be formally evaluated with the view to commitment to the service being commissioned for a further three years

Five trainee Advanced Clinical Practitioners have been recruited across the four Liaison Psychiatry sites and are due to commence in September 2026, strengthening clinical decision-making, service resilience and succession planning.

Integrated Community Care & Recovery (ICCR)

The division continues to focus on safe and timely care, pathway flow, workforce resilience and delivery of remedial action plans. Positive progress includes strengthened interfaces between services, approval of phase 2 funding for the Intensive Community Rehabilitation Team (ICRT), development of local rehabilitation capacity and planned improvements to Dynamic Support Register (DSR) oversight. Key areas of focus relate to workforce capacity in Solar and Solihull Early Intervention Service (EIS), alongside the need to sustain delivery of Learning Disability and Autism (LDA) improvement plans. Mitigations are in place and are being monitored through divisional governance.

Assertive Outreach Teams

Fortnightly interface meetings with Community Mental Health Team Hub Managers and Clinical Leads continue to strengthen the management of referrals and waiting lists. Monitoring indicates improved collaborative decision-making and more timely transitions of care. Locality bed management arrangements remain well established, supporting proactive admission and discharge management within agreed bed allocations. Staff are engaging with the new trauma-informed care training programme to strengthen multidisciplinary practice.

Intensive Community Rehabilitation Team

Intensive Community Rehabilitation Team continues to support people with complex mental health and rehabilitation needs to achieve and sustain community living. Caseload capacity and pathway flow have been maintained despite current demand and complexity. Phase 2 staffing funding has been approved. The model of care and staffing structure are in development, with completion planned for March 2027. Collaborative work with inpatient rehabilitation services, commissioners and community partners remains focused on timely discharge, reducing reliance on out-of-area placements and ensuring safe, sustainable implementation.

Learning Disability and Autism Remedial Action Plan

Improvement work is progressing through the ICCR Remedial Action Plan. A proposed new post will include a care-support function, which will be tested as the role is developed. Divisional leadership has increased attendance at Dynamic Support Register meetings and worked with Dynamic Support Register coordinators to improve operational oversight. This will enable the ICCR Divisional Leadership Team to monitor caseload numbers by team and allocate attendance appropriately.

Neighbourhood Mental Health Teams (NMHT's)

Neighbourhood Mental Health Teams are continuing to support the roll out of Integrated Neighbourhood Teams. There have been 2 recent workshops held with our Integrated Neighbourhood Teams mental health workers, to identify areas of inconsistent practice across, share ideas, and to strengthen processes. Next steps include a plan to meet with Integrated Neighbourhood Teams leads

to share some of our learning. A regular reflective space for our mental health Integrated Neighbourhood Teams workers has also commenced.

Secure Care & Offender Health (SCOH)

Secure Care & Offender Health services remain operationally stable and continue to deliver positive outcomes across forensic, secure care, offender health and community justice services. However, several common themes persist across the portfolio, including workforce recruitment challenges, estates pressures, increasing clinical demand and capacity concerns.

Workforce remains the most significant operational challenge. Recruitment challenges continue across several inpatient and community services. While a few successful appointments have been made, including psychology staff in forensic services and five Band 6 recruits within the Health and Justice Vulnerability Service, challenges continue to place pressure on caseload management, service capacity and workforce wellbeing. Sickness absence remains above Trust targets in some areas, notably Tamarind, and services continue to work closely with HR to improve attendance and support staff returning to work.

Clinical demand remains high across several services, with services reporting sustained demand and increasing complexity of presentations. Although services have maintained safe delivery and manageable caseloads in many areas, pressure continues to exceed capacity in some pathways. Strong governance arrangements remain in place to monitor and review the risks on an ongoing basis.

Estates and infrastructure continue to present challenges across several sites. The summer heatwave exposed issues relating to air conditioning provision within two of the inpatient settings, affecting both patient and staff comfort and medication storage. These have been reviewed and capital investment requests have been submitted to be considered through future capital programmes. Fire safety also remains a key area of focus following a positive Reach Out Quality Review at Tamarind. Areas of improvement are being implemented. These risks continue to be monitored through existing Trust governance arrangements and escalated where required.

Several positive quality, recovery and patient experience initiatives have been delivered. The Culture of Care programme at Tamarind has concluded successfully and transitioned into business-as-usual arrangements. A service user from Laurel Ward won the national 2026 Quality Network for Forensic Mental Health Services Artwork Competition. Across Children and Adolescent Mental Health Services, young people and families have benefited from successful engagement events and a well-received summer programme. Dawn House continues to report positive feedback from residents, who describe feeling safe and supported, while the service launch event attracted a broad range of stakeholders. Health and Justice services continue to advance Trauma Informed Care, neurodiversity pathways and recovery-focused work, including planning for the forthcoming "Beyond the Label" recovery event.

Looking ahead, services are preparing for winter through enhanced annual leave planning, promotion of staff and patient flu vaccination programmes, continued daily safety huddles and implementation of lessons learned from previous flu outbreaks. Overall, while demand, workforce pressures and estates challenges continue to require active management, services remain resilient, are delivering positive quality outcomes and continue to progress key transformation and improvement programmes.

Children & Young People's (CYP) Services

Children and Young People's services continue to experience sustained demand, with the most

significant access pressures remaining within neurodevelopmental pathways. There has been some positive progress in reducing the longest waits, with the number of children waiting more than 104 weeks within Learning Disability services reducing from 101 to 43 following focused validation and clinical activity.

However, waits remain significant, particularly within the attention deficit hyperactivity disorder pathway, where the average time from referral to diagnosis is approximately 658 days.

The Division has contributed to the development of a system business case intended to provide additional temporary capacity to reduce neurodevelopmental backlogs. Discussions are progressing further with regards to the wider challenges with the MH Provider Collaborative.

Eating Disorder services continue to provide strong assurance around the safe management of children and young people with significant clinical complexity. There were no under-18 admissions to specialist inpatient care during June, and use of Tier 4 beds remains very low, with high-risk young people continuing to be managed safely in the community. Access performance is strong for urgent presentations, although achieving the routine access standard remains challenging.

There is more positive progress across Early Help services. The Referral Management Centre continues to provide referral outcomes within two weeks despite high demand, while Mental Health Support Teams have reduced the average time to first attended contact to 15 days and recorded their highest level of appointment activity to date. Consultation activity within the Early Help offer is also significantly above expected levels. This is supporting access but is creating workforce sustainability risks, with the current wait between assessment and intervention remaining approximately 12.5 weeks in this part of the service.

Across the Division there is evidence of strengthening performance grip, including reductions in very long waits, improved management of delays in transfer of care, fewer appointments awaiting an outcome and increased use of clinical outcome measurement. This is translating into improvement in several areas, but sustained growth in demand alongside specialist workforce constraints means that access and capacity remain the principal operational risks for the Division.

CARE – Quality

Culture of Care

The Culture of Care programme continues to make progress across the Trust, with colleagues, service users and carers working together through Quality Improvement approaches to deliver practical, service-user-led improvements.

A recent Board Strategy Session highlighted several examples, including the Secret Garden at Eden PICU (Psychiatric Intensive Care Unit), improved engagement through Newbridge House's 'Out of Office Hour', enhancements to night-time experiences at Tamarind and Reaside, and new 'Planning the Service User Day' standards to support more personalised care.

Overall, the programme is helping to embed co-production, compassionate care and continuous improvement into everyday practice, with a focus on improving experiences for service users, carers and colleagues.

CQC Related Activity

The report related to the inspection undertaken of our Rehabilitation In patient Services has now been received in draft.

Our Children and Young Peoples services were subject to a CQC inspection in recent week, with colleagues involved reporting a positive experience of this.

CQC colleagues have confirmed with us their plan to undertake our Well Led inspection during November and we look forward to welcoming and working with them on this between 17th and 19th November.

Celebration**Award**

Our Quality Improvement (QI) work has been awarded ‘Highly Commended’ (runner up) at the recent HSJ Quality Awards.

BSol Mental Health, Learning Disabilities & Autism Provider Collaborative

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

A new Cluster wide Strategic Neuro Diverse Group has been established to oversee the delivery of the transformation ambitions across Birmingham, Black Country and Solihull. This Cluster wide group will ensure that key priorities such as waiting list management and the development of a new needs led offer including shared care are delivered across the cluster.

To drive forward actions across Birmingham & Solihull a new BSoL Delivery Group has been stood up with providers and stakeholders accountable for delivery included within the membership.

The BSoL Provider Collaborative continues to support the development of a new cluster anchor arrangement for mental health, learning disabilities and autism which will see a single lead provider across Birmingham, Black Country and Solihull. Through a Partnerships Transition Board both organisations are working closely to develop shadow operating arrangements including identifying opportunities to work at scale and pace for the benefit of our collective populations.

Working alongside colleagues across the Trust, the collaborative has led the development of an ambitious ‘Clinically Ready for Discharge’ plan which identifies the key areas of transformation required to improve timely discharge for patients clinically ready for discharge. This includes exploring how we work alongside our social care partners to improve access to housing and packages of care, improving the way we make decisions regarding care and support needs and co-producing solutions with our collective workforce and partners.

The BSoL Provider Collaborative welcomed Dr Farooq Ahmad as the new Associate Medical Director and Priscilla Young the new Associate Director of the Provider Collaborative.

CREATIVITY

Funding and Finances

The Trust continues to keep its financial position under regular review as part of its annual planning commitment to deliver a balanced position by the end of the year.

We continue to experience high levels of demand for our services, particularly in relation to inpatient beds, which is resulting in overspend.

The Trust continues to work with all its commissioners to explore whether additional funding is available to support these pressures. We have also started the work to prepare our plans for future years, including capital and savings plans.

Performance and Productivity

Trust performance and productivity generally remains good and progress is noted in the key areas of challenge. The national productivity benchmarking shows the Trust achieving very well in a number of areas (eg Agency usage) and reinforces the areas we continue to focus on driving improvements in (eg length of stay in inpatient services).

The latest National Oversight Framework (NOF) publication saw the Trust further improve its position in a number of areas resulting in the Trust moving within the league tables to 34 of 58 Trusts, the financial override associated with the NOF was applied to the Trust meaning we remained in segmentation 3.

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

New Mental Health emergency departments and community mental health centres across the West Midlands

NHS England announced plans for three new Mental Health Emergency Departments and 10 community-based mental health schemes across the West Midlands, including Mental Health Emergency Departments planned for Birmingham & Solihull and the Black Country.

BSMHFT AGM (Annual General Meeting)

Our Trust AGM was held on 29th September at our HQ. Almost three hundred people joined us for the meeting and the events that took place as part of this. We were supported by a number of our Experts by Experience (EBEs) and Team BSMHFT colleagues providing opportunities to learn more about some of our services and key programmes of work as well to participate on activities. Of particular note to all who attended was the powerful impact of three EBE colleagues sharing their experiences and personal stories with attendees.

Birmingham City Council visit to Neighbourhood Mental Health 24/7 Centre (NMHC)

Birmingham City Council colleagues including Stuart Lakenby Executive Director of Adult Social Care and Health visited our NMHC over the summer and as a consequence have made commitments to consider both how they can align social care colleagues to the team and support the continued engagement of the local VCFSE sector through their existing commissioned services with the sector.

Celebrating Sade's Legacy

In September, in partnership with Sade's family and Trust colleagues, a dedicated space in Sade's

memory was formally unveiled at the Oleaster. The afternoon brought together family members, staff and guests to reflect on the lasting impact of this work, recognise the importance of hope and recovery, and mark the contribution that Sade's legacy continues to make to our services.

HSJ Award Shortlisting

Our BSoL system work on workforce (known as the 4R's Programme), which the Trust has taken a lead role in a number of aspects, has been shortlisted for a HSJ Award.

NATIONAL NEWS

Major expansion of community mental health support

In August, the Government announced a £343 million programme to establish up to 159 new NHS mental health facilities across England, including 100 Community Mental Health Centres and 59 Mental Health Emergency Departments. The programme is intended to shift care towards earlier intervention, prevention and support closer to home, while providing dedicated specialist environments for people experiencing mental health crisis rather than relying on A&E. The announcement forms part of the NHS 10-Year Health Plan and represents a significant redesign of community and crisis mental health provision.

Source: [Major expansion of community mental health support across England - GOV.UK](#)

New national Mental Health, Learning Disability and Autism dashboard

From September 2026, NHS England is introducing a new mental health, learning disability and autism overview dashboard, replacing the previous Mental Health Dashboard. The new dashboard is intended to reflect the NHS's updated national strategic priorities and provide more current information on performance across the sector.

Source: [NHS England » NHS Mental Health Dashboard](#)

Updated national mental health data

An updated Adult Mental Health and Wellbeing Profile was published in September, providing information to support local service planning and commissioning. The latest update includes mortality and excess-mortality data for people aged 18–74 who have been referred to secondary mental health services, covering 2022–2024. The profile provides data at England, regional, ICB (Integrated Care Board) and local authority level to support understanding of local mental health needs and service planning.

Source: [Adult mental health and wellbeing profile: September 2026 update - GOV.UK](#)

Appointment of first Chief Executive of the Online NHS Trust

In August, Dame Caroline Clarke was appointed as the first Chief Executive of the newly established Online NHS Trust, which will deliver NHS Online and expand access to virtual specialist care through the NHS App. The new organisation represents a significant development in the NHS's approach to digitally enabled care, with virtual elective services expected to commence from the end of 2027.

Baroness Julia Neuberger appointed Chair of the CQC

In September, Baroness Julia Neuberger was confirmed as the next Chair of the Care Quality Commission, starting 1 October 2026. She has extensive NHS and healthcare leadership experience, including as Chair of Whittington Health NHS Trust and Joint Chair of University College London Hospitals.

Roisin Fallon-Williams

Chief Executive

Vanessa Devlin

Executive Director Operations

Report to Board of Directors						
Agenda item:	8					
Date	7 October 2026					
Title	Board Assurance Framework					
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 Following work to realign BAF risks to the Trust strategy, and a dedicated risk management strategy session on 30 September, the new Board Assurance Framework is presented for approval. The process for monitoring risks at Committees, Audit Committee and Board will remain, with the BAF embedded within agendas to drive discussion and focus reporting. The Board is asked to note that, following formal approval of the Risk Appetite Framework, the BAF risks will be updated to ensure agreed risk tolerance levels are reflected.						
Recommendation						
The Board is asked to approve the newly aligned BAF risks. The Board is asked to formally agree to close down the previous Board Assurance Framework.						
Enclosures						
Board Assurance Framework September 2026						

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	September 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	September 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 of services to be consistently safe for service users, carers and communities	July 2026	September 2026	CN	4 x 2 = 8	N/A	4 x 4 = 16
SR4	Failure to be a service user, family and carer-led organisation	July 2026	September 2026	CN	4 x 2 = 8	N/A	4 x 2 = 8
SR5	Failure to maximise the Culture of Care standard and ensure we are a clinically informed organisation	July 2026	September 2026	CN	3 x 3 = 9	N/A	4 x 3 = 12
SR6	Failure to provide timely access to and discharge from services	July 2026	July 2026	DOO	4 x 3 = 12	N/A	5 x 4 = 20
Creativity: Empowering and enabling people to make positive and bold change through innovation, improvement and research							
SR7	Failure to maintain a sustainable financial position.	Sept 2024	August 2026	DOF	5 x 2 = 10	5 x 5= 25	5 x 5= 25
SR8	Inability to maintain secure, reliable and well-embedded digital infrastructure and systems	July 2026	September 2026	DOF	3 x 3 = 9	N/A	5 x 4 =20
Communities: Working with and understanding our diverse local communities so that we are responsive to their specific needs							
SR9	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.	Sept 2024	September 2026	MD	3 x 3 = 9	4 x 3 = 12	4 x 3 = 12
SR10	Failure to work in partnership to meet patient and service user needs.	Sept 2024	July 2026	DOO	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 SR8	SR7
4 Major		SR4	SR1 SR2 SR5 SR9 SR10	SR3	
3 Moderate					
2 Minor					
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	- Deterioration in CQC Well-Led ratings and regulatory confidence - Increased patient safety risk linked to poor speaking up culture - Reduced effectiveness of PSIRF due to lack of psychological safety - Failure to meet statutory duties (Equality Act, PSED, WRES/ WDES expectations) - Reputational risk at system and community level	People Committee	Executive Director of Strategy, People and Partnerships	SR2
RISK APPETITE		Open - Innovation pursued – desire to ‘break the mould’ and challenge current working practices. High levels of devolved authority – management by trust rather than close control. <i>Target risk score range 9-10.</i>	INHERENT RISK SCORE		Impact	Likelihood	Risk score
					5	5	20
			DATE RISK WAS ADDED		June 2024		
CURRENT RISK SCORE	RATIONALE		TARGET RISK SCORE	RATIONALE		RISK HISTORY	
Impact 4 x Likelihood 3 = 12	- FTSU themes showing earlier resolution - Reduction in formal ER cases / escalation trends - Increase in the use of early resolution as appropriate - PCREF and health inequalities programme traction - NHS Staff Survey trend improvements (engagement, inclusion, speaking up)		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
			DATE OF LAST REVIEW	19 August 2026		June 2025	12

- Increased Active Bystander / Cultural Humility training uptake

August
2026

12

CONTROLS/ MITIGATIONS**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
- Role recommended compliance expectations linked to appraisal and performance management
- Clear divisional accountability framework for culture and EDI

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

GAPS IN CONTROL**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

• 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 • Strengthened governance route from divisional data to People Committee Patient Safety and Learning Culture • Implementation of the Patient Safety Incident Response Framework (PSIRF) • 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	31 st October 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	31 st October 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	30 th September 2026	• Learning and Development deep dive held at People Committee strategy session, ensuring alignment with the Trust Strategy 2026-2031. • A learning and development framework has been developed and was presented at People Committee in February 2026 • Progress on implementation and delivery of the framework is monitored through Multiprofessional Education and Training (MET) Committee.
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.	• 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.

		• 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. • 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:			
19 August 2026 • Risk score reviewed • Actions reviewed and updated with action number 3 moving from amber to green			

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. - Workforce instability including in retention, burnout increase and morale decline - Increased sickness levels.	People Committee	Executive Director of Strategy, People and Partnerships	SR1						
RISK APPETITE		Open - Innovation pursued – desire to ‘break the mould’ and challenge current working practices. High levels of devolved authority – management by trust rather than close control. <i>Target risk score range 9-10.</i>	INHERENT RISK SCORE		Impact	Likelihood	Risk score						
					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 remains stable and is in a healthier position with the vacancy factor reduced, turnover improved and pipelines strengthened. Challenges remain in hotspot areas which continue to be addressed through a more targeted	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.		<table><tr><td>Jan 2025</td><td>20</td></tr><tr><td>June 2025</td><td>12</td></tr><tr><td>August 2026</td><td>12</td></tr></table>		Jan 2025	20	June 2025	12	August 2026	12
Jan 2025	20												
June 2025	12												
August 2026	12												

	approach.	DATE OF LAST REVIEW	19 August 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. • Recruitment drives resulting in increase in the Band 5 nurse talent pool 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. Talent Management Strategy • Overarching talent management strategy to support the development and retention of key staff. 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. • No single organisation-wide vision for how ESR should be used, governed or optimised resulting in variation in workforce data and fragmented decision-making around process standards.	
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 2027	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 2027	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 2027	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	30 September 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).
Implement the NHS Leadership and Management Framework in a phased way, building on existing work and strengthening consistency in manager support, in line with priorities for staff experience, culture and organisational effectiveness.	Associate Director of People, Learning and Development	31 March 2027	The NHS Leadership and Management Framework was published in July 2026

Embed Staff Standards priorities consistently across the organisation, demonstrate impact, and strengthen readiness for emerging oversight and assurance requirements.	Associate Director of People, Learning and Development	31 March 2027	The NHS Staff Standards was published in July 2026
Develop a talent management framework and toolkit	Associate Director of EDI and OD and Head of workforce transformation	31 March 2027	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:			

19 August 2026

- Updated the rationale for risk score
- Reviewed the risk score
- Additional bullet point under control (Workforce Planning and Recruitment)
- Additional actions included
- Implementation of flexible contracts creating new pipeline and preceptorship support for new graduates/ asked to present at national conference

REF	STRATEGIC RISK	GOAL/ ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR3	Failure of services to be consistently safe for service users, carers and communities.	Creating simpler, more connected, high quality and responsive services where care is safe and inclusive, with service users and carers at the centre	- Inconsistent safety and learning culture, including openness, psychological safety and the translation of learning into improvement. - Variation in the effectiveness of patient safety, learning from deaths and safeguarding arrangements. - Unwarranted variation in quality, clinical risk management, safety planning and multidisciplinary practice. - Pathway, access, capacity and system pressures affecting continuity and responsiveness of safe care.	- Service users, carers, staff and communities experience avoidable harm or are not adequately protected from risk. - Patient safety risks, safeguarding concerns and learning from deaths are not consistently identified, escalated or acted upon. - Learning is not embedded or translated into sustained improvements in care, experience and outcomes. - Regulatory, commissioner and public confidence is reduced due to variation in safety, quality and responsiveness.	Quality, Patient Experience and Safety Committee	Executive Director for Quality and Safety/ Chief Nurse	SR4 SR6 SR9
RISK APPETITE		<u>Cautious:</u> 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. <i>Target risk score range 6-8.</i>		INHERENT RISK SCORE	Impact	Likelihood	Risk score
					4	5	20
				DATE RISK WAS ADDED	July 2026		
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	2 September 2026	
CONTROLS/ MITIGATIONS			GAPS IN CONTROLS	
Learning from Incidents and Clinical Effectiveness - Processes to review and learn from deaths, Coroner's reports, and QSI 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 - Culture of Care Standards Safety and Oversight Structures - Trust Safety Huddles - Quality Day including Quality Assurance Group, Service User Led Group & Safer Staffing Committee - Bronze/Silver/Gold escalation and resolution process - Clinical supervision maintained above 80% - Psychological support for staff & AVERTS training - Learning from Deaths Group - Reducing Restrictive Practice Group - Safeguarding Assurance Board, Health & Safety Committee, Infection Prevention Governance Quality Assurance and Improvement - Internal quality/assurance processes including AMaT utilisation for Audits - Development and use of RRP Dashboard, QAG and Safe Care Dashboards - QI resources and projects in place - Programme of external audits - QOC Insight data and regular joint meetings with regulators - Enhanced Therapeutic Observations of Care QI - Bands 5 – 6 training programme for new graduates - Nigel's Plan (Assertive & Intensive Plan) oversight through NHSE Policies, Procedures and IT Systems - Clinical policies, procedures, guidelines, pathways, supporting documentation, and IT systems			- Variation in MDT standards, first review completed Specialities - 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/ PFD - WHAT Tool for handover complex and to be replaced by SBAR - Non-compliance with fridge temperature checks and actions in response causing medicines risk - Community Team Caseloads across ICCR, HTTs and Care for Older People, CYP services - Searching policy compliance - Non-compliance with enhanced therapeutic observations and recording - Patients in bedroom seclusion - Access and waiting times in adult and CYP services - Experienced staff nurse vacancies HTT, PLT & CMHT - Caseload stratification and effective shared care model for patients in the community - Red route, access to MHA assessment in police custody suites - CYP Referral Management Centre skill mix and senior clinical oversight	

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 Peaside Clinic new hospital programme			
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	EDQ&S	September 2026	Physical health needs assessment completed, Strategic plan to be derived from the strategy with clear deliverables, in particular to focus on the identification and management of Diabetes, completed. Assurance report monthly through CEAG on training and skills
Implement Nigel's Plan – ensure the appropriate case management approaches for patients with a serious mental health condition where there may be a risk to themselves or others in the community	EQ&S	March 2027	Nigel's plan assured at regular NHSE & CQRM meetings Board Story to provide assurance with plan Case stratification across community teams in progress led by ICCR DLT. all SMI patients to be identified with associated risk and safety planning, caseload review tool, monitored through CGC, monthly report
Safecare dashboard to be utilised for Divisional assurance and provide Ward to Board assurance and Regulatory Assurance	EDQ&S	September 2026	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	EDQ&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, reduce response times for MHA assessments for admissions and discharges of patients	EDQ&S	September 2027	AMPH review completed, joint delivery plan agreed through BOC and BSMHFT governance progress monitored through MHLC
Bronze Silver Gold escalation process in place with the following services: CYP Referral Management Centre, Larimar Ward, Crisis CYP CAHMS, George Ward, QE PLT	EDQ&S	December 2026	Additional clinical staffing provided for CYP RMC, Larimar action plan now completed, awaiting feedback for CPS on criminal investigation, oversight of CYP waiting and support for children and families to be reviewed at October CGC

Red Route, number of patients with MH needs being committed to Prison leading to extended waits for transfer to PICU or secure services and more complex work required with courts	EDQ&S	March 2027	Commissioning and provider plan in development, review provision of assessments directly at police station, pilot Perry Barr, letter from HM Inspector of Prisons to Secretary of State, support for healthcare staffing at HMP Birmingham, commissioner led review of bed base including PICU
Increase awareness of Domestic violence and domestic abuse, including the identification of risk to families and carers in light of learning from deaths and high prevalence of matricide	EDQ&S	March 2027	Extend the 'Think Family' programme to incorporate approaches to the identification of risk factors for all Patients, in particular identifying adult children who pose a risk to the public or their families, training in place, monitor referrals through Safeguarding Assurance Board, IDVA in place, connecting through safeguarding system
Improve sexual safety in the Trust for Service Users, Staff and Families, working closely with People Directorate	EDQ&S	March 2027	Sexual safety policy in place, education, training and clear guidance in place for staff. Working group established, and support for staff through independent advocacy, joint work with Women's aid
Staff and Patient Flu Vaccination, target 60% front line staff	EDQ&S	February 2027	Flu plan agreed, starts September 2026, vaccinators identified and trained, comms to staff, education and incentives for teams in place
PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	GAPS IN ASSURANCE
Internal audit reviews 2026/27: - Clinical audit - CQC planned and unannounced inspection reports - Reaside commissioned support programme and Culture of Care Programme - Door alarm implementation programme - Triple A reporting to QPES from OGC - Quarterly reporting to Trust OGC on overall MHA compliance – high level reporting - QM Supdate reporting to QPES	- Staff training via e-learning and lack of assurance on competence in clinical practice - Assurance process with data on physical health checks and admission assessments to be added to dashboard - Reporting on implementation of Staff Safety Strategy	<u>Learning for improvement:</u> - Structured Judgment Reviews reviewed at local safety panels - Corporate-led learning from deaths meeting - Executive Director's Assurance Reports to QPES Committee and Board - NHS Digital Quarterly Data - Commissioner and NED quality visits - OGC Local review has been completed and actions implemented - Nigel's Plan (A&I) - Physical Health Strategy - CQC inspections Urgent care Pathways and Steps to Recovery - Staff Safety Strategy - Fire Safety Review - Food Safety Standards	- 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 - caseloads - Staffing levels for experienced RMNs Crisis pathway and community teams

• 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		• Water Safety Standards	
Update since last review:			
September 2026 In the last reporting period there have been a number of CQC inspections; Older People's Wards at Juniper Centre, Recovery House, Chamomile Mother and Baby Unit and Perinatal Community Services. Feedback was positive about staff engagement, kindness, compassion and care, some concerns about medication safety and storage and caseload levels in the community. CQC reports are still outstanding for a number of inspections since April, but the Teams have been able to act on feedback given at the end of inspections to address local issues such as medications management and caseload reviews. There is increased concern about the Red Route and access to assessment and mental health inpatient care for people subject to criminal justice pathways. There is pressure on places at HMP Birmingham and delays in transferring patients from prison custody to MH Care Beds. The Trust is working with commissioning, Secure and Acute Services to provide assessments in police custody suites, prior to court and avoiding protracted lengths of prison custody and management of seriously unwell people on normal location in HMP Birmingham. The ICCR Divisional Leadership Team continue to lead the work on caseload reviews with a view to improved assurance of the safe care of people in the community with a serious mental illness. The priority work of the Trust on Locality working will then provide an opportunity to align service users with locality teams and ensure the right level of follow up for them. The AOT Teams continue to provide a good focus on these service users and the Trust reports on assurance through to MHPC, ICB and NHSE. It is recognised that there is a large caseload in BSoL due to the nature of the demographics in the City and health inequalities. The staff Flu vaccination programme has commenced. The Physical Health Strategy and Staff Safety Strategy are now moving into implementation.			

REF	STRATEGIC RISK	GOAL/ ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR4	Failure to be a service user, family and carer-led organisation	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 SR9
RISK APPETITE		Cautious – Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. <i>Target risk score range 6-8.</i>		INHERENT RISK SCORE	Impact	Likelihood	Risk score
					4	4	16
				DATE RISK WAS ADDED	July 2026		
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.			
				2 September 2026			
			DATE OF LAST REVIEW				

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 PREOMS, patient and staff surveys reported through SULEG • PLACE reports and Nutrition and Food Group updates submitted to SULEG • Delivery and assurance of the National CQC Community MH Survey through SULEG 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 • Inconsistency in care plan provision to patients on wards • 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 • Community focussed recovery college model • Increase in patient activities and therapeutic interactions
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 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	The Recovery College review is complete and a Management of Change paper is being constructed to align to NHS10 Year plan and Trust strategy. HOPE strategy action groups will continue outside of refreshed recovery college process and will be governed through Service User Lead Engagement group
Work with third sector providers to enable engagement of Carers and family members in personalised care and service improvement	Chief AHP	31 March 2027	PCREF Triangle of Care pilot commencing August 2026 Trust wide Family and Carer Engagement group to commence in September Making Families Count family panels commence in September for Crisis and Urgent Care
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 SULEG	- 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 - Complaints relating to ADHD pathway
Update since last review:			

September 2026

PMO support has been secured to enable the Trust-wide implementation of Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs). This work will be delivered through a systematic and structured programme, ensuring that the measures adopted are clinically informed, meaningful and capable of providing actionable intelligence to support service improvement. The Service User-Led Engagement Group (SULEG) continues to provide an effective mechanism for gathering and considering the perspectives of service users, families and carers from across the Trust. As the arrangements continue to mature, the focus of the meetings is increasingly moving from reassurance towards formal assurance, with divisions expected to demonstrate how feedback and experience intelligence is being used to inform improvement. All divisions remain engaged and committed to this approach.

Engagement activity associated with the HOPE Strategy is now reducing as the current strategy approaches its conclusion in December. However, the development of the new Trust Strategy provides an opportunity to ensure that service user-led care, participation and involvement remain a clear and prominent strategic priority for the organisation. The pilot areas for the Patient and Carer Race Equality Framework (PCREF) and Triangle of Care programmes have now been confirmed, with implementation activity commencing this month. These pilots will support the Trust to strengthen its approach to addressing inequalities, improving carer involvement and embedding the voices and experiences of patients, families and carers within service delivery and improvement.

Work is progressing well with the Making Families Count programme, with a particular focus on strengthening support for vulnerable service users and their families and carers throughout the crisis care pathway. This work aims to improve involvement, communication and partnership working with families and carers at key points of need and transition.

REF	STRATEGIC RISK	GOAL/ ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR5	Failure to maximise the Culture of Care standards and ensure we are a clinically informed organisation	Creating simpler, more connected, high quality and responsive services where care is safe and inclusive, with service users and carers at the centre	Inconsistent leadership behaviours and organisational culture. Limited clinical involvement in strategic decision-making. Weak governance for quality improvement and learning. Failure to listen to patients, carers and staff. Workforce pressures affecting wellbeing and engagement. Insufficient focus on equality, diversity and health inequalities. Variable implementation of the Culture of Care standard across services. Poor triangulation of quality intelligence. Limited organisational learning from incidents, complaints, claims and deaths. Variation in practice. Limited opportunities for clinicians to speak up and share concerns	• Harm to patients. • Reduced quality of care and patient experience. • Poor staff morale, wellbeing and retention. • Increased complaints and serious incidents. • Failure to reduce unwarranted variation. • Poor CQC outcomes or regulatory intervention. • Reduced public confidence. • Failure to deliver strategic ambitions for quality and improvement. • Inequalities in outcomes and experience persist or widen.	Quality, Patient Experience and Safety Committee	Executive Director for Quality & Safety	SR3
RISK APPETITE		Open - Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance. <i>Target risk score range 9-10.</i>		INHERENT RISK SCORE	Impact	Likelihood	Risk Score
					4	5	20
				DATE RISK WAS ADDED	July 2026		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
Impact 4 X Likelihood 3 = 12	We are developing measures to demonstrate these outcomes in a systematic way, or focus our resources on their achievement, so there is currently no data to provide assurance of a lower risk	Impact 3 * Likelihood 3 = 9	It is a core purpose of the Trust to deliver against the culture of care standards, although there will always be competing demands		
		DATE OF LAST REVIEW	3 September 2026		
CONTROLS/ MITIGATIONS			GAPS IN CONTROL		
- Quality Strategic Goals - Culture of Care EXCELLENCE Framework and implementation programme. - Patient Safety Incident Response Framework (PSIRF). - People Strategic Goals - Equality, Diversity and Inclusion Strategy. - Freedom to Speak Up arrangements. - Multi-disciplinary Team Standards - Quality Governance Framework. - Clinical leadership embedded across services. - Quality Improvement methodology and training. - Patient and carer involvement in service improvement. - Clinical audit programme. - Mortality, incident and learning reviews. - Patient experience programme. - Staff engagement mechanisms. - Clinical supervision. - Leadership development programmes. - Learning from Lives and Deaths processes (where applicable). - Quality dashboards - Night Care - PCREF - Freedom to Speak Up Guardian, team and processes			- Variable maturity of Culture of Care implementation. - Inconsistent clinical engagement in corporate decision-making. - Limited protected time for quality improvement. - Workforce shortages affecting compassionate care. - Variable use of patient insight to shape services. - Inconsistent adoption of improvement methodologies. - Data quality limitations affecting quality intelligence.		
ACTIONS PLANNED					

Action	Lead	Due date	Update
Implement the Culture of Care Excellence Programme	EDQ&S	September 2026	Standards fully implemented across all services, Ward and Team self-assessments completed, reviews in place with Divisional Leadership Teams, celebration event planned 15 th September
Implement Culture of Care 12 standards across all BSMHFT services	EDQ&S	September 2026	Culture of Care Programme implemented across all clinical services, final service CYP launch date 28 th September
Implement findings and delivery plan from the review of speaking up arrangements	EDQ&S	January 2027	Implementation plan updated in response to review, increase in champions, detriment policy being consulted on, process in place for responding to staff who raise concerns about detriment
Monitor and assure on the implementation of Dialog+ and personalised care approach	EDQ&S	March 2027	Audit and monitoring of the use of Dialog+ in place through CEAG, care and safety plans to be shared with patients
Increase the range and opportunities for access to therapy and activities for service users	EDQ&S	March 2027	Deputy Chief AHP working together with lead Psychologist to identify baseline in activity offer, new activities plan for Ward areas to be launched and monitored through CEAG
Implement new model for care for service users at Night – 'Night Care'	EDQ&S	December 2027	SOOH leading on development of 'Night Care' to be shared and adopted across wards as part of Culture of Care Programme, NED Night visits planned bi-annually
PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
- Internal audit reviews 2026/27: Clinical audit - Activity and productivity for professional groups reporting through CEAG - Compliance with NICE guidance - Compliance with Policies and SOPs - Culture of Care Excellence Heatmap - PCREF - CoC Newsletters - Night visits for Board	- CoC Heatmap - Professional groups reporting into CEAG - MDT Standards - Dialog+ variation - Variation in uptake and response to FTSUG approach - Data use for FTSUG	- Culture of Care Programme reporting - Newsletters - PCREF plans - Clinical Audit through AMaT - Shared good practice and governance innovation at National DH conference and National Culture of Care Conference - Shared Excellence model and supported visits from other MH Trusts	- Variation in sharing care and safety plans with patients identified in QQC inspection - Night Care variable
Update since last review:			

Sept 2026

- Culture of Care Programme live across all services, final service launch for CYP in September. Sharing and celebrating excellence event planned 15th September
- Culture of Care Excellence Quality Framework launched and all ward areas have now completed self-assessments against the 12 standards, next steps Divisional and QAG reviews and development of Bronze, Silver, Gold Heatmap
- Multi-disciplinary Standards launched in September, used as framework to review recent concerns in clinical service area – Juniper, with positive and productive outcomes for improvement
- Clinical Audit programme in place with Quality Assurance Group driving compliance and improvement, latest learning relates to electronic recording of enhanced therapeutic observations of care and use of Trust WIFI bandwidth for patient facing activities
- 94% compliance with Policies updated and in date, due to reach 96% by month end, next steps to review all Trust operational SOPS
- Night Care to be shared by SOOH at Culture of Care celebration event
- Board and quality Committee level night visits of Acute Wards, PLT and SOOH planned for September as part of bi-annual cycle.

REF	STRATEGIC RISK	GOAL/ ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR6	Failure to provide timely access to and discharge from services	Care: Creating simpler, more connected, high quality and responsive services where care is safe and inclusive, with service users and carers at the centre	• 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.	Quality, Patient Experience and Safety Committee	Executive Director of Finance/ Executive Director of Operations	SR3 SR9 SR10
RISK APPETITE		Cautious - Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions. <i>Target risk score range 6-8.</i>	INHERENT RISK SCORE		Impact	Likelihood	Risk score
					5	5	25
			DATE RISK WAS ADDED		July 2026		
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			17 July 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 NHSE 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 2026	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.
Length of stay improvement and clinically ready for discharge action plan for all age. (Part of the Learning & Improvement Network)	AD Acute and Urgent Care/ Specialties. AD CYP Division	31 October 2026	A Senior Responsible Officer has been allocated to the Clinically Ready for Discharge programme, with a dedicated workstream being developed in partnership with the local authority to strengthen joint ownership of discharge barriers and improvement actions. Work has also begun to align length-of-stay objectives across divisions, including Secure Care and Offender Health and Integrated Community Care

			and Recovery, supporting a more consistent approach to metrics, governance and escalation. Through the Care Pathway Integration Programme, work is also underway to align bed management and patient-flow arrangements for people aged 18–25 with adult services. Work is also progressing on operational escalation frameworks to provide swift support to patients in emergency departments Trust would also benefit from gaining access to P2 beds this has been escalated to ICB and collaborative for support
PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE
Internal Audit reviews 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: ➤ Talking therapies moved from Red to Amber ➤ Increased oversight and work programme on LOS and CRFD ➤ Performance assurance panel review has taken place and now BAU			

REF	STRATEGIC RISK	GOAL/ ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR7	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 - Operational services facing increased demand and caseload growth	- 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) - Reduction in future capital funds in future years - Reputational damage given historical financial performance	Finance, Performance and Productivity Committee	Executive Director of Finance	SR1 SR3 SR6 SR9
RISK APPETITE		<u>Open</u> : Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels. Target risk score range 9-10.	INHERENT RISK SCORE		Impact	Likelihood	Risk score
					5	5	25
			DATE RISK WAS ADDED		September 2024		
CURRENT RISK SCORE	RATIONALE		TARGET RISK SCORE	RATIONALE		RISK HISTORY	
Impact: 5 x Likelihood 5= 25	Current score demonstrates the 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
						August 2025	25
						DATE OF LAST REVIEW	11 August 2026
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.				- 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 Planning and Delivery subcommittee.			

- Implementation and monitoring of the Savings Policy to support delivery of efficiency programmes. - Oversight and review through the Planning and Delivery Subcommittee, with enhanced financial oversight through Operational Management Team meeting - Alignment with Integrated Care System (ICS) expectations and reporting requirements. - Regular oversight by NHSE through provider Review Meetings and monthly finance reviews to ensure awareness and oversight of position			- The Trust has been unable to establish a robust pipeline of recurrent, cash releasing 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	October 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 – submission of draft plans	Senior Leaders	October 2026	Planning for savings delivery element 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). Reminder sent June 26 Awaiting submission of recurrent, cash releasing plans	
Controls around usage of non-NHS inpatient beds, and bank spend to be maintained	Executive Director of Operations / Executive Director of Quality and Safety	October 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.	
Financial Recovery plans for overspending divisions to be developed	Associate Directors of Operations	October 2026	In line with the Financial Strategy shared with Executive Team, FPP and senior leaders, operational divisions with overspends equivalent to NOF 4 required to produce Financial Recovery Plans – Acute and Urgent Care and Specialties first two divisions	
PLANNED ASSURANCE		GAPS IN ASSURANCE	POSITIVE ASSURANCE	NEGATIVE ASSURANCE

Internal audit reviews 2026/27: • BAF and Risk Management • Cyber Assessment Framework • Key Financial Controls • Ability to deliver planned financial position dependent on sufficient controls • External Audit review • Audit Committee and FPP oversee financial framework and monthly reporting of financial position and any deviation from plans. • Divisional Performance Assurance Panels • Ongoing oversight from NHSE around delivery of financial recovery plan.	• 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 financial plan not well developed	• 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	• Financial performance reviews at team level to be strengthened with Financial Management tightening controls around overspend • A high proportion of savings schemes remain non-recurrent, causing risks in the underlying position. • Transformation schemes not yet identifying savings opportunities as part of programme
Update since last review:			
18 July 2026 • Actions reviewed and updated.			

REF	STRATEGIC RISK	GOAL/ ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR8	Inability to maintain secure, reliable and well-embedded digital infrastructure and systems	Creativity: Empowering and enabling people to make positive and bold change through innovation, improvement and research	• Legacy infrastructure, ageing technology and estate limitations constrain digital development. • Increasing cyber security threats and vulnerabilities. • Insufficient capital and revenue investment in digital infrastructure and systems. • Variable digital capability, confidence and engagement across the workforce. • Failure to embed digital solutions effectively into clinical and operational practice. • Weak programme governance, benefits realisation or change management. • Increasing reliance on third-party suppliers and technology providers. • Emerging technologies, including AI, creating new opportunities alongside new risks and governance requirements.	• Patient safety incidents or disruption to clinical care. • Significant service disruption arising from cyber attack, system failure or technology outages. • Loss, compromise or inappropriate use of confidential information. • Failure to realise the benefits of digital investment, innovation and transformation. • Failure to improve productivity, efficiency and staff experience through digital solutions. • Inequitable access to, or benefit from, digitally enabled services. • Poor adoption of new technology resulting in wasted investment and increased workforce burden. • Regulatory or legal action. • Financial loss and increased operating costs. • Damage to organisational reputation and confidence. • Failure to develop a digitally enabled, innovative and future-ready organisation.	Finance, Performance and Productivity Committee	Executive Director of Finance	SR2 SR7
RISK APPETITE		TBC		INHERENT RISK SCORE	Impact	Likelihood	Risk Score
					TBC	TBC	TBC
				DATE RISK WAS ADDED	July 2026		
CURRENT RISK SCORE		RATIONALE	TARGET RISK SCORE	RATIONALE			RISK HISTORY

Impact 5 x Likelihood 4 = 20	Reflective of the potentially severe impact of digital failure and the continued high likelihood arising from ageing infrastructure and cyber threats.	Impact 3 * Likelihood 3 = 9	Strengthened infrastructure, cyber resilience and workforce capability reducing both the likelihood and impact of digital failure.		
		DATE OF LAST REVIEW	3 September 2026		
CONTROLS/ MITIGATIONS			GAPS IN CONTROL		
Information Governance Framework. Cyber Security Programme. Cyber Assessment Framework Multi-factor authentication and endpoint protection. Business Continuity Plans. Emergency Preparedness and Resilience Response arrangements Regular infrastructure refresh programme. Chief Clinical Information Officers established Clinical engagement and digital champions. Mandatory information governance and cyber awareness training. Digital programme governance and benefits realisation. Guidance and governance arrangements for the implementation and use of AI and emerging technologies. Clear guidance for implementation and use of Copilot across NHS services. Assurance through System Strategy Group Quarterly Digital and AI Reports to Finance, Performance and Productivity Committee Annual Digital and AI Report to Board of Directors			Ageing infrastructure requiring replacement, and ability to support sustainable digital systems Dependence on key suppliers. Variable adoption of new digital systems. Incomplete interoperability with partner organisations. Limited resilience for critical legacy applications. Embedding guidance for consistent implementation and use of Co-Pilot across NHS services Limited capital and revenue funding for digital and estate systems Inconsistent digital skills and capability across services. Emerging AI governance arrangements continue to develop. Benefits realisation and measurement of value from digital investment are not yet fully embedded.		
ACTIONS PLANNED					
Action	Lead	Due date	Update		
CYP transfer: device allocation	Head of ICT	30 September 2026	On track, some minor availability issue with staff being available, but broadly in line with what was predicted		
CYP transfer: infrastructure	Head of ICT	30 September 2026	Printing House Street is the last site to move; on track		

CYP transfer: licence allocation	CIO	30 September 2026	Microsoft licences are still allocated to BWC, these need transferring ASAP, escalated and alerted NHSE	
Microsoft 365 copilot licences	CIO	4 October 2026	2100 licences available there are 300 to be allocated to staff in CYP on final migration - on track	
Develop and deliver a structured training programme for administrative colleagues on the safe, effective and responsible use of approved AI software, including information governance, appropriate use and practical application.	Company Secretary/ CIO	January 2027	Continuing through regular training sessions and Admin Professionals Forums.	
Continue to develop the annual Board-level review of digital resilience, innovation and benefits, bringing together cyber security, infrastructure, adoption, AI, innovation and benefits realisation.	CIO	December 2026	Regularly received at Board of Directors meetings, with further work to align the report to the new strategy and provide assurance on innovation and cyber security.	
PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE		NEGATIVE ASSURANCE
Internal audit reviews 2026/27	- Benefits realisation reporting not fully embedded. - Limited independent assurance over digital transformation programmes. - Inconsistent reporting of user adoption and digital maturity. - Emerging AI governance arrangements still developing. - Limited benchmarking against peer organisations.	- Achievement of DSPT standards. - Improving system availability. - Reduction in cyber vulnerabilities. - Successful delivery of digital programme milestones. - Positive staff feedback on digital tools. - Increased digital maturity scores. - Successful business continuity testing. - Evidence that digital innovation is improving productivity, service quality or user experience. - Positive assurance through internal audit reviews		Increase in cyber incidents or phishing attacks. Critical infrastructure failures. Missed digital programme milestones. Major supplier outages. Poor system availability. High numbers of unresolved critical IT incidents. Failure to achieve DSPT requirements. Internal audit findings of limited assurance. Low staff uptake of digital solutions. Increasing clinical incidents linked to digital systems. Evidence that new technologies are introduced without sufficient governance, workforce engagement or assessment of risk.
Update since last review:				

September 2026:

- Language strengthened to capture the need to reflect being digitally ambitious, and remaining safe, secure and resilient
- Updates to Positive and Negative Assurances
- Actions updated

REF	STRATEGIC RISK	GOAL/ ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SP9	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	SP3 SP4
RISK APPETITE			Open - Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance. <i>Target risk score range 9-10.</i>	INHERENT RISK SCORE	Impact	Likelihood	Risk Score
					4	5	20
				DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
Impact 4 x Likelihood 3 = 12	Current score demonstrates the controls in place and level of assurance evidenced.	Impact 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
				April 2026	12
		DATE OF LAST REVIEW	3 September 2026		
CONTROLS/ MITIGATIONS			GAPS IN CONTROL		
• 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.			• 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. • Increased complaints from deprived communities; a breakdown has been requested for oversight at Quality, Patient Experience and Safety Committee.		

- 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.	Chief AHP	September 2026	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 SULEG meeting and Participation reports at local OGC
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, CYP plan to be developed as part of integration of CYP for Birmingham and SOLAR
Integrate Children and Young People Services to ensure consistent care and support offer across system	AD CYP	March 2027	Launch event in September, collective services also participating in Culture of Care launch in September
Identify locality based health needs and review community caseloads in line with strategic delivery of health improvement	CMO	March 2027	Data being drawn from Birmingham public health observatory to enable development of locality model for Birmingham and Solihull
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	- 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 OGC, QPES Committee and Board. - New processes have been devised to improve learning from deaths including improved oversight of	- 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.

- 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	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.	Structured Judgement Reviews (SURs) and associated learning/ actions. - Participation Experience and Recovery (PEAR) Group. - Community collaboration with system partners. - Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme. - PREOMS data from Secure and Offender Health showing a move towards parity for Black and white groups	- Inconsistent application of cultural change initiatives, including Just Culture and active bystander training. - 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:			
September 2026: - Progress being made on the development of Locality working and understanding the specific mental health needs within each - Local divisional Plans in place targeting the reduction in health inequalities, reporting established through CEAG			

REF	STRATEGIC RISK	GOAL/ ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR10	Failure to work in partnership 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		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.			Impact	Likelihood	Total score
				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	17 July 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.			- 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.		

- Comprehensive transformation planning and implementation to ensure sustainable 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	Enhancing our urgent and emergency care pathways has been identified as one of our key transformation for 2026-31. MHED Allocation of funding has been confirmed and we are currently in conversation with MMuH to explore opportunities. MHRV Review of operational model currently underway. WMP expressed interest in working with us and WMAS. Paper to be presented to TDG in August. PLT Staffing Review Review been undertaken. Paper will form the basis of conversations with acute trust colleagues around funding and expectation of PLT services. ACP being introduced to PLT. S136 Workshop facilitated with system partners to better understand high number and low conversion rates for S136. Outputs currently being drafted. HTT Business Case is currently being revised to incorporate CYP. ACP being introduced to PLT.
Implementation of the Talking Therapies Action Plan to address performance issues.	AD for Specialties	October 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.	Programme Lead	October 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. Programme lead role will require review as current post holder will be leaving the trust implementation of the east will now transfer into the wider NMHC programme delivery group which is being established to oversee the future NMHC delivery model and estates approach following capital funding being obtained	
PLANNED ASSURANCE	GAPS IN ASSURANCE	POSITIVE ASSURANCE		NEGATIVE ASSURANCE
- 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.	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.

recovery-focused training implemented (NMHT). - Physical health connectors pilot programme. - Internal audit reviews 2026/ 27			
Update since last review: ➤ Transformation section on Urgent care updated ➤ 24/ 7 PILOT now NMHC Neighbourhood mental health centre programme will deliver the future operation of the next 4 centres in plan			

Report to Board of Directors						
Agenda item:	9					
Date	7 October 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	Dave Tomlinson	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 are as follows: <u>Summary points:</u> A review of the performance report has been undertaken with a view to streamline and reduce duplication whilst retaining the relevant reporting. This has resulted in the removal of one overall Appendix previously titled, 'Performance Metric Trajectories' which focused on Trust local improvement metrics. Metrics included in this report are covered via the NOF update (Appendix 1a) with the exception of the following local Trust priorities, appraisals, bank and agency reduction and vacancies which are now being covered in this report. National Oversight Framework 2026/27 - Appendix I and 1a for detail 2026/27 Quarter 1 NOF ratings were published on the 10th September 2026 on the national public facing dashboard - see link Birmingham and Solihull Mental Health NHS Foundation Trust – Mental health and community provider – NHS Oversight Framework - NHS England public data gateway BSMHFT remains in segment 3, although it should be noted that our segmentation score has been capped due to the financial override relating to the Trust's position on variation from the financial plan. Overall, the Trust has been ranked as 34 of 58 Trusts. Appendix 1 provides a summary of the Q1 ratings. Appendix 1a contains details of the NOF and CEO priority metrics where internal improvement and action planning is required. A summary of the metric areas for improvement remains unchanged and is outlined below. - Percentage of patients in crisis receiving face-to-face contact within 24 hours. - Reducing Length of Stay for Adult and Older Adult services % of total open CYP MH related waits that are over 104 weeks - Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages)						

- % of acute mental health admissions with no contact with community mental health services in the previous year- ICB metric.
- Sickness absence rate
- Percentage of NHS Talking Therapies patients completing a course of treatment and achieving reliable Recovery
- Temporary staffing relative cost band
- Finance metrics – see finance report for detail

- **Inappropriate and Appropriate Out of Area Placements**

Year to date as at the end of August 2026, the Trust has not met the zero trajectory for inappropriate out of area placements. At the end of August 2026, there were 28 inappropriate out of area placements, 14 adults and 14 CYP due to clinical need and high demand - especially for female beds. However, improved trend being achieved in reducing all out of area placements.

- **Clinically Ready for Discharges** – high levels remain in both adult and older adult services. Main reasons for delays in adult acute care continue to remain allocation of a social worker, supported accommodation and care packages, and in older adults continues to be waits for nursing home placements. A targeted action plan based on reasons for delay with Birmingham City Council (BCC) is in place. The plan was shared and discussed at Trust FPPC in July.
- **2026/27 Length of stay (LOS) progress against the national planning trajectories** – The LOS position for adults shows an increase to 85.9 days as at August against the planned trajectory of 73.8 days (NOF band 4). Excluding CRFDs, LOS levels reduce to 57.47 days (NOF Band 3). In July and August there were 5 service users discharged who had long lengths of stay (the longest of which was 2196 days) which has contributed to the increases in quarter 2.

Older adults LOS was 104.8 days for August (NOF band 3), below their trajectory of 142 days. Excluding CRFDs, LOS would reduce significantly to 71.9 days. Discharges from the bed closures on Bergamot including long stay discharges will contribute to this position further going forwards.

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.

- **Talking Therapies 2026/27 BHMs recovery action plan** - The ICB activity and income trajectory for Birmingham Healthy Minds has deteriorated this month and now below trajectory having a negative impact on the financial activity performance with April – August 2026 showing a shortfall of £61,000. The Reliable Improvement Rate in August is 69% in line with the national target of 69%. The Reliable Recovery rate has decreased to 46.4% and remains below the 51% national target.
- **CYP Eating Disorders National waiting time standard – Routine 28 days (target 95%)**
August 2026 performance improved to 84.2% but remains below the 95% national standard. This relates to 3 of 19 service users not seen within 28 days. Position is being impacted by Avoidant/ Restrictive Food Intake Disorder (ARFID) referrals which require more complex consultation and consideration. Team capacity has been enhanced to support the pathway.
- **Sickness absence** – Decreasing trend observed with August 2026 at 6.3% but above the improvement trajectory of 5.7%.
- **Bank and agency reduction** – Bank at 674 WTE in August 2026 and above the trajectory of 575.68 WTE. Agency at 18 WTE and below the trajectory of 28.31 WTE.
- **Appraisals** – August position at 79% and below the improvement trajectory of 80.9%.
- **Vacancies** – July vacancy rate at 6.9% below trajectory of 10.32%. August data not yet available.

- **Mandatory Training** – August position at 93.7%, below the 95% target.

Quality

- AWOL patients coming to harm decreased to 0 compared to 4 last month
- Deaths within 30 days post discharge – has decreased to 0 from 1 last month
- Episodes of rapid tranquilisation decreased to 47 from 72 last month
- Harm-free Days have increased to 86 from 84 last month
- Incidents of moderate harm and above – decreased to 11 from 38 last month
- Number of patients prone restrained for anything other than intramuscular tranquilisation- has increased to 8 from 6 last month
- Number of Prone restraints for more than 10 minutes has remained at 0 for the 3rd month in a row.
- Safeguarding Incidents decreased to 135 compared to 199 last month

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 required improvement trend.

The summary of progress against improvement metrics 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 28	3, 14-15
People				
Vacancies			August data not yet available	8
Sickness			Improvement in last month August at 6.3%	8, 22-23
Appraisals			Improvement in August (79%) below trajectory	8, 24-25
Sustainability				
Monthly Agency costs				

Table 2: Performance

	On Track	Plan in Place	Progress	Page
Talking Therapies - Service users moving to recovery			Reduction last 2 months (47.9%) below national 50% target	
Talking Therapies Reliable Recovery Rate			Small reduction in month (46.4%) below national target of 51%	6, 20-21
Talking Therapies Reliable improvement rate			Small reduction trend in last 2 months (68.9%) below the national target of 69%	6, 18-19
Clinically Ready for Discharge: percentage of bed days			Improvement in last month. August 2026 at 14.5%.	3,
Clinically Ready for Discharge: Number of delayed days			Improvement in last month. August 2026 at 2342 bed days.	3, 16-17
CYP eating Disorders – Routine National Waiting Time standard			Improvement in month to 84.2% remains below target of 95%	7

Table 3: people

	On Track	Plan in Place	Progress	Page
Fundamental Training			Deterioration in last month (93.7%) below Trust target of 95%.	8, 25-29

Table 4: Quality

	On Track	Plan in Place	Progress- Reviewed at QPES.	Page
AWOL patients coming to harm			Decreasing trend last month from 4 to 0	8, 29-30
Deaths within 30 days post discharge			Has decreased to 0.	8, 31-32
Episodes of rapid tranquilisation			Decreasing trend over last month to 47 from 72	8, 33-34
Harm-free days			Small increase for last month August at 86	8, 35-36
Incidents of moderate harm and above			Decrease in last month from 38 to 11	8, 37-38
Number of patients prone restrained for anything other than intramuscular tranquilisation			Increase in last month from 6 to 8	8, 39-40
Number of Prone restraints for more than 10 minutes			Remained at zero for last 3 months	8, 41-42
Safeguarding Incidents			Decrease in month from 199 to 135	8, 43-44

- Purpose (why is coming to this meeting?)**

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

- Key Issues and Risks (What are the challenges? What are the risks? Is there anything specific to highlight?)**

CRFDs, inappropriate out of area placements remain above the zero target, Talking Therapies Recovery Plan targets, CYP Eating Disorders national waiting time target, reducing overall out of area placements, 2026/27 NOF metrics including Adult and Older Adult LOS, patients in crisis receiving face-to-face contact within 24 hours, CYP 104 week waits, percentage of people discharged from community mental health services with a paired outcome score recorded (all ages), % of acute mental health admissions with no contact with community mental health services in the previous year, sickness absence rate and temporary staffing cost band.

The detail of the NOF Finance metrics is discussed in the Trust FPPC finance report.

Recommendation

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

Enclosures

September 2026 Performance Report and Integrated Performance Dashboard
Appendix I FPPC September 2026 National Oversight Framework Q1 update
Appendix Ia FPPC September 2026 National Oversight Framework and CEO improvement metrics update 2026/27
Appendix Ib FPPC September 2026 BSMHFT NOF 2026-27 dashboard as at August 2026
Appendix II FPPC August 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 by exception via the Performance Assurance Panels (PAPs) to assess progress and delivery of recovery action plans where relevant. Feedback from PAPs is planned to be provided to the Planning and Delivery Sub-Committee and through to FPPC by relevant Leads.

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.

Trust Performance in August 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: A review of the performance report has been undertaken with a view to streamline and reduce duplication whilst retaining the relevant reporting. This has resulted in the removal of one overall Appendix previously titled, 'Performance Metric Trajectories' which focused on Trust local improvement metrics. Metrics included in this report are covered via the NOF update (Appendix 1a with the exception of the following local Trust priorities, appraisals, bank and agency reduction and vacancies which are now being covered in this report.

NEW: Update on the 2026/27 National Oversight Framework (NOF) Metrics (Appendix I and Ia)

2026/27 Quarter 1 NOF ratings were published on the 10th September 2026 on the public facing dashboard. BSMHFT remains in segment 3, although it should be noted that our segmentation score has been capped due to the financial override relating to the Trust's position on variation from the financial plan. Overall, the Trust has been ranked as 34 of 58 Trusts. Appendix 1 provides a summary of the Q1 ratings.

NOF metrics update as at August 2026:

In total there are 27 mental health metrics, plus 2 at ICB level (excluding talking therapies

which is also a contextual measure for Trusts). The summary dashboard outlining the performance updates is included as Appendix 1b.

In addition, MH CEOs have agreed to focus on an additional 4 mental health priority actions with related improvement metrics for delivery.

Appendix 1a contains details of the NOF and CEO metrics where internal improvement and action planning are required. Outlined below is a summary of the NOF metrics for improvement:

- Percentage of patients in crisis receiving face-to-face contact within 24 hours.
*Service level action plans continue to be implemented. August Trust performance improved to 69.6% but **Quarter 2 to date performance remains within NOF band 3.***
- LOS metrics are now aligned to the national planning guidance and based on a rolling 3-month average for adults and older adults.
*In August Adult LOS is now above the planning submission trajectory and older adults remain below. Overall, however, LOS levels remain high, impacted by high CRFD levels. Step changes in actions required including CRFD reductions. **For Quarter 2 performance to date, adult service remains in NOF band 4 and older adult service remains in NOF band 3.***
- Proportion (%) of total open CYP MH related waits that are over 104 weeks (help - intervention based clock stop and referral spells methodology) – *August local data indicates 25% of CYP service users are waiting over 104 weeks, a 2% improvement on previous month. **However, for Quarter 2 performance to date, the Trust remains in NOF band 3.***
As part of the planning submission, both Solar and CYP service submitted trajectories to achieve zero 104 week waits by end March 2027 equating to NOF band 1 by year end if achieved. Both services have confirmed that it will not be possible to bring this timeline forward due to a combination of demand and capacity challenges and low levels of recording of outcome measures. This is being kept under review as part of the action planning in place. Further detail on action plans is outlined in Appendix 1a. Improvement in the recording of outcome measures has been escalated for support to the Deputy Medical Director leading on the Trust's strategic approach.
- Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages) – *Local reporting is in development. Based on available national data as at July 2026, this shows the aggregated Trust performance at 16%. **The NOF national Q1 ratings confirmed performance for adults at 2% and 20% for CYP placing us in NOF Band 3.*** Improvement relies on a step change in the recording of outcome measures across both services.
- Sickness absence rate – increasing trend observed since May but August showing a reduction to 6.3%. There is lag to the publication of national data, (currently at May 2026) which informs the NOF bandings. **The Trust is in NOF Band 3 as part of the Q1 ratings and forecast for Quarter 2 is that this banding will remain.**
- Percentage of NHS Talking Therapies patients completing a course of treatment and achieving reliable Recovery (**ICB and Trust metric BUT is a non-scoring metric**). *Service action plan in place led by the AD for Specialties, previously reported to Trust FPPC. August performance at 46.4% and remains below the national 51% standard.*
- Temporary staffing relative cost band – Q1 NOF rating confirmed as band 1 – (based on Band 2 for bank and Band 1 for agency). **Action plan being led by the Executive Director of Nursing working with operational and corporate leads.**

- % of acute mental health admissions with no contact with community mental health services in the previous year - ICB metric. BSMHFT at 9% for August placing us in band 2 (2% improvement from July). Further detailed analysis is being undertaken to understand the population cohorts contributing to this measure and identify opportunities to increase earlier engagement with community mental health services prior to crisis presentation.
- Finance metrics – *see finance report for detail*.

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 Ia.

Clinically Ready For Discharge (CRFD) – The percentage level of occupied bed days (OBDs) lost to CRFD decreased in August 2026 to 14.5% from 15.2% in July, with overall levels remaining high. The decrease this month was due to reductions in both adult acute and older adult inpatient services. The percentage of OBDs taken up by CRFD service users in August 2026 for Adult Acute & Urgent Care was at 16.8% of OBDs (52 patients), a marginal reduction of 0.4% since July. In Older Adult Services, the CRFD levels decreased to 29.7% of OBDs (25 patients), a 3.5% reduction on July's position. Discharge of patients due to the temporary bed closures on Bergamot will have contributed to this.

The main reasons for the CRFD 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.

Jenny Watson, Deputy Director of Commissioning and Transformation MHPC as the CRFD SRO has developed a targeted action plan based on reasons for delay with Birmingham City Council. The plan was shared and discussed at Trust FPPC in July. A policy to support the management of patient choice options for placements has recently been approved as part of the CRFD action plan.

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.

Year to date as at the end of August 2026, the Trust has not met the zero trajectory. In August there were 28 inappropriate out of area placements, 14 adult and 14 CYP arising due to clinical need and demand. Out Oof Area and community demand remain high. CYP have highlighted that key areas of pressure relate to access to the agreed level of BSMHFT beds and the high demand for female beds.

The weekly Patient Flow Steering Group meeting supported by daily action plans oversees the Improvement Programme. Rapid improvement actions are reviewed weekly, with ongoing repatriation where appropriate. 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 appropriate and 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 July 2026 for Adult Acute & Urgent Care was at 17.2% of OBDs.

The charts below outline the overall trends and position for the week beginning 31st August 2026.

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.

Fig 1. Adult Acute Inappropriate Out of area placements

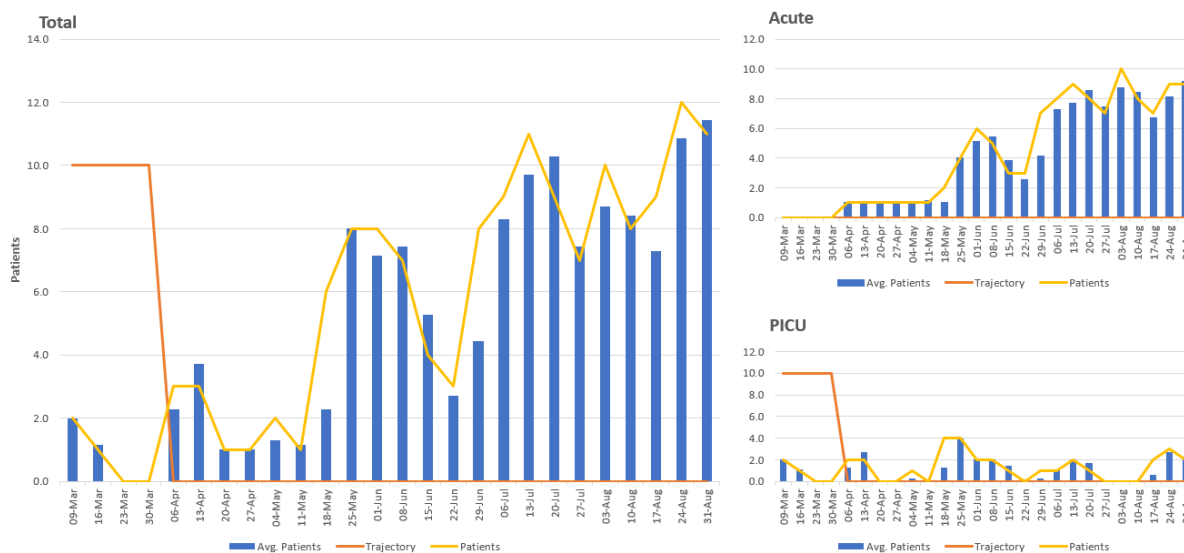
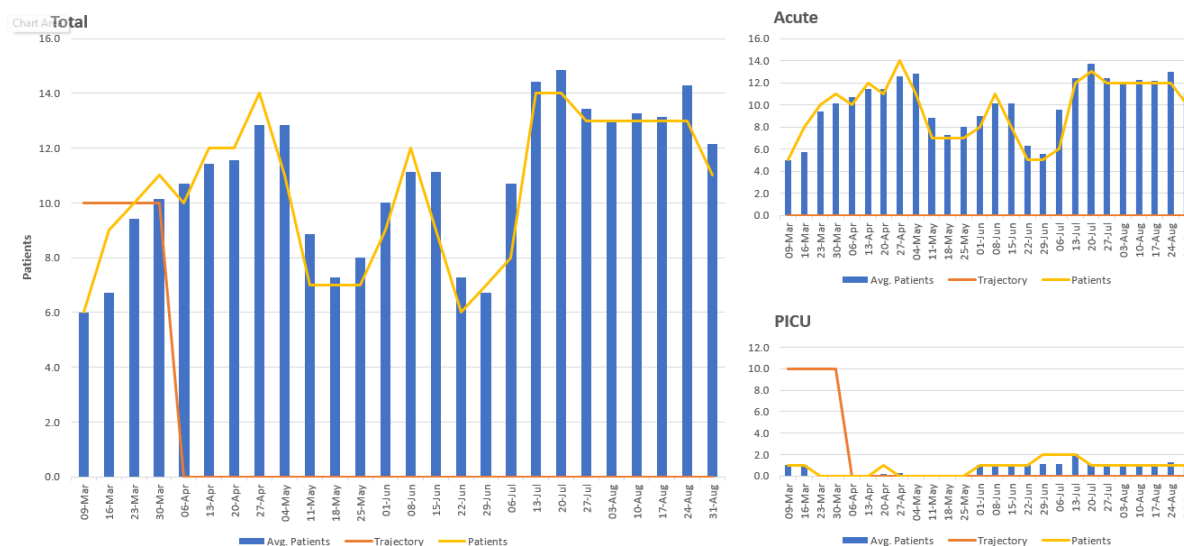


Fig 2. CYP Inappropriate Out of area placements



The Acute and Urgent Care Q2 productivity plan actions are summarised below

Admission avoidance

Goal: Ensure admissions are appropriate and alternatives are considered.

- Progress Home Treatment & Bed Management digital workstream, including live urgent referral reporting, screening and triage digitisation, and development of Service Overview and Action Plan.

- Continue PLT, ACP and front-door triage development to strengthen urgent review, diversion and alternatives to ED attendance.
- Complete and act on S136, MHRV and Health & Justice pathway reviews with system partners. Workshop held on S136 pathway with key actions being developed.
- Strengthen Recovery House, PDU, respite, Talking Spaces and Call Before Convey as alternatives to admission and ED attendance.

Inpatient Care & Reducing Length of Stay

Goal : Increase timely discharges and reduce delays in discharge

- Embed revised Red to Green RAG escalation framework, including named action owners, escalation routes and alignment to Gold escalation.
- Develop and implement Red2Green methodology across inpatient wards to support daily review of meaningful progress toward discharge.

Discharge Planning and Support

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

- Progress CRFD programme on key ambitions:
- Reduce avoidable delays due to patient choice
- Improve access to social care capacity and strengthen joint working
- Reduce delays caused by funding decisions and pathways
- Improve market management and access to appropriate accommodation and support

CYP – summary of actions in place to try and reduce the number of inappropriate Out of Area placements include:

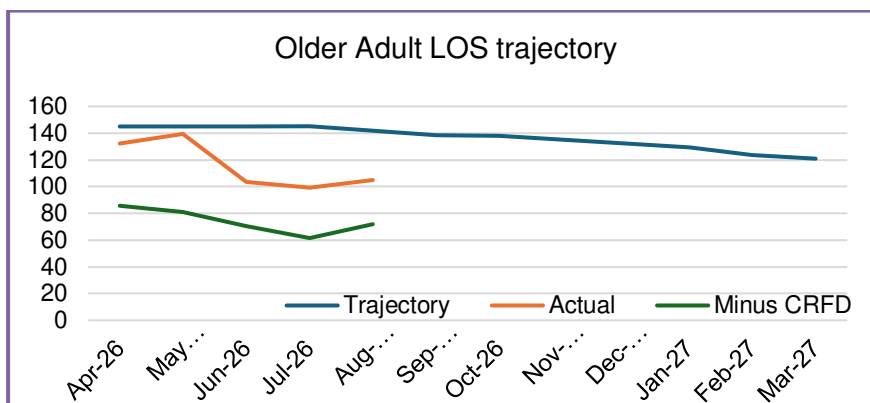
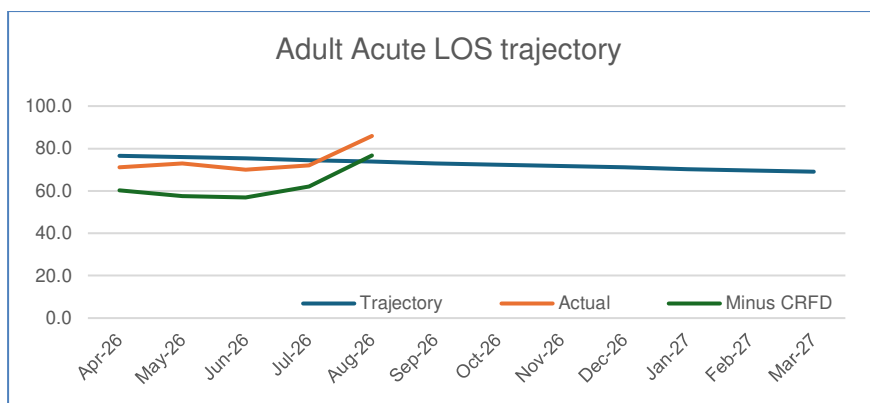
- Daily huddle reviews all discharges and admissions and transfers.
- Placing OOA patient on repatriation list as soon as admission takes place
- Reviewed daily in Capacity and Demand meeting
- Engaging Framework OOA team on weekly basis to review any barriers.
- Discharge coordinators attend regular MDT to review early discharge
- Daily meeting with Cygnet framework to review movement and discharges

Reducing Length of Stay (LOS)

Trusts were required to submit improvement trajectories for 2026/27 as part of the national planning submission using the 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 March 2027.
- Older Adults - 12% improvement (on average across the year) by the end of March 2027

The LOS trajectories agreed and monthly performance to date are outlined below (the figures are based on a 3-month rolling view)



In summary, the LOS position for adults shows an increase to 85.9 days as at August against the planned trajectory of 73.8 days (NOF band 4). Excluding CRFDs, LOS levels reduce to 57.47 days (NOF Band 3). In July and August there were 5 service users discharged who had long lengths of stay (the longest of which was 2196 days) which has contributed to the increases in quarter 2.

Older adults LOS was 104.8 days for August (NOF band 3), below their trajectory of 142 days. Excluding CRFDs, LOS would reduce significantly to 71.9 days. Discharges from the bed closures on Bergamot including long stay discharges will contribute to this position further going forwards.

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.

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

Trust FPPC were provided with a detailed update on progress with the recovery plan by the Associate Director for Specialties at the March 2026 FPPC meeting. Further update provide in Appendix II. 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:

BHMs: The ICB activity and income trajectory for Birmingham Healthy Minds has deteriorated this month and is now below trajectory having a negative impact on the financial activity performance with April – August 2026 showing a shortfall of £61,000.

The Reliable Improvement Rate in August is 69% in line with the national target of 69%. The Reliable Recovery rate has decreased to 46.4% and remains below the 51% national target.

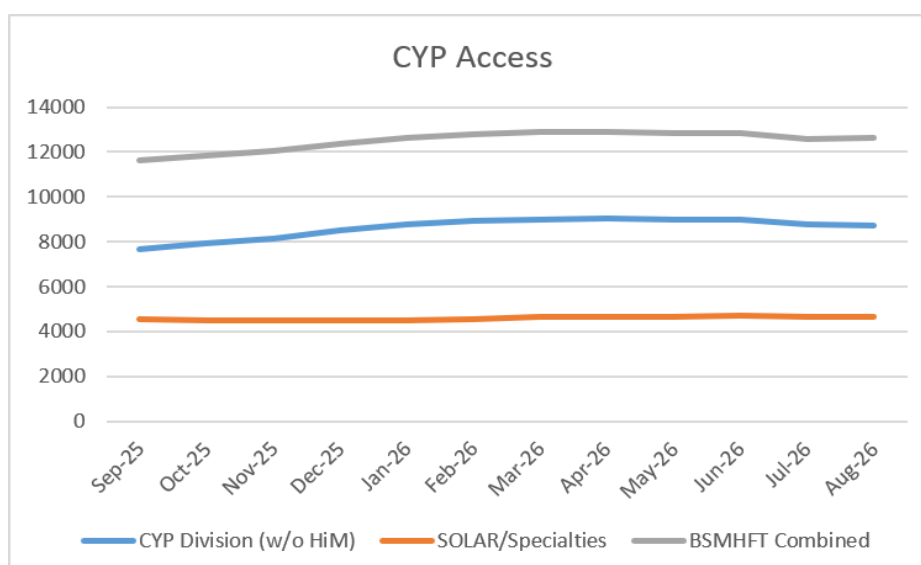
CYP Talking Therapies: FPPC is asked to note that this service is commissioned via Living Well Consortium. Under current contract timelines for data submission, this means that the activity and performance data will be reported to FPPC a month in arrears, however due to the later FPPC date this month August data has been included – see below.

Trust Combined BHMs & CYP Position (August 2026): The combined position for August 2026 for the Reliable Recovery rate was 46.6%, with Living well at 47% and BHM at 46.4%. The Reliable Improvement rate was 68.1% with Living well at 65% and BHM at 69%. The number of service users seen within 6 and 18 weeks exceeded the national targets.

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

Performance in August of 84.2% remains below the 95% national standard, this relates to 3 of 19 service users not seen within 28 days. Compliance has been impacted by Avoidant/ Restrictive Food Intake Disorder (ARFID) referrals which require more complex consultation and consideration. Weekly meetings are in place to review current waits and identify any potential breaches and barriers in advance including texting appointment reminders to service users to reduce DNAs. Ongoing collaborative work with Birmingham Community Healthcare Trust for ARFID referrals to ensure patients are accessing the right service and a band 7 CBT therapist has been recruited to increase capacity to support the pathway.

CYP Access Rate – being maintained. See chart below.



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 metrics will be discussed at QPES Committee. A summary of the position as at August 2026 is outlined below:

- AWOL patients coming to harm decreased to 0 compared to 4 last month
- Deaths within 30 days post discharge – has decreased to 0 from 1 last month
- Episodes of rapid tranquilisation decreased to 47 from 72 last month
- Harm-free Days have increased to 86 from 84 last month
- Incidents of moderate harm and above – decreased to 11 from 38 last month
- Number of patients prone restrained for anything other than intramuscular tranquilisation- has increased to 8 from 6 last month
- Number of Prone restraints for more than 10 minutes has remained at 0 for the 3rd month in a row.
- Safeguarding Incidents decreased to 135 compared to 199 last month

People workforce measures – The detailed position is outlined below and are discussed and managed via the People Committee.

- Sickness absence: The 2026/27 Trust trajectory is to reduce sickness levels by 0.5% reaching 5.3% by March 2027. August 2026 at 6.3%, a reduction on previous months and above the improvement trajectory of 5.7% for August.
- Bank and Agency WTE reduction – The 2026/27 target is to reduce the use of bank workers by 103 WTE to 489 WTE and to reduce agency workers by 8.5 to 24.4 WTE. Bank at 674 WTE in August 2026 and above the trajectory of 575.68 WTE. Agency at 18 WTE and below the trajectory of 28.31 WTE.
- Staff vacancy levels: The target for 2026/27 is to reduce the vacancy rate by 1.8% to reach 8.7%. July vacancy rate at 6.9% below the trajectory of 10.32% for July. August data not available at the time of writing.
- Appraisal: The 2026/27 trajectory is to increase appraisal performance by at least 2.75% to reach 82.65%. August position has seen a small increase to 79% but is below the trajectory of 80.9%. Bespoke recovery plans remain in place to support teams following the launch of the new appraisal form.

Mandatory Training: August position at 93.7%, below the 95% target due to the expiry of grace periods for a number of courses. 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.

Sustainability – (details in finance report)

Integrated Performance Dashboard

August 2026


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 (%)	92
Clinically Ready for Discharge: Bed Days	2342
Clinically Ready for Discharge: Bed Days (%)	14
CPA 3 Day Follow Up (%)	88
CPA 7 Day Follow Up (%)	98
Eating Disorders Adult Access Standard Urgent (%) *Jul 26	0
Eating Disorders: Waiting Time - Routine (%)	84
Eating Disorders: Waiting Time - Urgent (%)	100
First Episode Psychosis: Waiting Time (%)	62
Out of Area: Inappropriate Placement Bed Days	308
Out of Area: Inappropriate Placements Active	28
People on CPA with a Formal Review in last 12 Months (%)	89
Referrals over 3 Months with no Contact	5681
Talking Therapies: Reliable Improvement Rate (%)	68
Talking Therapies: Moving to Recovery (%)	48
Talking Therapies: Reliable Recovery Rate (%)	47
Talking Therapies: Seen in 18 Weeks (%)	99
Talking Therapies: Seen in 6 weeks (%)	93

People	
Bank & Agency Fill Rate (%)	93
Fundamental Training (%)	94
Staff Appraisals (%)	79
Staff Sickness (%)	6
Staff Turnover: Rolling 12m (%)	6
Staff Vacancies (%) *Jul 26	7

Quality	
AWOL patients coming to harm	2
Deaths within 30 days post discharge	0
Episodes of rapid tranquilisation	47
Harm-free Days	86
Incidents of moderate harm and above	11
Number of patients prone restrained for anything other than intramuscular tranquilisation	8
Number of Prone restraints for more than 10 minutes	0
Safeguarding Incidents	134

Sustainability	
Agency as % of Pay Spend	0
Agency Staff Spend	£150k
Bank as % of Pay Spend	9
Capital Expenditure	£163k
Cost Improvement Programmes	£4,461k
Group Cash Balance	£68,925k
Info Governance (%)	100
Operating Surplus	-£526k

Last refreshed 9th Sept 2026

Asterisk (*) in Measure name denotes the latest month where data is available is being shown

	Not meeting target
	Significant IMPROVEMENT
	Significant CONCERN
	Possible improvement
	Possible concern

August 2026



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Secure Services & Offender Health



Children & Young People



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Measure	Latest Target	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Clinically Ready for Discharge: Bed Days		2121	2193	2224	2005	2445	2342
Clinically Ready for Discharge: Bed Days (%)		13	14	14	13	15	14
CPA 3 Day Follow Up (%)	80	88	85	90	84	87	88
CPA 7 Day Follow Up (%)	95	96	92	94	95	95	98
Eating Disorders Adult Access Standard Urgent (%) *Jul 26			100		50	0	0
Eating Disorders: Waiting Time - Routine (%)	95	100	55	96	73	82	84 ↓
Eating Disorders: Waiting Time - Urgent (%)	95	100		100	100	100	100
First Episode Psychosis: Waiting Time (%)	60	100	50	78	56	66	62 ↓
Out of Area: Inappropriate Placement Bed Days	328	604	54	141	210	267	308 ↘
Out of Area: Inappropriate Placements Active	10	0	15	16	10	20	28
People on CPA with a Formal Review in last 12 Months (%)	95	93	90	90	90	89	89 ↓
Referrals over 3 Months with no Contact		4213	4901	5284	5334	5502	5681 ↓
Talking Therapies: Reliable Improvement Rate (%)	69	69	70	70	70	69	68 ↑
Talking Therapies: Moving to Recovery (%)	50	53	52	52	52	52	48
Talking Therapies: Reliable Recovery Rate (%)	51	50	49	48	49	49	47 ↑
Talking Therapies: Seen in 18 Weeks (%)	95	99	99	99	99	99	99
Talking Therapies: Seen in 6 weeks (%)	75	94	93	93	93	93	93 ↑

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

Integrated Performance Dashboard

August 2026



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Trust



Acute & Urgent Care



Specialties



ICCR



Secure Services & Offender Health



Children & Young People



Corporate

Measure	Target Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Bank & Agency Fill Rate (%)		91	95	93	94	90	93
Fundamental Training (%)		94	94	94	94	94	94
Staff Appraisals (%)	90 80.9	81	81	80	78	79	79
Staff Sickness (%)	4.1 5.7	6	6	6	6	7	6
Staff Turnover: Rolling 12m (%)		6	6	6	6	6	6
Staff Vacancies (%) *Jul 26	6 10.25	7	7	7	7	7	7

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

Integrated Performance Dashboard

August 2026



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PEOPLE



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SUSTAINABILITY



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Acute & Urgent
Care



Specialties



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Children &
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Corporate

Measure	Latest Target	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
AWOL patients coming to harm		2	5	3	2	4	2
Deaths within 30 days post discharge		1	1	2	2	1	0
Episodes of rapid tranquillisation		75	60	92	65	72	47 
Harm-free Days		86	85	85	85	84	86
Incidents of moderate harm and above		50	21	19	17	38	11
Number of patients prone restrained for anything other than intramuscular tranquillisation		14	7	13	11	6	8
Number of Prone restraints for more than 10 minutes		2	1	1	0	0	0
Safeguarding Incidents		155	145	171	188	199	134

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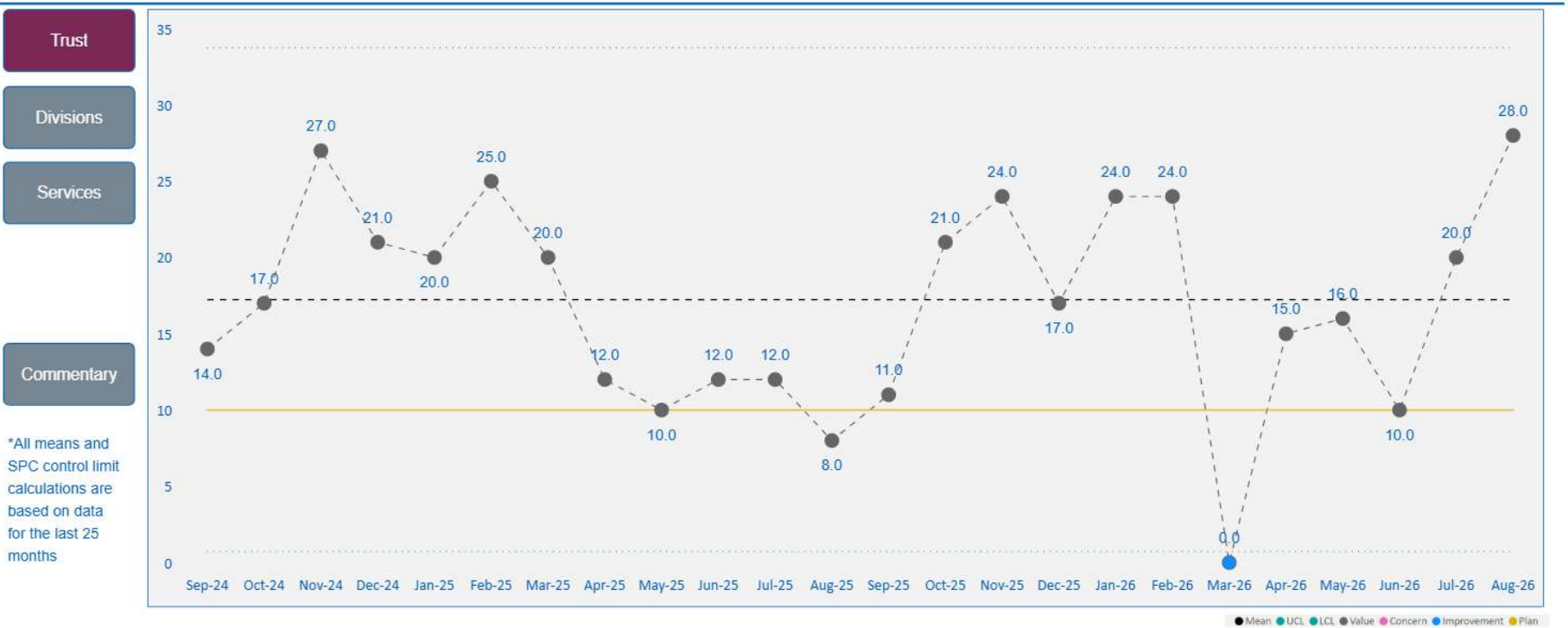
Measure	Latest Target	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Agency as % of Pay Spend		0	1	1	0	1	0 
Agency Staff Spend		£254k	£262k	£240k	-£198k	£219k	£150k 
Bank as % of Pay Spend		7	8	9	8	9	9 
Capital Expenditure		£10,394k	£559k	£1,322k	£276k	£308k	£163k
Cost Improvement Programmes		£6,105k	£1,790k	£2,194k	£4,030k	£2,444k	£4,461k 
Group Cash Balance		£67,580k	£73,265k	£74,572k	£64,357k	£71,280k	£68,925k 
Info Governance (%)		100	87	100	83	100	100
Operating Surplus		-£3,648k	£3,224k	£660k	£87k	-£687k	-£526k

	Not meeting target
	Significant IMPROVEMENT
	Significant CONCERN
	Possible improvement
	Possible concern

Out of Area: Inappropriate Placements Active

August 2026

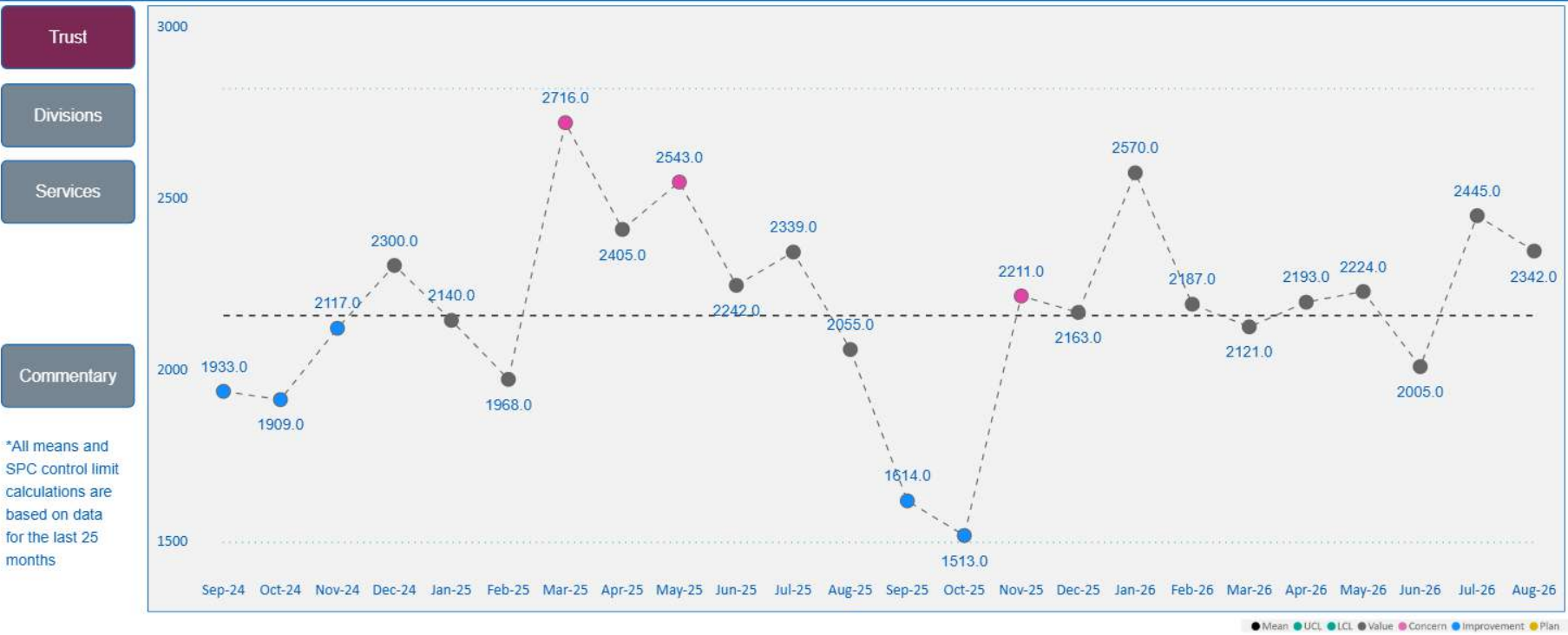
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Question	Answers
A: What has happened?	The number of inappropriate out of area placements at each month end remains a metric in the 2025/26 national planning guidance. A Trust trajectory agreed with NHSE as part of the 2026/27 national planning requirements 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 2026 these beds are now counted as appropriate following review and approval of the Trust's Standard Operating Protocol (SOP) for these beds by the Provider collaborative and NHSE as they meet the qualitative requirements of an 'appropriate' placement. There are 28 'inappropriate' out of area placements at the end of August above the trajectory of zero. 14 of these were adults and 14 were CYP. 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 2342 overall in August with adults at 1168 lost bed days which equates to 16.8%, an decrease of 0.4%. Adult bed occupancy has increased to 97.8% and length of stay has decreased to an average of 101 in August (from 111). The number of CYP Inappropriate admissions have reduced but there remains pressure on female beds. 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.
C: What are the implications and consequences?	Without a system wide approach and a review of patient flow across MH pathways, demand will continue to exceed available Trust capacity and risks to patients and staff potentially increasing without the reconfiguration of services needed to manage demand and manage patients in community teams that also have the staffing and skill mix levels to support. The bed waiting list identifies patients who are waiting to be admitted and are being risk managed in the community. Action plans continue to receive national and commissioner scrutiny which remain at a high level due to performance being above trajectory.
D: What are we doing about it?	A OOA reduction programme is in place with 3 key workstreams are in place to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. The 3 workstreams and Q1 actions include: Admission avoidance Goal: Ensure admissions are appropriate and alternatives are considered. • Progress Home Treatment & Bed Management digital workstream, including live urgent referral reporting, screening and triage digitisation, and development of Service Overview and Action Plan. • Continue PLT, ACP and front-door triage development to strengthen urgent review, diversion and alternatives to ED attendance. • Complete and act on S136, MHRV and Health & Justice pathway reviews with system partners. Workshop held on S136 pathway with key actions being developed. • Strengthen Recovery House, PDU, respite, Talking Spaces and Call Before Convey as alternatives to admission and ED attendance. Inpatient Care & Reducing Length of Stay Goal : Increase timely discharges and reduce delays in discharge • Embed revised Get to Green RAG escalation framework, including named action owners, escalation routes and alignment to Gold escalation. • Develop and implement Red2Green methodology across inpatient wards to support daily review of meaningful progress toward discharge. Discharge Planning and Support Goal : Increase timely discharges and reduce delays in discharge and active use of data to inform reporting and decision making • Progress CRFD programme on key ambitions: • Reduce avoidable delays due to patient choice • Improve access to social care capacity and strengthen joint working • Reduce delays caused by funding decisions and pathways • Improve market management and access to appropriate accommodation and support
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.

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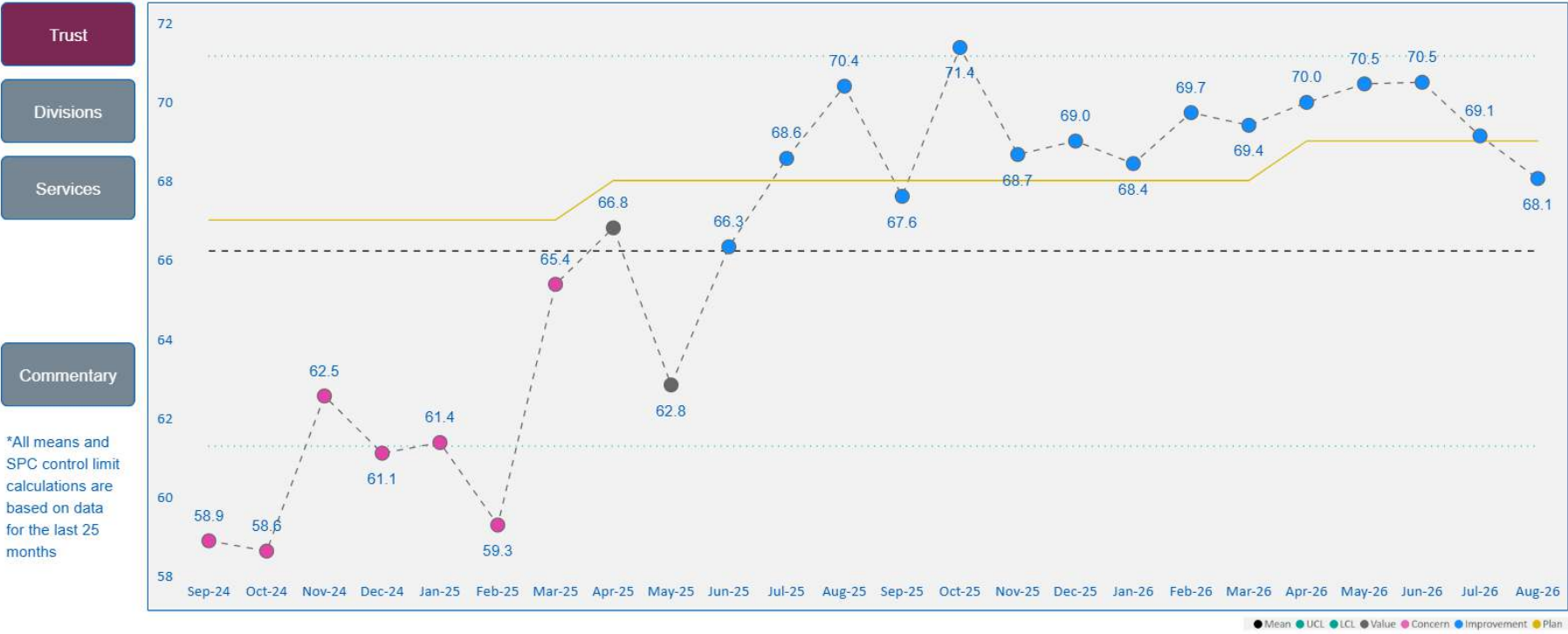
Question	Answers
A: What has happened?	The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. 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. August has seen a decrease to 2445 with Adults moving from 1171 days in July to 1168 days in August, which related to 52 patients, with a main delay reason of supported accommodation, awaiting social worker allocation and care packages and older adults moved from 690 days in July to 538 in August and related to 25 patients, who were waiting for care home placements.
B: Why has it happened?	The main reasons for the delays across both services include awaiting of a social worker and awaiting nursing home placements which requires social care input. These are system wide challenges and partnership working is taking place with local authority and ICS colleagues daily and weekly to review current barriers to discharge for each individual patient. However it is recognised that the ability of partners to aid timely discharge of service users is a continual challenge due to availability of appropriate alternatives.
C: What are the implications and consequences?	Failure to discharge patients in a timely way reduces the flow within in-patients, contributing to out of area placements and leads to an increased waiting time for beds and impacts on patient experience.
D: What are we doing about it?	Deputy Director of Commissioning and Transformation MHPC has been confirmed as the CRFD SRO and has developed a CRFD action plan working with internal clinical and operational leads and Birmingham City Council leads In addition internally reviewing patient flow and activities as part of operational and strategic management of demand and capacity as part of both community and acute and urgent care transformation work plans. A multi-agency bed management meeting is in place to support improved bed flow across inpatient services, along with production boards which provide an update on each patient's delay, identifying progress and tasks required to support discharge. There are some gaps in the current CRFD recording which the localities will be working with the discharge managers to address.
E: What do we expect to happen?	Via the partnership working, to begin to see reductions in delays due to availability of alternatives including social care support and nursing home capacity that is not in our immediate control.
F: How will we know when we have addressed issues?	Begin to see partnership and system wide solutions being implemented contributing to a reduction in these delayed discharges.

Talking Therapies: Reliable Improvement Rate (%)

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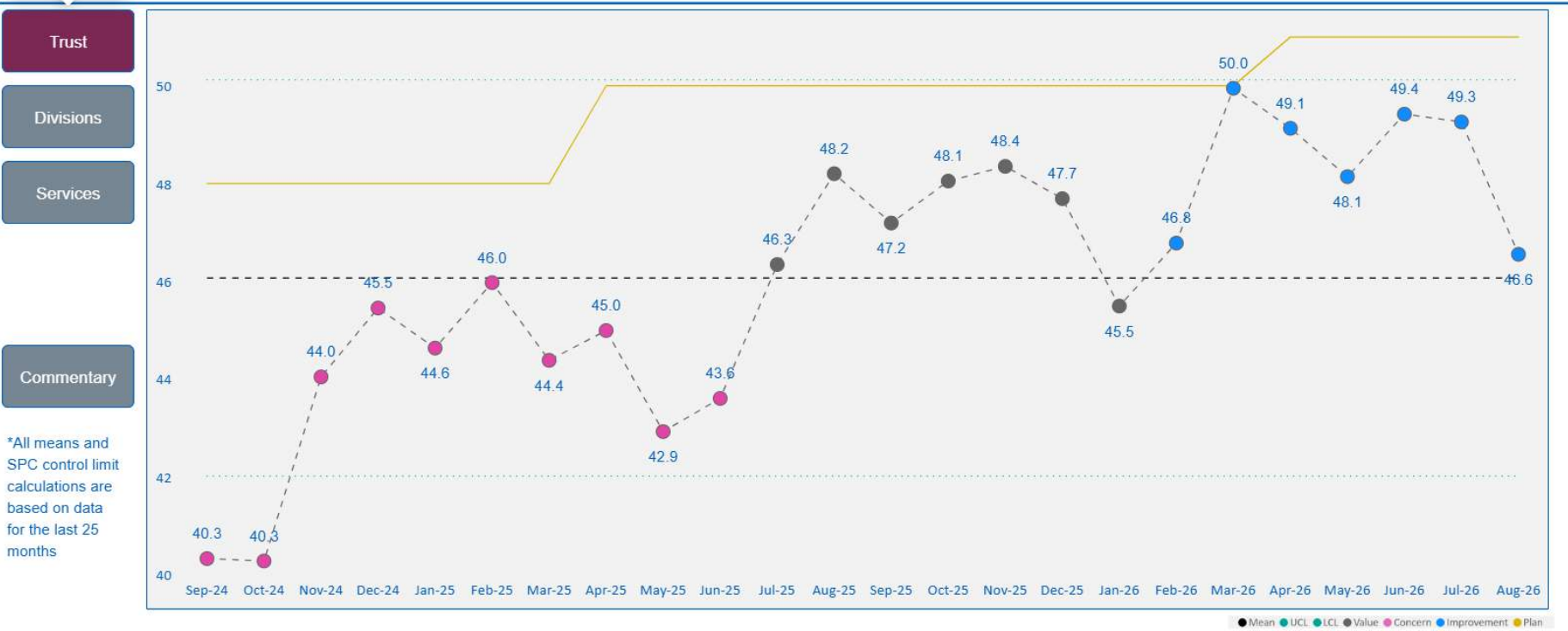
Question	Answers
A: What has happened?	This was a new national metric for 2024/25 with an increased focus on recovery and the target has increased 69% from April 2026. August 2026 at 68.96% below the 69% target for the second month in a row. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression has reliably improved at the end of their treatment. The shortfall to meet the 69% target was one case.
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 and this has now been supplemented with a recovery guide which has been shared with all staff in the service.
C: What are the implications and consequences?	Service users needs are not being met and the national 69% 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. Training took place across the service in January 2026 and a recovery guide has now been developed and distributed to staff alongside a one page reference summary. In addition learning has taken place 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 July has decreased to 10% from 11% in June
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 (%)

August 2026

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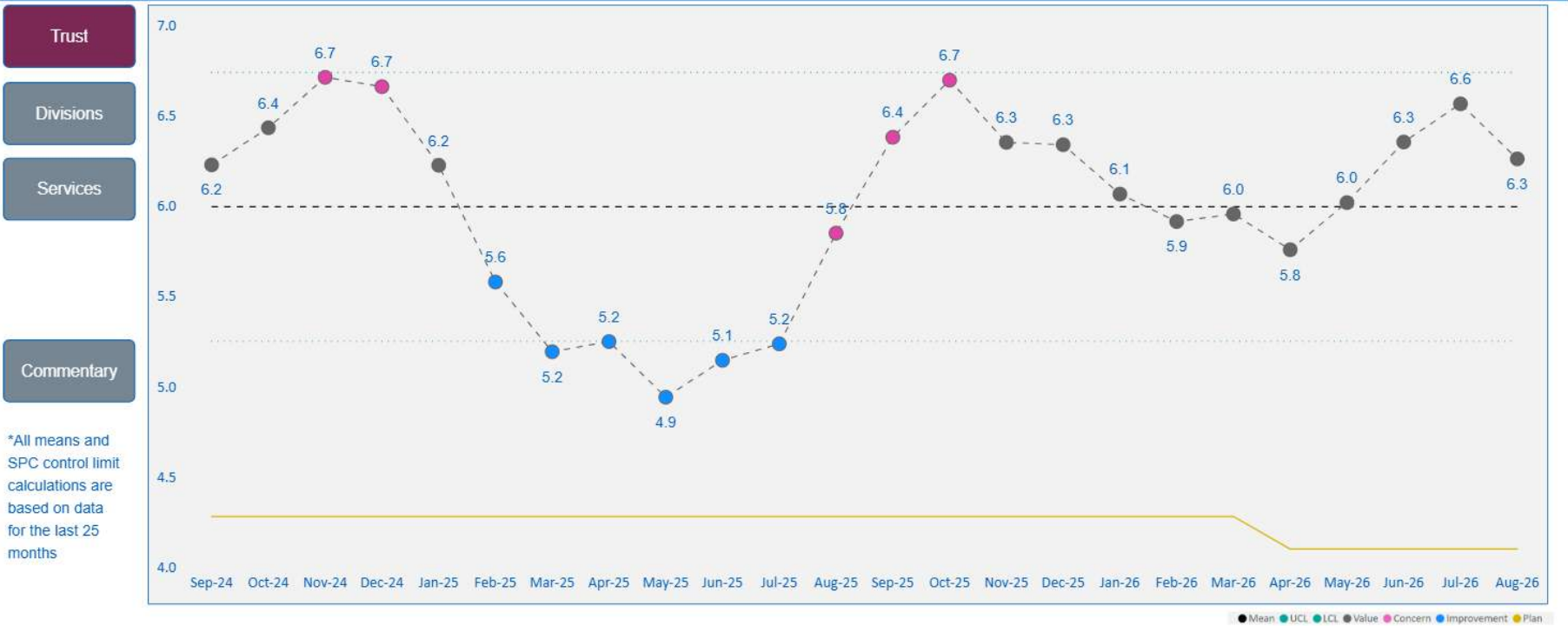
Question	Answers
A: What has happened?	The national target has increased from 50% to 51% from April 2026. The Reliable Recovery rate has fluctuated and is not meeting the 51% target, with August 2026 showing a small decrease to 46.4%, below target. Reliable Recovery Rate is the outcome measure to assess 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 51% 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. Training took place across the service in January 2026 and a recovery guide has now been developed and distributed to staff alongside a one page reference summary. In addition learning has taken place from other services in the country, undertaken 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 July has decreased to 10% from 11% in June
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 (%)

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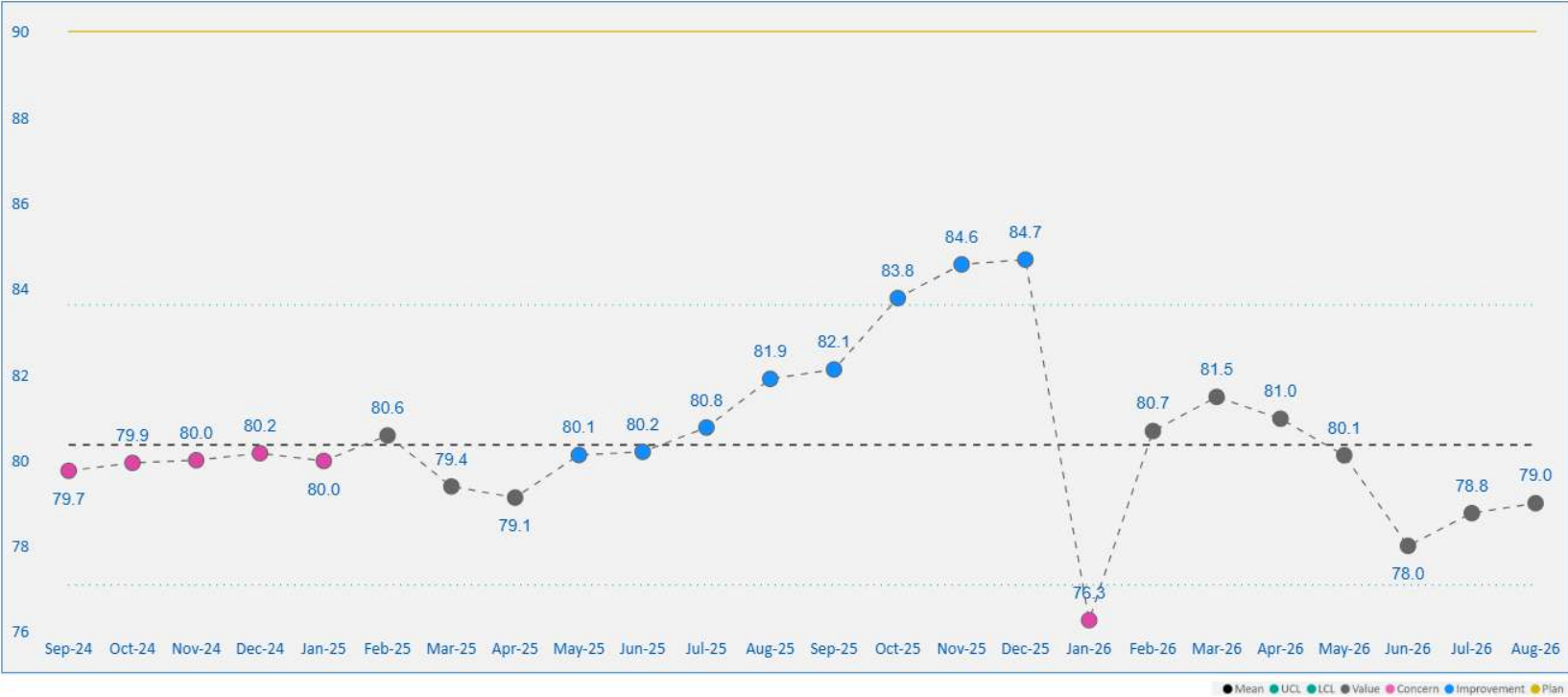


Question	Answers
A: What has happened?	Trust wide sickness absence rate for August 2026 was 6.3% against 6.6% in July 2026, 6.3% in June 2026, and 6.1% in May 2026. Across the divisions, the following services had the highest absence rates: - Primary Care and Dementia Specialties 9.3% (7.1% Long-Term to 2.2% Short-Term) - Acute and Urgent Care 7.6% (4.6% Long-Term to 3.0% Short-Term) - Secure Services and Offender Health 7.0% (4.6% Long-Term to 2.4% Short-Term)
B: Why has it happened?	The return to work rate remains below target in all areas with a Trust-wide rate of 58.1%. Historically, sickness absence has been driven by a combination of long-term mental health conditions (including stress, anxiety and depression), musculoskeletal (MSK) conditions and local workforce pressures. Recent analysis highlights significant variation between services, indicating that absence patterns are influenced not only by health conditions but also by local factors such as workforce demographics, management practices, service complexity, workload pressures and staff experience. The Trust is strengthening its data capability to better understand sickness reasons, absence frequency, trends and hotspot areas, allowing more targeted interventions and earlier support.
C: What are the implications and consequences?	Higher levels of sickness absence reduce workforce capacity, increase operational pressure on teams and can affect service resilience. Services with persistent absence hotspots are more likely to experience rota disruption, increased reliance on temporary staffing, pressure on remaining colleagues and reduced managerial capacity. Failure to intervene early can result in more long-term absences, higher costs, reduced staff wellbeing and poorer employee experience. Robust absence management is therefore a key component of workforce quality, productivity and financial sustainability.
D: What are we doing about it?	A Trust-wide sickness recovery programme is being implemented, supported by enhanced reporting, RTW compliance monitoring and targeted absence management interventions. Key actions include: • Return-to-Work meetings following every sickness episode, with improved monitoring of completion rates and timeliness. • Development of enhanced sickness dashboards and reporting to identify trends, repeat absence, long-term absence and service hotspots. • Use of trigger thresholds and management insight tools to support earlier intervention and case management. • Delivery of manager guidance, training, clinics and supporting documentation to improve confidence in managing attendance. • Review and improvement of RTW processes, including simplified documentation, digital workflow opportunities and closer ESR integration. • Strengthening wellbeing, mental health and MSK support alongside Occupational Health provision and targeted interventions where data indicates greatest need.
E: What do we expect to happen?	As reporting, RTW compliance and targeted intervention arrangements mature, we expect services with higher sickness absence to progressively move closer to Trust averages. Improved management oversight, earlier intervention, better quality data and enhanced wellbeing support should reduce repeat absence, prevent escalation into long-term sickness and improve overall attendance patterns. We also expect more consistent managerial ownership of attendance management and better employee experience throughout the absence and return-to-work process.
F: How will we know when we have addressed issues?	Success will be demonstrated through: • Sustained improvement against the Trust sickness absence KPI. • Increased RTW completion and timeliness rates. • Reduction in repeat short-term absence trigger breaches. • Reduction in long-term sickness cases and days lost. • Evidence that identified hotspot services are improving over time. • Improved quality, accuracy and granularity of absence data to support proactive intervention. • Reduced reliance on reactive absence management and greater use of targeted, evidence-based workforce interventions. • Positive indicators from staff wellbeing, attendance and workforce reporting measures.

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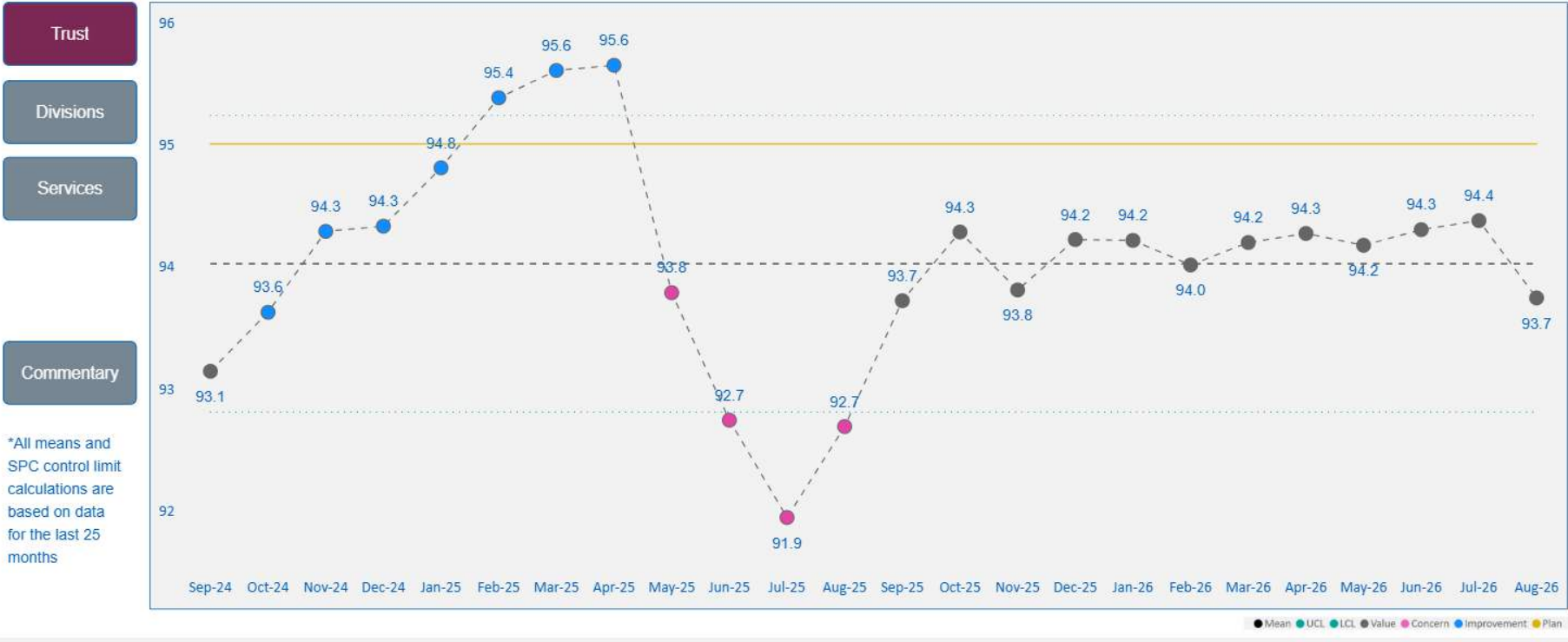


Question	Answers
A: What has happened?	August Appraisal compliance at 79%. A small increase from July. This remains below Trust target of 90 % and commissioners target of 85%.
B: Why has it happened?	The teams within the Trust are below 75% compliance are: Cyp 43.2% Exec Dir - Medical 71.9% Exec Dir - Nursing 66.3% Exec Dir - Resources 61% New Care Models 51.5% Trustwide 29.2% The implementation of the new appraisal form on 1 April 2026 has contributed to a decline in appraisal compliance, which had previously been maintained at an average of over 80% prior to its launch. For approximately 2–3 months, the ESR system did not allow staff to select the correct form. Further troubleshooting identified that IT access permissions were required, and this issue has now been resolved. - The CYP appraisal compliance has also impacted the overall trust compliance.
C: What are the implications and consequences?	The above information demonstrates a slight increase in compliance.
D: What are we doing about it?	L&D has continued to provide regular comms to staff and through FPP communication to alert staff of the system issues. Bespoke recovery plans remain in place to support improvement following the launch of the new appraisal form. Continuing current practice to raise compliance and monitoring. Additional VBA training dates scheduled, however we are experiencing low take up during the summer period 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 (%)

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Question	Answers
A: What has happened?	Fundamental Training compliance has slightly decreased to 93.7 %. While 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-73.3% Exec- Medical - 94.8% Acute And Urgent Care Services -93.3% Cyp-86.4% ICCR-93.8% Exec Resources 94.7% Trustwide (24/7 Team)-87.7% New Care Models 87.7% Strategy People and partnerships 94.9% Temporary staffing compliance has decreased from 94.1% to 92.6% 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, Oliver McGowan Training Tier 1, Oliver McGowan Training Tier 2 and Dual Diagnosis has had a direct impact on overall compliance performance. 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:89.2% Resus – ELS: 74.8% Resus – ILS: 89.5% SRS Conveyance: 71.4% The Care Certificate: 88.4% Oliver McGowan Tier 1 : 83% Oliver McGowan Tier 2: 85.6% 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.

- 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.


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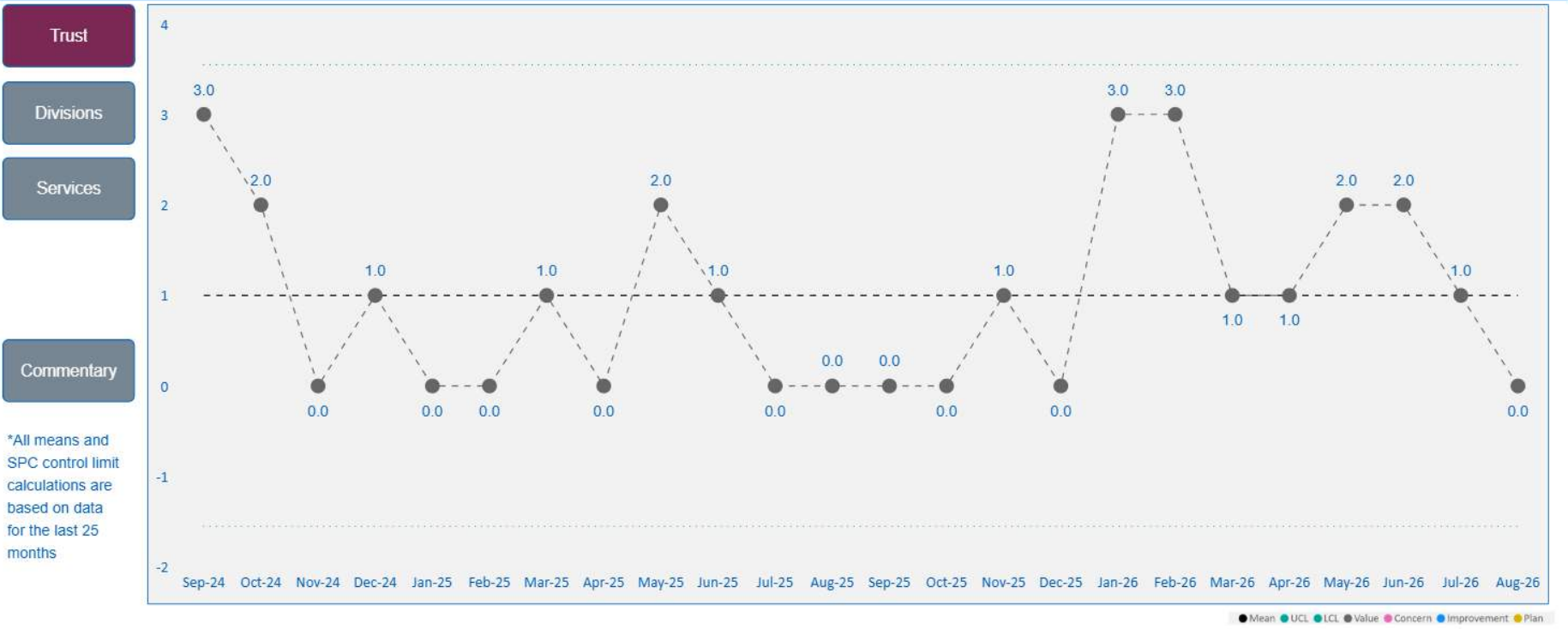
Question	Answers
A: What has happened?	No harm was recorded to services users whilst absent without leave.
B: Why has it happened?	
C: What are the implications and consequences?	
D: What are we doing about it?	
E: What do we expect to happen?	Continued monitoring of absconsion and failure to return 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 thorough divisional governance monitoring.

Deaths within 30 days post discharge

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Question	Answers
A: What has happened?	There were 0 reported deaths in August.
B: Why has it happened?	
C: What are the implications and consequences?	
D: What are we doing about it?	
E: What do we expect to happen?	
F: How will we know when we have addressed issues?	

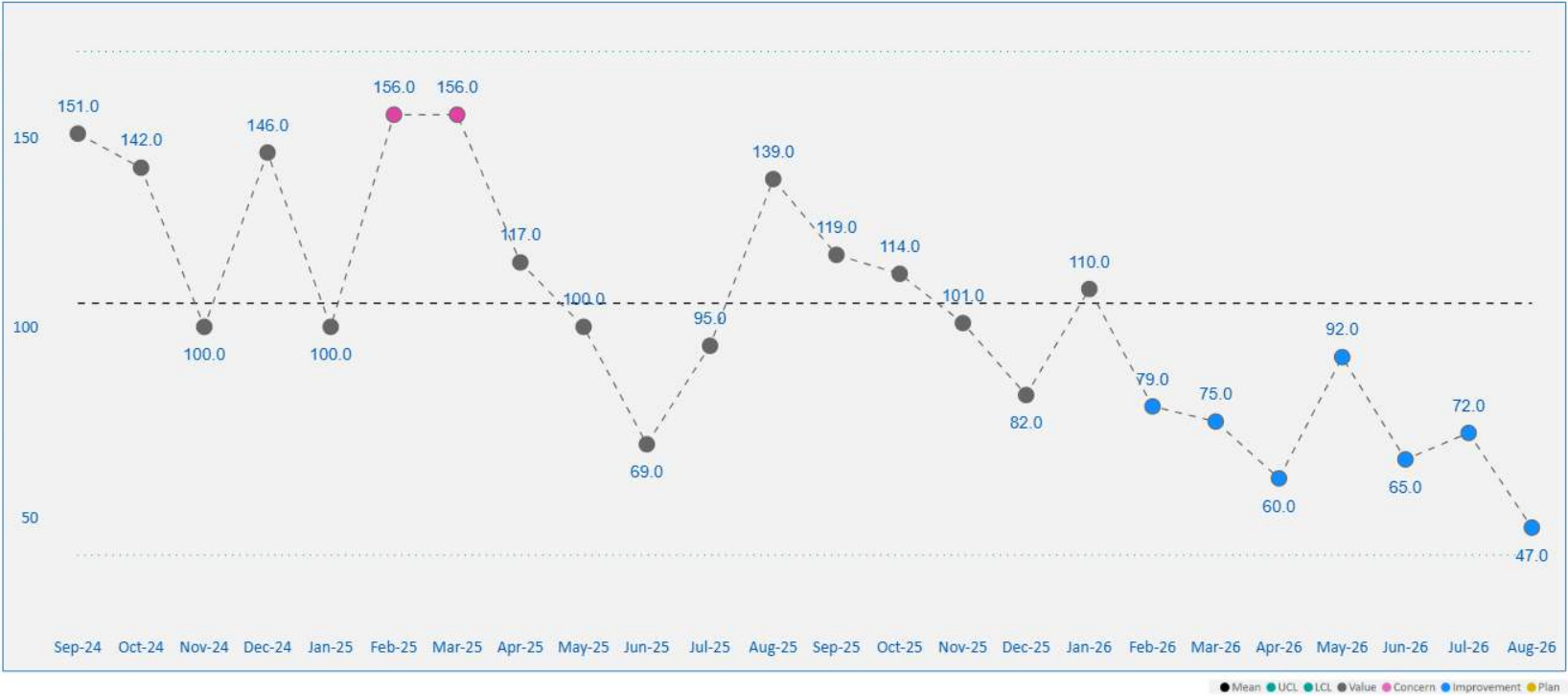
Episodes of rapid tranquilisation

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Question	Answers
A: What has happened?	For August there were 47 cases of rapid tranquilisation an decrease of 25 from last month.
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 guidance and could impact regulatory governance feedback for the organisation. Failure to consider the use of 'deltoid first' will increase
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
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 medication 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.

Harm-free Days

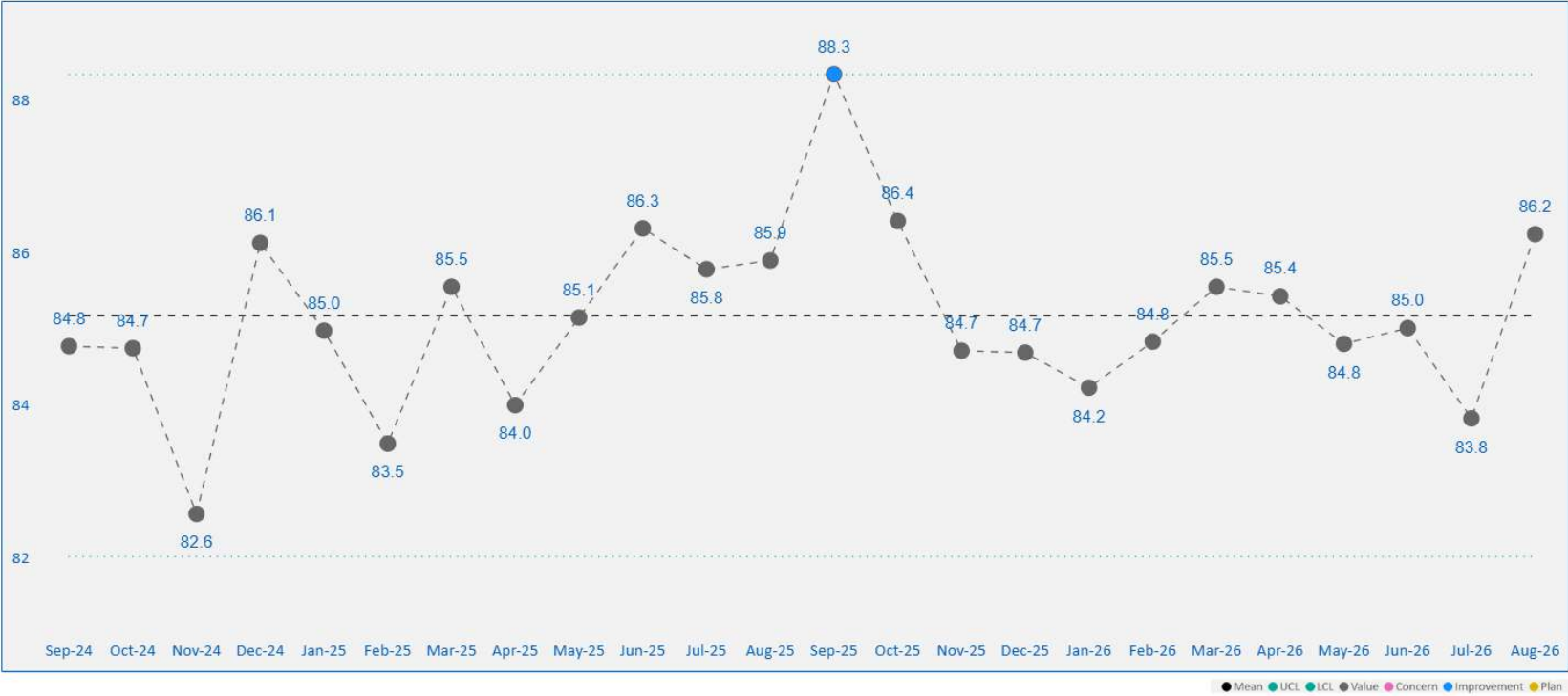
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Question	Answers
A: What has happened?	Improvement should be evidenced through named actions, accountable owners, deadlines, outcome recording, evidence of impact and agreed closure criteria. Month-on-month figures should be interpreted alongside qualitative themes and referral outcomes rather
B: Why has it happened?	The overall pattern suggests that inpatient teams have continued to embed learning from incidents, quality reviews and patient safety initiatives. The sustained use of the Eclipse incident reporting system supports an open and transparent culture, enabling
C: What are the implications and consequences?	The August position provides continued assurance that many inpatient services are maintaining high levels of harm-free care. The number of wards achieving 100% performance demonstrates that avoidable harm can be reduced through effective safety processes
D: What are we doing about it?	Harm-free day performance will continue to be reviewed through Quality Assurance Days and triangulated with incident reporting, workforce metrics, patient experience feedback and other quality indicators. Areas demonstrating deterioration or recurrent harm
E: What do we expect to happen?	We expect staff to continue reporting incidents and near misses through Eclipse and to utilise learning from investigations to strengthen patient safety. We also expect teams showing sustained high performance to maintain their standards, whilst areas expecting
F: How will we know when we have addressed issues?	Assurance will be demonstrated through sustained improvements in harm-free day performance, increasing consistency between wards, continued use of the Eclipse reporting system and evidence that reported incidents result in learning and improvement actions

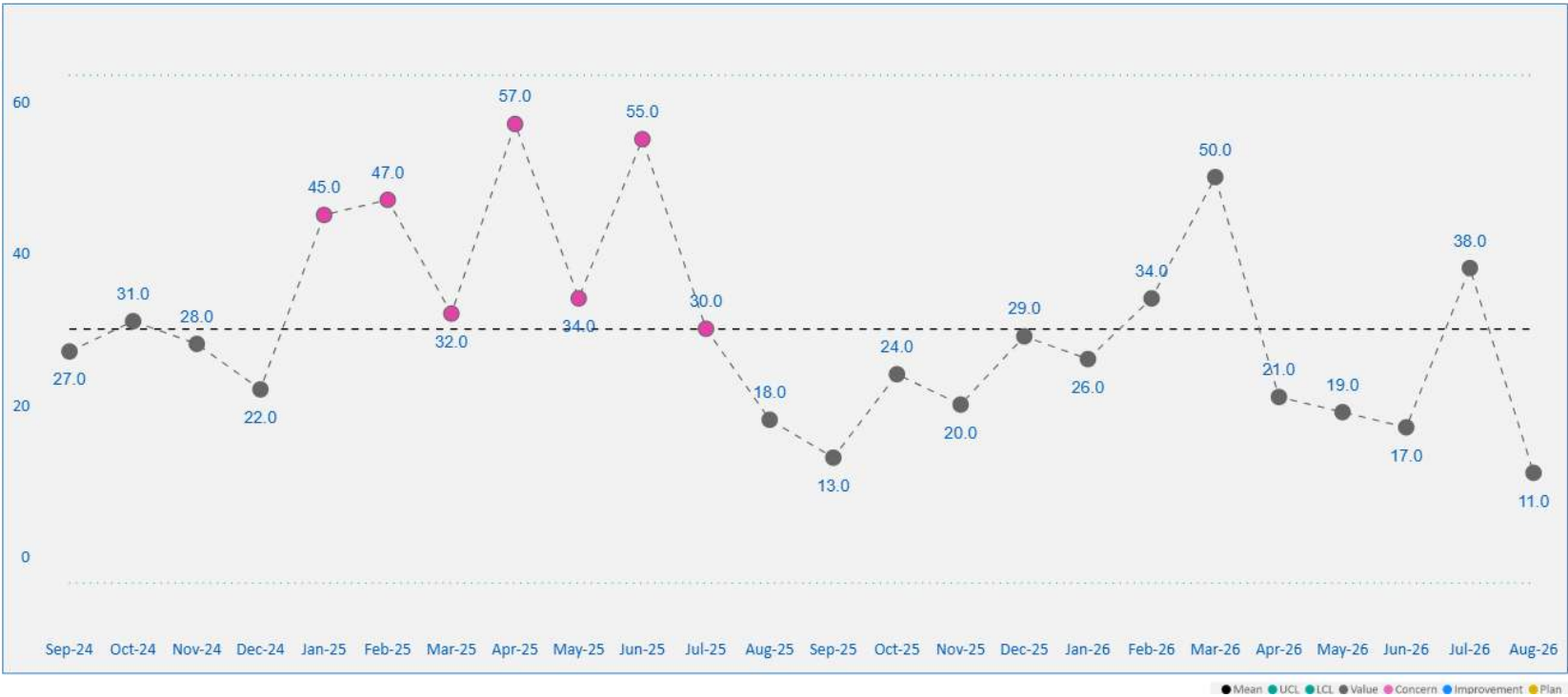
Incidents of moderate harm and above

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Question	Answers
A: What has happened?	There were 11 incidents of moderate harm recorded in August which is a reduciton from the 38 recorded in July.
B: Why has it happened?	Initial review indicates that harm has occurred in a variety of areas
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-b
D: What are we doing about it?	Post incident support continues for those affected, where needed a review of incidents will take place.
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...

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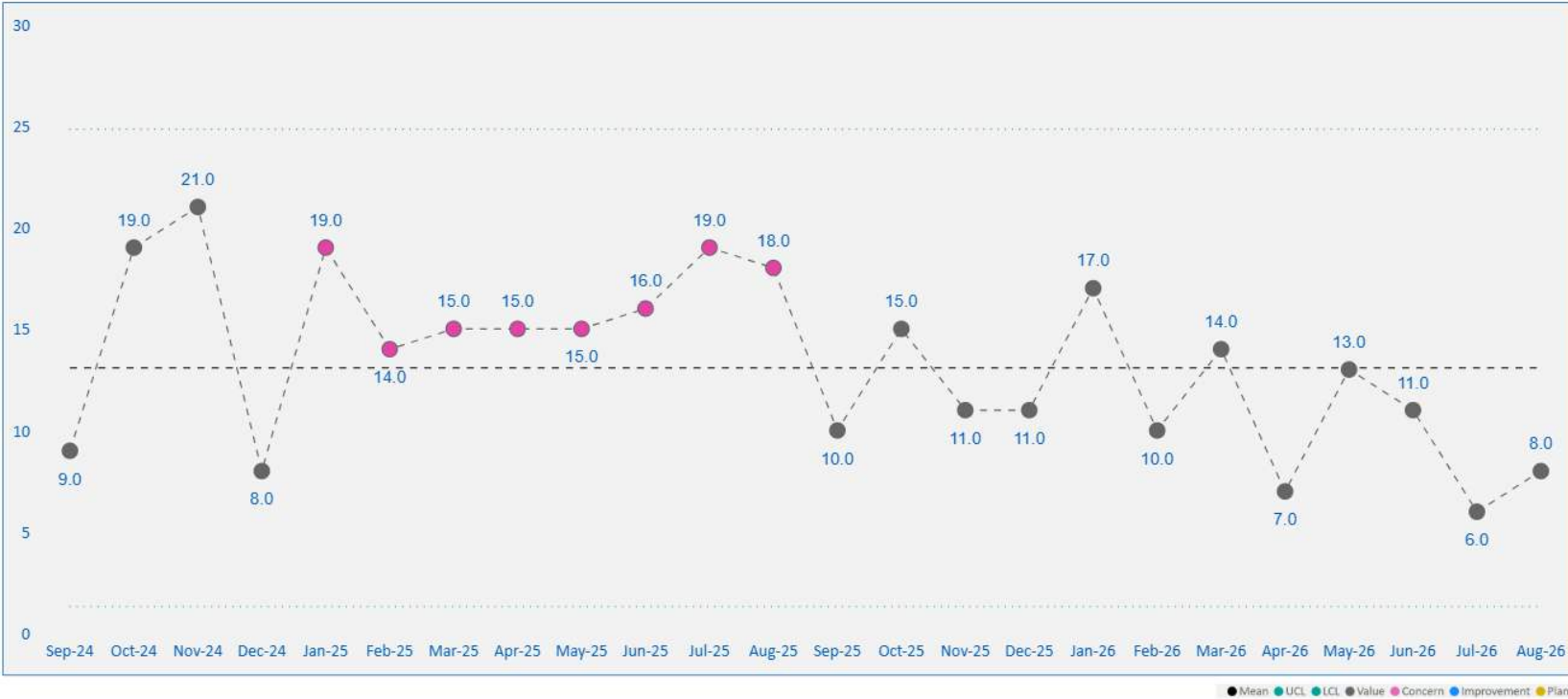
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SPC control limit
calculations are
based on data
for the last 25
months



Question	Answers
A: What has happened?	August shows a reduction moving from 6 to 8. SPC charts continue to show random variation with an improvement for the month of April July 2026. (further details awaited)
B: Why has it happened?	In April 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 Sa
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 en
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
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
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 questionnai

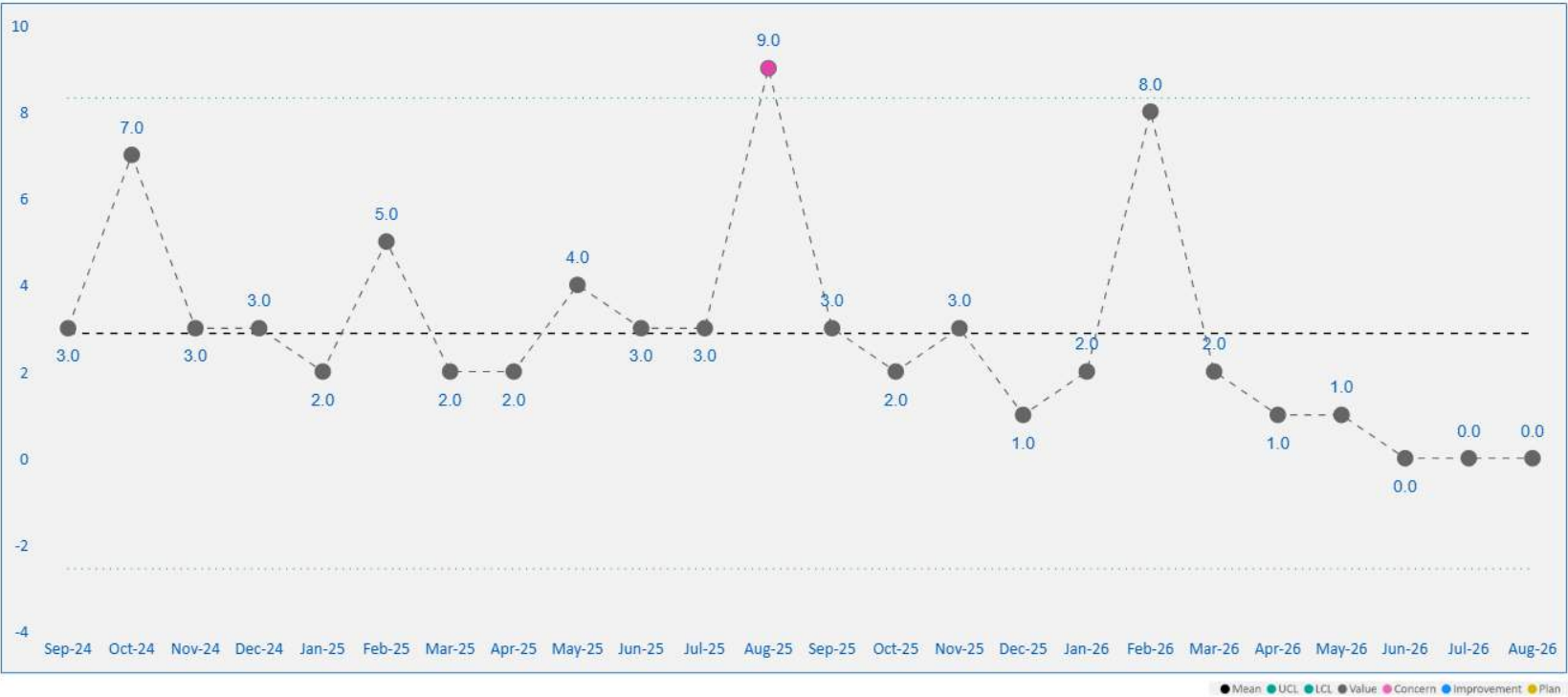
Number of Prone restraints for more than 10 minutes

August 2026

- HOME
- PERFORMANCE
- PEOPLE
- QUALITY
- SUSTAINABILITY

- Trust
- Divisions
- Services
- Commentary

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



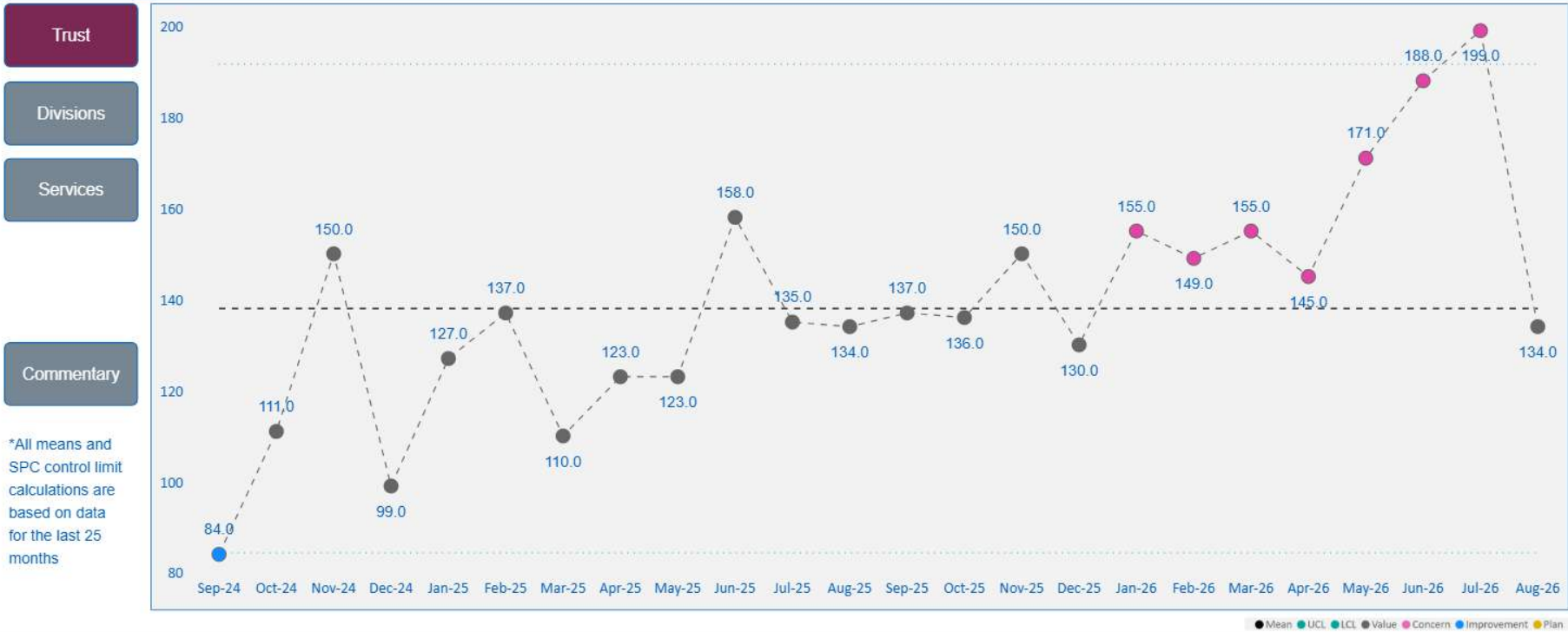
Question	Answers
A: What has happened?	There have been no prone restraints for more than 10 minutes in June /July/ August 2026.
B: Why has it happened?	
C: What are the implications and consequences?	
D: What are we doing about it?	Changes to AVERTS training and philosophy supporting Restrictive physical interventions. Review of incidents in local RRP meetings. Escalations through RRPSG. Identified workstreams for reduction of prone interventions. Deep dive into prolonged prone inte
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 appropriate subject to PSIRF review. The number of prolonged incidents should reduce over time as RRP strategies and oversight
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

August 2026



- HOME
- PERFORMANCE
- PEOPLE
- QUALITY
- SUSTAINABILITY



Question	Answers
A: What has happened?	August 26 The Integrated Performance Dashboard reported 134 safeguarding incidents for August 2026 using Incident Date. The July narrative reported 196 incidents. This is a numerical difference of 62 incidents, but the available information does not yet
B: Why has it happened?	The incidents reflect the vulnerability and complexity of service users and families. Several concerns involved overlapping risks, including domestic abuse affecting children, exploitation associated with substance misuse, and self-neglect compounded by h
C: What are the implications and consequences?	The breadth of reporting provides assurance that staff continue to identify and escalate safeguarding concerns across different services and pathways. The recurring themes of domestic abuse, self-neglect, exploitation and risks affecting children demonstr
D: What are we doing about it?	Staff used adult and child safeguarding pathways, Early Help, DASH and MARAC processes, supported by liaison with local authorities, police and other partner agencies. Records also showed safeguarding advice, risk assessment, safety planning, multidiscipl
E: What do we expect to happen?	We expect continued early recognition and appropriate escalation of safeguarding concerns, together with more consistent recording of referral pathways, agency decisions, protective actions and outcomes.
F: How will we know when we have addressed issues?	Learning and targeted support should be informed Progress will be monitored through the incident logs using incident date, routine thematic analysis, referral activity and outcomes, repeat themes, safeguarding supervision, audits and governance reporting.

NHSE 2026/27

National Oversight Framework

Quarter 1 Ratings

Published 10th September 2026

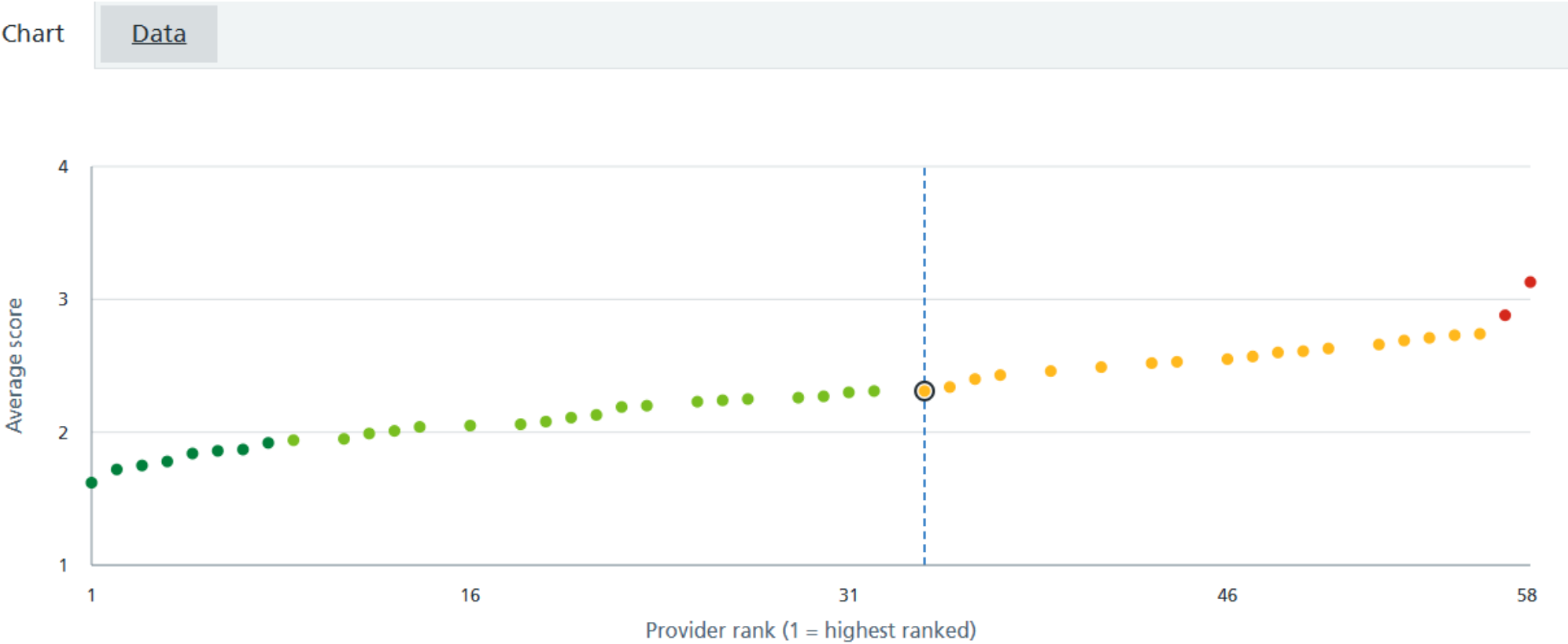
Q1 26/27 NOF Summary

Average score 2.31 Below Average and/or Financial Deficit Likely range: 1.87 to 2.68	Financial deficit Yes	Overall segment 3 Below Average and/or Financial Deficit Capped due to financial deficit
Capability rating Amber/Red	Provider rank 34 out of 58 providers Likely range: 27 to 50	

[Birmingham and Solihull Mental Health NHS Foundation Trust – Mental health and community provider – NHS Oversight Framework - NHS England public data gateway](#)

Q1 Average score - Provider Rank Placement

BSMHFT – Ranked 34 of 58 Providers



Selected organisation is marked with its segment colour, a white gap, and a black outline.

Q1 2026/27 Domain Scores & Segmentation position (published 10th September 2026)

Summary:

- Q1 segment remains at **Segment 3** (same as Q4 of 2025/26). Segment has been capped due to financial deficit & variation from financial plan.
- Q1 Trust position - ranking improves to **34 of 58** Trusts
- Q1 average metric score improved to **2.31** from 2.57 in Q4 2025/26.

Domain scores: *Experience and effectiveness have been placed in separate domains.*

- Finance, Productivity & Innovation: **Segment 1** - High Performing
- Effectiveness of care & Pop health: **Segment 1** – High Performing
- Experience of care: **Segment 3** – Below average
- Patient Safety: **Segment 4** - Low performing
- People: **Segment 3** – Below average
- Access to services: **Segment 4** – Low Performing

2026/27 NOF Metrics - Q1 ratings

Domain	Metric	Q1 Value	Q1 Rating (Public)	Q1 Rank	NOF Score	Q2 Rating (Public)	Rank Q2	Q3 value	Q3 rating (Public)	Rank Q3	Q4 value	Q4 Rating (public)
Access	% of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages combined)	n/a	Below Average	n/a	3							
	% of people accessing mental health services with at least 2 contacts and a paired outcome score (adult & Older Adults)	2.29%	Below Average	n/a	See above combined							
	% of people accessing mental health services with at least 2 contacts and a paired outcome score (CYP)	20.19%	Below Average	n/a								
	% of total Children's and Young Persons mental health patients waiting over 104 weeks for contact	25.92%	Below Average	24/58	3							
Effectiveness of care & Population health	% of acute adult discharges followed up within 72 hours	87.39%	High Performing	15/58	1							
	% of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery	No data	Contextual only	n/a	n/a							
	14-day readmission rate	No data	No data	n/a	n/a							
	% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	32.53%	High performing	7/58	1							
Patient Safety	Percentage of patients in crisis to receive face-to-face contact within 24 hours	65.8%	Below Average	37/58	3							
	NHS Staff Survey – Raising concerns sub score	6.46	n/a	48/58	3.47							

2026/27 NOF Metrics - Q1 ratings

Domain	Metric	Q1 Value	Q1 Rating (Public)	Q1 Rank	NOF Score	Q2 Rating (Public)	Rank Q2	Q3 value	Q3 rating (Public)	Rank Q3	Q4 value	Q4 Rating (public)
Experience of Care	CQC Community mental health survey satisfaction rate	6.4	Above Average	n/a	2							
	Mean length of stay for adult acute and psychiatric intensive care unit patients	70 days	Below Average	44/58	3							
	Mean length of stay for older adult acute discharges	103 days	Below Average	32/58	3							
	NHS staff survey advocacy rate	6.9	n/a	30/58	2.53							
People	Sickness absence rate	5.93%	Below Average	31/58	3.09							
	NHS staff survey engagement theme score	7.1	Above Average	22/58	2.11							
	National Education and Training Survey satisfaction rate	79%	n/a	50	2.28							
	NHS staff standards score	7.75	n/a	38/58	2.95							
	Temporary staffing cost relative band overall	n/a	High performing	n/a	1							
	Temporary Staffing Agency	n/a	High performing	n/a	1							
	Temporary staffing bank	n/a	Above Average	n/a	2							
	*Healthcare Worker Flu Vaccination Rate	31.4	Low performing	57/58	3.97							

* Flu data as of Q1 for 2025/26

2026/27 NOF Metrics - Q1 ratings

Domain	Metric	Q1 Value	Q1 Rating (Public)	Q1 Rank	NOF Score	Q2 Rating (Public)	Rank Q2	Q3 value	Q3 rating (Public)	Rank Q3	Q4 value	Q4 Rating (public)
Finance, productivity & Innovation	Combined Finance Score	n/a	Above Average	n/a	2							
	Planned surplus/deficit	0%	High performing	9/58	1							
	Variance year-to-date to financial plan	0.5-1%	Below Average	56/58	3							
	Relative difference in costs	94.7%	High performing	13/58	1							
	Data Quality Maturity Index	96.4%	High performing	13/58	1.36							
	% of clinical trials set up within 90 days	100%	High performing	1/58	1							

Appendix I FPFC 29th September 2026

NHSE 2026/27

National Oversight Framework

Update as at August 2026

Actions taken to date - summary

- Monthly performance updates provided to Trust FPPC, Executive Team, Local Divisional FPPCs and Operational Management Team focusing on areas of underperformance and recovery action planning.
- Monthly updates are also being provided to NHSE and to the ICB.
- All indicators have an allocated Executive Lead and Service/Management lead responsible for oversight and improvement planning where required. Support also provided by the Performance and Information Team to all areas regarding guidance requirements, definitions and application.
- Areas of improvement have been identified with action plan requested for new metric areas.
- For existing improvement metrics (those in place in 2025/26) action plans remain an area for continued oversight on progress and recovery.
- Local reporting developed or in development for some areas.

Performance report as at end August 2026 on NOF metrics where internal improvement is required.

Improvement metrics to date include:

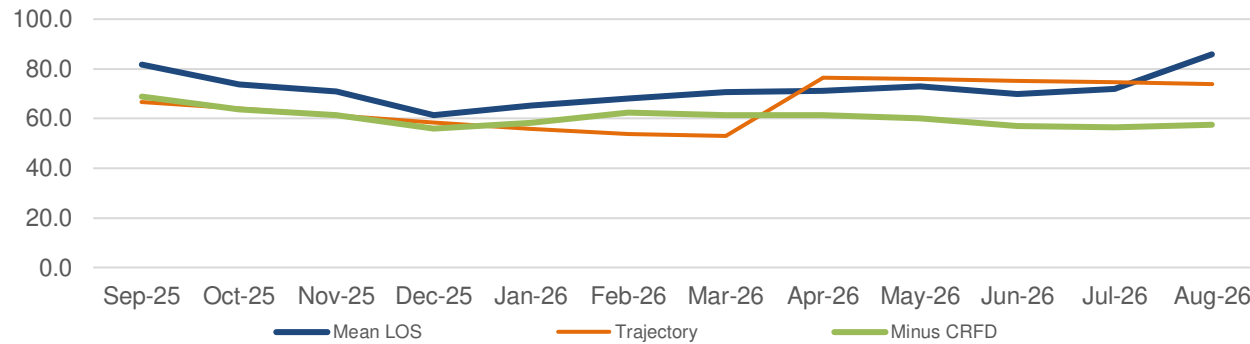
- Percentage of patients in crisis receiving face-to-face contact within 24 hours.
- Reducing Length of Stay for Adult and Older Adult services
- % of total open CYP MH related waits that are over 104 weeks
- Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages)
- % of acute mental health admissions with no contact with community mental health services in the previous year- ICB metric.
- % of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages)
- Sickness absence rate
- Percentage of NHS Talking Therapies patients completing a course of treatment and achieving reliable Recovery
- Temporary staffing relative cost band
- Finance metrics – see finance report for detail

Metrics based on national comparative assessment as follows:

- Percentage of % of clinical trials set up within 90 days
- NHS Staff survey Advocacy rate
- NHS staff standards score – not yet published
- Healthcare worker Flu vaccination rate
- % of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service
- Data Quality Maturity index score
- Adult inappropriate out of area placement bed days as a % of all bed days. ICB metric

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

Adult Acute Length of Stay 2026/27 trajectory (3 month rolling)



- As at August 2026, 3-month rolling average for LOS is at 85.9 days, above trajectory. Trust performance in NOF Band 4.
- CRFD impact on LOS remains a continuing challenge - see chart. Without CRFD, performance would move to Band 3.
- 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 of actions where appropriate.
- Granular level patient data provided to support operational and clinical oversight.
- **Q1 2026/27 national rating: Band 3, average LOS at 70 days.**
- Trust will return to Band 4 in quarter 2 based on July and August position this has been impacted by a 5 service users discharged with long lengths of stay (the longest of which was 2196 days) which has contributed to the increase in the last quarter.

Performance band	1	2	3	4
Length of Stay thresholds	0-40	41-49	50-70	71+

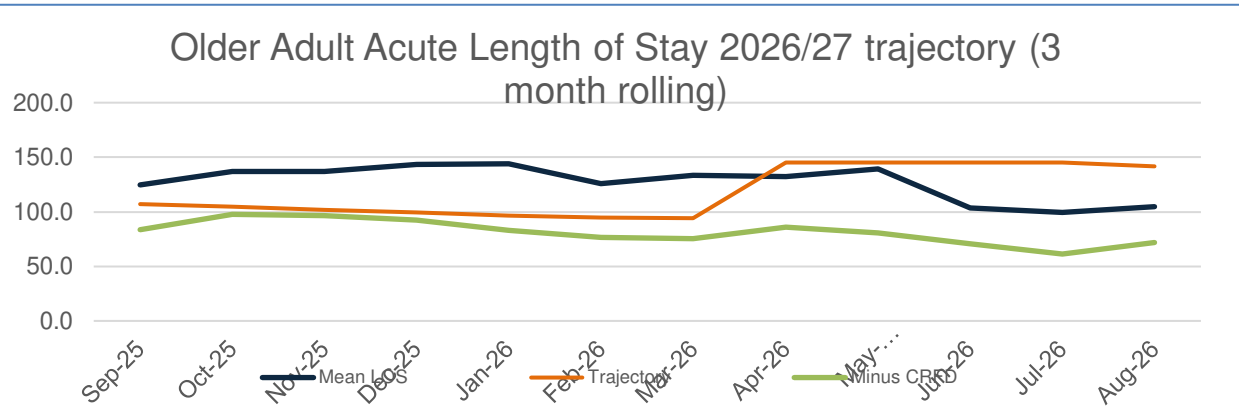
Methodology:

- Patients discharged from an acute or PICU bed
- Entire BSMHFT inpatient spell
- Transfers between bed types continue a spell (eg if a patient transfers from a rehab bed to an acute bed then the rehab length of stay is included).
- Includes leave
- Rolling 3 month view

Mean length of stay for Adult Acute and PICU

- Length of stay continues to be significantly impacted by the number of CRFD patients awaiting placement and support arrangements. Actions already underway include:
- Daily patient flow oversight through operational escalation processes.
- Enhanced focus on patients with extended lengths of stay through patient flow meetings.
- A policy to support patient choice has been approved
- Strengthened partnership working with Local Authorities and community providers to reduce discharge delays.
- Jenny Watson, Deputy Director of Commissioning and Transformation MHPC as the CRFD has developed a targeted action plan based on reasons for delay with BCC – The plan was shared and discussed at Trust FPPC in July.
- Continued implementation of the Productivity and Patient Flow Improvement Programme. Rapid improvement actions are reviewed weekly, with ongoing repatriation where appropriate.
- Executive oversight of CRFD cohorts and escalation of systemic barriers where required.
- The expectation is that these actions will support a gradual reduction in adult length of stay over the course of 2026/27, although performance remains highly dependent on system capacity and social care availability.

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

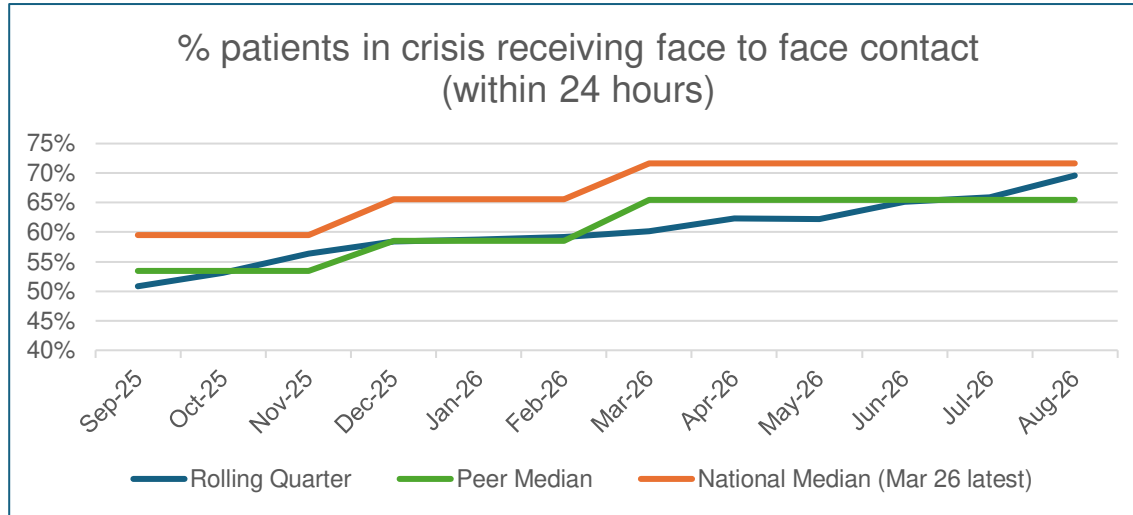


- As at August 2026, 3-month rolling average for older adult LOS is at 104.8 days, below trajectory – NOF Band 3.
- LOS significantly impacted by CRFDs - see chart, the majority of CRFD patients are waiting for a bed within a care home. Without the impact of CRFDs, performance would improve to Band 1.
- 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.
- Transformation improvement plan developed aimed at improving patient flow and earlier discharge of dementia and frailty patients linked to the CRFD action plan.
- Trust will remain in NOF band 3 without a step change including reductions in CRFD levels.

Performance band	1	2	3	4
Length of Stay thresholds	0-73	74-93	94-125	126+

Methodology:

- Patients discharged from an older adult acute bed
- Entire BSMHFT inpatient spell
- Transfers between bed types continue a spell (eg if a patient transfers from a rehab bed to an acute bed then the rehab length of stay is included).
- Includes leave
- Rolling 3 month view



- Internal local Trust data shows continued improvement, the rolling 3-month average performance is at 69.6% as at end August – remains in NOF Band 3.
- Improvement trajectories confirmed with the following services:
 - CYP CRHTT to reach 80% by end of September and sustain thereafter = Band 1 performance.
 - Adult HTT to reach 72% by end September, 79% by Dec 2026 and sustain thereafter = Band 2 performance.
- The Combined effect will be to move the trust to 74% (NOF Band 2) by September 26, and 79% by December 26 onwards (NOF Band 2).

Performance band	1	2	3	4
Thresholds	80%	71-79%	45-70%	<44%

Methodology:

- Denominator based on crisis referrals received by Crisis Resolution / Home Treatment services
- Numerator based on patients with an attended face to face contacts within 24 hours of the referral being received.

Rolling 3 month view

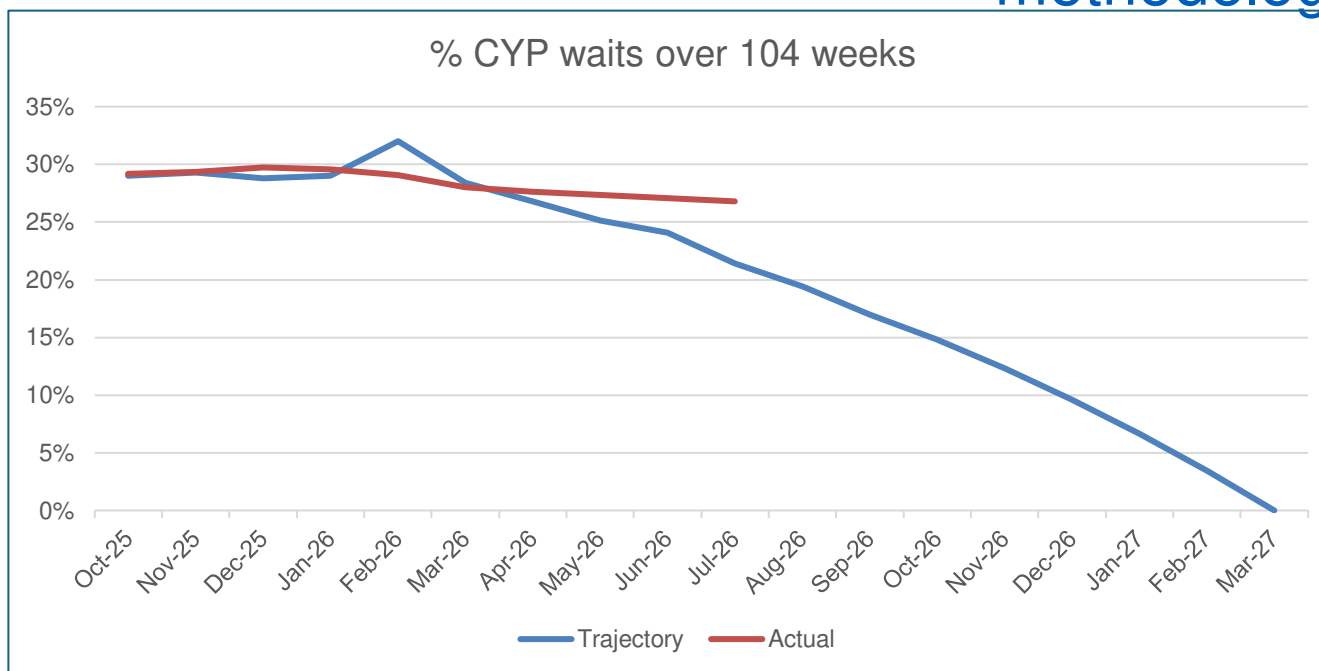
August 2026 - monthly data :

- Adult acute HTT at 75% - above August trajectory of 70%.
- CYP CRHTT is at 72.3% - significant improvement on previous month but below August plan of 80%. Recovery Plan being implemented.
- Solar at 50% (very small numbers)
- Local granular level data reports available to teams and clinicians to enable proactive action.
- Data quality work continues to be a focus.
- Summary of service action plans outlined on slides 9 and 10.

- **Shift Coordinators:** Record the time of referral on the crisis board and include it in the allocation sent to the crisis nurse, to maintain visibility of the 24-hour timeframe.
- **Duty/Shift Coordinator:** Add a RIO entry documenting the time the referral was received.
- **Crisis Nurse:** Ensure the diary outcome reflects the actual time of the assessment, not the time the entry is recorded. Add detail eg re Cancellations/Patient Declines to explain why appointment did not take place.
- Updating referrals to capture correct date/time + priority to ensure breaches are true breaches.
- Validating where contact took place but no appointment in diary.
- Ensuring PLT referrals are treated as trusted.
- Weekly review of breaches at the new UC leadership meeting and Operational validation.
- Validation and update for any error in the NOF to be completed in timely way – aligning to reporting.
- Reasons for breach to be tracked in detail and common themes to be circulated & eg identify training needs.
- True breaches to be captured and discussed by clinical leads.
- Bank staff unable to get access to caseload in a timely manner – Being explored via ICT.
- Noted challenges within CAMHS business continuity management of high caseloads, double and triple figures
- CAMHS Screening in hours may change crisis referral to non urgent following clinical assessment.

- Weekly performance monitoring through HTT operational meetings.
- Review of pathways and demand profiles at Urgent care Pathways Group - use of Urgent Care Dashboard.
- Referral categories aligned to service function: Emergency, Very Urgent, Urgent and Planned Support
- Standardised clinical triage using the UK Mental Health Triage Scale and HTT triage tool.
- SPOA referral form updates and targeted communication with GPs/referrers
- Daily operational grip through Rio live 24-hour clock reporting and team manager action/assurance.
- Identification and sharing of best practice across localities.
- Continued oversight and learning working with performance colleagues to ensure action planning on track, trajectories remain realistic and deliverable throughout 2026/27.

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



- 2025/26 baseline position of 1085 service users.
- As at August, 794 patients waiting over 104 weeks (CYP at 587 and Solar at 206), representing 25% of all waits over 104 weeks - Trust NOF position remains in Band 3.
- As at August, both services are behind in their planning trajectories as submitted to NHSE for 2026/27 - Solar have 206 service users over 104 weeks, above trajectory of 118 for August and CYP have 587 service users over 104 weeks, above trajectory of 433.
- Summary of action plans on Slides 12 and 13.
- 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 has been affected by non inclusion of data prior to the CYP transfer in July 2025 due to the break in MHSDS submissions. Going forwards this should no longer impact on this metric.

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

Methodology

- Percentage of open CYP mental health waiting time periods for patients that had waited over 104 weeks from waiting period start date.
- Excluding waiting times only for neurodevelopmental conditions, autism, or gender discomfort issues.
- Monthly view
- Applies to CYP and Solar services
- Based on proportion waiting (planning guidance based on reduction in numbers)

2025/26 Planning submission - to get to zero over 104 weeks by end March 2027. Reducing mental health waits is part of the service's overall priority to reduce and manage waiting times.

- SOLAR Remedial Action Plan (RAP) governance is fully established, with weekly progress meetings and performance reviewed through fortnightly RAP/KPI meetings and FPP.
- A phased recovery approach is in place, covering workforce mobilisation, waiting-list validation/cleansing, caseload flow, recording, reporting and productivity monitoring.
- Workforce capacity is the principal delivery constraint, with recent leavers, vacancies and recruitment timelines limiting the pace of assessment and recovery activity.
- Performance improvement remains dependent on recruitment, effective deployment of existing capacity, demand management, improved data quality and resolution of procurement and workforce dependencies.
- The Triage and Assessment Team is fully operational, providing dedicated experienced assessment capacity to reduce initial waits and strengthen early formulation.
- Demand and capacity are being actively reviewed against agreed job plans, with substantive, bank and partner capacity mapped against expected activity and emerging productivity.
- Admin teams are proactively reviewing forthcoming appointments to identify missing documentation, with clinical leads supporting completion where gaps could affect 4-week compliance. RiO recording and data quality are being strengthened.
- Screening and access arrangements remain a core recovery priority, ensuring CYP are directed to the most appropriate provision at the earliest opportunity and maximising commissioned and VCFSE support.

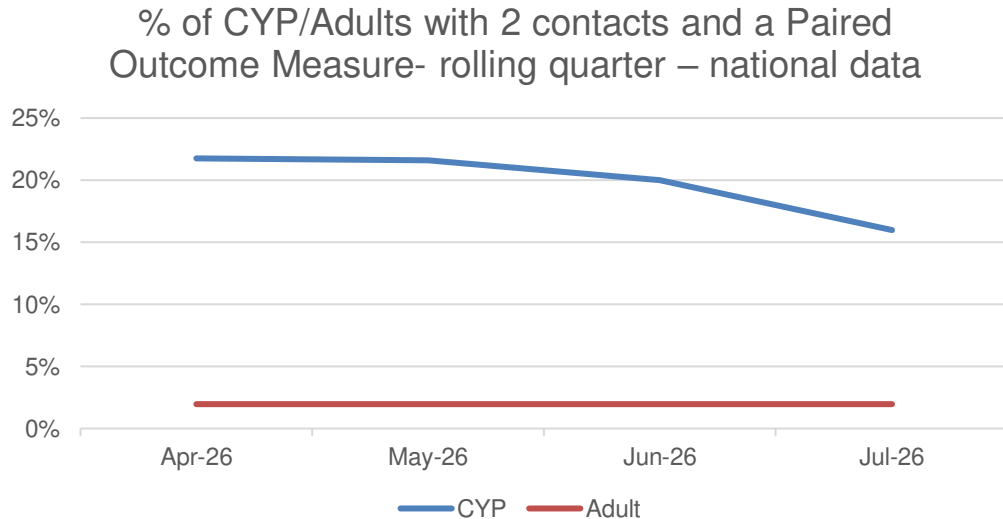


- 2025/26 Planning submission - to get to zero over 104 weeks by end March 2027. Reducing long waits is part of the service's overall priority to reduce and manage waiting times.
- Without improvement in recording of outcome measures, the planning trajectory will be challenging to deliver by end March 2027 and maintain thereafter.
- Current performance escalated by CYP AD as a priority area for action in PAP discussion due to challenges with capturing paired outcome measures. Following escalation, discussions arranged with the Deputy Medical Director to support proposal to establish AD's and AMD's (CYP and ICCR) to come together with joint working established at pace to identify key actions aligned to working within the leadership accountably framework. High levels of non face to face medic reviews impact the ability to provide outcome measures to be completed (level of Non face to face contacts due to be discussed at clinical senate)

Actions include:

- Dedicated fortnightly performance meeting to track clock stop performance & trajectory, review missed opportunities and highlight patients due to attend in next 2/52 for outcome measure completion.
- Outcome measures are being sent in advance along with appointment reminders via AccuRx
- Service level data validation is continuing as part of recovery action plan discussions including review of SNOMED code usage .
- The Learning Disabilities team have the highest number of potential 104-week breaches and are being supported by the Bronze/Silver/Gold framework

% of people discharged from community MH services with a paired outcome score recorded (all ages) – **national data**



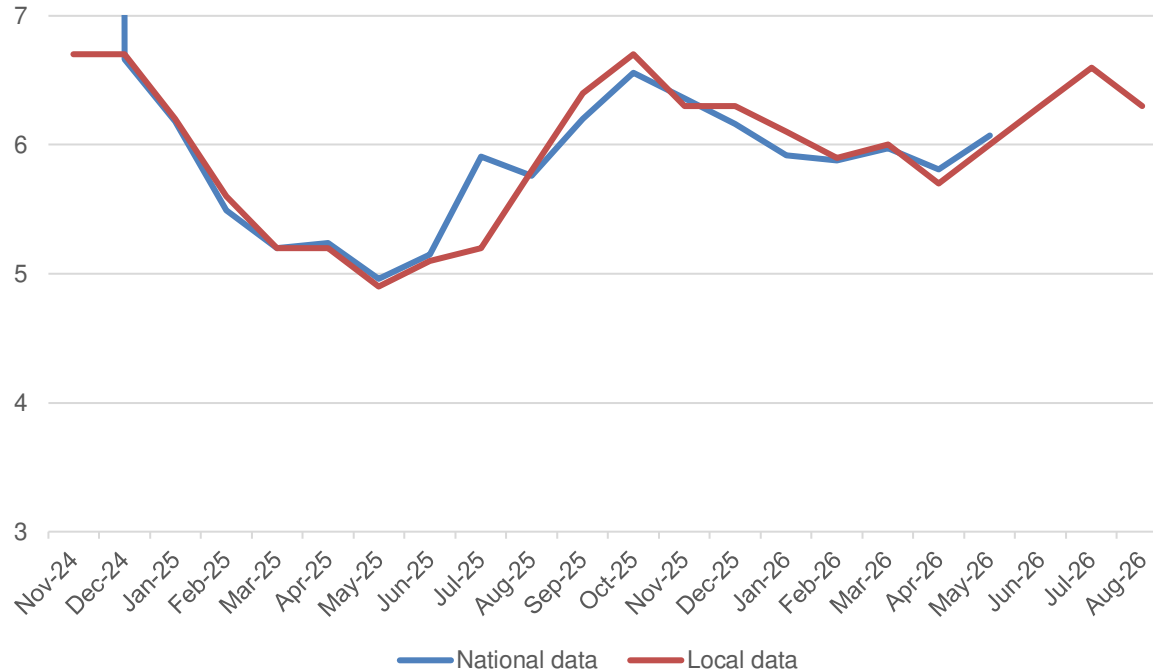
		CYP metric score			
		1: ≥28%	2: 20–27%	3: 13–19%	4: ≤12%
Adult metric score	1: ≥12%	1	2	2	3
	2: 8–11%	2	2	3	3
	3: 4–7%	2	3	3	4
	4: ≤3%	3	3	4	4

Methodology:

- Numerator: Number of patients discharged with paired outcome measures
- Denominator: the number of patients discharged in the quarter with 2+ contacts
- Reported as a percentage on a rolling quarter
- The data is calculated separately for adults and CYP as the outcome measures are different for the different age groups, the individual scores are then aggregated to give an all-age score.
- **Q1 national rating confirmed as Band 3 with adults at 2.2% (Band 4) and CYP at 20.19% (Band 1).**
- Latest available national data is at July 26, CYP service declining to 16%.
- Local reporting is in development.
- Improvement relies on a step change in the recording of outcome measures across both services.

Sickness Absence rate- Monthly view

Sickness Absence Rate: national and local data - monthly



Sickness Absence rate – NOF data source is ESR published monthly on NHSE Digital website.

The NOF indicator is based on quarterly figures.

Q1 2026/27 latest available national data published Jan-Mar 2026

Trust value: 5.93% (Band 3)

This represents an improvement on quarter 4 2025/26 which was at 6.36%.

The latest monthly national data available for the Trust is for May 2026 at 6.07%.

Local Trust data as August is at 6.3%.

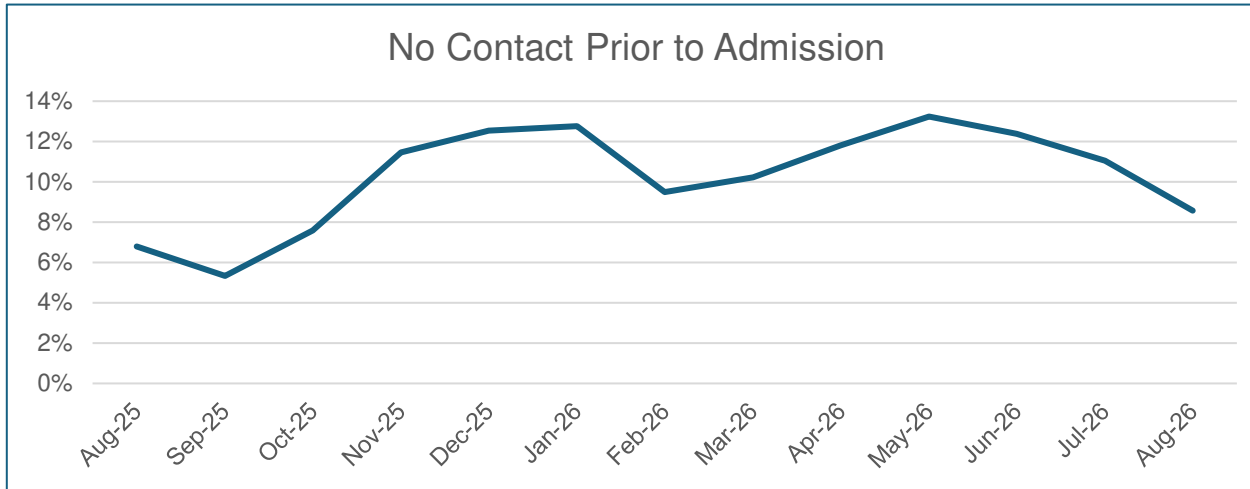
Good alignment between national and local data (see chart).

Unable to replicate NOF national assessment regarding performance banding.

Methodology:

- National data published monthly in arrears – latest available data is March 2026
- Numerator: FTE number of days sick (including non-working days) in the period
- Denominator: FTE number of days available in the period
- Exclusions: Exclude type of Contract: Bank, Honorary, Widow/Widower
- NOF Scoring methodology – Organisations ranked evenly between 1-4 based on 3 month rolling average rate of sickness absence.

% of acute mental health admissions with no contact with community mental health services in the previous year- ICB metric



- BSMHFT at 9% for August 2026 moving to NOF Band 2 if sustained, represents a reduction of 2% since July.
- Acute and Urgent care have undertaken an initial review indicating this reflects broader pathway and access issues across urgent care pathways. Further detailed analysis is being undertaken to understand the population cohorts contributing to this measure and identify opportunities to increase earlier engagement with community mental health services prior to crisis presentation.

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

Methodology:

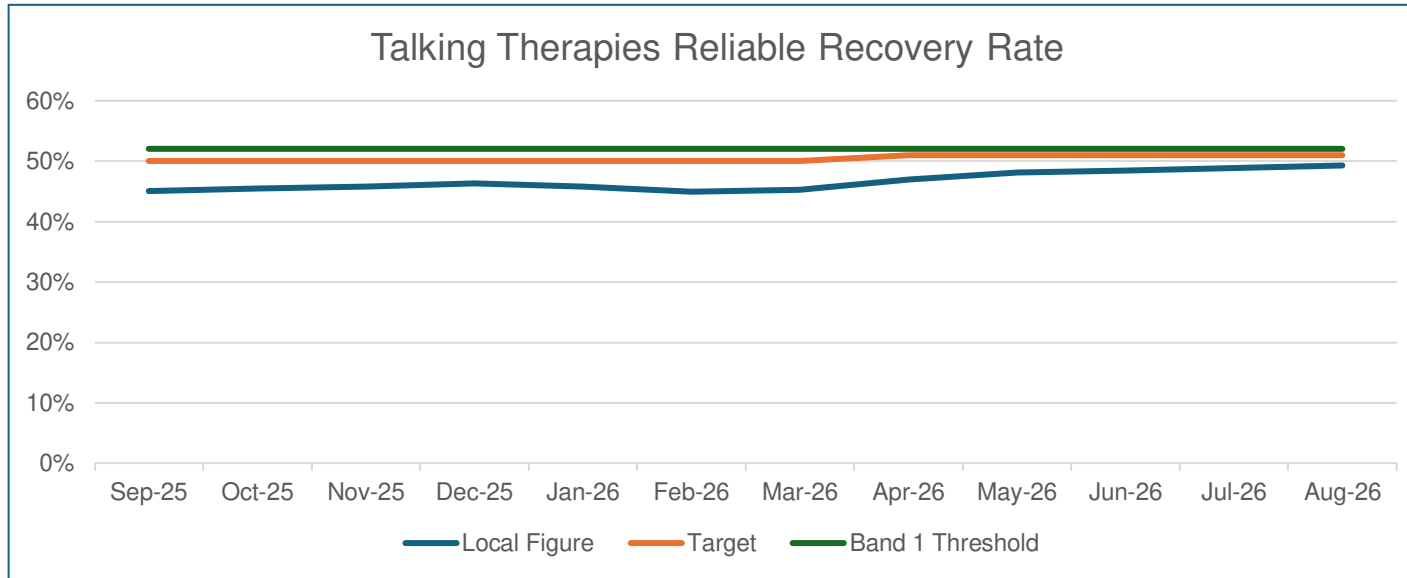
- Denominator based on admissions to adult acute, PICU or older adult beds
- Numerator based on patients who did not have an appointment with BSMHFT in the 12 months prior to admission
- Rolling 3 month view
- ICB Scoring metric

Proposed Plan work in place to confirm:

Establish a cross divisional working group to agree potential areas of focus include:

- Strengthening links between community and urgent care services.
- Earlier identification of deterioration and relapse indicators.
- Improved follow-up arrangements following urgent care contacts.

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



Performance Band	1	2	3	4
Thresholds	>52%	50-51%	47-49%	≤ 46%

National Methodology:

Numerator: Of the denominator, referrals that have showed reliable recovery (service user moved to recovery and shown reliable improvement).

Denominator: Count of referrals finishing a course of treatment minus those finishing a course of treatment who were not at 'caseness' at initial assessment.

Chart is – 3 month rolling average in line with NOF metric

- Since March 2026 Trust performance (Birmingham Healthy Minds) has been on an improving trend with August performance remaining at 49% based on rolling quarter. This however remains below the national standard of 51% and places the Trust in Band 3 NOF performance.
- Based on latest monthly view, August 2026 performance showing a reduction to 46.4%.
- Q1 forecast Band 3 performance with an average of 49%.
(national Q1 data on the metric yet to be published)
- This NOF metric is now **contextual (non scoring)** for 2026/27.
- BHM's recovery action plan in place, previously reported at FPPC. See Appendix II for summary.

National Oversight Framework: Annual NHS Staff Survey measures – Staff Standards

Selected question scores for each standard are averaged to provide six individual scores which are then further averaged to produce an overall trust score

The trust score based on the 2025 staff survey is 7.75 / 10. The national median at 7.77.

The metric is based on the individual scores covering 6 standards which are then aggregated to give an overall average score:

The 6 standards and their average scores are outlined below along with a colour coding which reflects the performance for each area

Line Management	7.24
Health and Wellbeing	5.91
Violence prevention & Reduction	9.02
Championing Sexual safety	9.58
Tackling racism	7.71
Promoting flexible working	7.02

Notes:

- Based on the annual staff survey.
- Latest data available: 2025 survey
- New staff survey metric added for 2026/27 – **NHS Staff standards Score**
- The trust score based on the 2025 staff survey is 7.75 / 10 with the national median at 7.77.
- The NOF Q1 score at 2.95.
- Unable to replicate national methodology.

Finance domain assessment

National Oversight Framework 2026/27	YTD Actual £'000					Forecast £'000			Commentary
	M1	M2	M3	M4	M5	Q2	Q3	Q4	
NOF - Finance									
NOF variance YTD to plan score	4	4	3	3	2	2	2	1	Scoring methodology: based on variation to plan as % of YTD income. Month 1 and 2 variance was beyond 1% adverse = score of 4. Month 3 and 4 improvement to a score of 3 (between 0.5% and 1% adverse). Improvement in month 5 to a score of 2 (less than 0.5% adverse). Significant improvement required on savings delivery, non-trust beds expenditure, bank and medication spend to achieve forecast score of 1 in line with break even plan by year end.
NOF plan surplus/deficit score	1	1	1	1	1	1	1	1	Scoring methodology: Break even plan = score of 1. The plan set for 2026/27 is break even, therefore, this metric will remain at 1 all year.
NOF combined finance score	3	3	2	2	1	1	1	1	Scoring methodology: YTD variance to plan and plan score plotted on 16 box grid to determine combined finance score.
NOF - Productivity									
Relative difference in costs score	1	1	1	1	1	1	1	1	Scoring methodology: National Cost Collection score of 100% or less = score of 1. The latest published National Cost collection score (2024/25) is 95%. The indicative 2025/26 score is 97.5%. Hence it is assumed this metric will remain at 1 all year.
NOF Finance & productivity domain score	2	2	2	2	1	1	1	1	Currently assumed to be average of combined finance score and relative difference in costs score as per 2025/26 methodology. Awaiting confirmation of 2026/27 methodology.

Implied productivity growth is an additional metric for 2026/27. This is non-scoring and work is underway to understand and assess this metric.

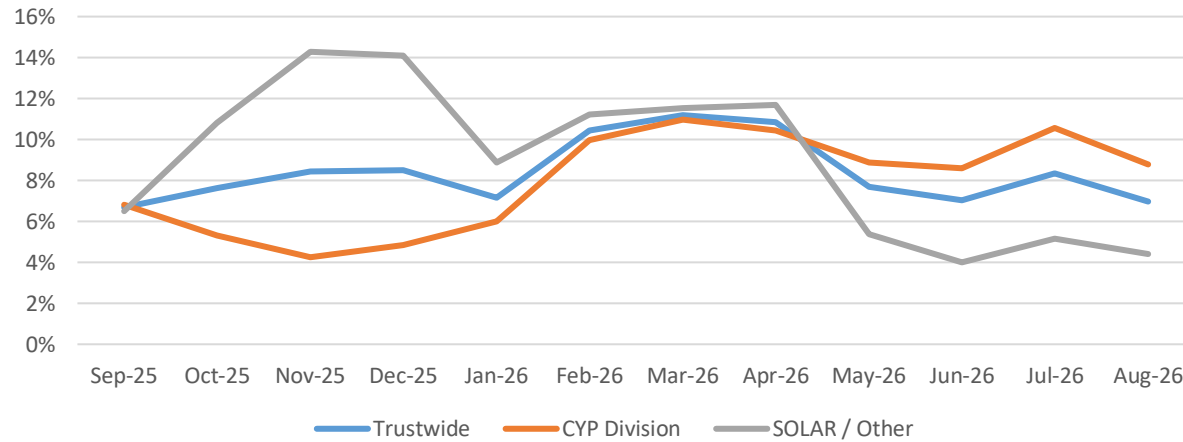
Temporary staffing cost relative band

National Oversight Framework 2026/27	YTD Actual £'000					Forecast £'000			Commentary
	M1	M2	M3	M4	M5	Q2	Q3	Q4	
NOF - People									
Bank score	2	2	2	2	2	2	2	1	YTD bank expenditure is £3.5m adverse to plan and bank spend as a % of total pay is 8.5% compared to the plan of 6.2%. <u>Scoring methodology:</u> overall bank spending as % of total pay is above average and forecast spend is on track to meet target = 2. Awaiting clarification from NHSE but current assumption is that the average equates to NHSE ceiling. If forecast worsens to be adverse to NHSE ceiling, score would move to at least 3. This is a significant risk given current level of overspend. <u>Key Actions to reduce bank spend:</u> The Bank Reduction Gold project is ongoing, led by the Chief Nurse - monthly monitoring with service areas. Introduction of Acute recovery plan, implementation of auto roster, review pathway for enhanced therapeutic observations and care (ETOC), streamlining HR processes including converting bank to substantive, graduate recruitment into vacant posts from September, sickness reduction and health and wellbeing action plan.
Agency score	1	1	1	1	1	1	1	1	YTD agency expenditure is £0.4m less than the NHSE ceiling and agency spend as a % of total pay is 0.6% compared to the plan of 0.9%. <u>Scoring methodology:</u> overall agency spending as % of total pay is below average and spend is on track to meet target = 1. We are awaiting clarification from NHSE but current assumption is that the average equates to NHSE ceiling. It is forecast that the agency underspend will continue for the remainder of the year, with a score of 1.
Temporary staffing cost relative band	1	1	1	1	1	1	1	1	<u>Scoring methodology:</u> bank and agency score plotted on 16 box grid to determine temporary staffing cost relative band score.

Temporary staffing					
		Agency			
Bank		1	2	3	4
	1	1	1	2	3
	2	1	2	2	3
	3	2	2	3	4
	4	3	3	4	4

- Slides 22-25 below outline current Trust performance.
- CYP waits – 50% of referrals to be seen within 4 weeks by end March 2027: This ambition will not be met without transformative action regarding demand management, commissioned capacity and recording of outcome measures. Current baseline indicates that 7% are seen within 4 weeks. Service Leads have confirmed that this ambition will not be met by March 2027 without a step change in demand management, commissioned capacity, recording of outcome measures and transformation of care pathways. Regular meetings are in place within services to review performance but requires step changes in the above areas to improve. Initial priority is also to focus on reducing long waits in line with the NHS Planning submission.
- Referrals to Liaison Psychiatry for People Known to Services – Current baseline indicates 58% of service users being known to services. Further detailed work across pathways is proposed including further data analysis looking at population cohort, geography area, age group, gender and ethnicity.
- Reduction in Acute Inappropriate Out of Area Placements - BSMHFT target is 1 inappropriate acute patient by March 27. Trust local target is to have zero inappropriate out of area placements by March 2027. Established action plan supported by daily and weekly meetings in place.

CYP Wait Times - 4 Week Waits (3 month rolling)



Methodology:

- Target is 50% within 4 weeks by March 2027.
- Denominator is CYP referral spells with a full clock stop in the reporting period.
- Numerator is CYP referral spells where the clock stop was within 28 days of the spell start.
- August 2026 Trust position at 7%, a 1% decrease from July

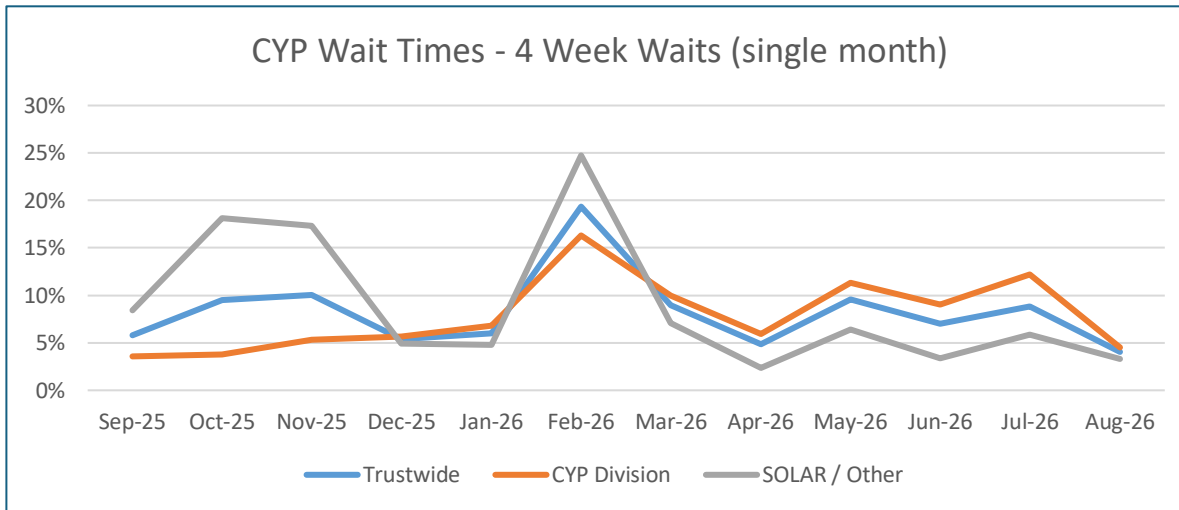
** Referral spells are continuous care spells, potentially across several teams, starting on receipt of an external referral with a mental health element within the spell.

Key issue is recording of outcome measures at initial / early contacts to stop the clock according to national definitions

Trustwide	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Within 4 Weeks	51	57	65	61	54	81	95	91	64	62	71	53
Clock Stops	762	746	770	717	755	775	850	838	831	880	851	761
Performance	7%	8%	8%	9%	7%	10%	11%	11%	8%	7%	8%	7%
CYP Division	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Within 4 Weeks	31	23	19	21	27	47	58	58	49	50	53	39
Clock Stops	454	432	448	433	451	472	529	556	552	581	501	444
Performance	7%	5%	4%	5%	6%	10%	11%	10%	9%	9%	11%	9%
SOLAR/Other	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Within 4 Weeks	20	34	46	40	27	34	37	33	15	12	18	14
Clock Stops	308	314	322	284	304	303	321	282	279	299	350	317
Performance	6%	11%	14%	14%	9%	11%	12%	12%	5%	4%	5%	4%

Mental Health Priority Actions:

(Single month) % of CYP MH related waits completed within 4 weeks (help/intervention-based clock stop and referral spells methodology)



Methodology:

- Target is 50% by March 2027.
- Denominator is CYP referral spells with a full clock stop in the reporting period.
- Numerator is CYP referral spells where the clock stop was within 28 days of the spell start.

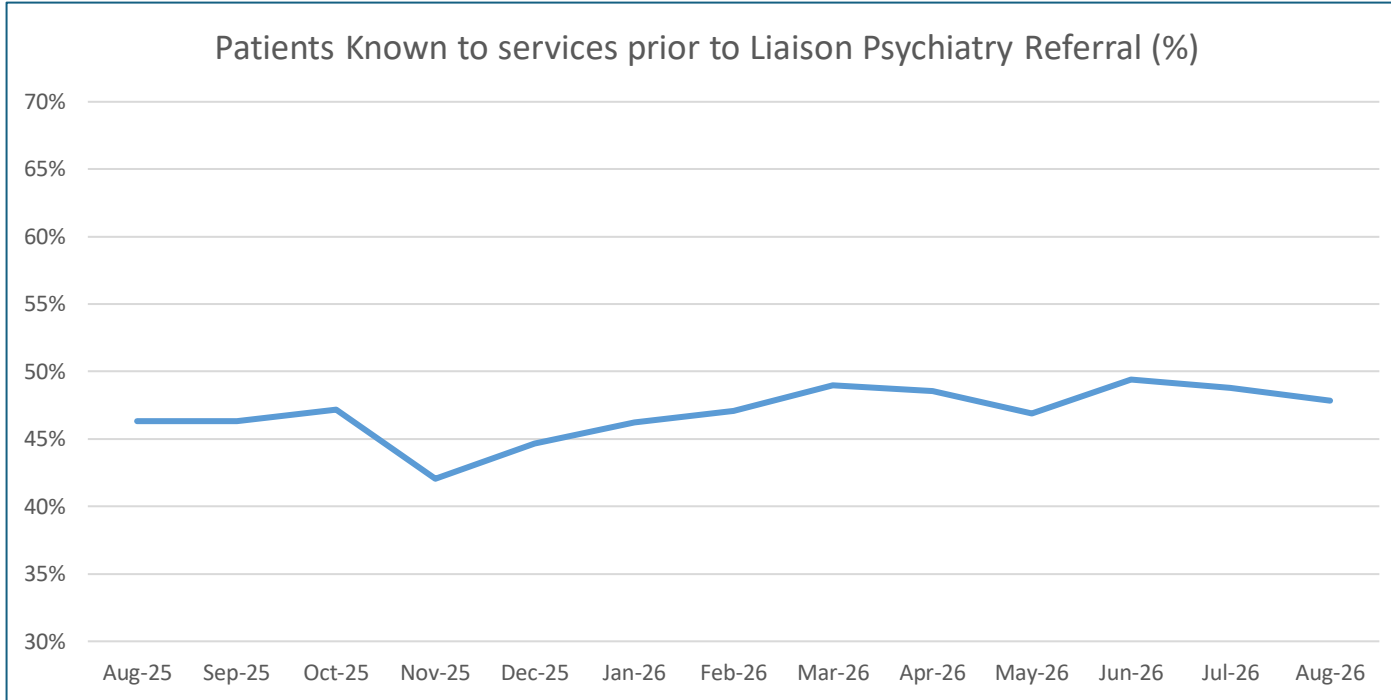
****** Referral spells are continuous care spells, potentially across several teams, starting on receipt of an external referral with a mental health element within the spell.

Solar at 3% and CYP at 5% for August 2026, both showing a deterioration

Trustwide	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Within 4 Weeks	15	25	25	11	18	52	25	14	25	23	23	7
Clock Stops	258	263	249	205	301	269	280	289	262	329	260	172
Performance	6%	10%	10%	5%	6%	19%	9%	5%	10%	7%	9%	4%
CYP Division	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Within 4 Weeks	5	6	8	7	12	28	18	12	19	19	15	5
Clock Stops	139	158	151	124	176	172	181	203	168	210	123	111
Performance	4%	4%	5%	6%	7%	16%	10%	6%	11%	9%	12%	5%
SOLAR/Other	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Within 4 Weeks	10	19	17	4	6	24	7	2	6	4	8	2
Clock Stops	119	105	98	81	125	97	99	86	94	119	137	61
Performance	8%	18%	17%	5%	5%	25%	7%	2%	6%	3%	6%	3%

Mental Health Priority Actions:

Referrals to Liaison Psychiatry for People Known to Services



Methodology:

- Denominator is Liaison Psychiatry Referrals made from A&E.
- Numerator where the patient had an open referral to another service within BSMHFT at the time of referral to Liaison Psychiatry.
- Previous Liaison Psychiatry contacts are ignored when calculating the numerator
- No target has been set, and methodology is not fully defined, but high percentages are considered good
- August 26 at 48% showing a decrease of 1% since July
- Please note that the methodology has been updated for this metric following further clarification from NHSE to base the numerator on referrals rather than Contacts which has reduced the overall percentages

Month	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Known to Services	625	628	638	562	604	612	601	706	649	673	760	736	703
Referrals	1349	1356	1352	1337	1353	1324	1277	1441	1337	1435	1539	1508	1470
Performance	46%	46%	47%	42%	45%	46%	47%	49%	49%	47%	49%	49%	48%

Mental Health Priority Actions:

Reduction in Acute Inappropriate Out of Area Placements

Methodology:

- Ambition to reduce Inappropriate Acute Out of Area placements by 95% by the end of March 27, as measured at month end. The figure at the end of March 26 will be used as the baseline position.
 - The national baseline is **185** patients.
 - The BSMHFT baseline is **15** patients.
 - The BSMHFT target is **1** inappropriate acute patient by March 27.
 - This target complements the Medium-Term Planning trajectory for the Trust of zero inappropriate placements throughout 2026/27.
 - This includes patients aged 18-25 under the care of CYP Division
-
- The BSMHFT baseline includes patients placed in hospital sites named as 'appropriate' under the current Standard Operating Procedure. This is due to the way MHSDS data submissions were specified at the time.
 - Submission guidance for the MHSDS has been clarified, allowing for locally agreed hospital sites to be identified as 'appropriate' in national submissions. We are in conversation with our framework provider hospitals to ensure they are submitting data following the revised guidance, as national figures will be calculated from the MHSDS returns of receiving providers.
 - Multidisciplinary weekly flow meetings oversee the Patient Flow Improvement Programme. Rapid improvement actions are reviewed weekly, with ongoing repatriation where appropriate
 - Patients clinically ready for discharge continue to occupy beds. A policy to support patient choice is approved; escalation with local authority colleagues continues, alongside a review of procedures to eliminate inefficiencies.

n.b. PICU placements are excluded from this measure

Appendix 1a: BSMHFT - 2026/27 NOF metrics														
There are 24 scoring mental health metrics at Trust level, 3 non scoring Trust metrics and 2 ICB metrics = 29 metrics.														
Q1 actual national NOF rating has been added where published. Q2 forecast based on 16 of the 24 scoring Trust metrics only as insufficient detail on national methodology or national comparative data is required for 8 of the metrics. Of the 16 metrics: 1 Band 4 or 3 (subject to national rounding), 7 Band 3, 4 Band 2 and 4 Band 1.														
	Domain area	Metric	Level	Q1				Q2		Q2 NOF Forecast	National NOF Thresholds			
				Apr-26	May-26	Jun-26	Q1 NOF Actual	Jul-26	Aug		Band 1	Band 2	Band 3	Band 4
1	Experience of care	Mean length of stay for adult acute and psychiatric intensive care unit patients	Trust	71.28	73.03	70.6	3	74.5	85.9	4	0-40	41-49	50-70	71+
2	Access to services	% of total Children's and Young Persons mental health patients waiting over 104 weeks for contact	Trust	28%	27%	27%	3	27%	25%	3	≤5%	6-11%	12-29%	≥30%
3	Experience of care	Mean length of stay for older adult acute discharges	Trust	132.4	139.4	103.3	3	99.2	104.8	3	0-73	74-93	94-125	126+
4	Finance productivity and innovation	Variance to plan year-to-date	Trust	>1%	>1%	0.5%-1%	3	0.5%-1%	<0.5%	2	on plan	below 0.5%	0.5%-1%	>1%
5	Patient safety	% of urgent crisis response patients to receive face to face care within 24 hours	Trust	62.30%	62.10%	65%	3	66%	70%	2 or 3	≥80%	71-79%	45-70%	≤44%
6	Patient safety	NHS staff survey raising concerns sub-score (annual)	Trust	6.46	6.46	6.46	3 (based on 2025/26)	6.46	6.46	3	TBC	TBC	TBC	TBC
7	People and workforce	Sickness absence rate	Trust	5.70%	5.40%	6.2%	3.09	6.6%	6.3%	TBC	TBC	TBC	TBC	TBC
8	Access to services	% of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages) - Overall score	Trust	TBC	TBC	TBC	3 Overall	TBC	TBC	4	≥28%	20-27%	13-19%	≤12%
		CYP		22%	22%	20.19%	2	16%	TBC		≥12%	8-11%	4-7%	≤3%
		Adult		2%	2%	2.29%	4	2%	TBC					
9	People and workforce	Healthcare Worker Flu Vaccination Rate	Trust											
10	Finance productivity and innovation	Combined finance score	Trust	3	3	2	2	2	1					
11	People and workforce	National Education and Training Survey satisfaction rate (annual)	Trust	79%			2 (based on 2025/26)	79%	79%	2	TBC	TBC	TBC	TBC
12	People and workforce	NHS staff survey engagement theme score (annual)	Trust	7.1			2 (based on 2025/26)	7.1	7.1	2	TBC	TBC	TBC	TBC
13	Experience of care	CQC community mental health survey satisfaction rate (annual)	Trust	6.4			2 (based on 2025/26)	6.4	6.4	2	TBC	TBC	TBC	TBC
14	People and workforce	Temporary staffing cost relative band	Trust	Agency =1 and bank=2	Agency =1 and bank=2	Agency =1 and bank=2	1 based on Agency =1 and bank=2	bank = 2 and Agency =1	bank =2 and Agency =1	1	1	2	3	4
15	Effectiveness of care	% of acute adult discharges followed up within 72 hours	Trust	90.54%	91.18%	88.40%	1	89.20%	90.0%	1	≥80%	71-79%	63-70%	0-62%
16	Effectiveness of care	14 day readmission rate	Trust	0%	0%	0%	no data	0%	0%		0-5%	6-10%	11-17%	18%+
17	Finance productivity and innovation	Planned surplus/deficit	Trust	Break even plan	Break even plan	Break even plan	1	Break even plan	Break even plan	1	0%	< 0% and above -1%	1% and -2%	>-2%
18	Finance productivity and innovation	Relative cost difference (National Cost Collection Index) annual	Trust	94.57%	94.57%	94.57%	1	94.57%	94.57%	1	<100%	Remainder are scored between 2.00 and 4.00 based on their		
19	Experience of care	NHS staff survey advocacy rate (annual)	Trust	6.9			2.53	6.9	6.9	2.53	TBC	TBC	TBC	TBC
20	Finance productivity and innovation	% of clinical trials set up within 90 days	Trust	100%	100%	100%	1	Met TBC	Met TBC		TBC	TBC	TBC	TBC
21	Finance productivity and innovation	Data Quality Maturity Index	Trust	96.3% (March 26)	96.3% (March 26)	96.4% (April 26)	1	96.4% (April 26)	96.4% (May)	1	TBC	TBC	TBC	TBC
22	People and workforce	NHS staff standards score (annual)	Trust	7.75			2.95	7.75	7.75	2.95	TBC	TBC	TBC	TBC
23	Population health, prevention and reducing inequality	% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Trust	28.20%	24.63%	27.27%	1	31.37%	24.20%		Remainder standardised from 1.00 – 3.00 on a continuous scale based on percentage			0%
MH Trust metrics - Contextual & Non scoring														
24	Patient Safety	Safety Incidents causing harm (contextual & non scoring)	Trust	29%	28%	27%		27%	24%					
25	Finance productivity and innovation	Implied Productivity Growth (contextual and non scoring metric)	Trust	TBC	TBC	TBC		TBC	TBC					
26	Effectiveness of care	% of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery (BHM) - Contextual only for Trust	Trust	45%	47%	48%		49%	49%					
27	Patient Safety	Crude rate of restrictive interventions per 100k bed days (Contextual & non scoring metric)	Trust	13.8	19	17		18	12					
MH ICB metrics														
28	Population health, prevention and reducing inequality	% of acute mental health admissions with no contact with community mental health services in the previous year	Trust performance	12%	13%	12%	3	11%	9%	2	≤5%	6-10%	11-15%	16%
29	Experience of care	Adult inappropriate out of area placement bed days as a % of all bed days.	Trust performance				*3 overall			3				
		Adult only		5%	3%	1%	1	2%	2%	2	≤1%	2-4%	≥5%	N/A
		Rehab		20%	19%	18%	3	17%	15%	2	0-4%	5-17%	18%+	N/A
30 (same as 26)	Effectiveness of care	% of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery (BHM) - Contextual only for Trust	ICB	45%	47%	48%	3	49%	49%	3	≥52%	50-51%	47-49%	≤46%

Cream indicates it has moved into band 2

Note - National thresholds have yet to be published.

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*This metric is at ICS level only and Q1 has not yet been published. There are only 3 performance bands for this metric 1-3. Both components are scored and combined into a single NOF score. The figures included here are based on our internal data for BSMHFT only.

This metric is at ICS level only and Q1 has not yet been published. The data shown relates to local trust BSMHFT data only

- 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	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Completed Treatment	739	751	845	870	625
Completed Treatment Trajectory	800	790	790	805	740
Reliable Recovery Rate	48.5%	48.5%	48.6%	46.3%	46.4%
Reliable Recovery Rate shortfall to meet 51% - Patients	19	18	20	39	28
Reliable Improvement Rate	69.70%	70.9%	71.4%	69%	68.96%
Reliable Improvement Rate shortfall to meet 69%	0	0	0	0	1

People referred to Talking Therapies in 6 and 18 weeks

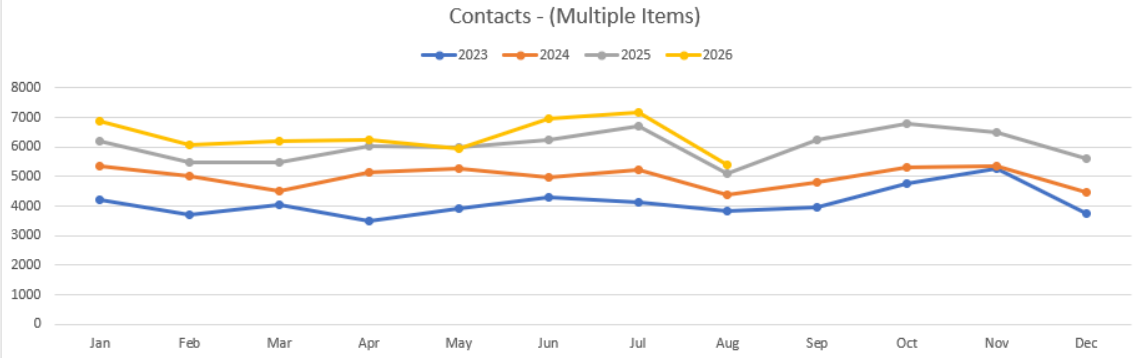
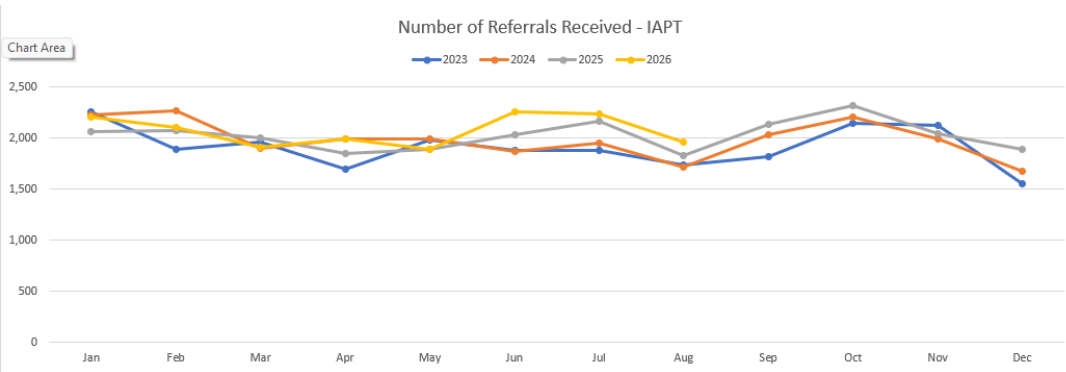
6 – weeks –96.3% in August 2026

18 weeks – 99.8% in August 2026 - Both above trajectory and national target

Access Target

August internal data shows YTD 40.7% of 2026/27 target

NHS TALKING THERAPIES – REFERRALS AND CONTACTS



RISK AND CHALLENGES	KEY ACTIONS	LEVELS OF IMPROVEMENT
- Digital front door proposal approved awaiting clarification around funding - Team managers are managing significantly large teams - Commissioner modelling inconsistent with national tool which states that we are significantly understaffed. 3 PWP's going through employment checks - High level of neurodivergent and long -term health issues within the team - Single Therapy Session discharges – Moved from 46.1% in July 2026 to 48.9% in August. - Financial risk remain on the risk register - August activity level below plan and YTD is now below target	- ICB funding available for 1 8a post and funding has been identified for 2 further Locality Clinical Lead. Clinical lead recruitment job matching review now complete and can be progressed - Business case being developed to secure further funding - Awaiting clarification and discussions re: alignment of teams to localities - Address performance issues by working closely with HR and Organisational Development team - Recruitment to all vacancies - Recruitment of HI and LI trainees for autumn 2026 cohort - Review of team managers job description	- Reduced activity level agreed with ICB for 2026/27 - Referrals averaged 2,025 in 2025. August 2026 at below last years average - Contacts averaged 6,028 in 2025 August 2026 at 5,378 below 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

DNA RATES

Sept 25 – Aug 2026

DNA rate by step

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

RISK AND CHALLENGES	KEY ACTIONS	LEVELS OF IMPROVEMENT
• Ability to achieve a 10% DNA rate – DNA rates for August have remained at 10% • Patient cancellations have increased by 1% to 14% in August • Trust cancellations have remained at 5% since July	• 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%] 46.4%

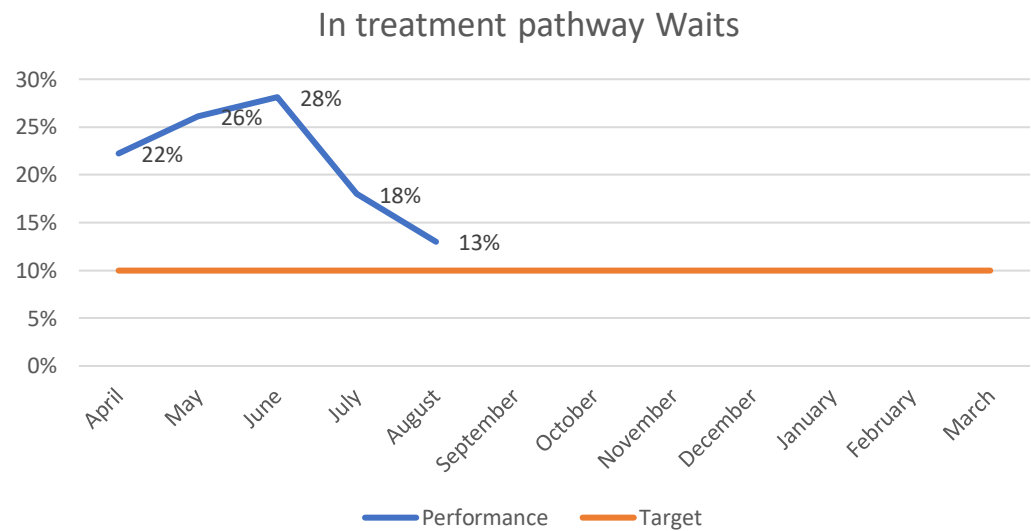


Reliable Improvement rate [Target 69%] 68.96%



RISK AND CHALLENGES	KEY ACTIONS	LEVELS OF IMPROVEMENT
• The target for Reliable Recovery Rate has increased to 51% for 2026/27 • 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 • Recovery guide developed and distributed to staff along with a 1-page reference summary.	• The service has consistently met the target for reliable improvement

NHS TALKING THERAPIES IN TREATMENT PATHWAY WAITS



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

RISK AND CHALLENGES	KEY ACTIONS	LEVELS OF IMPROVEMENT
Internal data continues to show decrease moving from 18% in July to 13% in August 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 improved 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	7 October 2026
Date(s) of Committee Meeting(s) reported	23 September 2026
Quoracy	Membership quorate: Y
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework • Corporate Risk Register • Integrated Quality Report • Health and Safety Committee Assurance Report • Clinical Governance Committee Assurance Report • Reducing Restrictive Practice Report • Safeguarding Annual Report • Safeguarding Management Board Assurance Report • Patient Voice Report • Mental Health Legislation Committee Assurance Report inc AMHP review • Freedom to Speak Up Review Findings and Consolidated Action Plan • Nigel's Plan Assurance Report, inc Learning from Nottingham Inquiry and Ockenden Report • NHS Learning Disability Improvement Standards • Clinical Effectiveness Advisory Group Assurance Report • Chief Pharmacist Report • Year in Clinical audit (inclusive of AMaT update) • ICCR divisional update
Alert:	Board Assurance Framework: Multiple strategic risks continue to require close monitoring, including • Patient Safety: Suicide review identified key themes of risk management, transitions of care, care planning and family involvement. Wider system issues including housing, terminal illness and substance misuse continue to contribute to suicides. Therapeutic Observations: Continued breaches in therapeutic observation compliance with no significant improvement demonstrated. BSMHFT remains an outlier for 15-minute observations. IT issues and non-compliance with policy remain contributory factors. Health and Safety: Rising Occupational Health referrals for staff wellbeing and mental health support. The Committee will continue to strengthen triangulation of staff wellbeing data between Health and Safety, Occupational Health, People Committee and Culture & Staff Experience governance routes • Quality Concerns: Deteriorating compliance indicators at George Ward and QEPH requiring recovery plans and targeted reviews. Clinical Governance: Ongoing Red Route delays for patients requiring transfer from police custody and prison settings.



compassionate



inclusive



committed

Assure:	• The refreshed Board Assurance Framework is aligned to the Trust Strategy, with strengthened review arrangements and clear links to the Corporate Risk Register. The Corporate Risk Register is reviewed regularly through the Risk Management Group, with risks actively escalated, de-escalated and closed where appropriate. • Learning from patient safety incidents, suicides and Learning from Deaths reviews continues to drive quality improvement activity across the Trust. Reducing Restrictive Practice initiatives, SafeWard implementation and Positive Behaviour Support approaches continue to demonstrate positive progress however provider contract notice remains under close monitoring with further improvements required despite progress. • The Trust continues to meet its statutory safeguarding responsibilities, with effective governance, partnership working and quality assurance arrangements in place. The Safeguarding Assurance Statement was endorsed by the Committee for submission to the Trust Board however there are increased safeguarding referrals and supervision demands. Approximately 122 sexual safety incidents were reported over six months, predominantly involving service users towards staff. • Mental Health Legislation processes remain stable, with no current DoLS cases requiring detention and recruitment underway to address workforce pressures. • Acute Care performance under Nigel's Plan demonstrated high MDT compliance (93%-100%) and strong diagnostic recording compliance however variable assurance submissions from divisions, with gaps particularly within ICCR services and concerns regarding community caseload management, DNA depot monitoring and patient follow-up. • Medicines governance remains effective, with strong assurance around medicines safety, Valproate and Topiramate monitoring and medicines optimisation processes however National medicine shortages continue to impact availability and costs of medications, including antipsychotic depot medication and ADHD treatments.
Advise:	• The Committee received a presentation from the ICCR divisional leads on caseload reduction plans. Committee members will arrange a visit to the team.
Reducing Health Inequalities impact:	Members recognised that health inequalities continue to impact access to services, patient experience and outcomes. While progress is being made through a range of improvement initiatives and partnership approaches (including PCREF and PSIRF), further work is required to strengthen the use, and cross population, of data and targeted interventions, and to work collaboratively with system partners to reduce inequalities and improve outcomes for local communities.
Board Assurance Framework	New risks identified: no new risks were identified.
Report compiled by:	Sue Bedward, Non-Executive Director Minutes available from: Hannah Sullivan, Corporate Governance Manager



Committee Escalation and Assurance Report

Name of Committee	Mental Health Legislation Committee (MHLC)
Report presented at	Quality Patient Experience and Safety Committee
Date of meeting	23 September 2026
Date(s) of Committee Meeting(s) reported	22 July 2026
Quoracy	Membership quorate: yes
Agenda	The MHLC considered an agenda which included the following items: • AMD MHL reports • MHL Service Update • MHL Integrated report • MHL Compliance • Policy reviews: MHA, MHLA, CTT, MCA • Associate Hospital Manager Report • Legal report • Risk Review
Alert:	The MHLC wishes to alert the committee to the following: • The Supreme Court decision on 2nd June overruled the acid test determined in the Cheshire West case for DoLS coming into effect immediately. The new guidance advises that there is no longer an acid test when it comes to assessing the objective element of deprivation of liberty. The starting point in assessing whether someone is deprived of liberty is to look at the specific situation of the individual and take into account the type, duration, effects and manner of implementation of restrictions on the person. • The committee were advised that there should not be any DoLS in the trust as usual practice, but if a case arises where DoLS may be considered, then this should be escalated to HMHL and the AMD MHL for a review • We need to ensure that there are enough approved clinicians to take on the Role of RC, as there should be no patient without an RC who can deliver the full remit of their role. • Establishment of a training programme supported by the AMD and the Mental Health Legislation team to enable those who have relevant experience to achieve approved clinician status through the portfolio route • The annual Conditional Discharge (CD) audit is complete. Some CDs had been transferred into the Trust that we were unaware of, and we are unable to locate original CD paperwork. RCs need to be reminded of the importance of keeping the MHL Office informed of any CD changes. • We are currently unable to record any CYP incidents as they are not a category on Eclipse • Incidents: 317 MHA-related incidents reported in Q1 compared to 400 in Q4, with the highest reporting directorate being Acute Care (234; 74%). The most reported category remains AMHP (Approved Mental Health Professional) issues, despite a 21% decrease, with 256 (312 in Q4).



	AHM report received and attached as per MHA CoP requirement.	
Assure:	The Committee was assured on the following: - Review of risks from a legal point of view and no major concerns. - A reduction in the use of section 3 noted for Q1, but an overall increase in detentions of 2%. No issues or unusual activity noted in relation to the demographics of those detained patients	
Advise:	The Committee was advised of the following matters: - There were a total of 1292 people reported to be detained under the MHA during quarter 1 (compared to 1279 in Q4), including an average of 304 people on a CTO per month. Only 12 of these were recalled at some point. - We received 0 CQC MHA inspections in Q1. - The Head of MHL attended an engagement event with EBEs and the patient engagement team to start the co-production of Advanced Choice Documents (ACDs). This initial event was to introduce the planned changes to legislation. For true co-production, a blank page was provided for EBEs to consider what they would like an ACD to look like, rather than presenting a template for consultation. The session was invaluable and insightful, with the group sharing some very emotive experiences, and a discussion about how ACDs could be helpful in case of future admission under the MHA. - The feedback was really positive. An invitation was extended to return to discuss the best way to proceed with co-production of ACDs and to ensure they are created through a health inequalities lens	
Board Assurance Framework		
Report compiled by:	Louise McLanachan, Head of Mental Health Legislation	Minutes available from: Louise McLanachan or Christiana Sodomala

Associate Hospital Manager Committee Escalation and Assurance Report

Name of Committee	Associate Hospital Managers Meeting
Report presented at	Mental Health Legislation Committee
Agenda item:	10
Date of meeting	22 July 2026
Date(s) of Committee Meeting(s) reported	19 March 2026
Quoracy	Membership quorate: yes
Agenda	The Committee considered an agenda which included the following items: • Training and updates for Associate Hospital Managers – Update regarding new Mental Health Act • Minutes of meeting held Thursday 11th December 2025 • Matters Arising • Chair & Deputy Senior Lay Manager comments • Mental Health Legislation Team Feedback • Managers' Concerns • Update from MHLC (report summaries)
Alert:	Data: Quarter 1 - 167 Associate Hospital Manager (AHM) hearings, 8 appeals and 159 reviews (2 discharges), Concerns: Reaside: The panel was concerned that there were long delays in commencing the hearing (40 minutes) due to difficulties in locating a laptop computer that worked at Reaside. This caused considerable inconvenience to the patient, his parents, the RC and the other professionals Response: No response received 2. Newbridge House: There was a delayed start due to technical issues of approximately 25 minutes. The administrator had to assist in providing a second computer for the nurse and patient. On eventually joining the meeting, the nurse present did not acknowledge the delay or provide reassurance to the patient, who appeared nervous due to the number of people present on the screen. The Panel also considered at the professionalism of the nurse who could have been more sensitive about the patient's history and family upbringing, e.g feminine hygiene. She was also not complimentary about her nursing colleagues, indicating that she makes the patient do things, e.g. wash, while her colleagues are more lenient. The approach and responses, at times, were not therapeutic or compassionate but focused on her being a "strong" person. The Social Worker also raised concerns for us about her professionalism. Her approach at times seemed confrontational in responding to the patient's comments. While there was a delay and some frustration about this, her body language did not appear positive throughout the hearing.



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	Response from Head of Nursing: has emailed the Ward Manager requesting that she meet with the staff member. 3. Oleaster: There were considerable delays (20 minutes) in beginning this hearing, due to 'technological problems with Teams. The ward was late in joining the hearing. When the nurse joined initially, we could not see or hear them. Then we could see them and not hear them for several minutes. There were several attempts made, and two changes of laptop before proper communication (auditory and visual) was made. The RC expressed particular concern because she needed to leave early for an urgent home visit. She pointed out that this problem has occurred several times recently with Teams. As well as inconvenience for staff, there was considerable inconvenience for the legal representative and frustration for the patient. The RC suggested that ward staff should prepare for hearings prior to the meeting, not immediately when it starts. Response: No response received 4. David Bromley House: The panel was concerned that the Risk Assessment did not give the information required to make an informed decision today. There was a lack of clarity about the risk to self or others Response received from the RC and matron: an email received detailing a review of the risk assessment addressing the issues raised by the panel. The reviewed risk assessment was also received.	
Assure:	The Committee was assured on the following: • AHMs annual reviews have been carried out and all but one AHM have continued in post. 1 AHM who has been on long term leave due to health problems has, post the reviews, resigned. • Senior AHM and head of Mental Legislation have reviewed the current numbers of AHMs and the overall diversity and assure MHLC that there are sufficient numbers and a good diverse mix in the Team. This is reviewed on an ongoing basis to ensure if recruitment is required it is done in a timely way. • Mental Health Legislation Team were able to feed back any concerns or updates from Mental Health Legislation Administrators • AHMs were given the opportunity to raise any concerns at the meeting	
Advise:	The Committee was advised of the following matters: • AHMs received the front sheets of all MHLC reports • AHMs given updates as required regarding changes to the MHA.	
Board Assurance Framework		
	New risks identified: None	
Report compiled by:	Jan Prior Louise McLanachan	Minutes available from: Louise McLanachan or Christiana Sodomala



Committee Escalation and Assurance Report

Name of Committee	Quality, Patient Experience and Safety Committee
Report presented at	Board of Directors
Date of meeting	7 October 2026
Date(s) of Committee Meeting(s) reported	19 August 2026
Quoracy	Membership quorate: Y
Agenda	The Committee considered an agenda which included the following items: • Integrated Quality Report • Clinical Governance Committee Assurance Report • Larimar Assurance Report • Patient Voice Report • Nigel's Plan Assurance Report, inc Learning from Nottingham Inquiry and Ockenden Report • Reflections on CMHT Visits • Board Assurance Framework Risks
Alert:	• Continued occurrence of suicides and attempted suicides within community services over recent months causing concern. • Implementation of Nigel's plan (Assertive and intensive community mental health services action plan) requiring sustained focus on access, MDT standardisation, caseload management and Integrated Neighbourhood Team implementation. • Medicines management concerns identified through recent CQC inspections, including out-of-date and incorrectly labelled medication stock, together with a reported discharge medication omission. • Access to services remains the Trust's most significant clinical risk, with concerns regarding the size and complexity of community caseloads and the need to prioritise resources towards those with the most serious mental illness. • Risks identified within Children and Young People (CYP) Services, including reliance on non-registered staff for referral triage and concerns regarding organisational culture and clinical voice. • Workforce sustainability concerns within Neuropsychiatry Services due to reliance on a small specialist workforce and recruitment challenges. • Variation in diagnostic recording and MDT audit compliance across divisions, particularly within Perinatal and some Community Mental Health Teams. • Significant operational pressures identified within the Zinnia CMHT relating to staffing, management vacancies, sickness absence, complaints and service demand.
Assure:	• Positive initial feedback from recent CQC inspections of Recovery House and the Older People's wards, with inspectors recognising the capability, culture and caring approach of staff.



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	• Strengthened oversight arrangements established for CYP Services through Bronze, Silver and Gold governance structures, enhanced senior clinical oversight and additional staffing. Significant progress against the Larimar Action Plan, with many actions completed and mitigations in place for longer-term actions. • Ensure lessons from the Larimar review are embedded Trust-wide, particularly around autism-informed care, relational security, long-stay patient reviews and family involvement. To be linked to BAF • Improvements in autism-informed care, CETR processes, safety planning compliance, relational security training and therapeutic observation monitoring. • CMHT visits provided assurance that governance information broadly reflects operational realities and identified examples of good practice, particularly within Longbridge CMHT. • Progress in implementation of Nigel's Plan, supported by strengthened governance, audit processes, CMHT reviews and assurance arrangements across all divisions. Caseload review work, Integrated Neighbourhood Team development and learning disability/autism identification programmes are progressing and expected to support safer, more targeted care. • Enhanced governance, risk escalation and quality assurance processes within Acute Care and across divisions. • Secure Care and Offender Health services demonstrated positive alignment with the Dartmouth Assertive Community Treatment model. • Family and carer inclusion work is progressing through partnership with the Carers Trust, Triangle of Care accreditation and alignment with PCREF. • Staff Safety Strategy implementation is being strengthened through dedicated project support and appointment of a Security Management Specialist.
Advise:	• Continue monitoring and reviewing trends in community suicides through longitudinal analysis, Structured Judgement Reviews and patient safety investigations. • Strengthening collaboration with West Midlands Police, including shared learning, joint training development and improved understanding of mental health services. • Ensure medicines management review is completed and assurance provided regarding compliance and risk mitigation. • Maintain focus on implementation of Integrated Neighbourhood Teams and caseload stratification to address access risks and improve capacity management. • Monitor progress in addressing CYP cultural concerns and strengthening MDT standards, clinical leadership and team effectiveness. • Continue development of dedicated reporting and oversight for patients with learning disabilities and autism. • Ongoing workforce and capacity challenges affecting Approved Mental Health Professional (AMHP) responsiveness within Birmingham City Council services are being addressed by a joint action plan with BCC. • National requirement to achieve at least 60% staff flu vaccination uptake, representing a substantial improvement on previous performance levels.



	Regular monitoring of flu vaccination uptake will be monitored through Committee, with a focus on accessibility, local accountability and delivery of the national target. • Strengthen consistency in MDT action tracking, diagnostic recording and depot medication follow-up processes across community services. • Continue	
Reducing Health Inequalities impact:	Members recognised that health inequalities continue to impact access to services, patient experience and outcomes. While progress is being made through a range of improvement initiatives and partnership approaches (including PCREF and PSIRF), further work is required to strengthen the use, and cross population, of data and targeted interventions, and to work collaboratively with system partners to reduce inequalities and improve outcomes for local communities.	
Board Assurance Framework	The Committee reflected on the continued development of the Board Assurance Framework (BAF), noting that priority actions are being updated ahead of the forthcoming Board Development Session. Members emphasised the importance of aligning key improvement programmes, including Nigel's Plan and the Larimar Action Plan, with the Trust's strategic risks to ensure a coordinated and focused approach to delivery. The Committee agreed that clear milestones, measurable outcomes and data-driven assurance would be essential to demonstrate progress against long-term priorities, including neighbourhood teams, caseload management, MDT effectiveness, patient safety and workforce sustainability. Members highlighted the importance of avoiding duplication, maintaining organisational focus and ensuring the BAF provides meaningful oversight of progress against the Trust's most significant risks. The Committee noted the update and agreed that further consideration of the refreshed BAF actions and associated metrics would take place at the forthcoming Board Development Session.	
	New risks identified: no new risks were identified.	
Report compiled by:	Nick Moor, Non-Executive Director	Minutes available from: Hannah Sullivan, Corporate Governance Manager



Report to Board of Directors						
Agenda item:	11					
Date	07 October 2026					
Title	Quality and Safety Report					
Author/Presenter	Lisa Stalley-Green, Executive Director for Quality & Safety/Chief Nurse					
Executive Director	Lisa Stalley-Green, Executive Director for Quality & Safety/Chief Nurse	Approved	Y	✓	N	
Purpose of Report		Tick all that apply ✓				
To provide assurance	✓	To obtain approval				
Regulatory requirement		To highlight an emerging risk or issue				
To canvas opinion		For information		✓		
To provide advice		To highlight patient or staff experience		✓		
Summary of Report						
Alert		Advise	✓	Assure	✓	

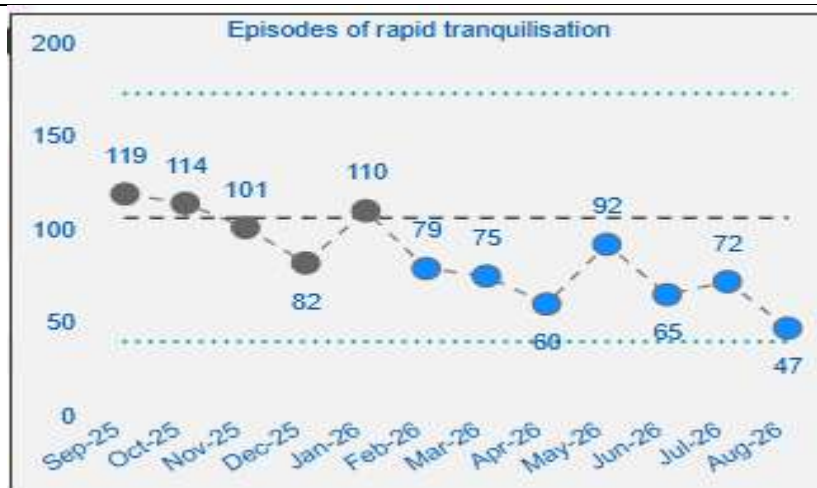
Executive Summary

This Quality Report has been developed to provide the Trust Board with more detailed information and assurance on the progress being made to improve the quality of services for our patients, service users and their carers. The report has been aligned with the Trust Strategy and updated QPES Board Assurance Framework.

Metrics to note for Quality, taken from the Integrated Performance Dashboard with figures available at mid-September.

Measure	Latest Target	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
AWOL patients coming to harm		2	5	3	2	4	0
Deaths within 30 days post discharge		1	1	2	2	1	0
Episodes of rapid tranquilisation		75	60	92	65	72	47 ↑
Harm-free Days		86	85	85	85	84	86
Incidents of moderate harm and above		50	21	19	17	38	11
Number of patients prone restrained for anything other than intramuscular tranquilisation		14	7	13	11	6	8
Number of Prone restraints for more than 10 minutes		2	1	1	0	0	0
Safeguarding Incidents		155	145	171	188	199	135

- For Absent Without Leave no harm was recorded to service users.
- There were no deaths within 30 days post discharge.
- Colleagues will note a marked improvement in the number of episodes of rapid tranquilisation having decreased by almost half between July and August.



- 11 incidents of moderate harm recorded in August which is a reduction from the 38 recorded in July. 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 wellbeing support. Incidents continue to be reviewed through MDT (multidisciplinary team meetings) and governance processes which identify themes and opportunities for learning.
- Prone restraints - AVERTS training has been modified to highlight preventative strategies followed by core skills. A sustained improvement in the number of prone restraints is anticipated further to this.

SR3 – Failure of services to be consistently safe for service users, carers and communities

Registered Nurse Recruitment

The Trust has further reduced vacancies for Registered Mental Health Nurses and Has filled all entry level posts.

A consistent positive pipeline of newly qualified nurses continues to support the Trust's workforce sustainability ambitions, with 82 graduate nurses appointed for September 2026. We will work proactively to transition all new graduate nurses into substantive vacancies or rotational programmes, while those awaiting permanent opportunities will be supported through Temporary Staffing Solutions (TSS) and enrolled in the Trust's preceptorship programme to ensure continued professional development, support and retention. In parallel, opportunities will be explored to strengthen career progression by expanding the Band 5 to Band 6 development offer, enhancing retention and workforce capability. Further actions include reviewing skill mix opportunities in areas with Health Care Assistant vacancies, continuing to support newly qualified nurses undertaking preceptorship whilst working on the bank, and improving targeted recruitment and promotional materials to better showcase specific ward and team opportunities across the Trust.

The Trust has been invited to facilitate a workshop at the Midlands Workforce Masterclass, "*Safe Staffing, Strong Futures: Turning Workforce into Action*", on 18th September 2026. This provides a valuable opportunity to showcase the Trust innovative workforce initiatives and best practice, including the newly qualified nurse recruitment and retention model, workforce transformation programmes, safer staffing approaches, career development pathways, and the effective integration of preceptorship and temporary staffing arrangements to support a sustainable nursing workforce. This external recognition highlights the Trust's leadership and commitment to developing future-focused workforce solutions that deliver safe, high-quality patient care and enable delivery of the Trust Strategy.

Safeguarding

Safeguarding arrangements across the Trust continue to provide assurance through effective governance, specialist safeguarding support, workforce development and partnership working. During the reporting period, the Safeguarding Team has focused on strengthening safeguarding intelligence and assurance arrangements through the development of enhanced systems for recording and analysing safeguarding activity. This work will improve the Trust's ability to identify emerging trends, themes and risks, supporting organisational learning and providing greater assurance regarding the quality and impact of safeguarding practice.

Work is also underway to implement revised safeguarding recording and referral standards, developed with input from Safeguarding Champions and Experts by Experience. The revised standards aim to improve consistency of practice, strengthen governance and support alignment with CQC Quality Statements and the NHS Culture of Care Standards. In addition, Child Protection Information Sharing (CP-IS) access has been successfully implemented across relevant child-facing services, strengthening the Trust's ability to identify children and unborn babies subject to Child Protection Plans or Children in Care arrangements and enabling earlier safeguarding intervention where required.

Demand across safeguarding services continues to increase in both volume and complexity. The team is managing rising levels of activity associated with self-neglect, complex multi-agency risk, Prevent concerns, statutory review processes and safeguarding supervision requests. Whilst all statutory safeguarding responsibilities continue to be met, capacity and demand remain under close review to ensure the service can continue to provide timely advice, effective oversight and robust organisational assurance.

Patient Safety – Learning and Improvement

During the reporting period, work has continued to focus on strengthening how the Trust responds to patient safety incidents, supports those affected and translates learning into meaningful and sustainable improvement.

A joint Standard Operating Procedure (SOP) has been developed between the Complaints and Patient Safety Teams to strengthen the interface between both functions and support a coordinated approach when concerns raise potential patient safety issues. The SOP is intended to ensure that patients, families and carers receive a timely, compassionate and consistent response, that relevant safety concerns are shared appropriately between teams, and that opportunities for learning and improvement are identified at an early stage. The work has also helped clarify respective roles and responsibilities and support a more joined-up approach to family engagement, Duty of Candour and organisational learning.

Work has commenced on further developing our Trust guidance to support staff following an inpatient death. Feedback from both families and staff highlighted variation in practice and a desire for greater clarity regarding responsibilities, communication, practical arrangements and available support. The guidance is intended to provide a more consistent approach to supporting families whilst ensuring staff are clear about expectations following a death. The guidance will be launched and discussed at Matrons and Wards Managers Development Days.

A Quality Improvement project has been initiated following learning from restrictive practice incidents. The project will explore how patients and staff are supported following restraint and seclusion, with a particular focus on post incident support and learning to reduce restrictive intervention.

Suicide Prevention

A thematic review of 130 Trust-associated confirmed and suspected suicide reviews completed between 2023 and 2025 has been undertaken to identify recurring learning and opportunities for improvement. The review identified common themes relating to communication and service interfaces, risk formulation and

care planning, previous self-harm, physical health concerns, medication adherence and prescribing, alcohol and substance use, missed contact, non-attendance and transitions between teams and services.

The findings reinforce that suicide prevention requires a whole-system approach. Across many reviews, distress and risk were influenced by a combination of mental health difficulties, physical health concerns, substance use, housing difficulties, financial pressures, employment challenges, family relationships and service transitions.

As a result, local suicide prevention plans are being strengthened with a focus on follow-up following missed contact and non-attendance, personalised safety planning, family involvement, post-discharge care, transitions between services and links between physical and mental healthcare. Progress against these plans will continue to be monitored through the Learning from Deaths Group.

Completed Patient Safety Incident Investigation (PSII)

One PSII was completed during the reporting period relating to the death of a young person known to Children and Young People's Services.

The investigation considered concerns raised through a third-party referral describing behavioural changes and possible psychosis. Despite repeated attempts, direct contact with the young person could not be established, meaning mental state, engagement, consent and capacity could not be assessed directly. Senior clinical advice was sought and a face-to-face GP review and additional information were requested.

The investigation identified opportunities to strengthen operational guidance where concerns relating to possible psychosis, deterioration or vulnerability are identified but direct contact cannot be established. Further learning related to the collection and use of collateral information, access to specialist psychosis advice, consent and capacity considerations within third-party referrals, and ensuring agreed clinical plans are accurately communicated and recorded.

The resulting improvement work focuses on establishing clearer escalation pathways, defining minimum expectations for gathering collateral information from relevant agencies and family members, strengthening access to specialist advice, developing a more consistent consent and capacity framework for third-party referrals and improving system checks and correspondence processes. The investigation also reinforced the importance of ensuring that information gaps remain visible and that staff have access to clear decision-support arrangements when direct assessment is not possible.
Learning from Patient Safety Reviews and Investigations.

Following transfer to the Trust the Referral Management Centre for Children and Young People risks identified with capacity, experienced nursing and medical capacity have been addressed. The service remains in the Bronze, Silver, Gold improvement framework with plans to further integrate referral management and reduce access delays across the Trust.

Personalised Care and Safety Planning - Dialog+

We have continued our transformation of care planning through the implementation of Dialog+, providing a more collaborative, person-centred approach in which people receiving care identify what matters to them, reflect on their quality of life and agree meaningful goals and actions with their clinical team. Implementation has been strongly informed by Experts by Experience and is now being embedded across services, with ongoing assurance work focusing on the quality and consistency of care planning, the involvement of patients and carers, and learning from variation between clinical settings. The Trust is also developing its approach to Safety Assessment, Formulation and Planning, moving away from reliance on static or predictive risk assessment towards a dynamic, personalised and strengths-based understanding of safety. This work brings together formulation, protective factors, individual warning signs, collaborative safety planning, family/carers involvement, proactive interventions and clear escalation arrangements, supported by training, supervision, audit and quality improvement.

These developments now provide the foundation for implementation of the NHS England Personalised Care Framework and Modern Care Programme Approach (CPA). Rather than being separate programmes, Dialog+ care planning and Safety Assessment, Formulation and Planning will become complementary components of a single personalised approach to care: Dialog+ provides the structure for understanding what matters to the person, their goals, strengths and outcomes; Modern CPA provides the overarching framework for coordinated, personalised care and shared decision-making; and Safety Planning provides a dynamic approach to identifying and responding to safety needs within that plan. The next phase will therefore focus on integrating these approaches into the Trust's care pathways, documentation, clinical supervision, workforce development and governance arrangements, with clear measures of implementation, experience, outcomes and safety. This represents the Trust's transition from traditional CPA and risk-assessment processes towards the national direction of travel for personalised, outcome-focused and safety-oriented care.

Regulatory Update

The draft report from the Care Quality Commission following the Steps to Recovery inspection that was undertaken in March 2026 has now been received. The factual accuracy process has been commenced and is currently with the service for checking. The draft report has identified a concern related to medicines management which we are addressing. The preliminary rating given by the CQC overall is 'Good'.

There have been two full unannounced inspections within the month of August 2026. The first was undertaken from 4th August 2026 for three days in the Older Adults Inpatient services, a full data request was requested by the CQC to support this, and this has been actioned. The second inspection was throughout Perinatal Community and Inpatients Services over three days commencing 25th August, a full data request was submitted by the CQC to support this inspection, and we are actioning this.

During September there has been an unannounced inspection of services for Children and Young People which was a positive experience for staff; and has highlighted the known challenges of waiting times and access for which the Trust has a recovery action plan in place.

The Well-Led inspection for the organisation was also announced during August. This will take place during November.

There was a respiratory outbreak on Sage Ward which was reported into the CQC, Integrated Care Board and Health and Safety Executive (HSE). The outbreak of a respiratory virus has since been declared ceased with no ongoing harm to patients or staff; all regulatory bodies were informed at the time. No further action will be taken by the HSE as it was deemed that all necessary actions were appropriately undertaken.

Quality Improvement and Clinical Effectiveness

Clinical Audit

- National Audit 11d – Antipsychotics in Dementia: Early findings are being reported to MOG (Medicines Oversight Group). The Trust sample included no patients recently commenced on antipsychotics, limiting assessment against several standards. Side-effect monitoring achieved approximately 70% compliance, representing a positive result with scope for further improvement.
- A Year in Clinical Audit: Presented to CEAG (Clinical Excellence Assurance Group) and scheduled for QPES and Board. A proposed Connect hub will give medical staff access to current national, Trust-wide and local clinical audit reports; approval is awaited. The report is available through the CEAG group.
- RMSUK (Resource Management Systems UK) Audit: The audit is nearing completion, with outcomes expected in the coming weeks.

- POMH (Prescribing Observatory for Mental Health) 25a: Preparatory work has started on the new topic concerning propranolol use.

Nigel's Plan: Assurance and Improvement Update

A national "Show and Tell" event was held on 29 July 2026, attended by the Associate Chief Nurse for Practice, Policy and Professions and the Deputy Medical Director for Quality and Safety, providing an opportunity to share learning and emerging practice.

To strengthen assurance arrangements, the Associate Chief Nurse and Deputy Medical Director have planned visits to Community Mental Health Teams on 23 September and 13 October 2026. These visits will provide oversight of the processes and standard operating procedures supporting Nigel's Plan, identify any implementation challenges, and determine where further support or assurance may be required.

All Divisions have provided assurance regarding governance oversight through local Clinical Governance Committees and other relevant governance forums.

A standardised divisional reporting framework has been developed and shared across the Trust to support assurance and improvement in relation to Nigel's Plan. The framework enables Divisions to:

- Demonstrate progress against the Assertive and Intensive Plan;
- Identify variation, risks and barriers to implementation;
- Assess the impact of improvement activity; and
- Agree priorities, escalation requirements and support needs for the forthcoming reporting period.

Acute Care services continue to demonstrate high levels of compliance with key elements of Nigel's Plan, including multidisciplinary team reviews (93% to 100%) and diagnostic recording (78% to 100%) across wards. Some variation remains in family and carer involvement, and further work is underway to understand the reasons for this variation and identify opportunities for improvement in line with the Trust's Culture of Care ambitions.

The Associate Chief Nurse for Practice, Policy and Professions and the Deputy Medical Director for Quality and Safety have also met with the Informatics Team to agree the development of a dashboard and supporting dataset to enhance reporting, oversight and assurance of Nigel's Plan.

In the Secure Care and Offender Health Division (SCOH), the FIRST (Forensic Intensive Recovery Support Team) dataset has been aligned with Nigel's Plan to support a consistent approach to performance reporting and governance oversight across services.

Governance arrangements are established across all Divisions, with further work underway to strengthen assurance through standardised reporting, enhanced data visibility, and direct engagement with operational teams to support consistent implementation of Nigel's Plan.

SR4 – Failure to be a service user, family and carer led organisation

Experts by Experience

BSMHFT's experts by experience (EBE) programme continues to provide service user and carer leadership. The HOPE strategy group meets monthly, and during the last quarter they have worked with the safeguarding team to develop a new EBE safeguarding partner role. The group has also commenced coproduction of new advanced statement approaches with the mental health legislation team. A new cohort of EBEs have completed their educator training, which has grown our team of EBEs who can confidently and effectively deliver staff training. Two of these will open the AGM (Annual General

Meeting). Other activities include EBE led recovery sessions in acute care, recovery suppers in secure care where EBEs influence care, and involvement in procurement alongside the commissioning team.

Customer Relations

Demand on the Customer Relations service remains high, with sustained volumes of enquiries and increasing pressure on team capacity. Telephone responsiveness has been affected by planned and unplanned staff absence.

The formal complaints backlog remains a significant area of concern, with the highest number of open complaints recorded at month end. The caseload continues to increase and includes a growing proportion of older cases, with response times now significantly above expected timescales. There has also been a deterioration in the proportion of complaints resolved within agreed timescales. A further concern is the backlog within the triage and allocation process, which presents a risk to timely investigation, response and organisational learning.

There is a continued concentration of complaints within the ICCR Division, which accounts for the majority of the open formal complaints and a significant proportion of new concerns received. The predominant themes relate to access to treatment or medication, communication, and staff values and behaviours, providing important intelligence regarding service accessibility and patient, family and carer experience.

There are positive indicators within PALS, with a reduction in the open caseload and improved response times. However, demand remains concentrated within ICCR and will continue to require focused oversight.

A revised operating model between the Customer Relations Team and ICCR has been introduced, including shared communication and workflow arrangements, to improve coordination, reduce delays and support more timely resolution. The effectiveness of this approach will be reviewed in October 2026, with progress monitored through established governance arrangements.

Friends and Family Test feedback remains broadly positive, although there has been a small reduction in the overall positive score.

The increasing volume and age of formal complaints, alongside deteriorating response times, remain key areas of operational and quality risk. Focused action is underway with ICCR and the Customer Relations Team to address the backlog, strengthen workflow and improve timeliness, with further assurance expected following the October review.

Recovery College Refresh Update

Following completion of the Management of Change process, approved through JOSC (meeting between union and BSMHFT colleagues), responsibility for the Recovery College will transfer to the ICCR Division from October 2026. This represents the next stage in the development of the Recovery College model and will enable its delivery to be more closely integrated with the Division's wider community transformation agenda.

The refreshed model will place an enhanced focus on supporting families and carers alongside service users, strengthening opportunities for co-production, early intervention, self-management and community-based learning. Work is progressing in partnership with the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector and is being informed by national learning and guidance from IMROC (charity dedicated to transforming mental health systems through lived experience) on the evolution of Recovery Colleges towards Community Learning Collaboratives.

The transition is aligned with the strategic direction set out in the NHS 10-Year Health Plan, particularly the shift from hospital to community and from treatment to prevention. The developing model will retain a strong clinical and evidence-informed foundation, while increasing community capacity and partnership working.

The transition will be monitored through the established governance arrangements to provide assurance on delivery, workforce, engagement and outcomes, and to ensure that the refreshed model remains aligned with the Trust's strategic objectives and delivers measurable benefits for service users, families and carers.

SR6 – Failure to provide timely access to and discharge from services

Community Caseload Reviews

The Integrated Community Care and Recovery Caseload Reduction Programme is establishing a safer, clinically led and sustainable approach to caseload management across community mental health teams. A comprehensive range of initiatives is being delivered concurrently, supported by significant multidisciplinary effort to ensure caseloads are systematically reviewed, effectively managed and reduced to safe and sustainable levels.

The immediate priority is to align Rio lead-clinician records with the clinicians currently providing care, before clinical validation, team-level review, caseload redistribution or any patient transfer takes place.

Programme Purpose and Five-Stage Approach

1. aligns RiO with current clinical relationships
2. validates individual cases
3. assesses team-level caseload implications
4. engages the team with the review outcome
5. transfers patients to the appropriate clinician caseload following team engagement and agree

External learning: A virtual learning session with Tees, Esk and Wear Valleys NHS Foundation Trust colleagues will explore how closely its model aligns with our local context, identify elements that can be replicated and determine where adaptation is required to meet local service needs.

Delivery will continue through a controlled, locally supported rollout, with clinical validation, team engagement and agreed transfers progressing after administrative alignment is complete. There is an expectation of a 20% reduction in caseloads requiring consultant input and a progression of service users into locality based primary care.

Quality Benefits

Accurate clinical records that reflect who is actively responsible for each patient's care
 Transparent, multidisciplinary decisions based on need, complexity, risk and professional capability
 Enhanced consultant capacity for higher-complexity patients and reduced inappropriate automatic allocation
 Standardised clinical documentation and data to support assurance, monitoring and future evaluation
 A controlled, phased rollout with local engagement, appropriate governance and implementation support

SR9 – Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities

Culture of Care

The Trust-wide Culture of Care Celebration Event was held on 15 September 2026, bringing together colleagues, service users, Experts by Experience, National and local partner organisations to celebrate

improvement, share learning and recognise excellence across services. The event showcased a range of Quality Improvement initiatives and examples of coproduced service development, demonstrating how staff and service users are working together to create more personal, inclusive and hopeful care experiences. The programme is designed to move away from a top-down oversight approach, empowering service users and staff to make changes and help shape the culture of their own wards and teams.

As part of the event, services were recognised through the Culture of Care Excellence and Accreditation Framework, which supports assurance, continuous improvement, shared standards and greater involvement of Experts by Experience in shaping services. Awards highlighted innovation in areas including therapeutic environments, carer engagement, sensory initiatives and reducing restrictive practice.

Next Steps

- Continue the phased rollout of the Culture of Care Accreditation Framework across services, including Specialties, Dementia & Frailty, ICCR and Children and Young People's Services.
- Complete moderation and quality assurance of self-assessments and accreditation submissions across divisions.
- Share learning from the celebration event through presentations, posters and examples of best practice to support spread and adoption across the Trust.
- Strengthen service user and Expert by Experience involvement within improvement, governance and accreditation processes.
- Align Culture of Care developments with quality governance arrangements and ongoing improvement priorities to support sustainable culture change.

The Culture of Care programme continues to gain momentum, with growing engagement from staff, service users and Experts by Experience. The celebration event demonstrated the significant commitment across the Trust to creating compassionate, person-centred care, and the next phase will focus on embedding, assuring and sustaining that improvement through the accreditation framework and shared learning

Recommendation

The Board is asked to: receive assurance from this report.

Enclosures

None

Report to Board of Directors						
Agenda item:	12a					
Date	7 October 2026					
Title	Safeguarding Annual Report 2025/26					
Author/Presenter	Melanie Yates, Associate Director of Safeguarding - Author					
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	?	
The Safeguarding Annual Report for 2025/26 was reviewed and supported by the QPES committee in September 2026 and is presented to Trust Board to provide organisational assurance regarding the Trust's discharge of its statutory safeguarding responsibilities. Key highlights: - The annual report provides assurance that BSMHFT has met its statutory safeguarding responsibilities during 2025/26 across children, adults, domestic abuse and sexual safety workstreams. - Significant progress has been made in strengthening safeguarding governance, quality assurance, workforce development, supervision, partnership working and the embedding of the Think Family approach across the organisation. - The successful integration of safeguarding arrangements following the transfer of Forward-Thinking Birmingham services has expanded safeguarding activity and oversight whilst maintaining continuity of safeguarding support, supervision and training. - Safeguarding incident reporting, demand for safeguarding advice and support, and uptake of safeguarding supervision have all increased across Trust services, including CYP and adult-facing teams. - This provides assurance of improved staff awareness, confidence and engagement with safeguarding processes across clinical services and supports earlier identification and escalation of safeguarding concerns - Intelligence-led audits, safeguarding assurance visits and thematic reviews have strengthened organisational learning, supported targeted quality improvement activity and enhanced organisational oversight and assurance. - Key challenges include increasing demand across safeguarding services, implementation delays relating to Child Protection Information Sharing (CP-IS), rising Safeguarding Adult Review and PREVENT activity, workforce capacity pressures, and the ongoing need to embed consistent safeguarding practice across all services. - Priorities for 2026/27 include implementation of CP-IS, further development and use of safeguarding intelligence to drive improvement activity, continued expansion of safeguarding supervision, rollout of						

sexual safety training, development of domestic abuse training resources with a focus on 16–17-year-olds and continued embedding of the Think Family approach across the Trust.

Recommendation

The Board is asked to approve the report for publication.

Enclosures

Safeguarding Annual Report 2025/26

Safeguarding Annual Report 2025–26

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)

1. INTRODUCTION

This report provides an overview of safeguarding activity, developments, and assurance across Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) during the period April 2025 – end of March 2026. It sets out how the Trust has met its statutory safeguarding responsibilities in line with the Care Act 2014, the Children Acts 1989 and 2004, and Working Together to Safeguard Children (2026), alongside relevant NHS England standards and contractual requirements.

Detailed safeguarding performance data, audit findings, training compliance metrics, incident reporting trends and assurance activity have been reported throughout the year via quarterly reports to the Safeguarding Management Board. This annual report provides a strategic summary of key achievements, challenges and priorities during 2025/26.

The reporting period has been characterised by significant progress, development, and strengthening of safeguarding practice across the Trust. This has been achieved against a backdrop of increasing demand, system complexity, and ongoing resource pressures, requiring a continued focus on prioritisation, partnership working, and effective use of intelligence to inform practice.

This report outlines the breadth and depth of work delivered by the safeguarding team and wider organisation, demonstrating a proactive, intelligence-led, and partnership-driven approach to safeguarding. It highlights progress in strengthening governance and assurance arrangements, enhancing staff capability through training and supervision, and embedding learning to support continuous improvement.

The progress described within this report provides a strong foundation for continued development, as the Trust remains committed to ensuring that safeguarding is integral to all aspects of service delivery and organisational culture.

2. SAFEGUARDING CHILDREN AND YOUNG PEOPLE (CYP) WORKSTREAM

During 2025–26, the Children and Young People safeguarding workstream has focused on strengthening governance, practice quality, and system oversight, particularly following the integration of Forward-Thinking Birmingham (FTB) services to BSMHFT in July 2025.

2.1 Key Achievements:

The Safeguarding Children and Young People Policy was updated in 2025 to reflect updated statutory guidance (Working Together to Safeguard Children, 2023), the expansion of the West Midlands Regional Safeguarding Collaboration, ratification of the Trust's Safeguarding Supervision Policy, and the expansion of the Child Protection Information System (CP-IS) to include mental health services. These updates ensure that safeguarding practice across the Trust remains aligned with current national and regional requirements, providing staff with clear guidance to support consistent decision-making, effective information sharing, and timely responses to safeguarding concerns. This helps ensure that children, young people, and families receive safe, coordinated, and compliant care.

Significant work has been undertaken to improve attendance and contribution to Initial and Review Child Protection Conferences (ICPCs and RCPCs), enhancing both the quality of professional reports and engagement in multi-agency safeguarding processes. Mental health practitioners are often uniquely placed to provide insights into parental mental health, family functioning, risk factors, and engagement with services, ensuring that conference discussions and subsequent child protection plans are informed by a comprehensive understanding of the family's circumstances. This approach strengthens multi-agency decision-making, improves information sharing, and supports more effective safeguarding plans for children and young people. This has been particularly important in response to increased CYP demand following the transition of FTB services.

A programme of audit and quality assurance activity has been expanded, including reviews of Early Help, quality of safeguarding referrals, supervision, and conference participation. These audits have helped identify variation in practice and informed targeted improvement plans across services.

In line with local partnership priorities, the Trust completed an evaluation of its recognition and response to child neglect, resulting in a detailed action plan. This included strengthening the internal neglect group and embedding a dedicated Key Line of Enquiry (KLOE) within safeguarding assurance visits. These developments support earlier intervention and reduce the risk of children experiencing ongoing cumulative harm.

Active participation in Solihull Safeguarding Children Partnership and its sub-groups, including Learning and Development and Quality and Assurance, has strengthened partnership working, enabled the Trust to influence local safeguarding priorities from a mental health perspective, and supported the translation of multi-agency learning into service improvements that benefit children, young people, and families accessing BSMHFT services.

Engagement and participation with Birmingham Safeguarding Children's Partnership and subgroups continues to grow following the integration of FTB (CYP) services, with requests for representation within Harm Outside the Home, Keeping Vulnerable Babies Safe, and Children Out of Sight workstreams. This enables the Trust to contribute a mental health perspective to local safeguarding priorities and supports the development of more coordinated responses for vulnerable children and families.

The safeguarding team have Participated in Partnership multiagency audits and learning events, contributing to the safeguarding agenda with a mental health lens, ensuring we are able to advocate for our service users and their families.

Oversight has been strengthened through routine review of all Sudden Unexpected Death in Childhood (SUDIC) notifications, providing greater organisational visibility, strengthening learning from child deaths, and supporting service improvements that contribute to safer care for children and families.

A comprehensive suite of 7-minute briefings has been updated and expanded to reflect emerging themes, including harmful sexual behaviour, fabricated or induced illness, hostile or intimidating parents, and care-experienced parents. These resources support workforce development by improving staff awareness, confidence, and understanding of complex safeguarding issues, promoting more consistent and informed safeguarding practice across services.

Safeguarding support and supervision arrangements have been embedded within all children-facing teams that transitioned from FTB into BSMHFT. This includes the integration of Think Family principles, a minimum requirement for quarterly safeguarding supervision, but many teams are offered a monthly opportunity to engage in safeguarding supervision.

Safeguarding supervision is delivered using a risk-based and proportionate model. Priority is given to services and roles with the highest level of safeguarding responsibility, risk, and complexity, including services that work across children's and adult populations where risks intersect. Safeguarding supervision, alongside clinical supervision, ensures staff are supported, competent and confident to safeguard children, young people and adults at risk, and to collaborate effectively with partner agencies.

The safeguarding team have increased their visibility to clinical teams, by weekly co-location of safeguarding facilitators within CYP core teams and multidisciplinary team (MDT) meetings, this enables staff to seek advice and support and ad-hoc supervision on cases whilst embedding a visible safeguarding presence and strengthening safeguarding culture within frontline practice.

Safeguarding Assurance Visits were completed across a range of services, including Street Triage and the Psychiatric Decisions Unit (PDU), a Community Mental Health Team (CMHT), and MSU-CAMHS. Assurance visits were also initiated within the CYP Division, with the first visit and report completed for the CYP Crisis and Home Treatment Team (CHTT) for under 18s. These visits have strengthened organisational assurance by providing oversight of safeguarding practice, identifying learning opportunities, and supporting targeted service improvements to enhance the safety and wellbeing of service users and their families.

Existing action plans arising from Child Safeguarding Practice Reviews (CSPRs) involving FTB were incorporated into the BSMHFT Safeguarding Team's external review tracker. Oversight and progress against these plans were maintained, alongside completion of multiple additional action plans where learning had been identified through reviews. This approach ensures that learning from serious safeguarding incidents is translated into tangible improvements in practice, helping to reduce the

likelihood of similar concerns recurring and strengthening the quality and safety of care provided to children and families.

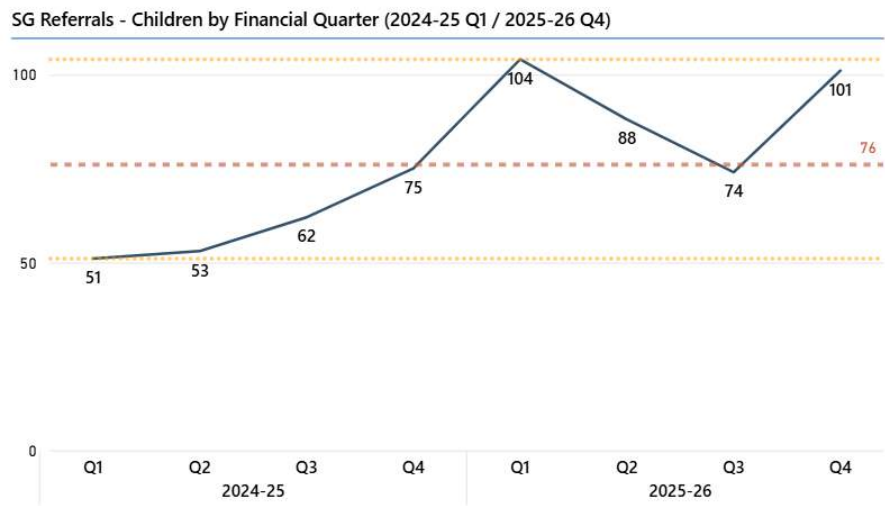
Early Help update sessions were delivered to the safeguarding team by Birmingham and Solihull children's services to strengthen the safeguarding teams' understanding of changes to Early Help models within both local authorities to ensure consistent advice and support for clinical colleagues seeking support. Correspondingly, a 7-Minute Briefing was updated and disseminated via the Safeguarding Hub, training sessions, supervision forums, and the safeguarding duty and advice line.

Safeguarding advice, support, and supervision were provided to Parkview Clinic through a Service Level Agreement between July 2025 and March 2026. A planned and successful handover of safeguarding arrangements back to Birmingham Women's and Children's Hospital NHS Foundation Trust were completed successfully in March 2026.

Changes and improvements to Level 3 Safeguarding Children face-to-face training were implemented. As a direct action arising from safeguarding assurance visits, communications were issued to all senior managers advising that staff working in children-facing services must access BSMHFT-delivered webinar or face-to-face training rather than the NHSE e-learning module. This ensures staff receive training that reflects local safeguarding arrangements, thresholds, referral pathways, and partnership processes, strengthening practitioner confidence and decision-making. As a result, of specialist face to face training, children and young people benefit from staff who are better able to recognise safeguarding concerns, make appropriate referrals, and contribute effectively to multi-agency safeguarding arrangements.

There has been improved incident reporting in relation to children's safeguarding activity, with evidence of more robust recognition, escalation, and response to safeguarding concerns across services, including adult-facing services such as HTTs and CMHTs. This reflects a strengthening Think Family culture, where staff are increasingly considering the impact of adult mental health on children and taking appropriate action to safeguard vulnerable children. Improved reporting supports earlier identification of risk, timely multi-agency intervention, and better outcomes for children and families.

This significant improvement in the completion of incident forms linked to safeguarding children's referrals, demonstrates increased staff awareness and improved governance and oversight of safeguarding through continued engagement with clinical teams via increased visibility, the scope and breadth of the safeguarding supervision offer and increased demand on seeking advice via the team's duty and advice line.



2.2 Key Challenges:

The transition of FTB services into BSMHFT has resulted in a significant increase in safeguarding activity and demand across the workstream. This has placed ongoing pressure on the team, both from an administrator perspective and Named Nurse and Named Doctor capacity. This is due to the volume and complexity of cases requiring advice, consultation, and support.

Challenges have also arisen from dual incident reporting systems (Datix and Eclipse), impacting efficiency and increasing administrative burden. Issues were experienced in the transition of CYP services who use Datix for incident reporting, limiting the BSMHFT Safeguarding Team’s ability to maintain oversight. Interim arrangements were implemented, including receipt of weekly reports, followed by direct Datix access. However, this has increased workload pressures due to the continued requirement to monitor and report across two separate systems.

The implementation of the Child Protection Information Sharing (CP-IS) system into mental health services has been delayed due to digital access issues via the Shared Care Record (SCR). This has been escalated to the ICB and NHS England colleagues, who are providing support. The CP-IS launch deadline has now been rescheduled to September 2026.

CP-IS is an important safeguarding tool for mental health services, providing clinicians with real-time access to information regarding children who are subject to Child Protection Plans, Looked After Children, and unborn children with safeguarding concerns. Access to this information strengthens risk assessment, supports the Think Family approach, improves information sharing with children's social care, and enables more informed safeguarding decision-making to improve outcomes for vulnerable children and families.

3. SAFEGUARDING ADULTS WORKSTREAM

The Safeguarding Adults function has made strong progress during 2025–26, with a clear focus on strengthening quality assurance, embedding safeguarding into everyday clinical practice, and using data and thematic learning to drive improvement.

Key developments include the introduction of intelligence-led audit processes, expansion of safeguarding supervision across all inpatient settings, and increased workforce development through targeted training such as PIPOT.

There has been a notable rise in safeguarding activity and reporting, reflecting improved staff awareness, confidence, and governance, evidenced by a significant increase in incident reporting and growing use of the duty and advice line.

Enhanced visibility of the safeguarding team, alongside deeper engagement with clinical services and multi-agency partners, has supported the embedding of the “Think Family” approach and improved organisational insight into complex themes such as self-neglect and hoarding.

While challenges remain, including rising demand, increased Safeguarding Adult Review and PREVENT activity, and the need for consistent practice across services, the overall trajectory demonstrates a more proactive, data-informed, and partnership-driven approach to safeguarding that is strengthening patient safety and outcomes.

3.1 Key Achievements:

Introduction of an audit of incident reporting, enabling identification of high-risk areas and emerging safeguarding themes. Two audits were completed in 2025/26, with more planned for 2026/27. This has enhanced the team’s ability to target support and drive preventative action.

Greater integration of safeguarding into routine clinical oversight through supervision and ward-based engagement has strengthened the identification, assessment, and management of safeguarding concerns within day-to-day clinical practice. This supports earlier recognition of risk, enhances staff confidence in responding to complex situations, and contributes to safer, more person-centred care for adults at risk and their families.

The expansion of safeguarding supervision to all inpatient settings has strengthened safeguarding practice, increased staff confidence in managing complex cases, and supported earlier identification and management of abuse, neglect, exploitation, self-neglect, and other safeguarding risks, contributing to improved patient safety and wellbeing.

A structured PIPOT (People in Positions of Trust) training package was developed, with rollout to inpatient services underway in 2026 and continuing as a priority for 2026/27. The training aims to strengthen staff awareness and understanding of their responsibilities when concerns arise involving people in positions of trust, promoting early recognition, timely escalation, and appropriate management of concerns. This supports a culture of openness, accountability, and patient safety, helping to protect some of the Trust’s most vulnerable patients from potential abuse, harm, or exploitation.

Increased organisational focus on complex safeguarding themes, including self-neglect, hoarding, and PIPOT, has improved organisational understanding of areas associated with significant risk and vulnerability. This has enabled targeted improvement activity, strengthened safeguarding practice,

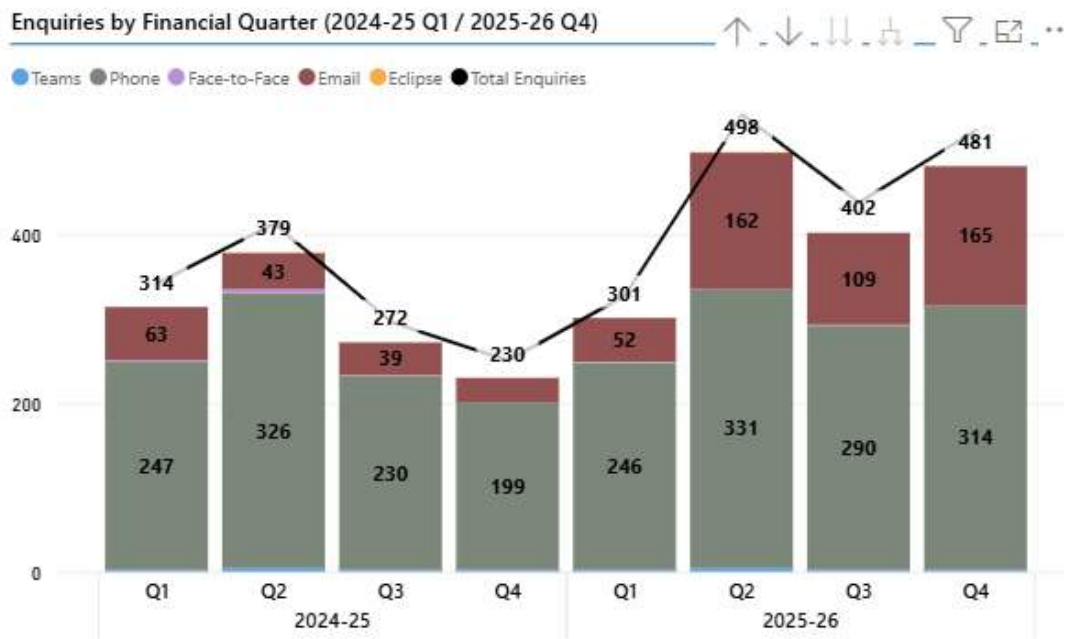
and supported earlier intervention for individuals who may be at risk of abuse, neglect, exploitation, or serious harm.

Completion of thematic audits relating to PIPOT, self-neglect and hoarding has provided valuable assurance regarding safeguarding practice, identified opportunities for improvement, and informed action plans to strengthen the recognition and management of some of the most complex safeguarding concerns encountered within mental health services. The audit work has strengthened organisational insight and informed future priorities. There is an ongoing programme of thematic audits to support learning and service improvement.

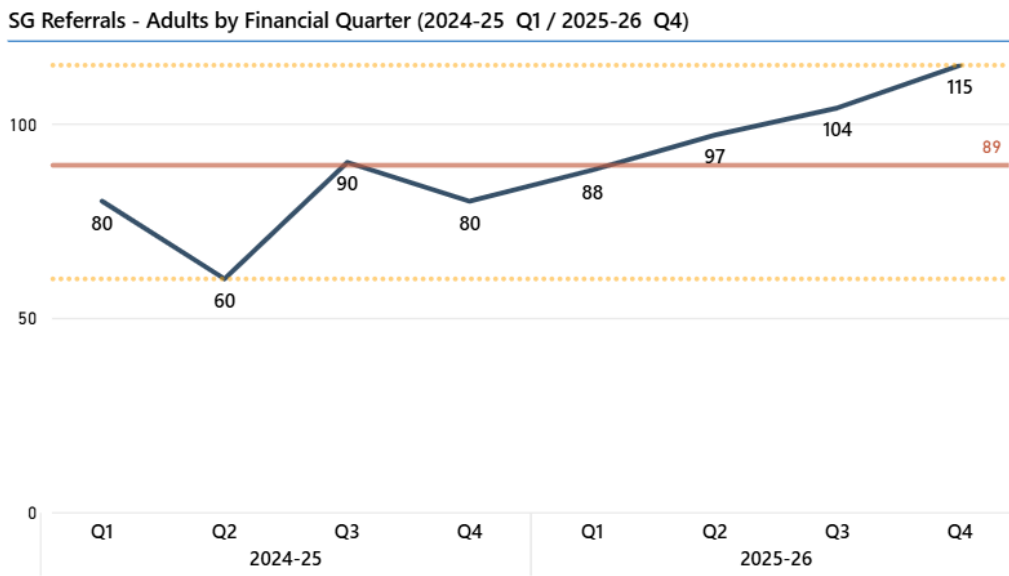
Increased visibility of the safeguarding team within clinical areas, and direct face-to-face engagement with frontline teams, has strengthened the embedding of the Think Family approach across services. Through safeguarding supervision, quality assurance activity, and real-time advice and support, staff have been encouraged to consider the wider needs and risks affecting children, adults, carers, and family members. This has supported earlier identification of vulnerability, improved multi-agency working, and more holistic, family-centred care for service users and their families.

Activity to the safeguarding team's duty and advice line has continued to increase during 2025/26, demonstrating that staff feel increasingly confident in seeking safeguarding advice, guidance, and support. This reflects a growing safeguarding culture across the Trust, where practitioners are proactively discussing concerns, seeking professional challenge, and accessing specialist expertise. As a result, safeguarding risks are more likely to be recognised, appropriately managed, and escalated where necessary, supporting safer outcomes for adults at risk, children, and families.

Analysis of duty and advice line activity demonstrates particularly high levels of engagement from Primary Care and Specialist Psychotherapy Services (SPS), Community Mental Health Teams (CMHTs), and Acute and Urgent Care services, reflecting the complexity of safeguarding concerns managed within these settings and the value placed on accessing specialist safeguarding support.



There has been improved incident reporting in relation to safeguarding activity, with evidence of more robust recognition, escalation, and response to safeguarding concerns across services.



The significant improvement in the completion of incident forms linked to safeguarding referrals demonstrates increased staff awareness, strengthened safeguarding culture, and improved organisational governance.

- Q4 2024–25: 80 incident forms
- Q4 2025–26: 115 incident forms

- This represents a 40% increase in reporting.

The increase provides assurance that staff are more confident in recognising and escalating safeguarding concerns, seeking appropriate support, and fulfilling their safeguarding responsibilities. Improved reporting also strengthens organisational oversight, enabling the Trust to identify emerging themes, monitor risk, share learning, and implement targeted improvements to safeguard adults at risk and improve patient safety. Whilst an increase in incident reporting does not necessarily indicate an increase in safeguarding incidents, it does demonstrate improved recognition, professional curiosity, and confidence amongst staff, strengthening the Trust's ability to identify risk and intervene and share information appropriately.

The safeguarding team has continued to actively engage with Birmingham and Solihull Safeguarding Adult Boards and their sub-groups, including Learning and Development and Quality and Assurance. This strengthens partnership working, ensures mental health perspectives are reflected in local safeguarding priorities and decision-making, and supports the implementation of multi-agency learning to improve safeguarding practice and patient outcomes across the Trust.

Participation in Safeguarding Adult Board multi-agency audits and learning events has enabled BSMHFT to contribute a mental health perspective to the wider safeguarding agenda, ensuring that the experiences and needs of people accessing mental health services are reflected in partnership learning and service development. This supports stronger multi-agency responses to safeguarding concerns, promotes shared learning across organisations, and enables the Trust to advocate for improved outcomes, safety, and wellbeing for service users, carers, and their families.

3.2 Key Challenges:

Rising demand: There has been a notable increase in Safeguarding Adult Review (SAR) activity during 2025/26, placing additional pressure on safeguarding team capacity and requiring sustained organisational engagement in information gathering, review activity, action planning, and assurance processes. Whilst these reviews provide important opportunities for organisational learning and practice improvement, the increasing volume and complexity of SAR activity creates additional resource pressures for both the safeguarding team and operational services.

Growth in PREVENT activity: The Trust has experienced a continued increase in PREVENT-related activity over the past two years, requiring ongoing staff support, training, advice, and multi-agency collaboration. The evolving nature of radicalisation risk and vulnerability requires organisations to maintain workforce competence and ensure timely identification, assessment, and management of concerns.

Consistency of practice: Ensuring consistent safeguarding practice across a large and diverse organisation remains an ongoing challenge. Continued focus is required to embed the Think Family approach, maintain safeguarding awareness, and support consistent reporting and escalation of safeguarding concerns across all services and care settings. Variations in clinical settings, patient groups, and staff experience require sustained investment in training, supervision, quality assurance, and safeguarding support.

4. DOMESTIC ABUSE AND SEXUAL SAFETY WORKSTREAM

The Domestic Abuse and Sexual Safety workstream has made significant progress in 2025–26 across training, culture, system improvement and strategic leadership. Key achievements include the expansion of bespoke training and awareness initiatives, particularly in relation to Domestic Abuse Related Death Reviews, sexual safety, and Adult Child to Parent Abuse; alongside the development of new resources and co-delivered programmes with specialist partners.

The Trust has strengthened a culture of routine enquiry and “Think Family” practice through targeted engagement, supervision, and leadership forums, while enhancing tools, pathways, and guidance such as MARAC processes, risk assessment training, and IDVA provision.

Strong multi-agency collaboration and leadership remain evident through active participation in governance structures, audits, and national forums. These efforts have contributed to improved reporting of domestic abuse and sexual safety concerns, demonstrating increased staff awareness and confidence, alongside ongoing assurance work and the continued embedding of trauma-informed safeguarding across services to enhance patient safety and outcomes.

4.1 Key Achievements:

The safeguarding team has continued to raise awareness of key themes arising from Domestic Abuse Related Death Reviews (DARDRs), including the links between domestic abuse and suicide, the importance of Routine Enquiry and Think Family approaches, and Adult Child to Parent Abuse (ACPA), through bespoke mandatory domestic abuse training. This helps staff to identify domestic abuse earlier, understand its impact on mental health and family functioning, and take timely action to improve safety and outcomes for service users and their families.

Following review of incident reporting, safeguarding intelligence and emerging practice themes, the safeguarding team has commenced development of a dedicated adult child to parent abuse (ACPA) training video resource. This work will continue into 2026/27 and aims to strengthen staff awareness, recognition, and response to a form of abuse that can often remain hidden or poorly understood. Improved practitioner understanding will support earlier identification of risk, more effective support for affected families, and a more coordinated safeguarding response.

The team has delivered a series of Safeguarding Sexual Safety bite-size awareness training sessions to targeted inpatient teams. This work supports the Trust’s commitment to creating safe, therapeutic environments by improving staff confidence in recognising and responding to sexual safety concerns, promoting professional curiosity, and encouraging a culture of openness, reporting, and early intervention. The ultimate benefit is improved safety, dignity, and wellbeing for patients receiving inpatient care and for staff providing the care. This work will continue as a priority in 2026/27.

The safeguarding team has co-facilitated Domestic Abuse Awareness Training across the Trust, based on the IRIS model and delivered in partnership with BSWAID’s Independent Domestic Violence

Advisor (IDVA). This approach combines mental health expertise with specialist domestic abuse advocacy, strengthening staff understanding of domestic abuse, its impact on mental health, and the importance of early identification and intervention. As a result, practitioners are better equipped to recognise abuse, undertake routine enquiry, assess risk, and support service users and their families to access appropriate safeguarding and specialist support.

Delivery of additional targeted safeguarding training is informed by intelligence gathered through Eclipse incident reporting, calls to the safeguarding duty and advice line, safeguarding supervision, assurance activity, and learning arising from statutory review processes. This ensures workforce development remains responsive to emerging risks, organisational learning, and areas of greatest need, supporting continuous improvement in safeguarding practice and enhancing safety outcomes for service users and their families.

The Trust has continued to strengthen its Independent Domestic Violence Advisor (IDVA) provision, which operates across five clinical teams and is available to all female staff across BSMHFT, with access now extended to CYP staff. Male staff requiring support are signposted to appropriate specialist services. The IDVA role provides specialist advice, advocacy, safety planning, and support for individuals affected by domestic abuse, helping to reduce risk, improve access to support services, and promote safer outcomes for both service users and staff experiencing abuse.

Routine Enquiry, Think Family principles, and the recognition and response to domestic abuse have continued to be promoted across mental health services through training, safeguarding supervision, the duty and advice line, and staff consultation. This has strengthened staff confidence in identifying domestic abuse, understanding its impact on adults, children, and family relationships, and responding appropriately to concerns. Increased awareness supports earlier identification of abuse, timely referral to specialist services, and improved safeguarding outcomes for service users and their families.

To further expand the Trust's broad and inclusive safeguarding supervision model, the safeguarding team extended the offer of safeguarding supervision to three Community Mental Health Teams (CMHTs) as a pilot, alongside CYP Crisis 18+. The CMHTs were selected using intelligence gathered through MARAC notifications, safeguarding duty and advice activity, and learning arising from statutory review processes. This targeted approach ensures that safeguarding support is focused on services managing higher levels of complexity and vulnerability, strengthening staff confidence, professional curiosity, and decision-making. The supervision model supports earlier identification of risk, promotes effective multi-agency working, and contributes to improved safeguarding outcomes for service users, children, and families. The pilot commenced in early 2026 and will continue throughout 2026/27, with evaluation informing future development of the supervision model.

The Named Nurse for Domestic Abuse and Sexual Safety attended a range of internal committees and forums, including the People Committee, Medics CPD Master Class, Matrons Away Day, and Freedom to Speak Up Guardian Away Days, promoting awareness of domestic abuse and sexual safety to a broad range of colleagues across the Trust. This has increased the visibility of these important safeguarding themes, strengthened leadership engagement, and supported the development of a culture where concerns are recognised, discussed, and responded to

appropriately. Increased awareness amongst leaders and frontline staff contributes to earlier identification of risk, improved support for those affected, and safer experiences for service users and staff.

A Non-Fatal Strangulation, DASH and MARAC referral training package was developed and delivered to clinical teams. Informed by organisational and partnership intelligence, the training has improved staff awareness of high-risk domestic abuse indicators and strengthened confidence in risk assessment, referral pathways, and multi-agency working, supporting earlier intervention and improved safety outcomes for victims and their families.

The safeguarding team provided support and advice to Urgent Care Matrons to review the Home Treatment Team (HTT) triage tool, embedding Think Family principles within the assessment process. This has strengthened the identification and consideration of children connected to service users at the earliest point of contact, ensuring that potential safeguarding concerns affecting children and family members are recognised and responded to appropriately. The revised approach promotes more holistic assessment, improves understanding of family circumstances, and supports earlier intervention to enhance the safety and wellbeing of service users, children, and their families.

The safeguarding team have continued to actively contribute to multi-agency Domestic Abuse Related Death Reviews (DARDRs), providing specialist mental health expertise to inform analysis, strengthen inter-agency learning, and ensure that recommendations are effectively translated into practice. This includes supporting services to implement agreed actions, monitoring progress, and embedding learning into policy, training, and clinical pathways to enhance safeguarding practice and improve patient safety outcomes.

The safeguarding team have revised and implemented a smarter BSMHFT MARAC administration process to ensure the timely upload of BSOL MARAC notifications onto the Trust's clinical system, enabling clinical teams to be promptly informed of high-risk domestic abuse concerns for service users open to BSMHFT and supporting appropriate risk management and intervention.

Clinical oversight from the safeguarding team has been provided in relation to actions agreed at MARAC for the Trust, including attendance at, and support to staff participating in, multi-agency professionals' meetings to ensure effective implementation and coordinated risk management.

The Named Nurse for Domestic Abuse & Sexual Safety continues to represent BSMHFT at the Priority Operational Group (POG), contributing to the delivery and oversight of Birmingham's Domestic Abuse Strategy. This ensures that mental health perspectives are embedded within the city-wide action plan and informs strategic decision-making reported to the Domestic Abuse Board.

The Named Nurse for Domestic Abuse & Sexual Safety provides senior representation for BSMHFT within MARAC governance structures, including active participation in external MARAC audits, strengthening multi-agency accountability, improving information-sharing, and enhancing partnership effectiveness in managing high-risk domestic abuse cases.

The Named Nurse for Domestic Abuse & Sexual Safety chairs Birmingham MARAC meetings, providing strategic leadership to ensure robust multi-agency risk assessment, coordinated safety planning, and effective oversight of actions to safeguard high-risk individuals and families.

The Named Nurse for Domestic Abuse and Sexual Safety presented BSMHFT's Domestic Abuse and Sexual Safety Workplan to the Violence Against Women and Girls (VAWG) Team at the National Police Chiefs' Council in London. This provided an opportunity to contribute to national strategic discussions, share innovative safeguarding practice, and showcase learning from within mental health services. Engagement at a national level helps ensure that emerging best practice and learning are reflected within Trust services, strengthens BSMHFT's reputation as a leader in safeguarding, and supports the continuous development of approaches that improve safety and outcomes for service users and their families.

There has been a sustained increase in domestic abuse reporting through Eclipse, demonstrating improved staff awareness, confidence, and willingness to identify and respond to safeguarding concerns. This enhanced visibility supports earlier intervention, contributing to improved safety outcomes for service users and reducing risk of escalation for individuals and their families.

A rise in Sexual Safety incident reporting, through both Eclipse and direct disclosures, reflects a strengthening culture of openness and psychological safety. This ensures that concerns are recognised, escalated, and addressed appropriately, with strengthened governance through reporting to the Safeguarding Management Board and TCSE. The impact is improved recognition of harm, enhanced support for victims, and a safer care environment for service users and staff.

Targeted safeguarding assurance visits to South Neighbourhood Mental Health Team (NMHT) and North Community Mental Health Team (CMHT) have enabled the identification of service-specific risks and learning needs, leading to tailored interventions including joint teaching sessions focused on domestic abuse. The introduction of ongoing quarterly safeguarding supervision for North CMHT supports sustained improvement, enhances practitioner confidence, and drives consistent, high-quality safeguarding practice that directly benefits service users and their families.

The team have, during 2025/26, continued to embed trauma-informed safeguarding approaches across BSMHFT services to strengthen person-centred care, ensuring that the safety, dignity, and rights of service users and staff remain central. This approach supports more compassionate, responsive interventions, improves engagement with services, and recognises the wider impact of trauma on individuals and their family networks, contributing to better overall wellbeing and recovery outcomes.

4.2 Key Challenges:

The BSMHFT Safeguarding Team encountered sustained challenges and delays in securing funding for a bespoke Level 3 domestic abuse training resource. The design of this resource is aligned with statutory refresher requirements, necessitating renewal every three years, and as such it is not suitable for repeated delivery to the same staff cohort. The current training provision is due to reach the end of its usable lifespan in November 2026.

Whilst Sexual Safety Awareness Training has been well received, operational pressures continue to impact staff release and training attendance within inpatient services. This presents a challenge to achieving consistent organisation-wide awareness and may slow progress towards embedding a culture where sexual safety concerns are routinely recognised, addressed, and escalated, supporting safer experiences for patients and staff.

Practitioners' understanding and application of safe enquiry in relation to domestic abuse continues to be a recurrent theme identified through Domestic Abuse Related Death Reviews (DARDRs) and safeguarding assurance visits. This highlights a persistent gap between policy expectations and frontline practice, indicating the need for a more targeted and systematic approach to workforce development. Where domestic abuse is not routinely or confidently explored, opportunities to identify risk, understand the experiences of victims, and intervene at an earlier stage may be missed. Strengthening practitioner confidence and competence in this area is therefore critical to improving the early identification of domestic abuse, enhancing risk assessment and safety planning, and ultimately improving safeguarding outcomes for adults, children, and families affected by abuse.

5. QUALITY ASSURANCE & TRAINING WORKSTREAM

5.1 Key Achievements and Progress:

The Section 11 / Children's Act (S11/CA) compliance self-assessment achieved an overall rating of 'Good', reflecting a marked improvement from the previous assessment where some areas required improvement. This demonstrates strengthened organisational assurance and a more robust approach to safeguarding children, supporting improved outcomes for children and families in contact with services.

Safeguarding assurance visits have progressed from a pilot phase to being fully embedded as business as usual, providing a consistent mechanism for identifying risks, sharing learning, and driving continuous improvement in clinical practice. This has supported earlier identification of safeguarding concerns and more responsive interventions for service users and their families.

Successful transition of safeguarding supervision and training arrangements following the FTB transfer/TUPE process has ensured continuity of support for staff and minimised disruption to safeguarding practice. This has been critical in maintaining safe, effective care and consistent safeguarding standards for service users and their dependents during a period of organisational change.

There has been a notable increase in internal audit activity across safeguarding workstreams, strengthening the Trust's ability to identify themes, monitor compliance, and target improvement activity. This data-driven approach enhances organisational learning and promotes safer, more consistent care delivery.

Practice development and capacity building have been strengthened through the introduction of a Safeguarding Champions pilot, supporting the development of local expertise within teams. This model promotes sustainable safeguarding knowledge, increases staff confidence, and improves the quality of care provided to service users and their families.

We have improved the Training evaluation feedback forms to evidence pre and post training knowledge and confidence in safeguarding. The evaluation has demonstrated improved staff confidence in key safeguarding practice areas, indicating that workforce development is translating into improved recognition of risk, more effective decision-making, and better support for individuals and families experiencing vulnerability.

5.2 Challenges:

Further work is required to improve and strengthen the identification, analysis, and presentation of safeguarding themes and trends to ensure intelligence is consistently translated into strategic action and service improvement, building upon the work already done in 2025/26 this will be a key focus for 2026/27.

Ongoing assurance is needed to ensure the consistent embedding of the Think Family approach and carer-focused practice across operational teams, so that the needs and risks of children and families connected to service users are systematically recognised and addressed.

6. PRIORITIES FOR 2026/27

- Work with digital colleagues to Implement CP-IS across identified teams and clinical areas.
- Continue embedding the Think Family approach across the Trust, including the CYP Division.
- Work with Women in Theatre to develop a new domestic abuse training resource with a focus on Adult Child to Parent Abuse (ACPA).
- Continue the rollout of face-to-face Sexual Safety training across inpatient services.
- Further develop safeguarding intelligence to inform priorities and improvement activity.
- Continue expansion of the safeguarding supervision offer.
- Continue delivery of the Safeguarding Assurance Visit Programme to strengthen organisational assurance, support triangulation of safeguarding intelligence, identify learning and development opportunities, and drive continuous improvement in safeguarding practice across the Trust.

5. CONCLUSION

Overall, 2025/26 has been a year of significant progress, development, and strengthening of safeguarding practice across BSMHFT. Despite increased demand, system complexity, and resource challenges, the breadth and depth of work delivered is a testament not only to the commitment and dedication of the safeguarding team, but also to the commitment, engagement, professionalism, and support of clinical colleagues, managers, corporate services, and partner organisations across the system. There is a strong sense of pride in the achievements outlined within this report, which collectively demonstrate a more proactive, intelligence-led, and partnership-driven approach to safeguarding. The progress described has been made possible through a shared organisational commitment to safeguarding, with staff across the Trust continuing to recognise, respond to, and act upon safeguarding concerns to improve outcomes for service users, families, carers, and wider communities.

These developments have not only strengthened governance, assurance, and staff capability, but have also contributed to improved safety, wellbeing, and experiences for service users and their families through earlier identification of risk, stronger partnership working, and more effective safeguarding interventions. As we move into 2026/27, there remains a clear commitment to building on these foundations, continuing to embed learning, drive improvement, and ensure that safeguarding remains central to all aspects of service delivery.

Author: Melanie Yates - Associate Director of Safeguarding

Date: July 2026

Report to Board of Directors						
Agenda item:	12b					
Date	7 October 2026					
Title	Board Safeguarding Commitment and Assurance Statement					
Author/Presenter	Melanie Yates, Associate Director of Safeguarding					
Executive Director	Lisa Stalley-Green, 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	x	
The Board Safeguarding Commitment and Assurance Statement has been reviewed and endorsed by the QPES committee and supported by the Chief Nursing Officer as Executive Lead for Safeguarding. The statement has been updated to reflect current safeguarding legislation, NHS England safeguarding assurance requirements and Trust governance arrangements. This statement supports compliance with Section 11 of the Children Act 2004, the Care Act 2014 and NHS England safeguarding assurance requirements by clearly demonstrating Board leadership, accountability and oversight of safeguarding arrangements. The statement will strengthen evidence within our Section 11 and Care Act self-assessments and provide supporting evidence for CQC Well-Led assessments by demonstrating a clear commitment to safeguarding, effective governance, continuous improvement and organisational accountability. The statement will also provide a clear, publicly available declaration of the Board's commitment to safeguarding and support organisational assurance against the NHS England Safeguarding Accountability and Assurance Framework (SAAF).						
Recommendation						
The Board is asked to approve the statement for publication on the Trust website as the Trust's formal Board Safeguarding Commitment and Assurance Statement.						
Enclosures						
Board Safeguarding Commitment and Assurance Statement						

Board Safeguarding Commitment and Assurance Statement

The Board of Birmingham and Solihull Mental Health NHS Foundation Trust is committed to safeguarding and promoting the welfare of children, young people, adults at risk of abuse or neglect and carers. We recognise our collective responsibility to ensure safeguarding is embedded throughout the Trust and that people who use our services are protected from abuse, neglect, exploitation and harm.

In accordance with the Children Act 2004, the Care Act 2014, Working Together to Safeguard Children (2023), the NHS England Safeguarding Accountability and Assurance Framework (SAAF), and local multi-agency safeguarding arrangements, we are committed to providing safe, effective, compassionate and person-centred care.

The Board is committed to creating a culture where safeguarding is everyone's responsibility and where individuals are listened to, respected and supported to achieve the best possible outcomes.

Our Assurance

The Board receives regular safeguarding assurance and is assured that effective arrangements are in place to support safeguarding across the Trust.

1. Leadership, Governance and Accountability

We are assured that:

- Clear lines of safeguarding accountability are established from Board level through to frontline services.
- Executive and professional leadership for safeguarding are in place and supported by appropriately qualified safeguarding professionals.
- Governance arrangements enable safeguarding performance, risks, incidents, learning and improvement activity to be effectively monitored and acted upon.
- Safeguarding remains a key component of the Trust's quality, safety and governance framework.
- Safeguarding governance, assurance and reporting are aligned to the NHS England Safeguarding Accountability and Assurance Framework (SAAF), enabling the Board to receive appropriate assurance regarding safeguarding effectiveness, statutory compliance and continuous improvement.

2. Competent, Supported and Confident Workforce

We are assured that:

- Staff understand their safeguarding responsibilities and receive role-appropriate safeguarding training.
- Staff have access to safeguarding advice, support and supervision.
- Safeguarding practice is supported through a culture of openness, learning and professional curiosity.
- The voices of children, adults, carers and people with lived experience are used to inform safeguarding practice, service improvement and governance.

3. Effective Policies, Procedures and Practice

We are assured that:

- Safeguarding policies, procedures and pathways are up to date, accessible and aligned to national and local requirements.
- Staff are supported to identify, record, escalate and respond appropriately to safeguarding concerns.
- Safeguarding practice promotes timely, person-centred and outcome-focused interventions.
- Effective partnership working supports coordinated responses to risk and vulnerability.

4. Learning, Improvement and Quality Assurance

We are assured that:

- Learning from safeguarding reviews, incidents, audits, complaints and feedback is used to improve practice.
- Safeguarding quality assurance activities provide oversight of compliance and identify opportunities for improvement.
- Learning from local and national safeguarding reviews is shared and embedded across services.
- Improvement actions are monitored and evaluated to demonstrate impact on practice and outcomes.

5. Think Family Approach

We are committed to a Think Family approach that recognises the interconnected needs of children, adults, carers and wider family networks.

We are assured that:

- Safeguarding practice considers the needs, experiences and wellbeing of all family members.

- Children and carers are recognised as partners in planning and decision making where appropriate.
- Services work collaboratively to provide coordinated support that promotes safety, wellbeing and resilience.

6. Commitment to the Care Act Safeguarding Principles

The Trust is committed to embedding the six safeguarding principles of the Care Act:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

These principles underpin our safeguarding practice and guide how we work with people, families, carers and partner agencies to achieve positive outcomes.

Our Commitment

We will continue to work collaboratively with safeguarding partnerships, commissioners, providers and community organisations to strengthen safeguarding arrangements and improve outcomes for local people.

The Board is committed to maintaining effective safeguarding arrangements, promoting continuous improvement and ensuring that safeguarding remains central to the delivery of high-quality care.

Through strong leadership, effective governance, skilled staff, meaningful engagement and partnership working, we will continue to strengthen our safeguarding culture and seek assurance that our arrangements are effective, responsive and continuously improving.

We are committed not only to meeting our statutory duties but to striving for excellence in safeguarding practice and delivering the highest standards of care, protection and support for the communities we serve.

We recognise that effective safeguarding requires curiosity, cultural humility and a commitment to understanding each person's unique circumstances. We will continue to challenge inequalities and work with individuals, families, carers and communities to ensure safeguarding arrangements are fair, inclusive and effective for all.

Approved by Birmingham and Solihull Mental Health NHS Foundation Trust Board

Signed by:

[Name]

Chair of the Trust Board

[Name]

Chief Executive Officer

[Name]

Chief Nursing Officer and Executive Lead for Safeguarding

Approval date:

Review date:

Committee Escalation and Assurance Report

Name of Committee	People Committee
Report presented at	Board of Directors
Date of meeting	7 October 2026
Date(s) of Committee Meeting(s) reported	22 September 2026
Quoracy	Membership quorate: Y
Agenda	The Committee considered the following items: • Staff Story • Board Assurance Framework Risks • Corporate Risk Register • Workforce Dashboard • Freedom to Speak Up Guardian Quarterly Report • Medical Directorate Quarterly Report • Staff Standards Report • Leadership and Management Framework • Workforce Plan Progress Report • Shaping our Future Workforce Committee Assurance Report • Transforming our Culture and Staff Experience Group Assurance Report • Race Equity Network Report • Multi-Professional, Education and Training Group Assurance Report • Safer Staffing Report
Alert:	• Workforce pressures remained a significant concern, with sickness absence reported at 6.6%, increasing from earlier in the year. The Committee highlighted the need for targeted intervention in identified hotspot areas and closer monitoring as the Trust entered the winter period. • Concerns were also raised regarding continued reliance on bank staffing, particularly within acute services, and the impact on workforce sustainability. • Racism and discrimination remained a material workforce risk. The Committee noted ongoing concerns regarding staff experience of racism and discrimination, including incidents involving service users and members of the public. Whilst improvement initiatives were in place, the issue continued to be reflected through staff feedback, Freedom to Speak Up data and workforce risk discussions. • Psychological safety and confidence to speak up continued to require attention. The Freedom to Speak Up Report highlighted concerns relating to workplace culture, fairness, consistency, leadership behaviours and staff confidence in raising concerns.
Assure:	• Assurance was provided that actions are underway to address workforce risks, including targeted support to identified hotspot wards, reduction of long-running employee relations cases, strengthened sickness management arrangements and focused oversight of bank staffing usage.



	- The Committee received positive assurance regarding the quality of education, training and workforce development arrangements, including continued progress against the Workforce Plan, strong appraisal performance within the medical workforce, enhanced leadership development opportunities and successful accreditation of key training programmes. - Assurance was provided that the Trust continued to progress its cultural improvement agenda through the Culture of Care programme, Listening Promise, Zero Tolerance approach, Freedom to Speak Up arrangements and staff network activity.
Advise:	The Committee endorsed the proposed approach to implementing the new NHS Staff Standards, noting the requirement for a Trust-wide baseline assessment to establish current performance, identify gaps and ensure readiness for future NHS oversight requirements. Significant emphasis was placed on leadership and management capability as a key dependency underpinning delivery of the Trust Strategy, Culture Goals, staff experience improvement and workforce performance. The Committee advised continued focus on demonstrating measurable outcomes and impact rather than process compliance alone. The Committee highlighted the importance of strengthening onboarding, retention and career development pathways, particularly for early-career staff, apprentices and future workforce pipelines.
Reducing Health Inequalities impact:	The Committee received assurance that reducing health inequalities continued to be embedded across the Trust's people, culture and workforce agendas. The Committee noted the alignment between the emerging NHS Staff Standards, leadership and management framework, Culture of Care programme, PCREF, health inequalities work and wider inclusion initiatives, recognising the importance of a coordinated approach to improving staff experience and outcomes. The Committee emphasised the need to ensure that all colleagues, regardless of background, profession or location, experienced equitable access to development opportunities, support mechanisms and positive workplace cultures. Continued scrutiny would be maintained through staff experience data, Equality, Diversity and Inclusion programmes, staff networks, Freedom to Speak Up intelligence and workforce metrics to ensure inequalities were identified, addressed and that improvements translated into measurable outcomes for staff and the communities the Trust serves.
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 alignment to the new Trust Strategy, and noted improved visibility of interdependencies between strategic risks and oversight through Board, Audit Committee and executive governance arrangements.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Sue Bedward, Non-Executive Director	Minutes available from: Kat Cleverley, Company Secretary

Report to Board of Directors						
Agenda item:	14					
Date	7 October 2026					
Title	Medical Directorate Annual Board Update – Medical Appraisal, Revalidation and Job Planning					
Author/Presenter	Kerry Rowley – Presenter Dr Fabida Aria					
Executive Director	Dr Fabida Aria	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 Trust Board is requested to note the content of this report, receive assurance regarding the Trust's arrangements for medical appraisal, revalidation and job planning, and approve the signing of Annex A, the Designated Body Annual Board Report and Statement of Compliance, provided as Appendix 1. Introduction The Medical Directorate is required to report annually to Trust Board regarding medical appraisal, revalidation and job planning. This report provides an update on current priorities, achievements and emerging challenges across these areas and provides assurance regarding the Trust's delivery of its statutory and organisational responsibilities. For medical appraisal and revalidation, the relevant reporting period is the 2025/2026 appraisal year, from 01 April 2025 to 31 March 2026. At the end of this period, 308 doctors held a prescribed connection with Birmingham and Solihull Mental Health NHS Foundation Trust. The Designated Body Annual Board Report and Statement of Compliance is provided separately as <i>Appendix 1</i> and sets out the detailed evidence and assurance required by NHS England in relation to the Trust's appraisal and revalidation arrangements. Key Issues and Risks Service demand has increased significantly since April 2025, driven by changes to workforce models, the expansion of fixed-term medical appointments and the transfer of additional services. This has resulted in a substantial increase in the number of doctors requiring appraisal, revalidation and job planning support, creating sustained pressure across the Medical Directorate portfolio. Despite these pressures, the service continues to operate effectively. Medical appraisal compliance remains high at 98.4%, demonstrating sustained adherence to statutory requirements and established processes. The current medical job planning round is entering its closing stages, with 85% of job plans formally approved and signed off. This represents an improvement of 13% compared with the previous year's closing position.						

A number of capacity constraints continue to present risks to operational resilience. These include suboptimal medical appraiser and appraisal audit capacity, workforce fragility, reliance on a relatively small number of individuals with specialist knowledge and the continuing requirement for senior management oversight. Limited medical appraiser and appraisal audit capacity restricts operational flexibility, places additional pressure on existing resources and remains an ongoing service risk requiring continued monitoring and oversight.

Following a period of workforce instability and recruitment challenges, all vacant posts within the team have now been successfully appointed to. However, implementation of elements of the revised staffing model took longer than originally anticipated, resulting in a prolonged period of operational pressure. The benefits of the strengthened establishment are beginning to be realised as newly appointed staff become established in their roles and revised working arrangements are embedded. Additional senior management oversight and support arrangements remain in place during this transition period.

All agreed actions arising from the medical job planning internal audit have now been completed. The final outstanding action was closed following completion of the required policy amendments, bringing all actions associated with the audit to a conclusion. Assurance regarding completion and implementation has been reported to the Audit Committee.

The next phase of the medical job planning programme will focus on developing and implementing a more standardised, team-based approach. The organisational rationale is the need to improve consistency, transparency and strategic alignment across services and provide greater assurance that medical capacity and programmed activities are aligned with team requirements, patient demand and organisational priorities. This direction is consistent with NHS England guidance supporting standardised job planning, improved understanding of workforce capacity and alignment between clinical capacity and service requirements.

Overall, delivery has been maintained to a high standard. However, continued oversight, stabilisation of workforce capacity and timely implementation of agreed service improvements will remain important in sustaining performance, strengthening resilience and ensuring ongoing statutory compliance.

Recommendation

Trust Board is requested to note the content of this report, receive assurance regarding the progress and actions undertaken in relation to medical appraisal, revalidation and job planning, and **approve** the signing of *Annex A: Designated Body Annual Board Report and Statement of Compliance*, provided as Appendix 1.

Trust Board is also asked to note the sustained increase in service demand, the completion of all agreed medical job planning internal audit actions, the progress made in strengthening workforce capacity and the continuing operational resilience risks. Particular attention is drawn to the importance of strengthening medical appraiser and appraisal audit capacity, embedding the strengthened staffing arrangements and progressing the development of a more standardised, team-based approach to medical job planning.

Enclosures

Appendix 1: Annex A - Designated Body Annual Board Report and Statement of Compliance.

1. Situation

The Medical Directorate is required to provide an annual report to Trust Board regarding the Trust's arrangements for medical appraisal, revalidation and job planning.

The annual reporting process enables Trust Board to receive assurance that appropriate systems, governance arrangements and controls are in place to support the Responsible Officer in discharging their statutory responsibilities. It also provides an opportunity to consider progress achieved during the reporting period, review current and emerging risks and approve the annual Statement of Compliance for submission to NHS England.

Trust Board is therefore requested to consider this report alongside the Designated Body Annual Board Report and Statement of Compliance provided as Appendix 1.

2. Background

Medical appraisal and revalidation form part of the statutory framework through which licensed doctors demonstrate that they remain up-to-date and fit to practise. Birmingham and Solihull Mental Health NHS Foundation Trust, as a designated body, is responsible for maintaining appropriate appraisal and revalidation arrangements for doctors who hold a prescribed connection with the organisation.

The original Framework of Quality Assurance was developed to support Responsible Officers in providing assurance to their organisational boards regarding medical appraisal. Following its temporary suspension during the COVID-19 pandemic, the framework was reviewed and revised with input from Responsible Officers.

The revised Framework for Quality Assurance and Improvement places greater emphasis on continuous quality improvement alongside organisational assurance. It is intended to strengthen the ability of designated bodies to demonstrate that effective appraisal and revalidation arrangements are in place, while supporting the identification and sharing of good practice.

Under the revised framework, designated bodies are required to submit a Designated Body Annual Board Report and Statement of Compliance to NHS England. The scope and level of detail required have been enhanced compared with previous arrangements, placing greater emphasis on assurance, governance and continuous improvement.

The Designated Body Annual Board Report and Statement of Compliance provided as Appendix 1 relates to the 2025/2026 appraisal year, covering the period from 01 April 2025 to 31 March 2026. It applies to the 308 doctors who held a prescribed connection with Birmingham and Solihull Mental Health NHS Foundation Trust as at 31 March 2026.

Medical job planning is an established annual requirement for medical staff who fall within the scope of the Trust's policy. Electronic medical job planning has been embedded within the Trust since February 2015 and provides a consistent organisational framework through which job plans can be completed, reviewed, approved and reported.

The scale and complexity of these responsibilities have increased throughout the reporting period. Changes to workforce models, the expansion of fixed-term medical appointments and the transfer of additional services have increased the number of doctors requiring support through the appraisal, revalidation and job planning processes. This substantial portfolio requires coordinated administrative, managerial and clinical oversight to maintain compliance, quality assurance and continuity of service.

3. Assessment

3.1 Medical Appraisal and Revalidation

Medical appraisal compliance remains high at 98.4%, demonstrating sustained adherence to statutory requirements and established processes. This provides assurance that effective arrangements remain in place to support doctors through appraisal and revalidation and to enable the Responsible Officer to discharge their statutory responsibilities.

Governance, quality assurance and compliance monitoring arrangements continue to support oversight of appraisal and revalidation activity. These arrangements provide assurance regarding compliance, support the identification of emerging concerns and enable appropriate intervention where required.

Service demand has increased significantly since April 2025, driven by changes to workforce models, the expansion of fixed-term medical appointments and the transfer of additional services. These changes have resulted in a substantial increase in the number of doctors requiring medical appraisal and revalidation support and have created additional demand across all areas of the portfolio.

The scale of the designated body has increased demand across appraisal scheduling and monitoring, revalidation administration, compliance reporting, quality assurance, appraisal audit activity and associated governance requirements.

The current number of trained medical appraisers and appraisal auditors remains suboptimal in relation to the demands of the expanded workload. Capacity constraints continue to place additional pressure on existing resources and increase vulnerability during periods of increased demand, annual leave and unplanned absence.

The Directorate continues to explore opportunities to strengthen medical appraiser and appraisal audit capacity and improve resilience within the existing operating model. However, limited capacity remains an ongoing service risk requiring continued monitoring and oversight.

Service resilience also remains affected by workforce fragility and reliance on a relatively small number of individuals with specialist knowledge and expertise. This limits operational flexibility and reduces resilience during periods of increased demand or absence.

Ongoing workforce management activity continues to require senior management input and oversight, resulting in additional demands on available management capacity. Appropriate arrangements remain in place to maintain operational delivery, statutory compliance and service continuity.

Following a period of workforce instability and recruitment challenges, all vacant posts within the team have now been successfully appointed to. This represents a significant positive development

and is beginning to strengthen service capacity and resilience as newly appointed staff become established in their roles and revised working arrangements are embedded.

Implementation of elements of the revised staffing model took longer than originally anticipated, resulting in a prolonged period of operational pressure. These delays extended the period during which delivery remained dependent on additional management oversight and support.

Although the benefits of the strengthened establishment are beginning to be realised, the full benefits of the additional capacity have not yet been achieved. Additional senior management oversight and support arrangements therefore remain in place during this transition period to maintain performance, statutory compliance and service continuity.

Despite the sustained increase in demand and the capacity pressures experienced throughout the reporting period, the Trust has continued to maintain effective arrangements for medical appraisal and revalidation. This reflects the continued commitment of the team and provides assurance regarding the delivery of the Trust's statutory responsibilities.

3.2 Medical Job Planning

The current medical job planning round is entering its closing stages. At the time of reporting, X% of job plans have been formally approved and signed off. This represents an improvement of approximately X% compared with the previous year's closing position.

Meetings and additional support have continued to be provided to Clinical Directors and Associate Medical Directors throughout the cycle. These arrangements have supported progress, enabled operational issues to be addressed and facilitated the review and approval of outstanding job plans and required in-year changes.

Progress within the current round remains encouraging, particularly when considered alongside the significant increase in the size and complexity of the medical workforce. Greater engagement across clinical and operational leadership teams will be required to ensure that outstanding discussions, reviews and approvals are concluded and the current round is brought to completion.

The Trust is also required to submit a monthly NHS England Provider Workforce Return detailing the number of completed job plans for medical staff. This reporting requirement reinforces the importance of maintaining accurate and current job planning records.

The medical job planning internal audit, undertaken jointly by internal audit and Local Counter Fraud Services, reviewed the Trust's arrangements for maintaining current medical job plans and overseeing potential conflicts involving NHS time and responsibilities.

The audit identified a number of opportunities to strengthen existing arrangements. Progress against some of the recommendations was affected by workforce limitations, competing operational priorities and wider capacity pressures, contributing to delays in implementing elements of the required improvement work.

All agreed audit actions have now been completed. The final outstanding action was closed following completion of the required policy amendments, bringing all actions associated with the audit to a conclusion. Assurance regarding completion and implementation has been reported to the Audit Committee.

Completion of the final action represents an important milestone for the Medical Directorate and responds to previous Audit Committee concerns regarding the outstanding policy amendments.

The next phase of the medical job planning programme will focus on the development and implementation of a more standardised, team-based approach. The organisational rationale for this development arises from the current predominantly individualised approach to medical job planning and the variation in processes, information quality and governance between services. These arrangements limit visibility of collective medical capacity and reduce assurance that programmed activities are consistently aligned with team requirements, patient demand and organisational priorities.

This direction is consistent with NHS England guidance, which supports standardised and transparent job planning, improved understanding of workforce capacity and stronger alignment between clinical capacity and service requirements.

A more integrated approach will support improved oversight of medical resource deployment, greater consistency across services and stronger links between job planning, workforce planning and service delivery. It will also provide a clearer basis for considering capacity and demand collectively rather than relying solely on individual job planning information.

The proposed approach is intended to strengthen governance, accountability and workforce information, supporting more effective deployment of medical capacity and stronger organisational assurance regarding workforce utilisation, financial stewardship and service delivery.

Greater engagement across clinical and operational leadership teams will be required to support the successful development and implementation of team-based medical job planning. Appropriate governance, communication and stakeholder engagement arrangements will also be required to ensure that responsibilities are clear and that the intended benefits are fully realised.

Overall, medical job planning continues to progress despite sustained growth in demand and the operational pressures experienced during the reporting period. Completion of the current round, continued monitoring of the revised audit arrangements and development of a standardised, team-based approach will be important in strengthening the consistency, transparency and effectiveness of medical job planning across the organisation.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Birmingham and Solihull Mental Health NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	Review and appoint to a Deputy Responsible Officer role if deemed necessary
Comments:	Discussions have been initiated regarding appointing to a Deputy Responsible Officer role to support the existing portfolio, which has significantly increased in size due to the number of designated body connections.
Action for next year:	Establish if a Deputy Responsible Officer role is necessary.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Review and realign resources to ensure the Responsible Officer role is adequately supported, reflecting the size and complexity of the current portfolio. Progress interim secondment to provide short-term operational support while delays in appointing the Medical Appraisal and Job Planning Lead continue. Expand the appraiser cohort by formally training experienced staff recently transferred under TUPE arrangements. Maintain audit continuity through the current interim arrangement while evaluating sustainable long-term solutions.
Comments:	The organisation has historically provided sufficient funding, capacity and resources to enable the Responsible Officer to discharge the duties of the role effectively. Whilst increasing service demand and workforce changes have created operational pressures, steps have been taken to strengthen the existing support arrangements. The administrative model supporting medical appraisal and revalidation was reviewed during the reporting period to improve resilience and capacity. A dedicated Medical Appraisal and Job Planning Lead was appointed to support the day-to-day delivery of the function, and a small number of additional medical appraisers were appointed to strengthen appraisal capacity. The Trust remains committed to ensuring that the Responsible Officer is adequately resourced to fulfil statutory responsibilities, with ongoing oversight through the Medical Directorate and Workforce governance structures. Consideration has also been given to opportunities to strengthen audit processes and improve long-term sustainability. Whilst the potential use of digital and AI-enabled solutions has been identified as an area for further development, operational priorities and capacity constraints limited the ability to fully explore these opportunities during the reporting period. The recent increase in administrative and appraisal capacity provides a stronger foundation from which this work can now be prioritised.
Action for next year:	Review longer-term arrangements for appraisal audit support. Prioritise exploration of digital and AI-enabled solutions to strengthen audit efficiency and sustainability.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	No action.
Comments:	There is robust monthly monitoring of all licensed doctors with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust which is further enhanced by the triangulation of information at the pre-employment check stage.
Action for next year:	No additional action required at present.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Medical Appraisal and Revalidation policy to be ratified and published.
Comments:	The review period for the policy has been extended to allow for operational pressures within the team. The policy is now under review.
Action for next year	Complete the review of the Medical Appraisal and Revalidation Policy and progress ratification and publication

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Undertake reciprocal peer review with Leicestershire Partnership Trust.
Comments:	A reciprocal peer review arrangement was established with Leicestershire Partnership Trust, and the peer review of appraisal and revalidation processes was completed.
Action for next year:	Arrange and undertake a further reciprocal peer review with Leicestershire Partnership Trust.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	No action from last year.
Comments:	Robust processes are currently in place to identify locum and short-term workers within the organisation. Annual appraisal is provided to those doctors with a designated body connection to BSMHFT, in addition to regular 1-1 meetings, supervision meetings, provision of fundamental and other relevant training and access to governance activities and meetings.
Action for next year	No additional action required.

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Implement a process for an annual Responsible Officer to Responsible Officer communication
Comments:	A mechanism for the transfer of information relating to complaints, patient safety incidents and Learning from Deaths has been established which ensures that all doctors have access to this information for the process of medical appraisal. Refresher training for existing appraisers and new appraiser training for new appraisers is provided. Regrettably we have not yet been able to implement a process for an annual Responsible Officer to Responsible Officer communication.
Action for next year:	Implement a process for an annual Responsible Officer to Responsible Officer communication

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Implement a process for an annual Responsible Officer to Responsible Officer communication.
Comments:	Progress was limited by operational pressures and capacity constraints within the team. The recent increase in capacity provides an opportunity to prioritise and progress this work during the next reporting period.
Action for next year:	Implement a process for an annual Responsible Officer to Responsible Officer communication.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Updated Medical Appraisal and Revalidation policy to be ratified and published.
Comments:	The review period for the policy has been extended to allow for operational pressures within the team. The policy is now under review.
Action for next year:	Updated Medical Appraisal and Revalidation policy to be ratified and published.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	Expand the appraiser cohort by formally training experienced staff recently transferred under TUPE arrangements.
Comments:	A small number of additional medical appraisers have been appointed over the past 12 months. The Trust has also experienced a small number of established appraisers stepping down from the role during the same period. In addition, a cohort of medical staff joined the organisation through TUPE transfer from a neighbouring Trust. This group included several individuals with previous appraisal experience, and a small number have now completed formal appraiser training and have been integrated into the Trust's medical appraiser workforce, helping to strengthen appraisal capacity and resilience.
Action for next year:	Continue to develop and maintain appraisal capacity through succession planning, recruitment and training of medical appraisers.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	Reassess operational capacity and set a timeline to implement 1:1 Medical Appraiser feedback sessions. Finalise and approve the updated Medical Appraisal and Revalidation Policy. Initiate honorary Lay Member appointment process using guidance from the Trust signposted by the GMC. Undertake reciprocal peer review as diarised.
Comments:	Implementation of 1:1 Medical Appraiser feedback sessions was deferred due to operational pressures within the team but will now be prioritised following an increase in capacity. The Medical Appraisal and Revalidation Policy remains under review and completion of the review will now be prioritised.

	Contact has been established with a Trust that has successfully implemented an honorary Lay Member arrangement, and a meeting has been arranged to share learning and inform the Trust's next steps. A reciprocal organisational peer review arrangement was established with Leicestershire Partnership Trust, and the initial peer review has now been completed.
Action for next year:	Implement 1:1 Medical Appraiser feedback sessions. Finalise, ratify and publish the Medical Appraisal and Revalidation Policy. Progress the honorary Lay Member appointment process. Arrange a further reciprocal peer review with Leicestershire Partnership Trust.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Maintain oversight of meeting attendance to ensure continued quorum throughout future personnel changes. Progress honorary Lay Member appointment to completion and embed role within relevant governance structures. Deliver and evaluate outcomes from the reciprocal peer review, incorporating findings into quality improvement planning.
Comments:	Diaries were reviewed following a further change in personnel and continue to support quorate meetings. Progress has been made towards the honorary Lay Member appointment. Contact has been established with a Trust that has successfully implemented this approach, and a meeting has been arranged to share learning and inform the Trust's next steps. A reciprocal organisational peer review arrangement was established with Leicestershire Partnership Trust, and the initial peer review has now been completed.
Action for next year:	Continue to monitor meeting attendance and quorum arrangements. Progress the honorary Lay Member appointment process.

	Arrange a further reciprocal peer review with Leicestershire Partnership Trust.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	No action identified.
Comments:	There have been no missed submission dates for this reporting period.
Action for next year:	No further action required.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	No action
Comments:	All positive revalidation recommendations are made immediately following the Trust's Revalidation Meeting, with doctors being notified in writing the same day. Conversations relating to deferrals or non-engagement are held with the doctor prior to any submissions being made. Additionally, there is a process in place to notify our GMC Liaison Officer prior to revalidation for any doctors where non engagement may be of concern.
Action for next year:	No action

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	No action
Comments:	The Trust has established medical governance arrangements which support effective clinical governance for doctors. These are led through the Medical Director, supported by the Deputy Medical Directors, Clinical and Associate Medical Directors and relevant corporate and operational governance structures. Medical governance includes oversight of appraisal and revalidation, job planning, medical workforce matters, professional standards and concerns, statutory and mandatory training, and arrangements for responding to concerns about doctors' practice. The Trust has implemented the Patient Safety Incident Response Framework (PSIRF), with learning from patient safety incidents, emerging themes and improvement activity feeding into wider clinical governance and medical leadership processes. There are clear routes for identifying, reviewing and escalating concerns relating to clinical practice, conduct, capability or professional performance, with appropriate links to HR, patient safety, safeguarding and other governance processes. Learning and assurance from these processes are used to support continuous improvement in medical practice and patient care.
Action for next year:	No further action required

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Implement a process for an annual Responsible Officer to Responsible Officer communication.

Comments:	The Trust continues to maintain established arrangements for information sharing between the Investigation, Complaints, Learning from Deaths and People Teams. The Trust also continues to operate a Decision-Making Group and follows the Maintaining High Professional Standards (MHPS) framework. Development of an annual Responsible Officer to Responsible Officer communication process in relation to private providers and serious incidents, complaints, mortality case note reviews and disciplinary matters has not yet progressed due to operational pressures within the team. Following recent increases in capacity, this work will now be prioritised.
Action for next year:	Implement an annual Responsible Officer to Responsible Officer communication process relating to private providers and serious incidents, complaints, mortality case note reviews and disciplinary matters.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Implement a 'nil return form' in relation to patient safety incidents, complaints and Learning from Deaths data.
Comments:	Our appraisal process is managed via an electronic system, with any additional information relating to patient safety incidents, complaints and Learning from Deaths information being collated and triangulated locally within the appraisal team prior to being shared with the appraisee. It is noted that at this point, receiving this information should not be of 'surprise' to the appraisee, as this information will already have been shared by the relevant Complaint and Patient Safety Teams etc beforehand, as part of the Trust's fact finding and investigation processes. Whilst we have established processes in place in relation to the triangulation of patient safety incidents, complaints and Learning from Deaths, we also wish to implement a 'nil return form' confirming zero patient safety incidents, complaints and Learning from Deaths data for those appraisees with no events to report for inclusion into their appraisal documentation. Unfortunately, we have not yet been able to implement this due to capacity issues within the immediate team.
Action for next year:	Implement a 'nil return form' in relation to patient safety incidents, complaints and Learning from Deaths data.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	No action required.
Comments:	The organisation follows the MHPS which is underpinned by Trust policy.
Action for next year:	No further action required.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	No actions identified.
Comments:	The People Team report into People Committee and Board. The Medical Director, Deputy Medical Director and Senior People Partner (Medical Workforce) have regular meetings with our GMC Liaison Officer to discuss current and potential concerns. The Trust utilises the MHPS Framework to identify and the Decision-Making Group to address required actions.
Action for next year:	No further action.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	Implement a process for an annual Responsible Officer to Responsible Officer communication.
Comments:	A robust method for the use of Medical Practice Information Transfer Forms (MPIT) is in use within the Trust. We are also in the process of scoping a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs, complaints, mortality case note reviews and disciplinary matters. Regrettably, due to team capacity issues this has not yet been actioned.
Action for next year:	Implement a process for an annual Responsible Officer to Responsible Officer communication.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	Re review our governance and performance against 'The Effective Clinical Governance for the Medical Profession document'
Comments:	An initial review was previously undertaken. However, it is planned to complete a further review. This action is carried over from last year.
Action for next year:	Review progress against 'The Effective Clinical Governance for the Medical Profession document'

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Review progress against 'The Effective Clinical Governance for the Medical Profession' document

Comments:	We have previously benchmarked our governance and performance against 'The Effective Clinical Governance for the Medical Profession' document. This action is carried over from last year.
Action for next year:	Review progress against 'The Effective Clinical Governance for the Medical Profession document'

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	No action required
Comments:	The Trust continues to support the professional development and engagement of the medical workforce through a range of established forums, meetings and learning opportunities. These include a development programme for new consultants, the monthly Medical Advisory Committee, Senior Leadership Team meetings, Consultant Continuing Professional Development (CPD) meetings and regular masterclasses. These arrangements provide opportunities for professional development, leadership engagement, knowledge sharing and collaborative working across the medical workforce.
Action for next year:	No further action required

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	No actions required
Comments:	Our Medical Resourcing Team are responsible for the undertaking of pre-employment and background checks prior to doctors commencing in post with the Trust. The use of robust

	documentation to enhance the sharing of information between our Teams continues to work successfully
Action for next year:	No further action

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	No reported action.
Comments:	The organisation has policies and procedures in place to support a safe and secure environment, establishing basic principles for the recognition and response to potential or actual situations. Managing incidents in such a structured and cohesive manner underpins the ability for all staff to work in a safe and secure environment.
Action for next year:	No additional action required.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	No action required.
Comments:	We have a Trust policy in place to promote equality and remove any discrimination to ensure that everyone can fulfil their full potential within the organisation that is inclusive, compassionate, and committed, keeping in line with the Trusts values, the NHS People Plan commitment to equality, diversity and inclusion and reflects the provisions of the Equality Act 2010.
Action for next year:	No action.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	No previous action
Comments:	Our raising concerns and Freedom to Speak up Policy ensures that any concerns raised within the Trust are handled sensitively and appropriately, outlining a clear procedure for reporting if other avenues have failed, are inappropriate or where barriers may exist.
Action for next year:	No further action.

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Implement a 'nil return form'
Comments:	Our appraisal process is managed via an electronic system, with any information relating to complaints information being collated and triangulated locally within the appraisal team. Additionally, there are plans in place to implement a 'nil return form' - carried over from last year.
Action for next year:	Implement a 'nil return form'

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	No action identified.

Comments:	We have policies in situ to support the approach to be taken by the Trust when dealing with incidents and matters of alleged misconduct, and to identify the most appropriate way of dealing with such matters, so that we encourage improvement and learn lessons. The policies provide clarification of the considerations which managers should give to an event and, if appropriate, what processes and employee's rights are applicable when dealing with such matters, to ensure matters are dealt with fairly and consistently and in a supportive manner.
Action for next year:	No further action required.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	No action.
Comments:	The Trust continues to support the development of those involved in medical appraisal and revalidation through a range of professional networks, training and peer support opportunities. The Medical Directorate Manager is a member of a peer support network where medical appraisal and revalidation matters are discussed. Staff supporting the appraisal and revalidation process undertake relevant training and attend national and regional events. The Responsible Officer also participates in professional networking opportunities to support ongoing development and the sharing of good practice. Medical Appraisers undertake appropriate training and refresher development and are invited to attend Appraiser Peer Support sessions twice each year. A reciprocal peer review arrangement is also in place, supporting ongoing assurance, learning and continuous improvement.
Action for next year:	No further actions identified.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	308
Total number of appraisals completed	303
Total number of appraisals approved missed	46 (41 doctors completed their appraisal late following agreed deferrals, with 5 doctors remaining incomplete to due long term sickness absence, maternity or sabbatical leave)
Total number of unapproved missed	4 (all 4 doctors have now undertaken their appraisal)
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	16
Total number of late recommendations	0
Total number of positive recommendations	14
Total number of deferrals made	2
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	14 Trust Case Investigators were initially trained in 2022. Further Case Investigator training has been arranged for 29 October 2026, with 20 staff scheduled to attend.
Total number of trained case managers	No formal record of Case Manager

	training. This will now be prioritised.
Total number of concerns received by the Responsible Officer ²	4
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	172
Median duration of concerns processes closed (working days) ³	75
Total number of doctors excluded/suspended during the period	2
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	69
Total number of new employment checks completed before commencement of employment	Every new starter will complete the following checks: • ID Check • Right to Work / Visa status • DBS • Professional Registration • Qualifications • Occupational Health • Completion of NHS Declaration Form A • Employment References
Total number claims made to employment tribunals by doctors	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of these claims that were not upheld ⁴	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

During the 2025/26 reporting period, the Trust continued to maintain effective arrangements to support medical appraisal, revalidation and professional standards. As of 31 March 2026, the Responsible Officer portfolio comprised 308 doctors with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust. Medical appraisal compliance remained high, with 303 appraisals completed during the reporting period and no missed GMC recommendation deadlines or non-engagement referrals recorded.

A number of actions identified within the previous reporting cycle have been completed. These include the appointment of a dedicated Medical Appraisal and Job Planning Lead, the expansion of appraisal capacity through the appointment and training of additional medical appraisers, and completion of a reciprocal peer review with Leicestershire Partnership Trust. Arrangements also remain in place to support ongoing professional development, quality assurance and networking for the Responsible Officer, Medical Appraisers and staff supporting the appraisal and revalidation process.

Whilst the overall position remains positive, several actions remain in progress. These include completion of the Medical Appraisal and Revalidation Policy review, implementation of an annual Responsible Officer to Responsible Officer communication process, progression of the honorary Lay Member appointment and introduction of Medical Appraiser feedback arrangements. Progress in these areas was impacted by operational and capacity pressures during the reporting period; however, recent increases in administrative and appraisal capacity are expected to support delivery during 2026/27.

The Trust remains committed to continuous improvement and organisational assurance. Particular focus during the coming year will be placed on strengthening appraisal audit arrangements, progressing outstanding quality improvement actions, and exploring opportunities to utilise digital and AI enabled solutions to improve the efficiency, resilience and sustainability of appraisal, revalidation and associated governance processes.

Actions still outstanding

- Establish whether a Deputy Responsible Officer role is required.
- Complete the review, ratification and publication of the Medical Appraisal and Revalidation Policy.
- Implement an annual Responsible Officer to Responsible Officer communication process.
- Implement 1:1 Medical Appraiser feedback sessions.
- Progress the honorary Lay Member appointment process.
- Implement a nil return process for patient safety incidents, complaints and Learning from Deaths information.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

- Review longer-term appraisal audit arrangements.
- Explore digital and AI-enabled solutions to improve audit efficiency and sustainability.
- Review progress against the Effective Clinical Governance for the Medical Profession document.

Current issues

Medical appraisal compliance remained high throughout the 2025/2026 reporting period, with 98.4% compliance achieved. As of 31 March 2026, 308 doctors held a prescribed connection with Birmingham and Solihull Mental Health NHS Foundation Trust. This provides assurance that effective appraisal and revalidation arrangements remain in place and that statutory requirements continue to be met despite increasing demand across the service.

The reporting period was characterised by sustained growth in workload arising from workforce expansion, changes to workforce models and the transfer of additional doctors into the organisation. These factors increased demand across appraisal scheduling, revalidation administration, compliance monitoring, quality assurance, appraisal audit activity and associated governance arrangements.

Whilst all vacant posts within the team have now been filled and additional medical appraisers have been appointed and trained, capacity constraints within the medical appraiser and appraisal audit workforce continue to present challenges to operational resilience. The service remains reliant on a relatively small number of individuals with specialist knowledge and expertise, limiting operational flexibility during periods of increased demand, annual leave and unplanned absence.

A number of actions identified within previous reporting cycles remain in progress. These include completion of the Medical Appraisal and Revalidation Policy review, implementation of an annual Responsible Officer to Responsible Officer communication process, progression of the honorary Lay Member appointment process, introduction of Medical Appraiser feedback arrangements and implementation of a nil return process. Further work is also required to review longer-term appraisal audit arrangements and explore opportunities to utilise digital and AI-enabled solutions to strengthen audit efficiency, resilience and sustainability.

Despite these challenges, recent investment in staffing and appraisal capacity has strengthened the service and provides a more stable foundation from which to progress the remaining improvement actions during 2026/2027 while maintaining effective appraisal and revalidation arrangements.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- Establish whether a Deputy Responsible Officer role is necessary.
- Review longer-term arrangements for appraisal audit support.
- Prioritise exploration of digital and AI-enabled solutions to strengthen audit efficiency and sustainability.
- Complete the review of the Medical Appraisal and Revalidation Policy and progress ratification and publication.
- Arrange and undertake a further reciprocal peer review with Leicestershire Partnership Trust.
- Implement a process for annual Responsible Officer to Responsible Officer communication relating to private providers, serious incidents, complaints, mortality case note reviews and disciplinary matters.

- Continue to develop and maintain appraisal capacity through succession planning, recruitment and training of medical appraisers.
- Implement 1:1 Medical Appraiser feedback sessions.
- Progress the honorary Lay Member appointment process.
- Continue to monitor meeting attendance and quorum arrangements.
- Implement a nil return process in relation to patient safety incidents, complaints and Learning from Deaths data.
- Review progress against the Effective Clinical Governance for the Medical Profession document.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

The Trust continues to maintain effective medical appraisal and revalidation arrangements and has sustained high levels of compliance despite significant growth in the size and complexity of the medical appraisal portfolio. Progress has been made in strengthening workforce capacity, improving service resilience and delivering a number of planned improvement actions during the reporting period.

Whilst some quality improvement actions remain ongoing, these are now supported by a more stable staffing position and increased appraisal capacity. The Trust remains committed to continuous improvement and will focus during 2026/2027 on completing the remaining actions, strengthening organisational assurance arrangements and further developing appraisal and revalidation processes to support safe, effective and sustainable service delivery.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Birmingham and Solihull Mental Health NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Kerry Rowley
Email address:	Kerry.rowley@nhs.net

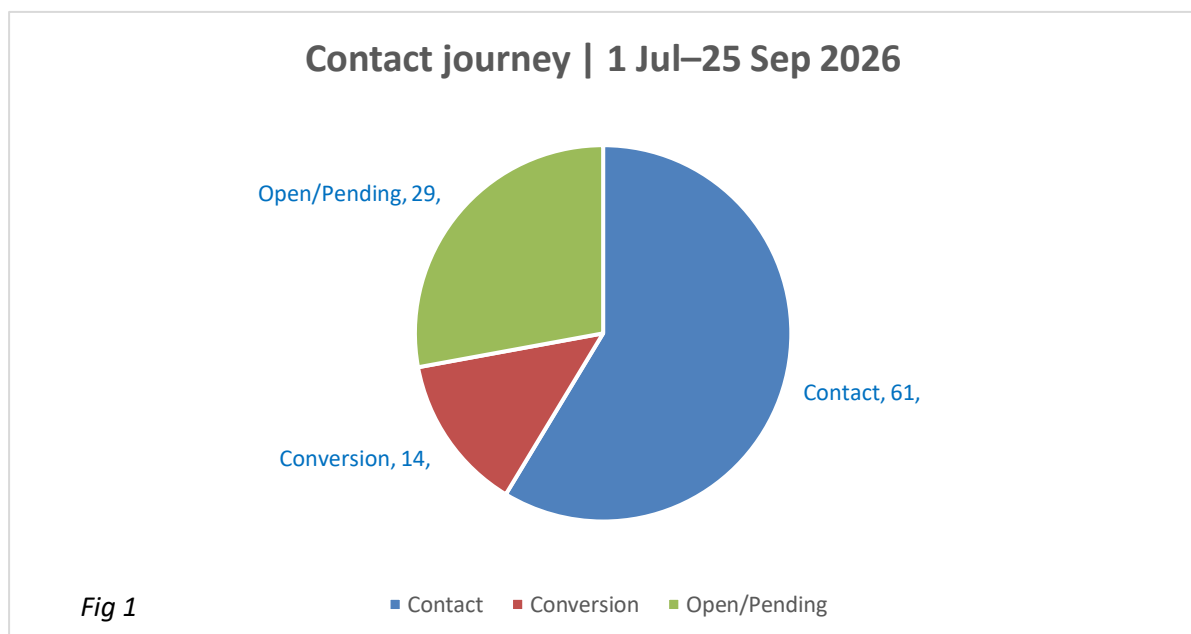
Report to Board of Directors						
Agenda item:	15					
Date	7 October 2026					
Title	Freedom to Speak Up Guardian Report					
Author/Presenter	Emma Randle, Lead Freedom to Speak Up Guardian					
Executive Director	Lisa Stalley-Green (Director of Quality and Safety & Chief Nurse.	Approved	Y	✓	N	
Purpose of Report		Tick all that apply ✓				
To provide assurance		To obtain approval				
Regulatory requirement		To highlight an emerging risk or issue	✓			
To canvas opinion		For information	✓			
To provide advice		To highlight patient or staff experience	✓			
Summary of Report						
Alert	x	Advise	X	Assure	X	
Purpose To provide assurance to the Board of Directors that the Freedom to Speak Up Guardians in partnership with the Trust are taking action to promote the following: <i>Colleagues throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up</i> <i>Speaking up policies and processes are effective and constantly improved</i> <i>Senior leaders role model effective speaking up</i> <i>All colleagues are encouraged to speak up</i> <i>Individuals are supported when they speak up</i> <i>Barriers to speaking up are identified and tackled</i> <i>Information provided by speaking up is used to learn and improve</i> <i>Freedom to speak up (FTSU) is consistent throughout the health and care system, and ever improving</i> This report reflects activity from Quarter 2 (July -September 25, 2026).						
Recommendation						
For Board of Directors to approve the FTSU strategic improvement plan in October's meeting which is informed by the NHSE independent review and the NHSE Reflection and Planning Tool.						
Enclosures						
N/A						

1. INTRODUCTION AND BACKGROUND

- 1.2. This report reflects the activity of the Freedom to Speak Up Guardian (FTSUG) since the Annual Report presented to the Board in April 2026. It covers an incomplete **Quarter 2** (July–25 September 2026) and excludes Freedom to Speak Up Champion activity (FTSUC) as the reporting period is not yet complete.

2. WHO IS SPEAKING UP?

- 2.1 The guardians have recorded 104 contacts.
- 2.2 Guardians and Champions are one route for speaking up, alongside other established routes across the organisation. As expected, most speaking-up activities take place locally through a range of mechanisms.



- 2.3 *Fig 1* above shows that just over 13% of closed contacts required third-party intervention. Although incomplete the trends to date show that 60% of closed cases involve signposting, connecting people with others, wellbeing, and listening support, and are resolved relatively easily. Nine percent of concerns raised were reported anonymously.

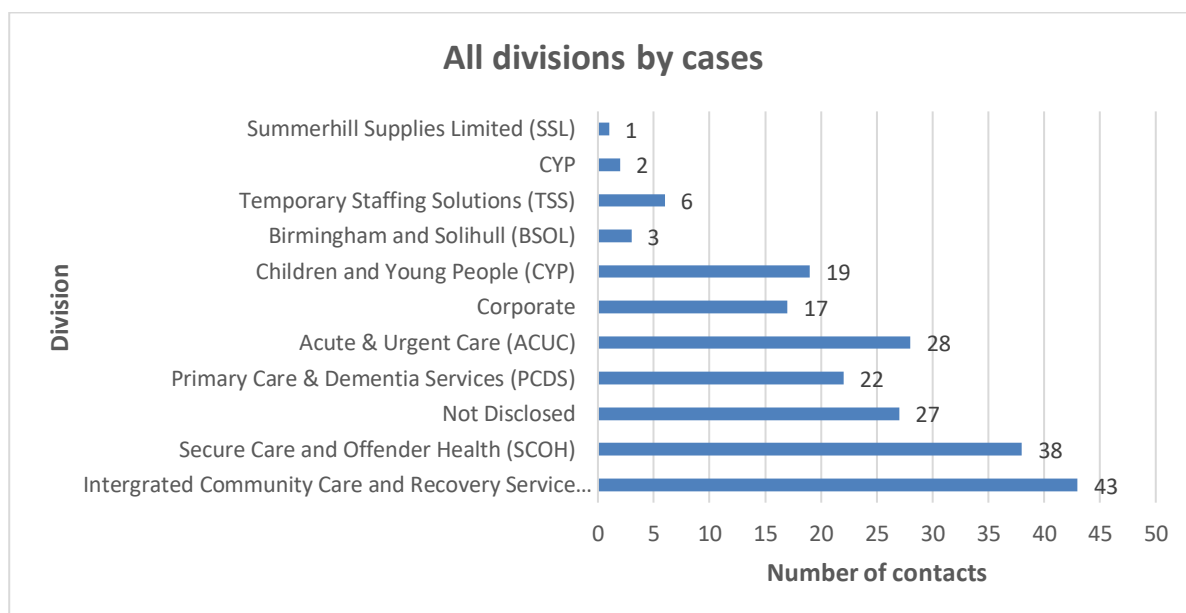
- 2.4 The table below shows the percentage category of concern raised:

Concern category	Selections	% of selections
Inappropriate attitudes/ behaviours	36	35%
Bullying & harassment	10	10%

Worker safety & wellbeing	46	44.%
Patient safety/quality	13	13%

2.5 By staff group, the largest number of contacts came from clinical colleagues, including nurses and others delivering direct patient care, such as healthcare assistants. Almost a third of contacts disclosed a protected characteristic (Global Majority 27%; Disability 4. % ; LGBTQ 2%).

2.6 The graph below details category of concern via location (when this is recorded):



2.7 We meet monthly with executive colleagues to share themes, hotspots, and relevant learning. We take great care to protect individuals' identities where required and seek consent from speakers before escalating cases. Themes and other intelligence are shared with local leadership teams on a case-by-case basis.

2.8 Before closing a case we ask managers and leaders for assurance that concerns have been acted on and feedback is provided, closing the speaking up loop.

2.9 This quarter, cases of disadvantageous demeaning treatment (detriment) per se have been heard by independent decision-making groups (DMGs) chaired by the Executive Lead for FTSU. We will be working with our People Team colleagues to refine and standardise these processes through People/FTSU workshops, and policy guidance The authorship of this policy forms part of our wider improvement plan awaiting sign off by the Board.

3. PATIENT SAFETY CULTURE & THEMATIC ANALYSIS

3.1 **Patient safety concerns** appear closely linked to workplace culture and operating conditions rather than isolated patient harm incidents. Communication failures, weak escalation structures, leadership behaviour, staff wellbeing, and role clarity may reduce the organisation's ability to identify and manage clinical risks early. Records reveal clusters of related concerns raised by different speakers.

3.2 In more detail:

- Direct clinical/quality risks: medication prescribing and failure to collect patient feedback.
- Safety-enabling conditions: absent safety huddles, weak prioritisation, unclear delegation and poor communication
- Leadership culture: staff feeling unsafe to raise concerns or fearing punishment
- Workforce wellbeing: burnout, health-related adjustments and pressure affecting staff's ability to work safely
- Team dysfunction: management conflict, inconsistent processes and poor coordination

3.3 **Wider culture themes** frequently relate to how teams are managed, heard and supported. There is a strong patient safety connection suggesting that poor culture can create conditions in which safety risks are harder to identify, escalate or resolve

3.4 In more detail:

- Fairness and consistency: The largest theme concerns HR procedures, performance processes, investigations, adjustments and perceived inconsistent treatment
- Staff feeling unheard: Communication concerns include inadequate feedback, delayed responses, unclear decisions and concerns not being acted upon
- Leadership behaviour: Management style, delegation, prioritisation and team conflict appear repeatedly and often overlap with wellbeing and safety concerns
- Wellbeing and morale: Stress, anxiety, sickness and low morale suggest that cultural pressures are affecting staff experience and potentially operational resilience
- Speaking-up confidence overall: (50%) were anonymous /restricted to Guardians only indicating that confidentiality remains important when staff raise concerns and that staff remain fearful.

3.5 This analysis suggests a need to strengthen the organisational environment around safety strengthening inconsistent management practice, visibility in follow up, clear

psychologically safe escalation routes, staff support, role clarity and routine safety communication. These are recorded perceptions and signals for review- not confirmed findings or measures of prevalence

4. ANALYSIS by DIVISION

- 4.1 **SCOH** has the strongest combined patient and worker -safety signal. Prominent themes were organisational processes, communication, wellbeing and training/competence. Cases were progressed and resolved quickly
- 4.2 **CYP** has the second largest patient safety signal alongside management, fairness and wellbeing themes. We have received a high number of concerns from CYP and with consent from speakers shared these themes with some of our executives who confirmed there is a comprehensive action plan in place. We have since confirmed this follow up with our speakers and thanked them for their courage in speaking up.
- 4.3 **ACUC** has a significant confidentiality signal- 78% was identity -restricted. Communication and inappropriate behaviour were prominent, suggesting that staff may require stronger reassurance about safe escalation
- 4.4 **ICCR's** main signal is worker safety rather than recorded patient safety. It's high confidential/restricted rate (63%) may indicate sensitivity or fear around speaking openly
- 4.5 **PCDS** predominately reflects HR/process fairness, leadership and communication with 64% using identity restricted routes to raise concerns.
- 4.6 **TSS** has low volume but proportionately higher worker-safety content; conclusions should remain cautious because of small numbers
- 4.7 **BSOL** and other very small groups are too limited for meaningful comparison
- 4.8 Overall, patient safety concerns are concentrated in SCOH and CYP, while cultural concerns- management behaviour, fairness, communication and wellbeing- occur across most divisions. This analysis reflects the use of the Guardian speaking up route, not prevalence or confirmed findings.

5 STRATEGY, CULTURE & PROACTIVE WORK

- 5.1 This month the "listening promise" and the zero-tolerance work will be launched. The main strategic objectives are as follows:
 - Helping colleagues understand what support is available

- Demonstrating that concerns are listened to and acted upon
- Building confidence in speaking up
- Challenging harmful behaviours
- Sharing real examples of change
- Creating a culture where every voice matters

- 5.2 This quarter, we have undertaken day surgeries at the FIRST team at Main House (SCOH); a virtual surgery for the EDS team (CYP) and a full day HMP Birmingham site visit.
- 5.3 The Culture of Care Masterclass “*Conversations that matter*” continues amongst Acute and Urgent Care colleagues. Satisfaction is strong with 95% of colleagues Very or Extremely satisfied; 99% are somewhat or very likely to recommend and 73% say the training is very likely to help leaders build psychological safety.
- 5.4 We have combined the recommendations from NHS England’s external view with the latest completion of the NHS E reflection and planned tool into a consolidated action plan with confirmed oversight and target dates to be agreed. Please refer to link separately.
- 5.5 Feedback from our Champion survey confirmed the network is underused as a driver of culture. Increasing Champion visibility and awareness has therefore been incorporated into the Listening promise communications strategy.
- 5.6 We have started collaborative work on the quarterly safety culture report with our patient safety team. We will be triangulating our data with complaints, and patient safety to more effectively highlight the significant links between organisational culture and patient safety
[NHS Resolution: Being fair 2](#)
- 5.7 In October’s speaking up month our Chair Phil Gayle will be re-launching his *Pull Up a Chair* initiative. This is an informal opportunity to have an open conversation with the Chair about experiences, ideas, suggestions or concerns. The purpose is to listen to colleagues and better understand what is working well and where improvements could be made. Sessions have been arranged at different locations from October- December.

6 ORGANISATIONAL LEARNING & IMPROVEMENT

- 6.1 In February 2026 (Quarter 4) we highlighted the learning and development from the Tamarind Centre which has been highlighted in September’s issue of the Patient Safety Bulletin [Patient Safety Bulletin](#) . This exemplar continues to be presented and discussed with all local CGC’s and in other forums.
- 6.2 Much work has gone into the FTSU Dashboard which can, by division, identify hotspots, map trends, understand themes across professional groups, indicate where detriment is

recorded and provide safety insights without breaching confidentiality. We

plan to provide open access via our internal webpages monthly enabling our workforce to see themes and trends from the previous month, per reporting quarter and historical data from the start of the year. Tips and suggestions are inbuilt into the analysis indicating what a particular view may be telling us about an area, what managers can do and how they can recognise signs of improvement. We will be testing this initially and trialling how the dashboard can be used to triangulate with other service data before it is launched. Analysing our data through AI will allow for a greater level of sophistication and assurance of safety culture insights. Importantly, mechanisms are in place to safeguard speaker identity and accidental disclosure.

6.3 The Thirlwall Public Enquiry [Chapter 40 – Freedom to Speak Up Guardians | The Thirlwall Inquiry](#) reported on September 15th with the following recommendations for FTSU Guardians:

- Support for FTSU Guardians should transfer to the Parliamentary and Health Service Ombudsman.
- The Ombudsman should have powers to investigate poorly handled NHS whistleblowing concerns, refer cases to the appropriate NHS bodies and oversee responses.
- This would strengthen independent oversight and simplify NHS regulation.

Committee Escalation and Assurance Report

Name of Committee	Finance, Performance and Productivity Committee
Report presented at	Board of Directors
Date of meeting	7 October 2026
Date(s) of Committee Meeting(s) reported	29 September 2026
Quoracy	Membership quorate: Y
Agenda	The Committee held a short meeting and considered an agenda which included the following key business items: • Integrated Performance Report • Finance Report • Winter Plan
Alert:	• Operational pressures remained significant. Demand, acuity, clinically ready for discharge levels and inappropriate out-of-area placements had increased, with no assurance at this stage that system winter plans will be sufficient to sustain services through the Christmas period. • The Committee noted that the absence of an appointed Deputy Director of Operations represented a material capacity gap at a time when the organisation needed to deliver transformation at pace. • The Committee noted the improved financial NOF position to segment 1, but acknowledged the significant underlying deficit that required sustainable and deliverable plans to address.
Assure:	• The Committee gained assurance from the breadth and quality of discussion at the Risk Management Group and recognised the significant progress made in strengthening organisational risk management arrangements. • The Committee noted the improved NOF position and the established weekly monitoring of demand, caseloads and operational pressures. • The Committee considered the Winter Plan to be robust and supported its onward submission to the Board for approval, while recognising the challenge of managing existing pressures.
Advise:	• The Committee requested clearer forward projections showing the underlying position before and after mitigations, together with further articulation of the current demand and capacity position. • The Committee requested clear trajectories and evidence of improvement for length of stay, inappropriate out-of-area placements, 24-hour access measures and 104-week waits for children and young people. • The Committee emphasised the need for the transformation plan to support future-proofing, alignment to the Trust strategy and triangulation with oversight through other Board committees. The Committee noted the
Reducing Health Inequalities impact:	The Committee recognised that increasing demand and acuity, delays in discharge, inappropriate out-of-area placements and extended waits for children and young people could result in unequal access to timely and appropriate care. The discussion



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	emphasised the importance of earlier support, reducing avoidable delays and enabling people to receive care in the right setting. Delivery of the transformation and winter plans should therefore consider how these pressures may affect equitable access, experience and outcomes.	
Board Assurance Framework	The Committee considered the two realigned risks during this meeting: • Failure to maintain a sustainable financial position. • Inability to deliver secure, reliable and well-embedded digital infrastructure and systems The Committee noted that a discussion on the BAF would take place at the Board Strategy session in September for agreement and formal approval in October.	
	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	7 October 2026
Date(s) of Committee Meeting(s) reported	20 August 2026
Quoracy	Membership quorate: Y
Agenda	The Committee held a short meeting and considered an agenda which included the following key business items: - Integrated Performance Report - Finance Report
Alert:	- System flow and bed capacity pressures remained significant, with high levels of clinically ready for discharge patients, sustained reliance on out of area placements and ongoing challenges in reducing length of stay. These issues continued to impact operational performance and financial sustainability. - Talking Therapies performance remained below national expectations and was subject to NHS England scrutiny. The Committee noted that historic underinvestment and demand pressures continued to constrain delivery, with further commissioner support required to achieve mandated access standards. - Children and Young People (CYP) services faced ongoing demand and capacity challenges, creating a risk to delivery of national waiting time ambitions and trajectory reductions for long waits. - Financial and delivery risks remain within the 24/7 Neighbourhood Mental Health transformation programme, including recurrent revenue pressures following pilot funding cessation and challenges in utilising national capital allocations within required timescales. - Capital programme risks were highlighted, including the need to reprofile expenditure associated with the Highcroft development and uncertainty regarding delivery of the full Neighbourhood Mental Health Centre capital programme within the current financial year. - Given the ongoing cost and financial pressures, the Finance team had strengthened financial discipline through clear governance and communication, supporting continuous review and control across a broad range of financial measures, including pay, non-pay and technical financial management.
Assure:	- The Committee received assurance that, despite ongoing operational and financial pressures, the Trust remained assessed as low financial risk by NHS England and continued to work towards delivery of its financial plan. The month four position showed a modest improvement against forecast. - Assurance was provided that actions were underway to improve oversight of National Oversight Framework requirements and strengthen local performance reporting arrangements.



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	- Additional clinical capacity had been approved to strengthen CYP referral and triage processes, supporting patient safety and service quality. - The Committee noted strengthened transformation governance arrangements, with refreshed delivery oversight and a programme of work to support implementation of neighbourhood and locality-based models of care. - Transformation remained focused on the redesign of existing services rather than service expansion, with the longer-term aim of improving outcomes, reducing inequalities and reducing dependence on inpatient care.	
Advise:	- The Committee held a substantive discussion on the delivery of the Trust's neighbourhood and locality model and emphasised the importance of maintaining momentum on transformation, recognising this as a critical enabler of the Trust Strategy. - The Committee requested further benchmarking and comparative analysis to provide context for the Trust's position on bed utilisation, discharge performance, out of area placements and workforce pressures. - The Committee recommended greater focus on reviewing transformation delivery plans and benefits realisation to strengthen oversight and assurance of strategic change programmes. - The Committee was advised that early planning for the 2027/28 financial position and efficiency programme was underway and will be developed further.	
Reducing Health Inequalities impact:	The Committee noted that reducing health inequalities remained a core objective of the Trust's transformation programme. Discussion highlighted the role of Neighbourhood Mental Health Centres and locality-based models in improving access to services for underserved communities, particularly where historic patterns of engagement had been low. Early learning from the pilot programme suggested improved access for local populations and greater opportunity to provide timely intervention closer to home, with the potential to reduce reliance on inpatient care and address inequalities in access, experience and outcomes. The Committee was advised that tackling health inequalities would remain a key measure of success as neighbourhood models were further developed and embedded across the Trust.	
Board Assurance Framework	The Committee did not consider the two realigned risks during this meeting: - Failure to maintain a sustainable financial position. - Inability to deliver secure, reliable and well-embedded digital infrastructure and systems	
	New risks identified: no new risks were identified.	
Report compiled by:	Bal Claire, Non-Executive Director	Minutes available from: Kat Cleverley, Company Secretary



Finance Report

Financial Performance: 1st April 2026 to 31st August 2026

Group financial position: £1.4m deficit

Group Summary	Annual Budget	1.24% indicative CUF uplift	Revised Plan	YTD Position		
	£'000	£'000	£'000	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	720,306	8,401	728,706	303,263	309,129	5,866
Other Income	36,377		36,377	15,155	17,246	2,091
Total Income	756,682	8,401	765,083	318,418	326,375	7,957
Expenditure						
Pay	(372,161)	(5,355)	(377,516)	(157,294)	(155,834)	1,460
Other Non Pay Expenditure	(343,813)	(3,045)	(346,858)	(144,131)	(153,413)	(9,282)
Drugs	(7,776)		(7,776)	(3,240)	(4,998)	(1,758)
Clinical Supplies	(857)		(857)	(358)	(316)	43
PFI	(14,550)		(14,550)	(6,064)	(5,780)	283
EBITDA	17,525	(0)	17,525	7,330	6,033	(1,296)
Capital Financing						
Depreciation	(9,505)		(9,505)	(3,960)	(4,340)	(379)
PDC Dividend	(500)		(500)	(208)	(208)	-
Finance Lease	(7,263)		(7,263)	(4,767)	(4,983)	(216)
Loan Interest Payable	(1,275)		(1,275)	(532)	(341)	191
Loan Interest Receivable	3,063		3,063	1,277	1,532	255
Surplus / (Deficit) before taxation	2,046	(0)	2,046	(861)	(2,307)	(1,446)
Impairment	-		-	-	-	-
Profit/ (Loss) on Disposal	-		-	-	-	-
Taxation	(380)		(380)	(158)	(158)	(0)
Surplus / (Deficit)	1,666	(0)	1,666	(1,019)	(2,465)	(1,446)
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease						
I&E impact	78		78	32.36	32	-
Adjust PFI revenue costs to UK GAAP basis	(1,743)		(1,743)	1,004	1,004	-
Adjusted financial performance Surplus / (Deficit)	0	(0)	0	17	(1,429)	(1,446)

The Group position is driven by a £1.5m deficit for the Provider, £285k surplus for Summerhill Services Limited (SSL), break even position for the Mental Health Provider Collaborative (MHPC) and a surplus of £104k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

2026/27 Group Financial Position

The month 5 year to date 2026/27 consolidated Group position is a deficit of £1.4m. 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 5 position is £1.4m adverse to the break-even plan year to date. In month 5, the year to date variance has reduced to less than 0.5% of the year to date income and as such, the National Oversight Framework (NOF) finance score has improved as per the table below.

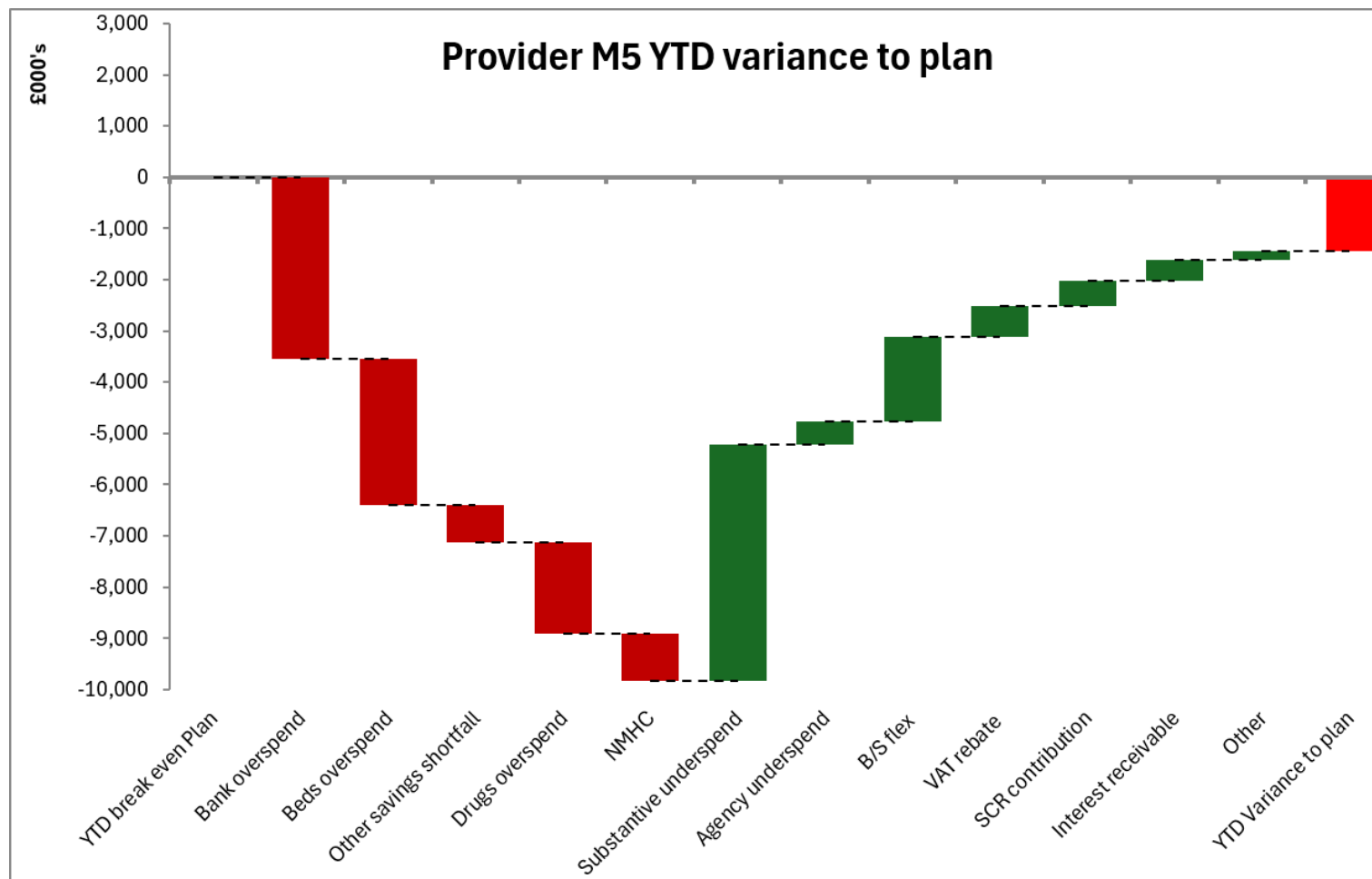
Shortfall on savings delivery, overspend on bank, non-trust beds, and medication is partly offset by substantive pay underspend, release of balance sheet flexibility and other one-off benefits including VAT rebate, additional ICB provider support funding and shared care record contribution. The position includes £0.9m financial impact year to date in relation to the Neighbourhood Mental Health Centre in the East.

On 20.8.26, NHSE issued updated guidance relating to 2026/27 pay awards which confirmed an updated net Cost Uplift Factor (CUF) of 1.24%. This includes the estimated impacts of 2026/27 NHS pay awards, the resident doctor deal and other national pay-related policies. Income and expenditure has been accrued in relation to the updated CUF. The pay reforms in the resident doctor deal will be implemented in staff pay from September 2026, back dated to April 2026. The Agenda for Change pay award was implemented from April 2026 and the pay award for medical and dental staff groups was implemented in June 2026 and backdated to April 2026.

National Oversight Framework 2026/27	YTD Actual £'000				
	M1	M2	M3	M4	M5
NOF - Finance					
NOF variance YTD to plan score	4	4	3	3	2
NOF plan surplus/deficit score	1	1	1	1	1
NOF combined finance score	3	3	2	2	1

Provider variance to plan

ALERT: YTD £1.4m variance to plan



2026/27 National Oversight Framework (NOF)

Finance, productivity and innovation domain

Finance, productivity & innovation domain

- The 2026/27 quarter 1 NOF scores were published by NHSE in September 2026.
- For 2026/27, two additional metrics related to innovation have been added to the finance and productivity NOF metrics.
- All of the domain metrics and the quarter 1 scores are shown in the tables below. The overall finance, productivity and innovation domain score for quarter 1 is 1.34. This places BSMHFT in quartile 1 for this domain.
- At quarter 1, the finance and productivity domain score (excluding innovation) was 2. This has been assessed as improving to a score of 1 at month 5 year to date. The detail of the year to date finance and productivity score is shown on the next page.

Domain summary

Average score

1.34

Performance declined
1.30 in previous quarter

Quartile

1 Highest-scoring 25%

No change
Quartile 1 in previous quarter

Metric	Sub domain	metric score	Q1 domain average score
Combined finance score	Finance	2.00	
Relative difference in costs	Productivity	1.00	
Finance & productivity score		3.00	1.50
Data Quality Maturity Index score	Innovation	1.36	
%of clinical trials set up within 90 days	Innovation	1.00	
Innovation score		2.36	1.18
Finance, productivity & innovation score		5.36	1.34

Domain metrics

Metric ▲	Sub-domain ↕	Value ↕	National benchmark ↕	Score ↕	Rank ↕
Combined finance score	Finance			2	
Data Quality Maturity Index score	Innovation	96.40		1.36	13
Percentage of clinical trials set up within 90 days	Innovation	100%		1	1
Planned surplus/deficit	Finance	0%		1	9
Relative difference in costs	Productivity	94.57%	100%	1	13
Variance year-to-date to financial plan	Finance	-0.97%		3	56

2026/27 National Oversight Framework (NOF)

Finance & productivity domain assessment

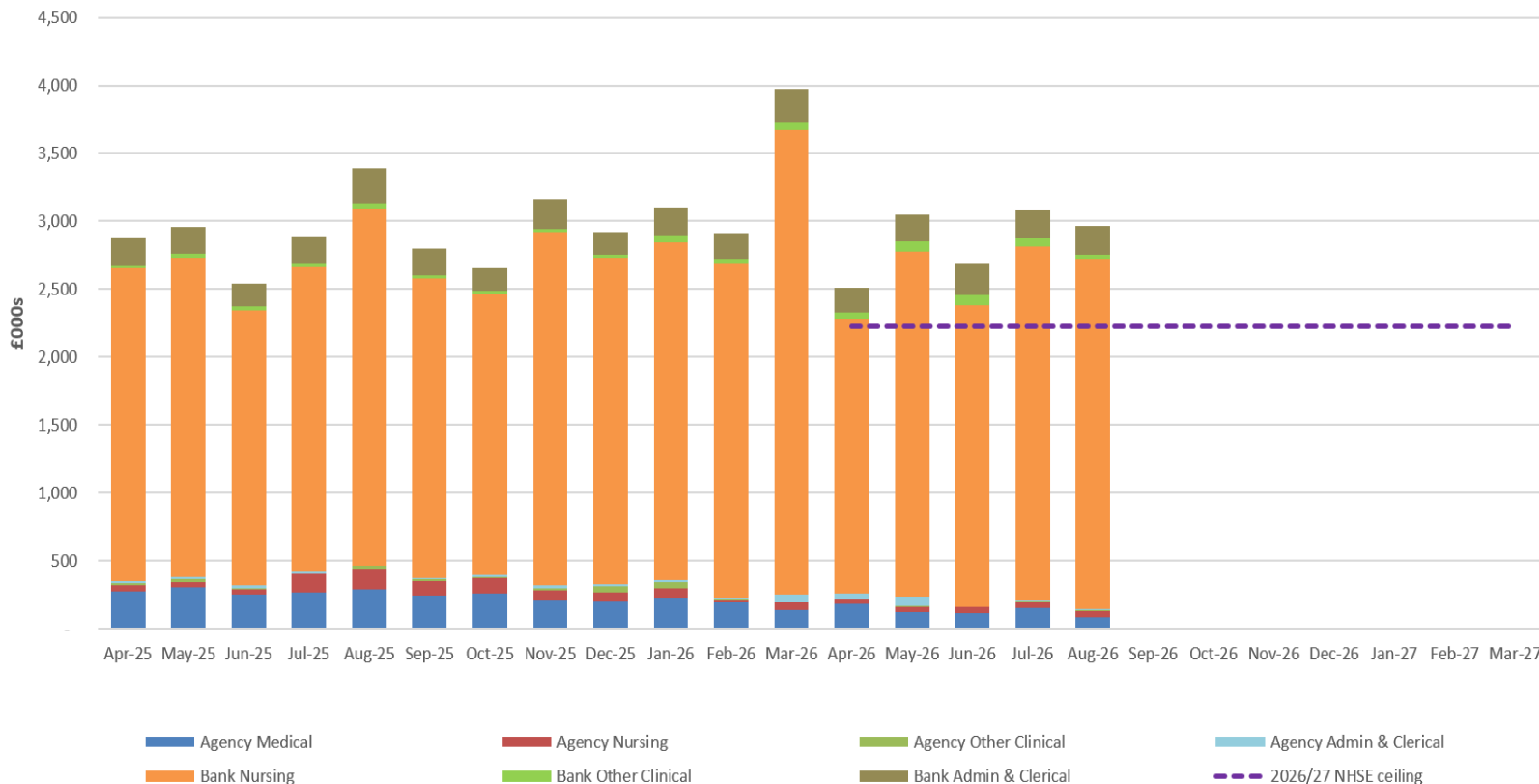
National Oversight Framework 2026/27	YTD Actual £'000					Forecast £'000			Commentary
	M1	M2	M3	M4	M5	Q2	Q3	Q4	
NOF - Finance									
NOF variance YTD to plan score	4	4	3	3	2	2	2	1	Scoring methodology: based on variation to plan as % of YTD income. Month 1 and 2 variance was beyond 1% adverse = score of 4. Month 3 and 4 improvement to a score of 3 (between 0.5% and 1% adverse). Improvement in month 5 to a score of 2 (less than 0.5% adverse). Significant improvement required on savings delivery, non-trust beds expenditure, bank and medication spend to achieve forecast score of 1 in line with break even plan by year end.
NOF plan surplus/deficit score	1	1	1	1	1	1	1	1	Scoring methodology: Break even plan = score of 1. The plan set for 2026/27 is break even, therefore, this metric will remain at 1 all year.
NOF combined finance score	3	3	2	2	1	1	1	1	Scoring methodology: YTD variance to plan and plan score plotted on 16 box grid to determine combined finance score.
NOF - Productivity									
Relative difference in costs score	1	1	1	1	1	1	1	1	Scoring methodology: National Cost Collection score of 100% or less = score of 1. The latest published National Cost collection score (2024/25) is 95%. The indicative 2025/26 score is 97.5%. Hence it is assumed this metric will remain at 1 all year.
NOF Finance & productivity domain score	2	2	2	2	1	1	1	1	Average of combined finance score and relative difference in costs score.

Implied productivity growth is an additional metric for 2026/27. This is non-scoring and we are awaiting further guidance in order to understand and assess this metric.

Temporary staffing expenditure

ALERT: YTD overspend £3.1m

Agency & Bank Spend by Type



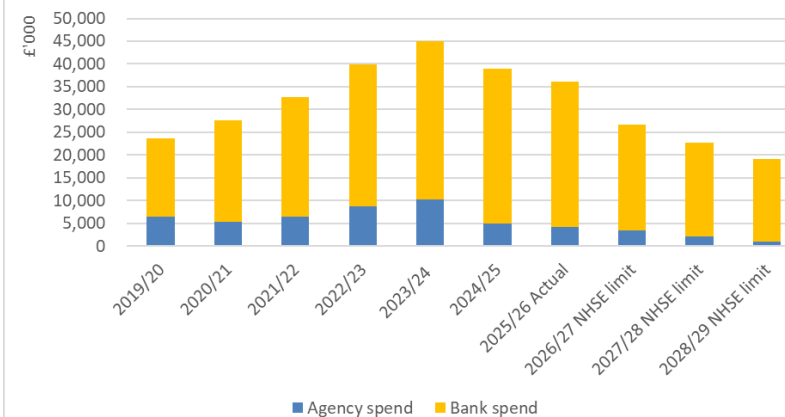
The 2026/27 temporary staffing budget has been set in line with the NHSE limit of £27m (£23.4m bank and £3.4m agency).

Temporary staffing spend is £14.2m year to date, this is £3.1m above the NHSE limit (driven by bank).

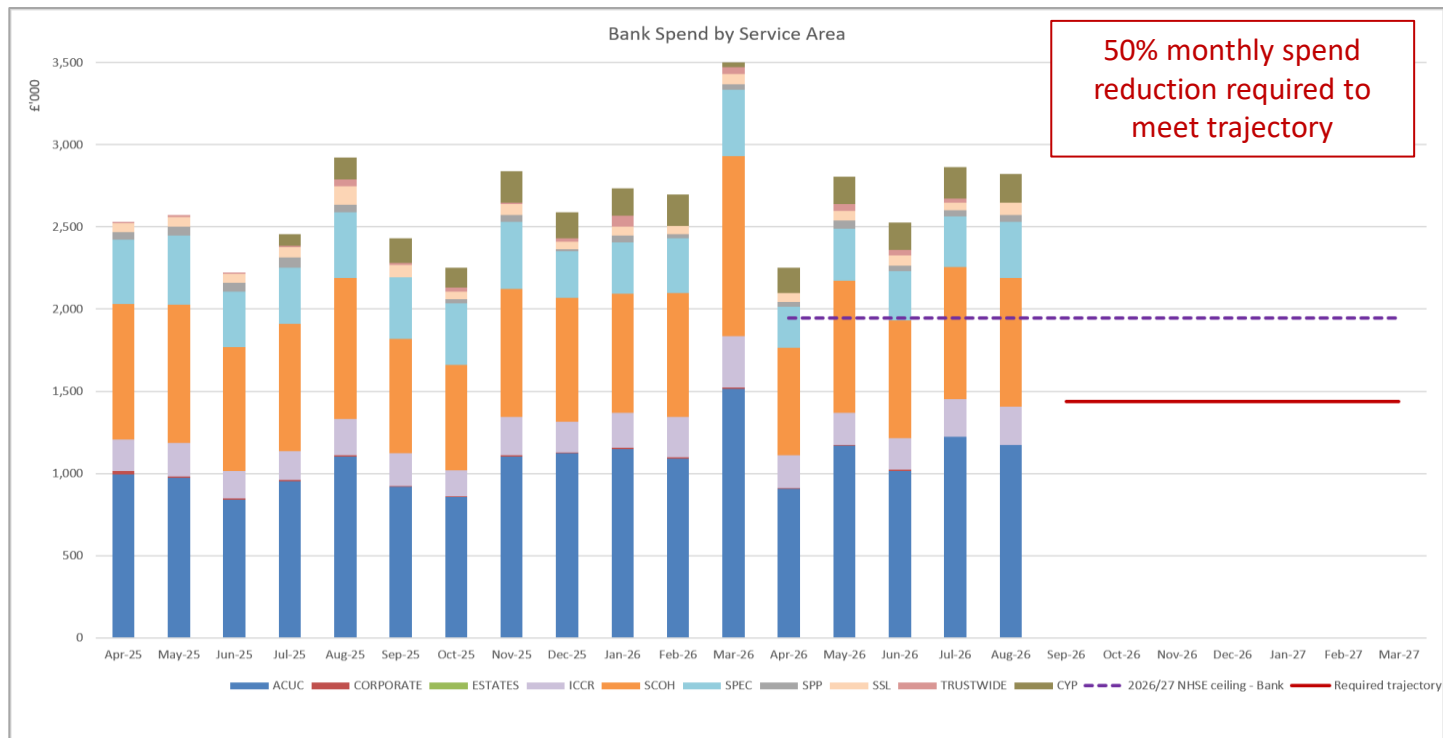
Bank expenditure £13.3m (93%) – the majority of bank expenditure relates to nursing bank shifts - £12m

Agency expenditure £0.96m (7%) – the majority of agency expenditure relates to medical agency - £0.7m.

Total temporary staffing spend



ALERT: YTD overspend £3.5m, forecast risk £7m



Area	2025/26 Actual spend £'000	Annual Plan = NHSE limit £'000	YTD plan = NHSE limit £'000	YTD Actual £'000	YTD Variance £'000
Acute	9,007	6,457	2,690	4,002	(1,311)
Urgent Care & Home Treatment	3,611	2,589	1,079	1,485	(407)
ICCR	2,515	1,788	745	1,046	(301)
Secure & Offender Health	9,488	7,131	2,971	3,758	(787)
Specialties	4,371	3,468	1,445	1,513	(68)
CYP	1,416	1,238	516	855	(340)
Operational	30,408	22,670	9,446	12,659	(3,213)
Corporate	561	114	48	232	(185)
SSL	752	561	234	292	(58)
Trustwide	228	7	2	93	(91)
Total	31,949	23,353	9,729	13,276	(3,546)

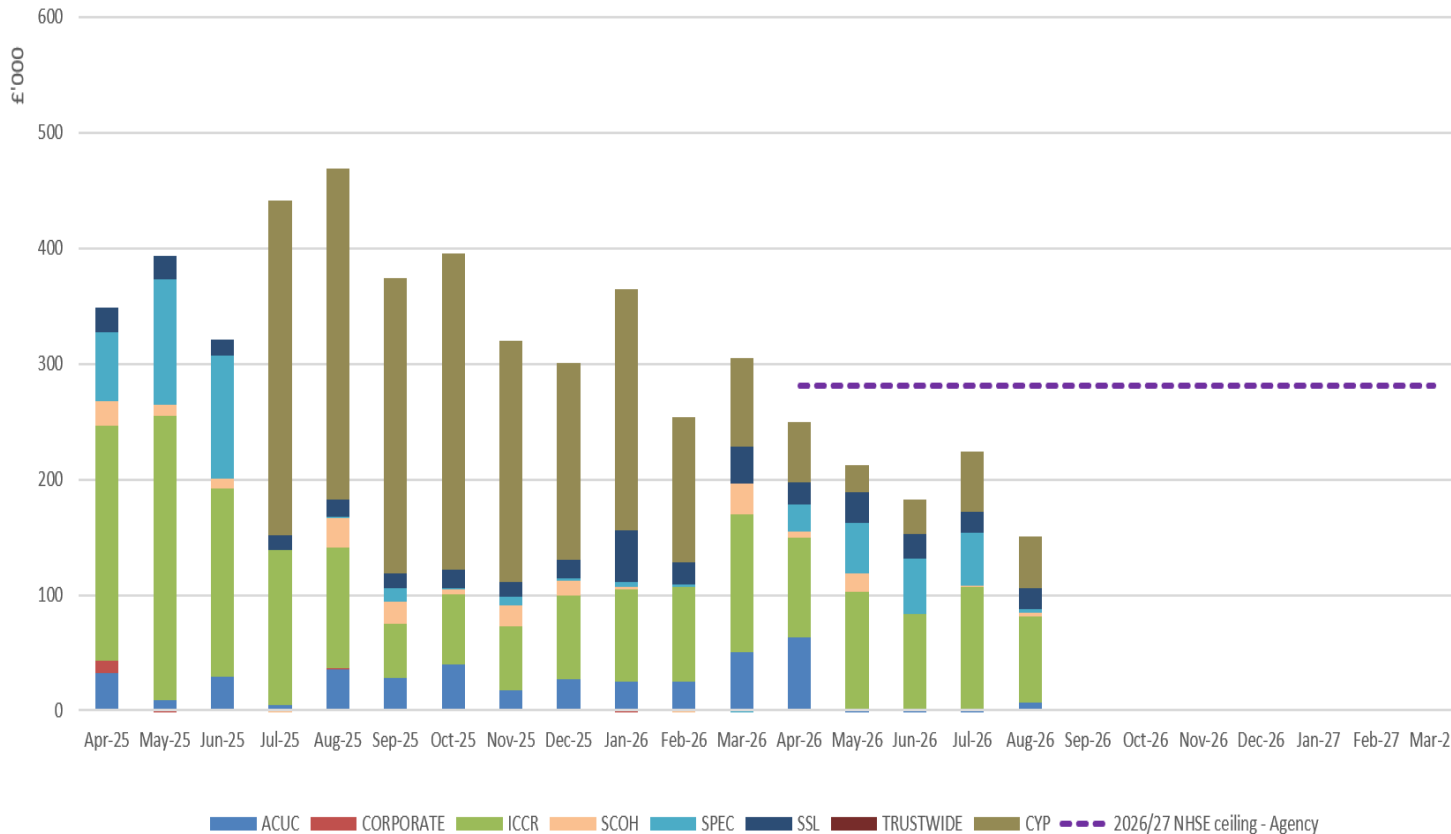
Bank expenditure

- The 2026/27 bank budget has been set in line with the NHSE limit of £23.4m which equates to £1.95m per month.
- Month 5 year to date bank expenditure is £13.3m, which is £3.5m adverse to the NHSE ceiling.
- The year to date monthly average spend is £2.7m which is just above the 2025/26 monthly average. The forecast risk is circa £7m.
- To ensure full year spend is within the NHSE limit, monthly expenditure would need to reduce by half to £1.4m per month for the remainder of the year.
- Almost one third of all bank expenditure and £1.3m of the year to date overspend relates to Acute inpatient wards.
- The Bank Reduction Gold project is ongoing, led by the Chief Nurse. Key actions in process: Introduction of Acute bank expenditure recovery plan, implementation of auto roster, review of pathway for enhanced therapeutic observations and care (ETOC), streamlining HR processes including converting bank to substantive, graduate recruitment into vacant posts from September, sickness reduction and health and wellbeing action plan.

Agency expenditure

Assure: YTD underspend £0.4m

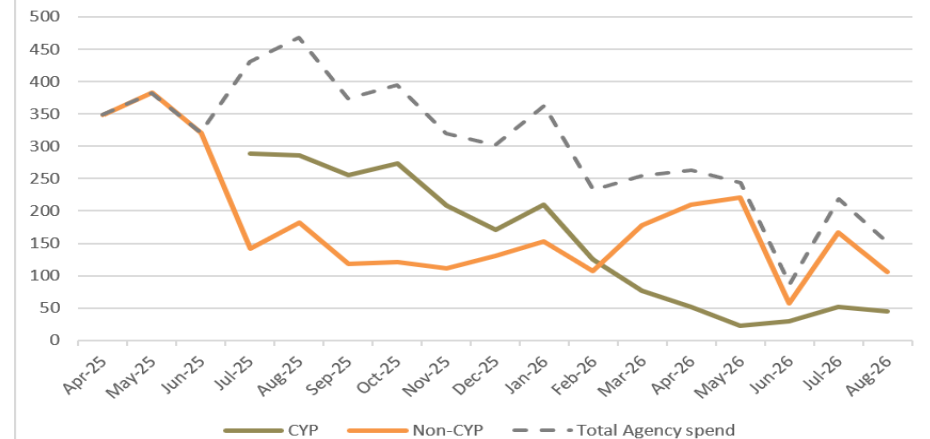
Agency Spend by Service Area



Agency expenditure

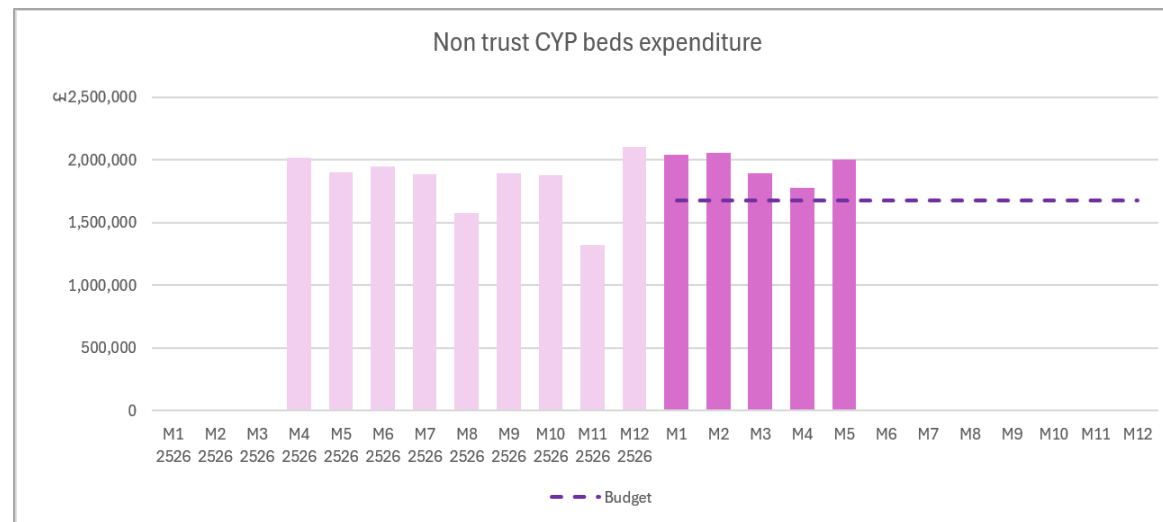
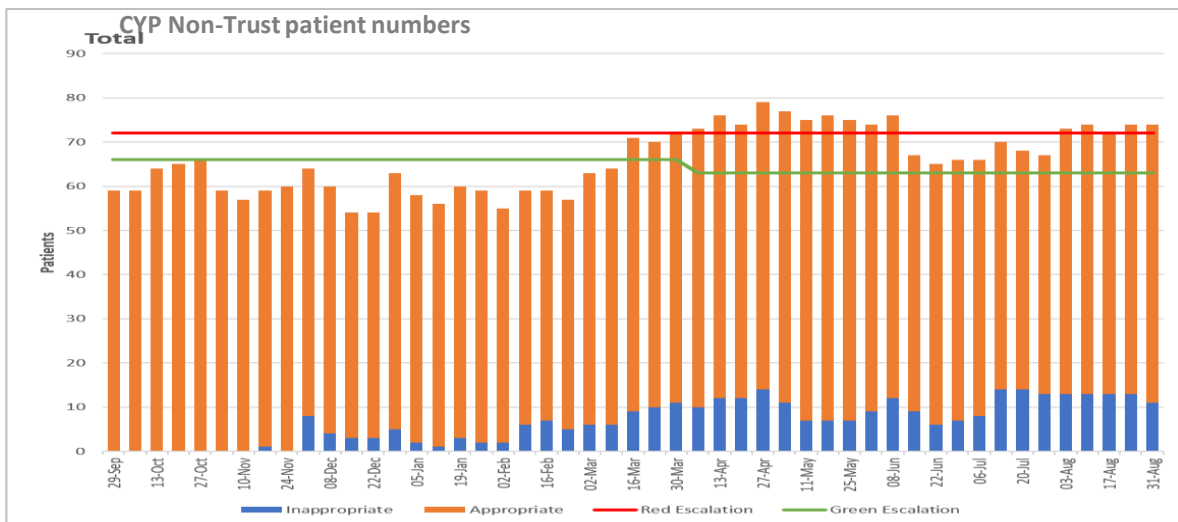
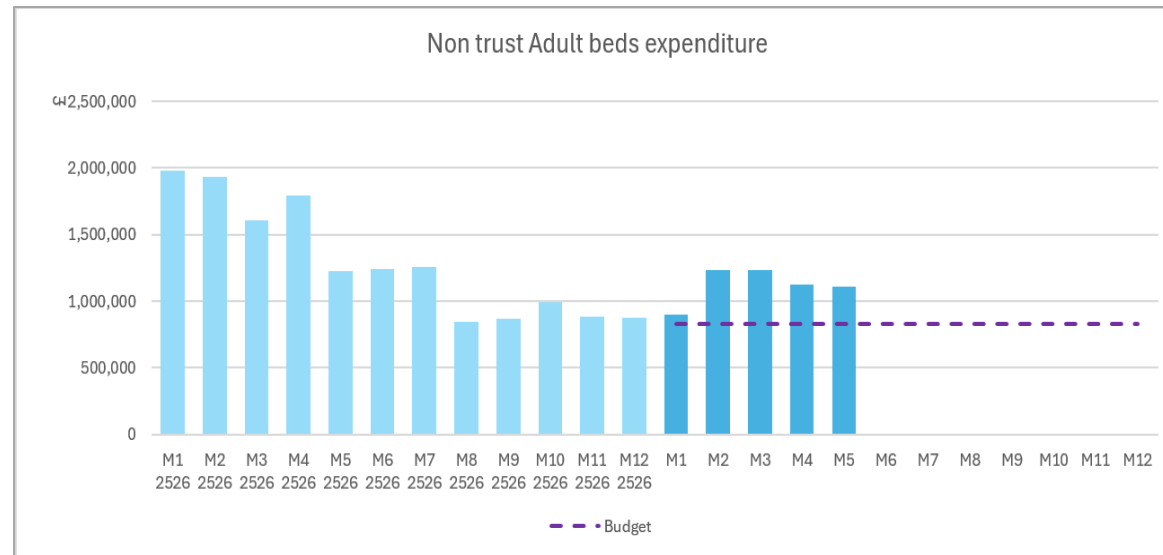
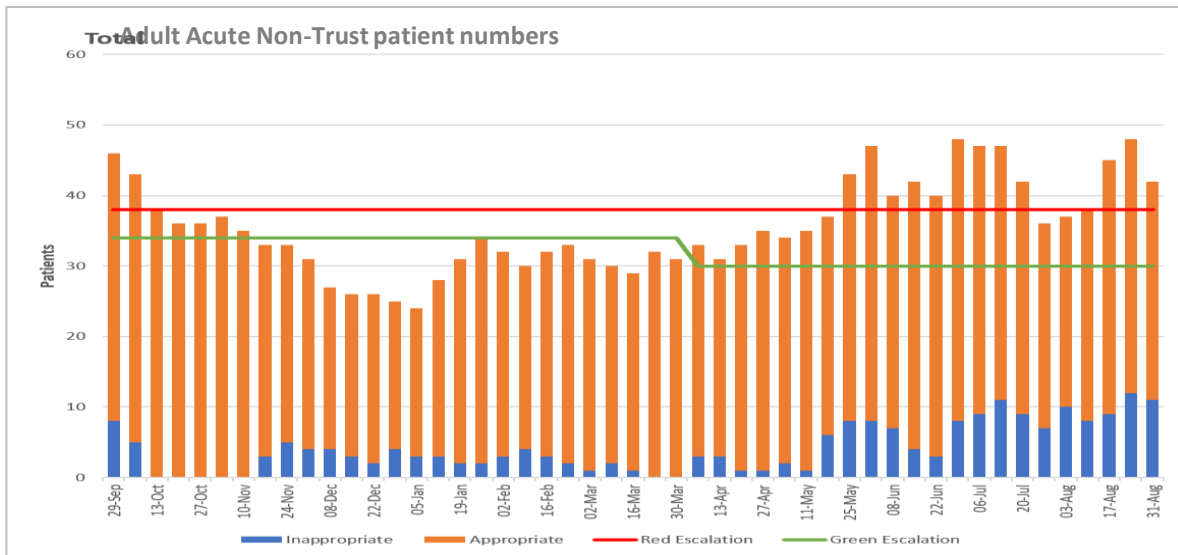
- The 2026/27 agency budget has been set in line with the NHSE limit of £3.4m which equates to £281k per month.
- Month 5 year to date agency expenditure is £1m which is £0.4m less than plan. (CYP £0.57m favourable, non-CYP £0.13m adverse).
- Agency spend in August is £0.1m less than July, with reductions in Specialties and ICCR. The monthly year to date average of £0.2m is £0.15m less than the 2025/26 average.

Agency run rate



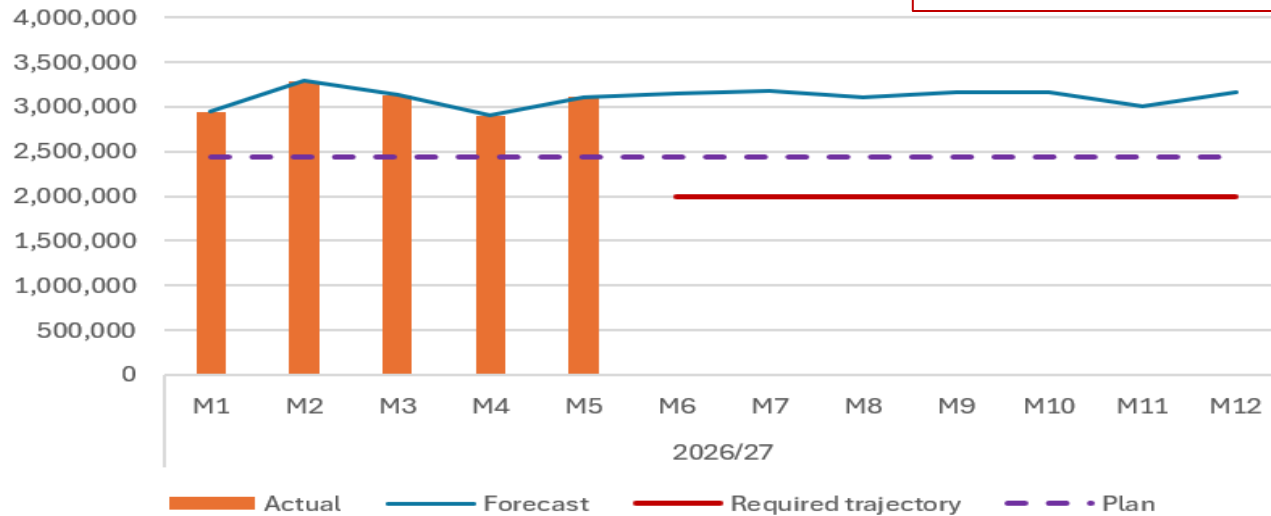
Non-Trust Inpatient Beds

ALERT: YTD overspend £3.2m, forecast risk circa £8m

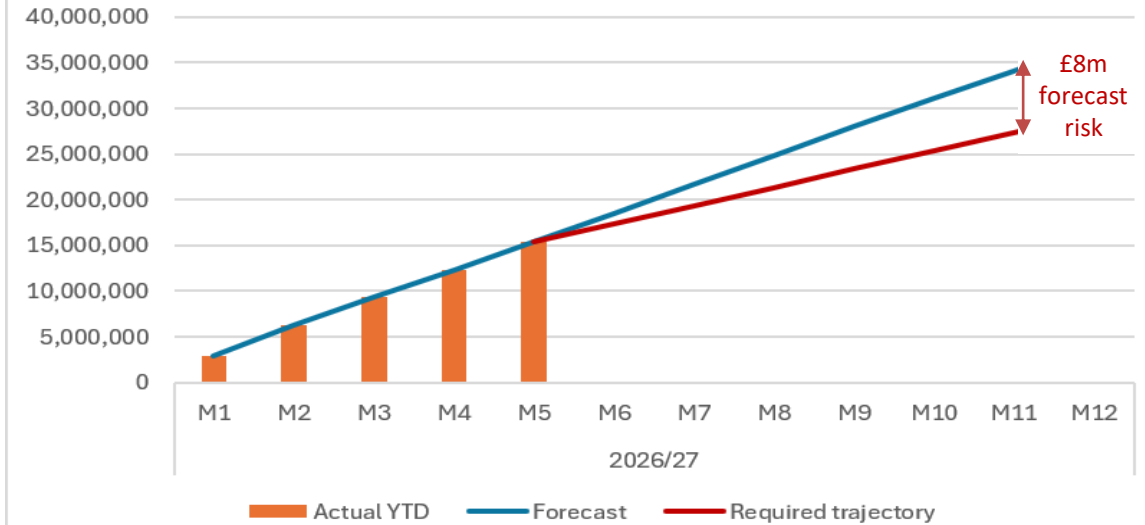


Total Non-Trust Beds
(run rate)

35% monthly spend
reduction required to meet
trajectory



Total Non-Trust Beds
(cumulative)



Total non-Trust Inpatient beds position

- The total non-Trust inpatient beds expenditure is £3.2m adverse to plan year to date (including £2m beds stretch savings target shortfall relating to length of stay and clinically ready for discharge).
- Total monthly expenditure would need to reduce by £1.1m (35%) for the remainder of the year to be within budget. Current forecast risk is £8m (£5m adults and £3m CYP).

Adult non-Trust beds

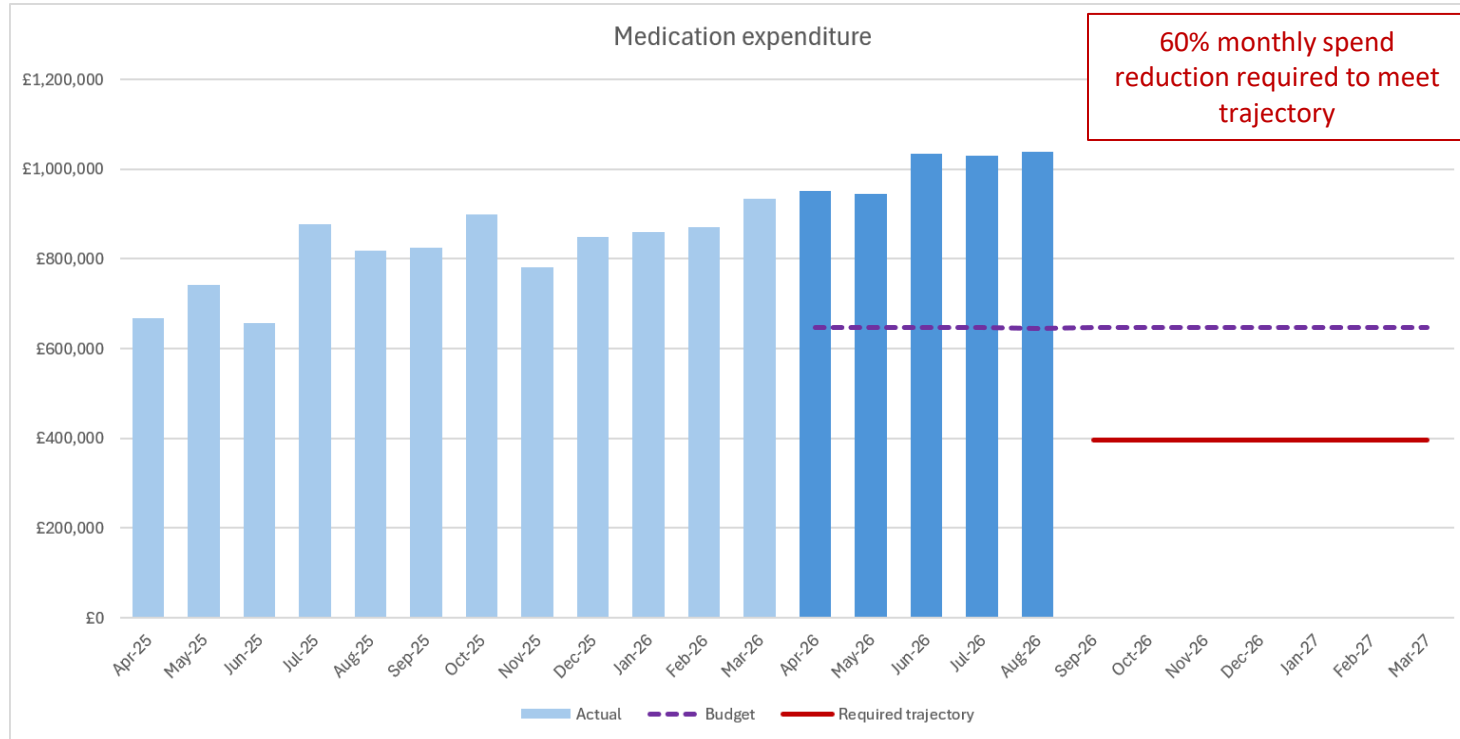
- The adult non-Trust beds year to date expenditure of £5.6m is £1.8m adverse to plan (including £0.6m savings shortfall).
- Monthly expenditure would need to reduce by £0.6m (54%) to meet the required trajectory. The forecast risk is £5.1m.

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

- The year to date expenditure of £9.7m is £1.4m adverse to plan (including £1.4m savings shortfall).
- Monthly expenditure would need to reduce by £0.5m (25%) to meet the required trajectory. The forecast risk is £2.9m.

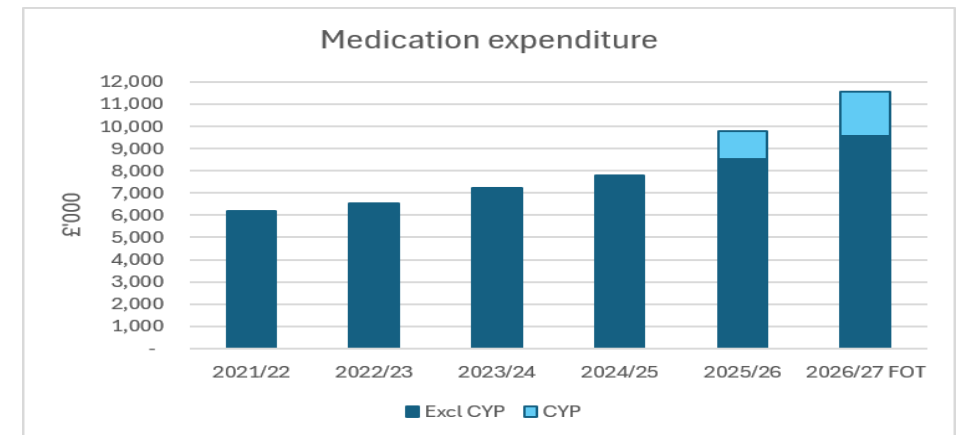
Medication expenditure

ALERT: YTD overspend £1.8m, forecast risk £4m



Area	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
ICCR	4,036	1,682	2,810	(1,128)
SPEC	852	355	631	(276)
CYP	1,686	702	826	(124)
ACUC	630	262	364	(102)
Other	573	239	367	(128)
Total	7,776	3,240	4,998	(1,758)

Expense Code Description	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
Drugs Aripiprazole	288	120	700	(580)
Drugs Risperidone	1,755	731	1,100	(369)
FP10'S	1,892	788	1,062	(274)
Drugs Central Nervous System	599	250	404	(155)
Drugs Clozapine	386	161	297	(136)
Other	2,857	1,190	1,435	(245)
Total	7,776	3,240	4,998	(1,758)



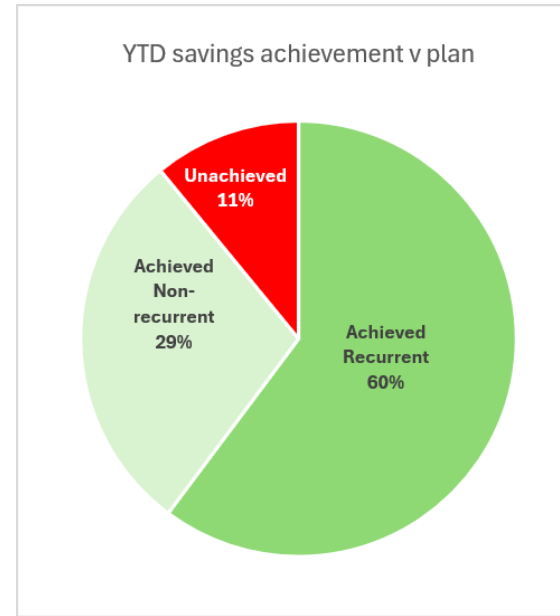
Medication expenditure

- The 2026/27 medication budget is £7.8m which equates to £650k per month.
- Year to date expenditure of £5m is £1.8m adverse to plan. The forecast risk is £4m.
- Monthly expenditure would need to reduce by 60% from the year to date average of £1m to £0.4m for the remainder of the year to be within budget.
- The 2026/27 forecast spend is 86% higher than spend in 2021/22. £2m of this relates to CYP expenditure. Excluding CYP, the growth in medication spend since 2021/22 is 54% (£3m).

Efficiencies

ALERT: YTD £1.8m savings shortfall

Row Labels	Original Plan £'000	Current Target £'000	YTD Target £'000	YTD Actual £'000	YTD Variance £'000
ACUC	5,365	6,913	2,876	2,235	(641)
ICCR	3,353	3,353	1,397	1,391	(6)
SCOH	2,216	2,216	928	923	(5)
SPEC	1,380	1,380	582	288	(294)
SPP	156	156	66	65	(1)
CYP	3,208	6,468	2,698	1,122	(1,577)
CORP	2,343	2,343	980	1,069	89
Trustwide	17,106	12,298	5,124	5,719	595
PC'S	5,203	5,203	2,158	2,158	-
Grand Total	40,330	40,330	16,809	14,971	(1,838)



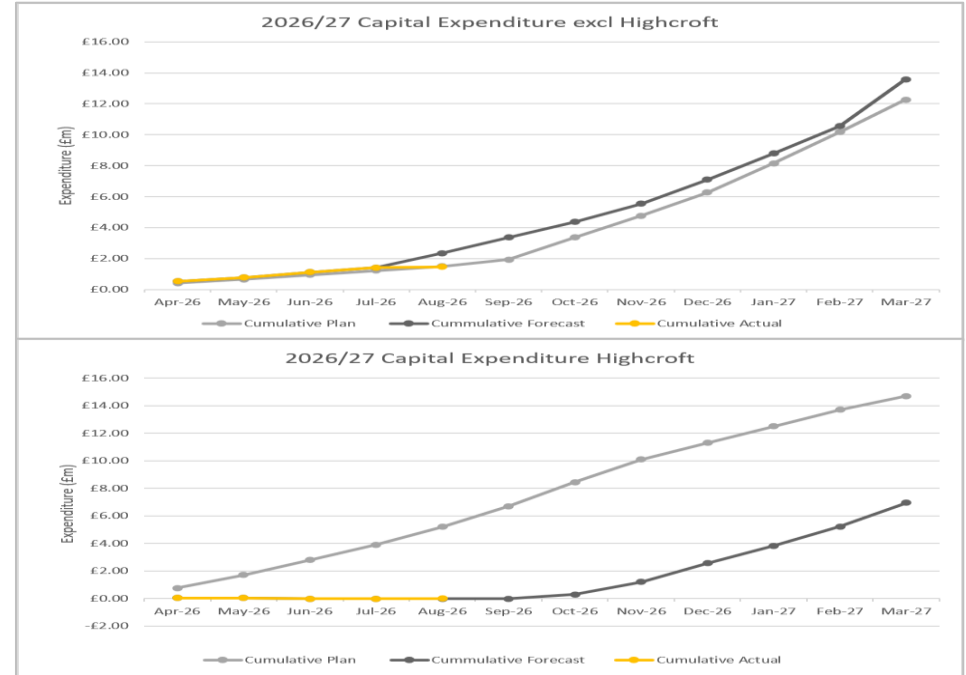
Row Labels	Original Plan £'000	Current Target £'000	YTD Target £'000	YTD Actual £'000	YTD Variance £'000
Recurrent	29,510	29,510	12,304	10,122	(2,182)
Non-Recurrent	10,820	10,820	4,505	4,849	344
Grand Total	40,330	40,330	16,809	14,971	(1,838)

Efficiency status	Original plan £'000	Forecast £'000
Fully developed	18,675	39,010
Plans in Progress	3,714	802
Opportunity	13,133	518
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).
- £15m savings have been achieved to date (89% of year to date plan), with £10.1m being recurrent.
- The year to date delivery is a shortfall of £1.8m against plan. The key drivers are:
 - £2m inpatient beds. This relates to stretch target, with focus on length of stay and clinically ready for discharge, agreed in April 2026. This £4.8m annual target was allocated from trustwide to ACUC (£3.2m) and CYP (£1.5m) in month 3.
 - £0.8m relating to transformation scheme.
 - £0.5m regarding operational budgeted administrative posts.
 - The above shortfalls are partly offset by £1.9m new non recurrent schemes not in original plan (including VAT rebate, provider support funding and balance sheet flexibility).

2026/27 Capital Expenditure

Capital schemes	Annual Plan	Adjustments	Revised Plan	YTD Forecast (phasing adjusted to reflect cashflow)	Actual (paid)	YTD Variance to Forecast
	£m					
Approved Schemes:						
Old year projects (25/26)	0.00	0.30	0.30	0.27	0.27	0.00
Ardenleigh – Extension and Refurbishment of Production Kitchen	0.50	(0.30)	0.20	0.03	0.00	0.03
Children & Young People – Works to properties	0.50	0.00	0.50	0.11	0.04	0.07
Trustwide Decarbonisation Works	0.50	0.00	0.50	0.14	0.05	0.09
SSBM Works	2.00	0.10	2.10	0.54	0.41	0.13
Medical Devices	0.08	0.15	0.23	0.15	0.15	0.00
Lease Cars	0.57	0.40	0.97	0.42	0.18	0.23
Renewals of existing property leases	0.07	0.00	0.07	0.00	0.00	0.00
CYP ICT Infrastructure Parkview	0.00	0.21	0.21	0.12	0.07	0.05
ICT Infrastructure & Equipment Replacement & Refresh	0.10	0.03	0.13	0.03	(0.01)	0.03
Minor Works	1.81	(0.66)	1.15	0.13	0.09	0.04
IFRS16 Remeasurement	0.01	(0.01)	0.00	0.20	0.20	0.00
Estates Safety Fund 26/27	0.57	0.00	0.57	0.04	0.01	0.03
24/7	4.56	0.00	4.56	0.18	0.00	0.18
MH Emergency Department	1.00	0.00	1.00	0.00	0.00	0.00
Digital Transformation to support MH ED	0.02	0.00	0.02	0.00	0.00	0.00
GSEC Dilapidations	0.00	0.90	0.90	0.00	0.00	0.00
Total excl Highcroft	12.27	1.12	13.39	2.34	1.46	0.88
Highcroft New Build	14.70	(7.74)	6.95	(0.01)	0.01	(0.02)
Total incl Highcroft	26.96	(6.62)	20.34	2.33	1.46	0.86



Group Capital Expenditure

- Month 5 year to date capital expenditure is £1.5m which is £0.9m behind the revised forecast.
- Total actual expenditure on some of the schemes is shown as a credit due to VAT reclaims.
- Following the rephasing of Highcroft spend, there is a balance of £6.62m to be allocated. Proposed allocations are shown in the table opposite.

Highcroft underspend from rephasing	£7.74m
Less spend approved at previous CRG meetings	
ICT spend approved 16.06.26	(£0.03m)
GSEC delays approved 18.08.26	(£0.90m)
Lease cars additional spend approved 18.08.26	(£0.20m)
Revaluation of leases	£0.01m
Remaining balance to allocate	£6.62m
Less proposed allocations	
Estates spend to bring forward from 27/28	(£1.97m)
Capitalisation Review	(£0.44m)
Main House	(£0.63m)
Other proposals (CRG reviewing opportunities)	
Balance to allocate/redistribute	£3.59m

Consolidated Statement of Financial Position (Balance Sheet)

Statement of Financial Position - Consolidated	EOY - 'Audited' 31-Mar-26 £m's	NHSI Plan YTD 31-Aug-26 £m's	Actual YTD 31-Aug-26 £m's	NHSI Plan Forecast 31-Mar-27 £m's
Non-Current Assets				
Property, plant and equipment	228.8	237.8	235.1	252.5
Prepayments PFI	1.0	2.3	2.4	2.3
Finance Lease Receivable	0.0	-	-	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	229.8	240.1	237.4	254.8
Current assets				
Inventories	0.7	0.9	0.8	0.9
Trade and Other Receivables	34.9	27.7	34.4	27.7
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	67.6	84.4	68.9	72.8
Total Current Assets	103.2	113.0	104.1	101.4
Current liabilities				
Trade and other payables	(70.0)	(77.1)	(74.6)	(76.9)
Tax payable	(9.3)	(8.9)	(8.2)	(8.9)
Loan and Borrowings	(2.5)	(2.5)	(2.4)	(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)	(33.8)	(46.1)
Total Current Liabilities	(119.0)	(136.7)	(121.1)	(136.5)
Non-current liabilities				
Deferred Tax Liability	0.3	0.2	0.3	0.2
Loan and Borrowings	(18.6)	(17.5)	(17.5)	(16.4)
PFI lease	(78.9)	(80.9)	(80.9)	(79.4)
Finance Lease, non current	(5.3)	(5.5)	(13.6)	(5.1)
Provisions	(2.3)	(2.3)	(1.7)	(2.3)
Total non-current liabilities	(104.9)	(106.0)	(113.4)	(103.0)
Total assets employed	109.2	110.4	107.0	116.7
Financed by (taxpayers' equity)				
Public Dividend Capital	122.7	124.9	122.7	128.5
Revaluation reserve	46.7	49.1	46.9	49.1
Income and expenditure reserve	(60.2)	(63.6)	(62.6)	(60.9)
Total taxpayers' equity	109.2	110.4	107.0	116.7

SOFP Highlights

The Group cash position at the end of August 2026 is £68.9m.

For further detail on the current month cash position and movement of trade receivables and trade payables see pages 17 to 18.

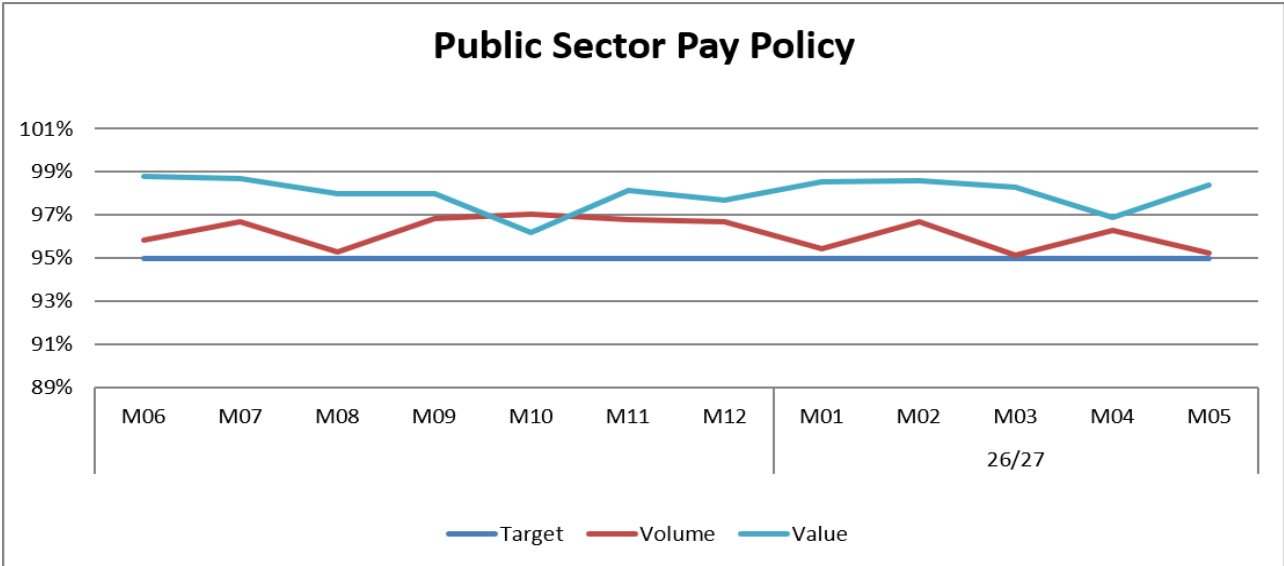
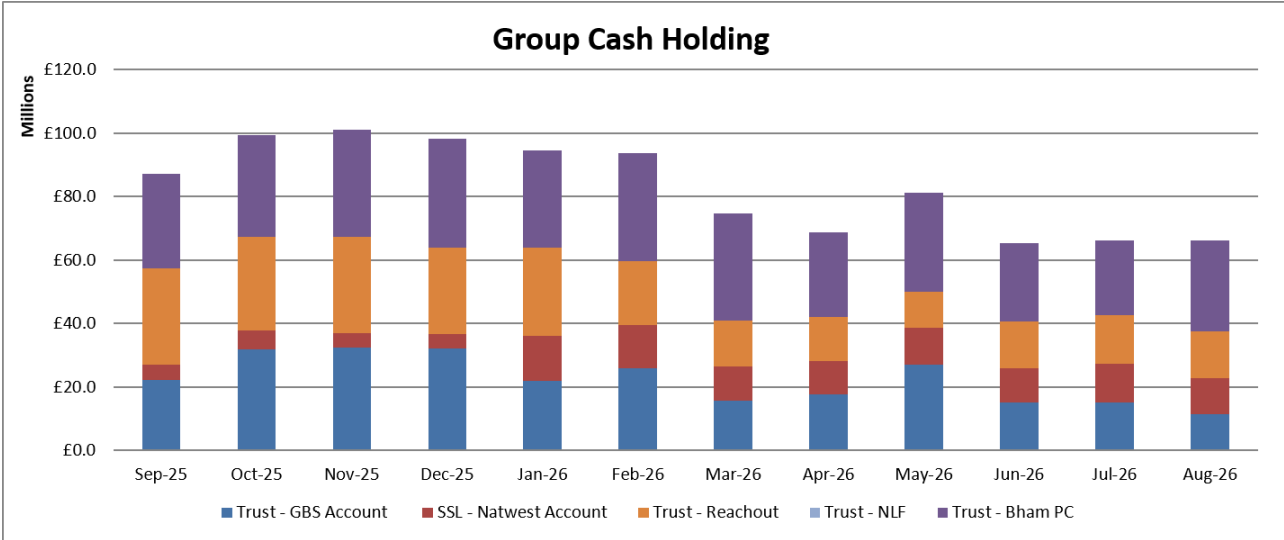
Current Assets & Current Liabilities

Ratios

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

Current Ratio :	£m's
Current Assets	104.1
Current Liabilities	-121.1
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

The Group cash position at the end of August 2026 is £68.9m. This comprises of Trust £11.4m, SSL £11.4m, Reach Out Provider Collaborative £14.6m and Mental Health Provider Collaborative £31.5m.

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

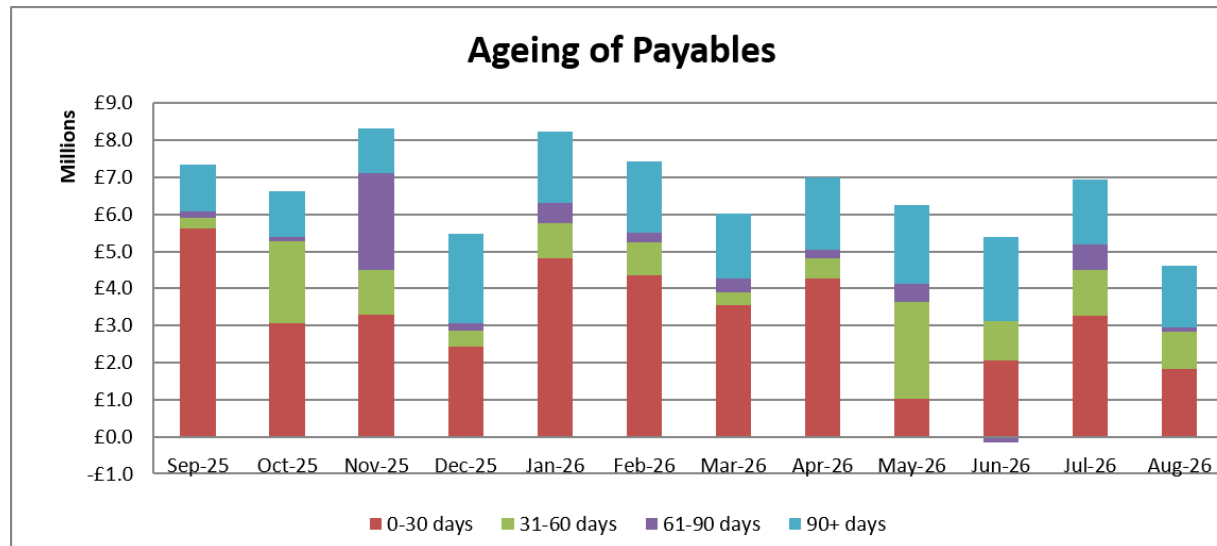
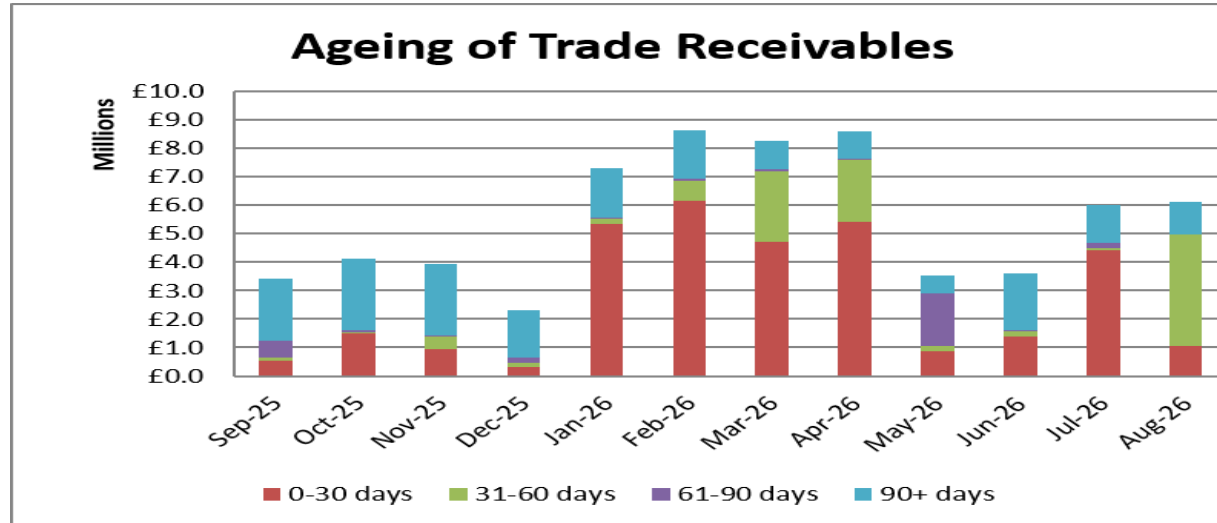
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

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	97%	✓	100%	✓
Non - NHS Creditors within 30 Days	95%	✓	98%	✓

Provider Receivables and Payables



With a focus in the NHS currently around intra-NHS debts BSMHFT have been working with NHS colleagues to ensure as far as possible any issues are rectified. Where required, escalations to Deputy Director of Finance or Executive Director of Finance have been pursued between organisations.

Trade Receivables :

- **0-30 days-** Overall Balance £1.1m - decrease in balance. Balance consists of monthly/daily ad hoc invoices waiting to be advised if approved or in query. Some balances are awaiting approval/payment or have been settled in September 2026.
- **31-60 days-** Overall Balance £3.9m – increase in balance. Several debts are awaiting approval/payment or have been settled in September 2026 (mainly MFPT £3.8m). Remaining balance mainly staff overpayments (on payment plans).
- **61-90 days-** Overall Balance £18k- decrease in balance. Several debts are awaiting approval/payment. Remaining balance mainly staff overpayments (on payment plans).
- **Over 90+ days-** Overall Balance £1.1m– decrease in balance. *Awaiting authorisation:* UHB - £123k, UofB - £464k, Mecury Pharma - £249k. Remaining balance mainly staff overpayments (on payment plans).

Trade Payables-Over 90 days:

NHS Suppliers £387k: UHB £215k, CNWL £55k in query, Nottinghamshire £52k, other small balances in query.

Non-NHS Suppliers (58+) £1.3m mainly bed/out of area fees invoices in query/awaiting approval, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in September 2026.

Report to Board of Directors						
Agenda item:	18					
Date	7 October 2026					
Title	Winter Plan 2026/27					
Author/Presenter	Vanessa Devlin, Executive Director of Operations					
Executive Director	Vanessa Devlin, Executive Director of Operations	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 BSMHFT Winter Plan 2026/27 sets out how the Trust will maintain safe, effective and resilient mental health services throughout winter while supporting the wider Birmingham and Solihull system response. The plan focuses on crisis prevention and alternatives to emergency department attendance, effective admission gatekeeping, inpatient flow and discharge, workforce resilience, infection prevention, vaccination and clear escalation arrangements. - The Trust's principal winter risk is limited inpatient capacity caused by high occupancy, clinically ready for discharge delays and extended length of stay. This reduces the ability to absorb increases in demand, workforce absence or capacity lost through infection outbreaks. Controls include daily flow oversight, strengthened crisis and Home Treatment pathways, early discharge escalation, active management of out-of-area placements, workforce and IPC arrangements, and four levels of operational escalation aligned with system command. - Most readiness actions are complete. Outstanding actions include completion of the regional stress test, Board approval and submission of the Board Assurance Statement, and confirmation of the Older Adult inpatient bed configuration. These actions will be monitored through the Trust's winter governance arrangements and escalated where required. Purpose The BSMHFT Winter Plan 2026/27 and sets out the Trust's readiness position, principal risks, controls and remaining actions. The plan provides a credible framework for maintaining safe mental health services and contributing to the Birmingham and Solihull system response.						

Key Issues and Risks

- Limited inpatient capacity: High occupancy, clinically ready for discharge levels and extended length of stay leave little capacity to absorb additional demand.
 - Delayed discharge: Social care capacity, housing availability, funding decisions, patient choice and limited provider-market capacity may delay discharge and reduce bed availability.
 - Older Adult bed capacity: The impact of the Bergamot Ward closure and any confirmed P2 capacity must be reflected in the winter capacity assumptions.
 - Crisis and emergency-department pressure: Increased crisis presentations could lead to longer assessment waits, avoidable admissions and additional pressure on liaison, Home Treatment and emergency-department services.
 - Section 136 and place-of-safety demand: Simultaneous demand, transport delays or unavailable suites could result in prolonged waits and increased use of emergency departments.
 - Workforce resilience: Sickness absence, vacancies, rota gaps and staff fatigue may affect safe staffing, access and continuity of care.
 - Infection outbreaks: Respiratory illness or other outbreaks could reduce available inpatient capacity, delay transfers and discharge, and increase staff absence.
 - Out-of-area placements: Limited local capacity may increase reliance on external beds, creating additional cost, clinical oversight and repatriation pressures.
 - Dependence on partner services: Winter resilience relies on timely support from local authorities, acute hospitals, ambulance, police, the ICB and commissioned providers.
 - Data quality and timeliness: Incomplete or delayed information may prevent early identification of pressure and weaken operational decision-making and assurance.
- Outstanding readiness actions: The regional stress test, Board Assurance Statement and Older Adult bed configuration remain to be completed or formally assured.
- Escalation arrangements: Broad escalation triggers could lead to inconsistent activation unless thresholds, decision-making authority and de-escalation criteria are clearly understood.

Recommendation

The Board is asked to approve the Winter Plan 2026/27.

Enclosures

Winter Plan 2026/27



**Birmingham and Solihull
Mental Health**
NHS Foundation Trust

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

WINTER PLAN 2026/27

Document owner: Executive Winter Lead, BSMHFT

Executive Winter Lead: Vanessa Devlin

Deputising Executive Lead: Dan Webster

Version/date: September 2026

FOR APPROVAL

Document status and required approvals

Requirement	Position / action
Provider organisational winter plan	Complete by September 2026.
Named Executive Winter Lead	Vanessa Devlin, Executive Director of Operations
Regional stress test	Participate in September 2026 and close actions arising.
Board assurance	Board approval using the National Board Assurance Statement.
Submission	Board Assurance Statement to be submitted by 30 September 2026.
System alignment	Plan to be aligned with the Birmingham and Solihull ICB whole-system winter plan and partner escalation arrangements.

1. Executive summary

The BSMHFT Winter Plan 2026/27 sets out how the Trust will maintain safe, effective and resilient mental health services during winter, while contributing to the wider Birmingham and Solihull system response. The plan is clinically led and focuses on preventing avoidable crisis, providing alternatives to emergency department attendance and admission, maintaining inpatient flow, protecting staff and patients from seasonal infection, and ensuring tested escalation and leadership arrangements are in place.

The Trust's principal winter vulnerability is the limited headroom within inpatient capacity. Although mental health demand does not consistently follow traditional acute winter peaks, sustained high occupancy, CRFD and length of stay mean that even relatively modest increases in demand, workforce pressures or loss of capacity can have a significant impact on flow and access.

However, seasonal infection, staff absence, reduced community and social care capacity, increased complexity, emergency department pressure and delays to discharge can materially affect mental health demand, safety, flow and available capacity. The plan therefore uses historic activity, current operational intelligence and scenario-based planning to prepare for baseline, surge and super surge conditions.

2026/27 priorities

- Resilient all-age crisis services, including NHS 111 mental health access, home treatment, liaison psychiatry and crisis alternatives.
- Proactive crisis planning for high-risk patients and frequent attenders before winter.
- Strengthened alternatives to emergency department attendance and avoidable conveyance.
- Improved inpatient flow, reduced clinically ready for discharge delays and reduced reliance on out-of-area placements.
- Robust workforce, on-call leadership, staff welfare, flu vaccination and infection prevention arrangements.
- Tested escalation, surge, mutual-aid and business-continuity arrangements aligned with the ICB coordination centre and OPEL framework.

- Protection of agreed 2026/27 quality, access, flow and performance trajectories throughout winter.

2. National expectations and Trust response

National expectation	BSMHFT response	Evidence / assurance	Lead	Status
Organisational winter plan completed by end of September	This document provides the Trust organisational winter plan and action framework.	Final plan; Executive approval; Board papers		
Named Executive Winter Lead	A named Executive will be accountable for preparedness and response, supported by a deputising lead and operational command structure.	Terms of reference; on-call rota; governance map	Vanessa Devlin	
Regional stress test in September	The Trust will undertake internal preparation and participate in the regional exercise.	Exercise record; action log; closure evidence	Dan Webster	
Board Assurance Statement by 30 September	The national BAS will be used to shape assurance and will be submitted following Board approval.	Completed BAS; Board minutes; submission confirmation	Dan Webster	
Tested escalation, IPC, on-call leadership and staff welfare	Trust arrangements will be reviewed and tested before winter.	Escalation plan; IPC plan; rotas; workforce and welfare plan	Multiple	
Protect agreed trajectories	Winter actions will be tracked against quality, access, flow and performance indicators.	Winter dashboard and weekly reporting	PMO	

3. Learning from winter 2025/26

The 2025/26 plan identified the importance of earlier system planning, stronger social care escalation, consistent admission gatekeeping, improved internal interfaces between community, home treatment and liaison services, strengthened in-reach to non-Trust beds, real-time alerts for known patients presenting to emergency departments, and more structured discharge escalation.

- Mental health demand does not mirror traditional acute winter peaks, requiring MH-specific monitoring and escalation.
- High occupancy, CRFD and LOS significantly reduced the ability to absorb variations in demand.
- Early escalation of complex discharge barriers and stronger Local Authority interfaces remain essential.
- Existing crisis alternatives, HTT gatekeeping and OOA in-reach need to be maximised rather than relying solely on additional winter capacity.
- Workforce sickness remained high and requires earlier targeted intervention.
- Local/peer vaccination delivery was more effective than reliance on fixed clinics.

4. Demand and capacity assessment

The Trust has refreshed its winter demand and capacity modelling using three years of mental health activity covering the winter periods October 2023 to March 2026. The modelling establishes a baseline based on historic winter activity and tests this against surge and super-surge scenarios.

Mental health activity does not demonstrate the same seasonal pattern as acute physical healthcare, and peak demand does not necessarily coincide with traditional acute winter peaks. The Trust will therefore monitor mental health-specific demand and capacity indicators throughout winter rather than assuming a uniform seasonal uplift.

The principal winter resilience risk is not solely an increase in presentations or admissions, but the Trust's limited ability to absorb additional demand because inpatient services are already operating at very high occupancy, with significant CRFD volumes and extended lengths of stay. These factors constrain bed turnover and reduce the capacity available to respond to short-term peaks in demand.

- Three-year winter activity data (October 2023–March 2026) has been used to establish baseline, surge and super-surge scenarios.
- Mental health demand does not follow the same seasonal pattern as acute hospital demand; activity peaks can occur at different points in the year and across different pathways.
- Internal adult acute and PICU occupancy is forecast to remain **very high throughout winter**, leaving limited headroom to accommodate additional demand.
- CRFD remains a major constraint on capacity, particularly within older adult services, with adult acute CRFD also forecast to increase across the winter period.
- Length of stay remains high, particularly within older adult services, limiting bed turnover and the Trust's ability to create capacity quickly when demand increases.
- Consequently, relatively modest increases in admissions, ED demand, Section 136 activity or loss of capacity through staffing/IPC pressures could have a disproportionate operational impact.

Scenario	Planning assumption	Operational impact	Required response
Baseline	Expected activity based on current run rate and normal seasonal variation.	Services remain deliverable through existing operational arrangements. However, sustained high inpatient occupancy, clinically ready for discharge levels and length of stay leave limited capacity to absorb fluctuations in demand. Localised pressures may result in short delays to assessment, admission, discharge or transfer and	Business-as-usual controls and weekly monitoring.

Scenario	Planning assumption	Operational impact	Required response
		may require increased operational oversight.	
Surge	Increased activity and/or reduced available capacity associated with winter pressures such as respiratory illness, staffing pressures or increased urgent care demand.	Increased demand and/or reduced staffing or bed availability creates a widening gap between demand and available capacity. Likely impacts include increased crisis and liaison activity, higher Home Treatment caseloads, longer waits in emergency departments and places of safety, delayed admission to local beds, increased out-of-area placement use and greater pressure on discharge pathways. Staff may require redeployment or additional bank and agency support, with reduced capacity for non-urgent activity and therapeutic interventions.	Enhanced command, increased review frequency and targeted capacity actions.
Super surge	Combined pressures across demand, workforce, IPC and patient flow that materially reduce the Trust's ability to accommodate additional activity.	Simultaneous and sustained pressure across demand, workforce, infection prevention and patient flow exceeds the capacity of normal operational controls. This may result in prolonged waits for crisis assessment and admission, saturation of places of safety, inability to admit patients locally, significantly increased out-of-area placements, delayed repatriation and prioritisation or temporary reduction of lower-risk services. There would be an increased risk of patient-safety incidents, restrictive practice, staff fatigue, compromised patient experience and wider system pressure across acute hospitals, ambulance, police, local authorities and commissioned providers.	Executive command, mutual aid, prioritisation of critical services and exceptional capacity measures.

The precise impact will depend on the combination of demand, available staffing, inpatient capacity, infection outbreaks and partner-service capacity. The Trust will monitor these factors collectively rather than relying on a single demand indicator.

5. Proactive winter support and frequent attenders

The Trust recognises that it is not practical to identify in advance every individual who may experience crisis or deterioration during winter, particularly given the size and changing nature of community and Home Treatment caseloads. The winter approach will therefore combine a universal offer of information and support for service users with more targeted proactive review of a smaller, identifiable cohort where this is likely to have the greatest impact.

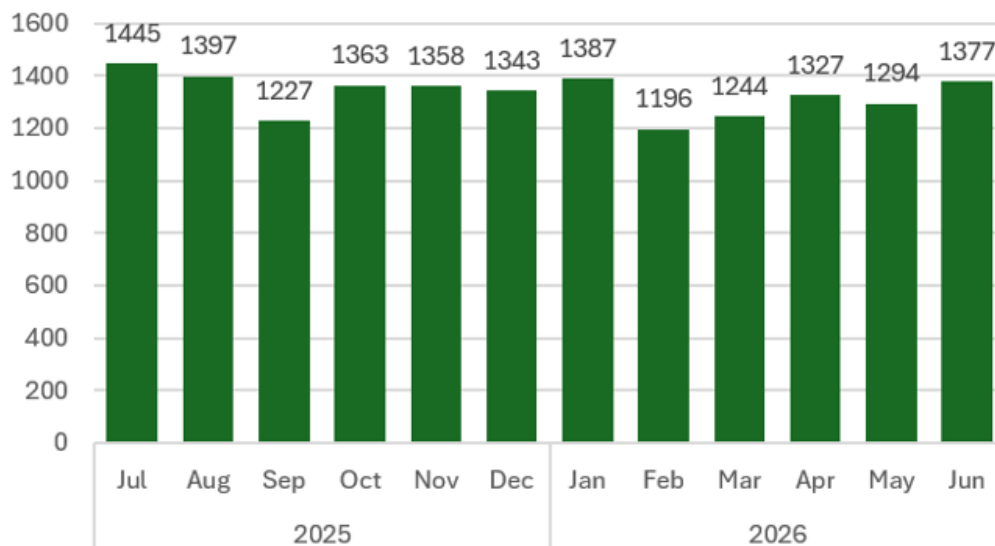
- Develop a general winter support bulletin for service users.
- Ask the Partnerships Lead to identify community/warm-space/food/homelessness/medication and other offers.
- Use frequent A&E attenders known to CMHTs as the principal proactive cohort.
- Use PLT alerts to help identify repeated attenders.
- Each CMHT reviews its frequent-attender list and considers whether current crisis/contingency plans remain appropriate.
- Maintain Call Before You Convey as a preventive A&E admission action to support
- Strengthen information sharing between CMHT, PLT, HTT and Urgent Care.
- Allow clinical teams to identify additional individuals for targeted review where there are particular safeguarding, complexity or recent-discharge concerns.

6. Resilient all-age crisis services and alternatives to ED

The Trust will maintain resilient all-age crisis provision throughout winter, including evenings, weekends, bank holidays and the Christmas period. Pathways will support direct access, senior clinical decision-making, admission avoidance and safe alternatives to emergency departments.

Service / pathway	2026/27 requirement	Lead
NHS 111 mental health	Reliable access, clear referral routes, capacity monitoring and escalation.	k.nirsimloo@nhs.net
Crisis Resolution and Home Treatment	24/7 resilience, gatekeeping, senior decision-making and surge response.	c.maiden@nhs.net
Recovery House	Maximise admission avoidance and supported step-down, with clear referral and escalation criteria.	bethany.solway2@nhs.net
Talking Spaces / Solihull Oasis	Maximise appropriate use as crisis alternatives and strengthen partner referral pathways.	bethany.solway2@nhs.net
Psychiatric Liaison	Safe response across acute sites, escalation of delays and surge arrangements.	jessica.asson@nhs.net
PDU / Place of Safety	Safe flow, timely assessment, transport escalation and clear system interfaces.	k.nirsimloo@nhs.net
Call Before You Convey / MHRV	Support ambulance and police partners to access alternatives to ED.	k.nirsimloo@nhs.net

NHS 111 Option 2 Calls Monthly



7. Emergency department and liaison psychiatry pathways

Across the four hospital sites, Liaison Psychiatry recorded 16,779 contacts/referrals between June 2025 and May 2026, averaging approximately 1,398 per month. Activity was highest in June 2025 (1,560), before generally reducing through the latter part of 2025 to its lowest point in January 2026 (1,295). Demand subsequently increased, reaching 1,539 in May 2026—almost returning to the June 2025 level. Although this may indicate lower activity during autumn and early winter followed by renewed pressure in spring, more than one year of data would be required to establish whether this represents a recurring seasonal pattern.

QEH and Heartlands generated the greatest volume of activity, together accounting for approximately two-thirds of all Liaison Psychiatry contacts. QEH recorded the highest average monthly activity at approximately 487 contacts, followed by Heartlands at 442. Metropolitan activity was comparatively stable, ranging from 225 to 269 contacts per month. Good Hope had the lowest average activity and showed greater proportional variation, including an increase to 258 in February followed by a fall to 181 in March. This site-level variation would benefit from exploration alongside emergency department attendances, referral rates, staffing levels, operating hours and differences in recording practice.

Across the period, 486 transfers to the PDU and 405 transfers to POS were recorded. PDU was the more frequently recorded destination in nine of the 12 months, although use of both pathways varied considerably. Combined transfers were highest in December 2025, at 98, despite overall Liaison Psychiatry activity being relatively low that month. This suggests that transfer requirements may be influenced by patient acuity, pathway capacity and clinical need rather than referral volume alone. Only two referrals to Talking Spaces appear to have been

recorded; this should be validated to determine whether it reflects limited pathway use, incomplete reporting or inconsistent recording. Overall, further destination and outcome data would help establish what proportion of patients were discharged home, admitted to a mental health bed, transferred to community services or remained within the acute hospital.

- Maintain and test the Psychiatric Liaison Team response and escalation process.
- Agree expected response arrangements and senior escalation across all acute hospital sites.
- Use front-door triage and early mental health input to support rapid assessment and diversion.
- Escalate prolonged waits, delayed transfers and unclear clinical ownership through agreed system routes.
- Support the reduction of corridor care by ensuring mental health patients do not experience avoidable delays in acute settings.
- Review demand by site and time of day to align staffing and senior decision-making with peak demand.
- Maintain operational links between liaison, home treatment, bed management and community teams.

Liaison Psychiatry Overview: 12 Months to June 2026 – Number of contacts

Hospital	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Met	256	234	258	256	242	225	245	257	247	259	269	259
Good Hope	241	229	225	217	186	202	204	212	258	181	228	248
Heartlands	503	419	388	405	412	490	434	413	437	450	451	500
QEH	560	487	495	485	503	443	451	413	517	458	495	532
Total	1560	1369	1366	1363	1343	1360	1334	1295	1459	1348	1443	1539

Transfer destination:	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
PDU	40	25	34	47	43	42	51	30	45	39	48	42
POS	23	43	24	25	20	43	47	28	39	40	33	40
Triaged to Talking Spaces						1		1				

8. Section 135/136 and place-of-safety resilience

- Maintain real-time oversight of all Section 136 patients and available place-of-safety capacity - Urgent Care Pathways Group
- Use the agreed escalation framework for delayed assessment, transport or onward placement.
- Triangulate data with local authority, police and ambulance partners.
- Review Right Care, Right Person impacts and avoidable detention themes.

- Finalise business case for new Mental Health Response Vehicle – Kevin Heffernan.
- Outline contingency arrangements for simultaneous demand, IPC restrictions or unavailable suites - Zalika Geohaghon
- Monitor conversion rates, assessment timeliness, transport delays and use of acute emergency departments – Urgent Care Pathways Group

Number of people detained on a S136												
	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Taken to Liaison Psychiatry	32	27	27	24	28	33	18	18	38	38	32	36
Taken to Liaison Psychiatry and Transferred to POS	13	28	17	18	17	32	26	22	27	26	24	27
Taken to Place of Safety	59	65	61	65	60	54	62	48	72	62	63	64
Total	104	120	105	107	105	119	106	88	137	126	119	127

9. Inpatient capacity, patient flow and discharge

The Trust enters winter with limited inpatient headroom. High occupancy, extended length of stay and significant numbers of patients who are clinically ready for discharge mean that relatively small changes in demand or available capacity can result in significant operational pressure. Maintaining flow and reducing avoidable delays to discharge are therefore central to the Trust's winter resilience.

Reducing clinically ready for discharge occupied bed days is a critical winter resilience measure. Current levels materially reduce available bed capacity and the Trust's ability to respond to fluctuations in demand. Existing CRFD improvement work with local authority and system partners will therefore form a core component of the winter response.

Older Adult capacity requires specific review ahead of winter, including the anticipated impact of the planned closure of Bergamot Ward and any confirmed reintroduction of P2 capacity. Demand, occupancy, CRFD and length-of-stay assumptions will be refreshed once the timing and capacity implications of these changes are confirmed.

The Trust will continue to seek to minimise the use of out-of-area placements. However, given the limited headroom within existing inpatient capacity, commissioned/non-Trust capacity remains a contingency where internal capacity is exhausted and clinically appropriate alternatives are unavailable. Active in-reach and repatriation arrangements will be used to minimise length of stay and return patients to local care at the earliest opportunity.

Key winter actions will include:

- Daily monitoring of admissions, discharges, occupancy, CRFD, length of stay and out-of-area placements.
- Home Treatment Team gatekeeping and senior clinical oversight of admission decisions.

- Early identification and escalation of emerging gaps between admissions and discharges.
- Enhanced patient-level review where occupancy or CRFD thresholds are reached.
- Early discharge planning and rapid escalation of social care, housing, funding and Section 117 barriers.
- Active use of Recovery House and other admission-avoidance and step-down pathways where clinically appropriate.
- Active in-reach to out-of-area placements and timely repatriation to local services.
- Escalation to commissioned/non-Trust capacity where internal capacity is exhausted and no safe clinical alternative is available.
- Protection of safe staffing, therapeutic care and quality during periods of sustained occupancy pressure.

10. Workforce resilience, leadership and staff welfare

A review of ACUC divisional sickness absence data for October 2025 to March 2026 identified persistently high absence levels, with a weighted sickness rate of approximately **7.46%** and **11,435.3 FTE days lost**. Sickness peaked at **8.0% in November 2025** and remained above 7% for five of the six winter months.

Long-term sickness was a significant contributor, peaking at **4.6% in January 2026**, while short-term sickness also created pressure during October, November, February and March. This presents a risk to rota stability, safe staffing, service continuity and staff wellbeing during periods of increased winter demand.

The division will strengthen workforce resilience through:

- Proactive management and review of long-term sickness cases.
- Consistent completion of return-to-work meetings.
- Monthly monitoring of sickness trends by team and staff group.
- Targeted support for teams with high absence, including management support, Optima Occupational Health input, temporary adjustments and wellbeing interventions.
- Promotion of staff wellbeing, Employee Assistance Programme support and local wellbeing contacts.
- Promotion of flu and COVID-19 vaccination uptake.
- Strengthened rota, temporary staffing and escalation arrangements.
- Escalation of significant workforce risks through divisional governance to senior operational leads and the People Team.

See Appendix B – Workforce resilience and staff welfare action plan

SICKNESS

	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026
FTE Days Available	25387.3	24616.8	25728.8	25342.9	26299.7	26120.8	23619.6	26129.3	25521.6	26382.2	25473.1	26280.3
FTE days lost	1789.8	1865.6	2005.1	2039.5	1870.7	1938.9	1777.4	1803.7	1582.6	1909.5	2109.6	1669.1
Total Sickness %	⊗ 7.0%	⊗ 7.6%	⊗ 7.8%	⊗ 8.0%	⊗ 7.1%	⊗ 7.4%	⊗ 7.5%	⊗ 6.9%	⊗ 6.2%	⊗ 7.2%	⊗ 8.3%	⊗ 6.4%
Long Term Sickness %	⊗ 4.3%	⊗ 4.2%	⊗ 3.8%	⊗ 4.4%	⊗ 4.3%	⊗ 4.6%	⊗ 3.9%	! 3.3%	! 3.3%	⊗ 4.2%	⊗ 5.2%	⊗ 4.6%
Short Term Sickness %	⊗ 2.7%	⊗ 3.4%	⊗ 4.0%	⊗ 3.7%	⊗ 2.8%	⊗ 2.8%	⊗ 3.6%	⊗ 3.6%	⊗ 2.9%	⊗ 3.1%	⊗ 3.1%	! 1.8%

11. Staff and patient vaccination

Learning from the 2025/26 campaign has informed a more locally delivered, peer-to-peer vaccination model for 2026/27. Vaccination will be taken directly to teams and wards through locally identified vaccinators, with matrons supporting larger corporate events and induction sessions. Optima pharmacy vouchers will remain available, supported by early communications, visible executive leadership, improved digital reporting and targeted engagement with harder-to-reach staff groups. Vaccinator training, vaccine storage, stock tracking and wastage arrangements will also be reviewed before campaign launch.

- The 2026/27 campaign will move away from relying mainly on fixed clinics, as these became less effective later in last year's campaign.
- Vaccination will be taken closer to staff through a peer-to-peer model, using locally based ward and team managers as vaccinators.
- Matrons will focus on larger corporate events, induction sessions, NAC and other Trust-wide forums, rather than carrying both local and corporate delivery.
- Heads of Nursing and Matrons are identifying local vaccinators, with Pharmacy also identifying pharmacists able to support delivery.
- Vaccinator training requirements and e-learning materials will be reviewed early, including clarification of which professional groups are authorised to vaccinate.
- Optima Health will continue to provide pharmacy vouchers for staff who prefer to receive their vaccination outside the Trust.
- The communications campaign will begin early, with simple, evidence-based messages focused on protecting colleagues, patients and families.
- Senior leaders and executives will be encouraged to role-model vaccination, supported by friendly competition between teams and services.
- Reporting will be strengthened through the vaccination portal, with possible use of QR codes on campaign materials to enable staff to record their vaccination status.
- Staff will be reminded to keep ESR details up to date where these differ from GP registration, to improve reporting accuracy.
- Vaccine stock, storage, cool-box arrangements, wastage and recovery of unused vaccines will be more closely monitored.
- The campaign will consider staff groups who are harder to reach through ward-based delivery, including psychology and corporate teams.

- Engagement with ICB partners will explore the involvement of faith leaders to support confidence and uptake.

25/26

- Total staff vaccinated (including by Optima): 1829
- Total frontline staff vaccinated (including by Optima): 1353

See Appendix C – Staff and patient vaccination plan.

12. Infection prevention and control

The Trust's Infection Prevention and Control arrangements are designed to support safe service delivery throughout winter, ensure early identification and management of infection risks, and minimise avoidable disruption to inpatient capacity and patient flow.

- The IPC Team provides specialist support Monday to Friday, 9:00am–5:00pm, with out-of-hours, weekend and bank holiday advice available through the on-call Consultant Microbiologist.
- Daily SITREPs and IPC surveillance are used to identify infections, outbreaks and emerging trends. Significant concerns are escalated through the Director of Infection Prevention and Control and the Trust Safety Huddle, with outbreak management meetings convened where required.
- All inpatient accommodation consists of single-occupancy bedrooms, with most rooms having en-suite facilities, providing a high level of isolation capacity. Cohorting arrangements can also be implemented where clinically appropriate and supported by risk assessment.
- Patient placement, transfer and discharge decisions are supported by clinical and IPC risk assessment, with precautions reviewed regularly and stepped down in line with clinical assessment, microbiological results and current guidance.
- Enhanced and terminal cleaning arrangements support the timely turnaround of rooms and help minimise delays to admissions, transfers and discharges following isolation or outbreak situations.
- Respiratory virus testing is available across all inpatient areas using 4-in-1 lateral flow devices, with PCR testing available where required. Results inform isolation, cohorting and outbreak management decisions, and testing capacity can be increased during periods of heightened activity.
- Where admission to an area affected by an outbreak is clinically necessary, an individual risk assessment is undertaken to balance the service user's clinical needs against infection risks and identify appropriate mitigations.

- IPC arrangements support winter capacity and flow by promoting early identification and containment of infection, minimising unnecessary bed closures and supporting safe continuation of admissions, transfers and discharges where possible.

Vaccination forms a key component of the Trust's wider winter IPC response, with staff and patient vaccination arrangements set out separately in Section 11.

See Appendix D – IPC Winter Plan 2026/27.

13. Escalation, surge, mutual aid and command

The Trust will operate a clear escalation framework linked to operational pressure, patient safety and the wider ICB OPEL response. Triggers, actions, decision-makers and de-escalation criteria will be explicit and tested.

Level	Indicative triggers	Trust response	System interface
Level 1 – Business as usual	Demand and capacity within normal operating range.	Routine operational management and weekly winter oversight.	Routine reporting.
Level 2 – Increased pressure	Localised capacity, staffing, ED, bed or IPC pressure.	Enhanced review, targeted actions and senior operational oversight.	Notify ICB coordination arrangements as required.
Level 3 – Severe pressure	Sustained or multi-service pressure affecting safety or flow.	Daily command, executive oversight, capacity actions and partner escalation.	OPEL escalation and mutual-aid requests.
Level 4 – Critical / super surge	Critical service failure risk or multiple simultaneous pressures.	Executive command, critical service prioritisation and exceptional measures.	Full system command and cross-boundary mutual aid.

14. Performance, quality and assurance

Regular monitoring of key performance and quality data will enable regular oversight of demand, capacity, safety, workforce, infection, flow and delivery of agreed trajectories. This will support operational decisions and formal assurance to the Executive Team and Board.

Domain	Example indicators	Reporting
Crisis and ED	NHS 111 demand; crisis referrals; HTT gatekeeping; PLT waits; ED waits; diversion outcomes.	Daily/weekly
Inpatient flow	Admissions; discharges; occupancy; LOS; CRFD; OOA; Recovery House use.	Daily/weekly/monthly
Section 136	Volumes; assessment times; transport delays; suite use; ED use; conversion.	Weekly/monthly
Workforce	Vacancies; sickness; bank/agency; critical rota gaps; staff welfare.	Weekly
IPC	Outbreaks; infections; ward closures; hand hygiene; PPE/fit testing.	Weekly/monthly
Vaccination	Staff and patient uptake by division, site and cohort.	Weekly
Quality and safety	Incidents; restrictive practice; complaints; patient experience; safeguarding.	Weekly/monthly

15. Governance and accountability

Forum	Purpose	Frequency	Escalation
Trust Winter Planning Group	Preparation, readiness, action tracking and cross-divisional coordination.	Monthly	Executive Winter Lead
Operational command / patient flow	Daily operational oversight during periods of pressure.	Daily as required	Executive on-call / system command
Urgent Care Pathways Group	System oversight of urgent and crisis pathways.	Monthly	Transformation Delivery Group
Quality and safety committee	Assurance on patient safety, IPC and quality risks.	Monthly	Executive Winter Lead
Trust Executive Team	Executive oversight, decisions and risk management.	Monthly	Trust Board and ICB system command
Trust Board	Approval of the plan and Board Assurance Statement.	By 30 September 2026	NHS England submission

16. Principal winter risks and mitigations

Risk	Potential impact	Mitigation	Lead
Limited ability to absorb increases in demand due to high occupancy, CRFD and length of stay.	Reduced ability to admit locally, increased ED waits, pressure on crisis pathways and increased reliance on out-of-area placements.	Daily flow oversight; CRFD programme; discharge escalation; HTT gatekeeping; Recovery House/crisis alternatives; OOA in-reach; escalation to local authority/ICB; surge and mutual-aid arrangements.	Tariro Nyarumbu
Increased crisis and ED presentations	Longer waits, avoidable admission and pressure on partner services.	Crisis alternatives, HTT, 111, liaison escalation, proactive high-risk planning.	Dan Webster
Workforce absence or vacancies	Unsafe staffing, reduced access and staff fatigue.	Rota assurance, bank controls, redeployment and welfare support.	Sophia Fletcher
IPC outbreak	Ward closure, reduced capacity and staff absence.	Surveillance, outbreak plan, PPE, cleaning, isolation and mutual aid.	Sophia Fletcher
Section 136 pressure	Delayed assessment, prolonged ED waits and suite saturation.	Real-time tracking, partner escalation and contingency arrangements.	Dan Webster
Failure of commissioned capacity	Reduced crisis or inpatient capacity.	Contract escalation, contingency routes and mutual aid.	Jenny Watson
Data quality or delayed intelligence	Late recognition of pressure and weak assurance.	Defined datasets, owners, validation and regular dashboard reporting.	Tasnim Kiddy

17. Winter readiness action plan

No.	Action	Owner	Due date	Evidence	Status
1	Confirm Executive Winter Lead, deputy and governance.	Jason Nash	07/08/2026	Named leads and governance map	Complete
2	Complete refreshed demand and capacity analysis.	Tasnim Kiddy	14/08/2026	Data pack and scenario analysis	Complete
3	Confirm all-age crisis, NHS 111, HTT and liaison resilience.	Jason Nash	21/08/2026	Service readiness evidence	Complete
4	Complete workforce, on-call and staff welfare assurance.	Jack Wilkinson	21/08/2026	Workforce plan and rotas	Complete
5	Finalise flu vaccination campaign and trajectory.	Maxine Blake Jones	21/08/2026	Vaccination plan	Complete
6	Refresh IPC winter plan and outbreak readiness.	Zalika Geohaghon	21/08/2026	IPC plan	Complete
7	Finalise escalation, surge and mutual-aid arrangements.	Dan Webster	21/08/2026	Escalation framework	Complete
8	Participate in regional stress test and close actions.	Dan Webster	September 2026	Regional exercise evidence	Open
9	Complete Board Assurance Statement and Board approval.	Dan Webster	30/09/2026	BAS and Board minutes	Open
10	Submit Board Assurance Statement to NHS England.	Dan Webster	30/09/2026	Submission confirmation	Open
11	Confirm the 2026/27 Older Adult inpatient bed configuration, including the timing and impact of the Bergamot Ward closure and any confirmed P2 capacity, and refresh demand and capacity assumptions accordingly.	Kiesha Dell	30/09/2026		Open

Appendices

- Appendix A – 2026/27 demand and capacity data pack



Demand and Capacity Data Pack E

- Appendix B – Workforce resilience and staff welfare action plan

Action	Lead	Timescale	Intended outcome
Review all long-term sickness cases and agree management plans	Ward and team managers, supported by HR	September–October	Improved oversight and earlier return-to-work planning
Complete return-to-work meetings after every sickness episode	Line managers	Ongoing	Earlier identification of support needs and improved attendance management

Action	Lead	Timescale	Intended outcome
Monitor sickness trends by team and staff group	Divisional Management Team through SMT, FPP and ACUC People Partner	Monthly, October–March	Early identification of hotspots and targeted intervention
Promote flu and COVID-19 vaccination uptake	Ward and team managers with Occupational Health support	Throughout winter	Reduced risk of avoidable illness and service disruption
Promote wellbeing support, EAP and local wellbeing contacts	Managers, HR and wellbeing leads	Ongoing	Improved staff support and reduced stress-related absence
Review temporary staffing reliance linked to sickness	Operational managers, Temporary Staffing and Finance	Monthly	Improved oversight of bank usage and sickness-related staffing gaps

Appendix C – Staff and patient vaccination plan

Staff and patient vaccination

The organisation-wide staff flu-vaccination delivery model includes:

- Mobile or roaming vaccination teams at staff bases and clinical areas
- Dedicated clinic sessions
- Inclusion within staff induction processes
- Large-scale planned vaccination events
- A pharmacy voucher scheme to support convenient community access
- A communications campaign is planned to support uptake, alongside staff engagement and incentives. Learning from the previous year's campaign has been reviewed and incorporated to optimise delivery and improve uptake.

Uptake targets are to be agreed through the NHS England Immunisations and Vaccination Forum. Engagement is already underway, led by the Associate Chief Nurse.

Weekly uptake data reviews are in place. Data is shared with local teams and divisional leadership to support targeted action and assurance.

An organisational flu-vaccination programme is in place for eligible patient cohorts. COVID-19 vaccinations will be offered alongside flu-vaccination delivery where appropriate. Collaboration with University Hospitals Birmingham is in place to align COVID-19 delivery for priority cohorts with the broader winter vaccination programme.

The programme is aligned with NHS England winter-planning expectations. Regular reporting will take place through local winter-planning and operational-oversight structures. The delivery approach will be refined based on real-time uptake and operational feedback.

Key risks include:

- Uptake risk: Staff and eligible-patient vaccination uptake may fall short of targets, reducing protection and affecting winter resilience.
- Delivery-capacity risk: Operational pressures and workforce constraints may limit the ability to deliver the programme fully across all sites and services.
- Engagement risk: Vaccine hesitancy, inconsistent communications or insufficient local leadership engagement could affect participation.
- External-dependency risk: Delivery is reliant on vaccine availability.

Appendix D – IPC Winter Plan 2026/27

Infection prevention and control coverage

The Infection Prevention and Control (IPC) Team is available Monday to Friday, 9:00am–5:00pm. Outside these hours, including weekends and bank holidays, IPC advice and support are provided by the on-call Consultant Microbiologist.

In the event of increased infection incidents or outbreaks, weekly outbreak management meetings are convened with relevant internal and external stakeholders to review the situation, coordinate actions and provide assurance regarding ongoing control measures. Daily Situation Reports (SITREPs) are completed by clinical leads and reviewed by the IPC Team to identify emerging risks, provide specialist advice and support the implementation of appropriate control measures.

The IPC Team undertakes daily surveillance monitoring to identify potential infections, outbreaks and emerging trends requiring further investigation or intervention. Any significant concerns are escalated through the appropriate governance structures, including the Director of Infection Prevention and Control (DIPC) and the weekly Trust Safety Huddle.

Where admission to an area experiencing an outbreak is required, a risk assessment is undertaken to ensure that the clinical needs of the service user are balanced against the potential infection risks and that appropriate mitigation measures are implemented.

Cohorting, isolation and surge arrangements

All inpatient accommodation within the Trust consists of single-occupancy bedrooms, with the majority of rooms having en-suite facilities. This provides a high level of isolation capacity and supports the effective management of infectious service users while reducing the risk of transmission within inpatient environments.

The Trust has arrangements in place to implement cohorting where clinically indicated and where a risk assessment identifies this as an appropriate control measure. Cohorting decisions are made in collaboration with the IPC Team, clinical teams and operational leads, taking into account the infectious agent, mode of transmission, patient vulnerabilities and service requirements. Escalation and surge arrangements are available to support service delivery during periods of increased demand or outbreak activity.

Policies and procedures are in place to support the isolation of infectious service users, environmental cleaning, decontamination and outbreak management. Service users requiring IPC precautions are reviewed regularly by the clinical team, with support from the IPC Team and Consultant Microbiologist where required. Decisions regarding the continuation or discontinuation of isolation precautions are based on clinical assessment, microbiological results and current national guidance.

Risk assessments are undertaken to inform patient placement, transfers and discharge planning, ensuring that infection risks are appropriately managed while supporting patient flow. Where ongoing IPC precautions are required following transfer or discharge, relevant information is communicated to receiving services to ensure continuity of care and patient safety.

Cleaning and decontamination activities are undertaken in accordance with Trust policies and procedures, including enhanced and terminal cleaning requirements following isolation or outbreak situations. These arrangements support the timely turnaround of rooms and help minimise delays to admissions, transfers and discharges while maintaining safe infection prevention and control standards.

Respiratory-virus testing

Respiratory-virus testing is available across all inpatient areas, with access to four-in-one lateral-flow devices and PCR testing where required. Testing is undertaken in accordance with a Trust Standard Operating Procedure, supporting consistent practice and timely decision-making.

Test results are used to inform IPC measures, including patient placement, isolation and outbreak management. The availability of rapid testing supports patient flow by enabling timely clinical decisions and reducing delays.

Testing capacity can be increased during periods of heightened respiratory-virus activity or outbreaks. Routine respiratory-virus testing of staff is not undertaken.

Appendix E –CRFD joint delivery plan



**Birmingham & Solihull Mental Health NHS Foundation Trust
&
Birmingham City Council
Clinically Ready for Discharge – Joint Delivery Plan
June 2026**

Role	Lead
SRO	Jenny Watson, Deputy Director
Finance	Mark Godwin, Accountant
Performance	Tasnim Kiddy
Clinical	Farooq Ahmad
Operational Leads	Associate Directors (Divisional Leads)
PMO	TBC
BCC Lead	TBC
SMBC Lead	TBC

Version	Governance Sign Off	Date Approved
V0.1 Draft Template	FPP	July 2026
V0.2 Include BCC joint activities 3/7/26		

Clinically Ready For Discharge Programme Plan

This plan acknowledges that there needs to be a system wide response to reducing the number of Birmingham & Solihull patients clinically ready for discharge within inpatient settings.

A patient is considered clinically ready for discharge when the multidisciplinary team determines that no further inpatient assessments, interventions, or treatments are required, and the patient can safely continue care in the community.

Across Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT) there are on average 18% of beds for adults of working age that are clinically ready for discharge and 30-45% of older adult beds clinically ready for discharge. Whilst these patients remain in trust beds they are reducing the trusts capacity to respond to the demand currently flowing from acute trusts and community and increasing the use of out of area beds and associated costs.

Reasons for delay in discharge (post clinically ready) can include (but not limited to):

- Delays due to patient choice – often this can include patients declining packages sourced through brokerage as appropriate for level of need, often due to location.
- Delays due to social care capacity to undertake assessments

- Delays due to complicated and timely processes related to funding decisions and packages of care
- Delays due to a limited provider marketplace which results in costly packages of care.
- Delays due to limited and available housing
- Adaptations to home, purchase of white goods and deep cleans can also lead to a delay in discharge.
- Delays in requesting changes to MOJ restrictions

Costs associated to Clinically Ready for Discharge delays

A summary of costs associated to CRFD's for the period April 2024 – January 2026 (Older Adults)

Delay Reason	Costs
Placement in care home with nursing	6,173,352
Placement in care home without nursing	1,784,272
Social Worker Allocation	1,071,852
Care package in place of residence	551,320
Housing – supported accommodation	217,664
Not Recorded	208,356
Patient or family Choice	120,288
Disputes – post discharge care pathway	95,228
Public Funding or funding panel decision	31,504
Delays to NHS-Led Assessments	19,332
Delays to non-NHS led assessments	11,456
Housing – private rented accommodation	7,876
Equipment or adaptations to own home	7,160
Total	10,299,660

In summary the above delays equated to:

Period	No. CRFD Bed Days	Cost (£)
April 2024 – March 2025	6,757	£4,838,012
April 2025 – January 2026	7,628 (871 increase)	£5,461, 648 (+£623,636 increase)
	14,385	£10,299,660

A summary of costs associated to CRFD's for the period April 2024 – January 2026 (Adults of Working Age)

Delay Reason	Costs
Social Worker Allocation	3,199,986
Housing – supported accommodation	3,151,560
Public Funding or funding panel decision	1,350,537
Not Recorded	979,929
Disputes – post discharge care pathway	971,097
Care package in place of residence	798,555
Placement in care home with nursing	751,275
Placement in care home without nursing	618,390
Awaiting outcome of legal proceedings	450,225
Housing – not eligible for funded support	429,975
Delays to non-NHS led assess community	390,825
Delays to NHS-led assessments - community	379,785
Housing – council housing waiting list	369,900
Housing – Local Authority temp accom	235,525

Equipment or adaptations	231,525
Residential special school or college	212,946
NHS non-inpatient services	202,500
Patient or Family Choice	178,875
Care co-ordinator allocation	164,700
Housing – private rented accommodation	149,175
Housing -purchasing/sourcing home	132,300
Ministry of Justice agreement	130,860
Non social care support	103,275
Public safety concern	98,550
Reason not known	78,300
No lawful support available	13,500
Total	15,774,120

Period	No. CRFD Bed Days	Cost (£)
April 2024 – March 2025	12,569	£8,953,644
April 2025 – January 2026	9,745	£6,820,476
	22,314	£15,774,120

Ready for Discharge Priorities & Ambitions

This plan identifies 4 key priority areas which will ensure a reduction in Clinically Ready for Discharge across BSMHFT. These priorities are set out below along with proposed improvements which will be monitored weekly.

Escalation processes will be embedded across the pathway to ensure that appropriate actions are taken following admission, rather than at the later stage of the pathway.

CLINICALLY READY FOR DISCHARGE PRIORITIES	
CRFD1	Reduce avoidable delays in relation to patient choice
CRFD2	Improve access to social care capacity and strengthen joint working
CRFD3	Reduce delays cause by funding decisions and pathways
CRFD4	Improve market management and access to appropriate accommodation and support

Ambition from implementation of plan – to be monitored on a weekly basis

Ambition	Current % of beds CRFD's	Target reduction 6 months -Dec 26
Reduction in AWA Clinically Ready for discharge	18%	10%
Reduction in OA Clinically Ready for discharge	45%	19%

Progress Status: Not Started/In Progress/Complete

Delivery Status: On Track/Some delay/At Risk

UPDATED PLAN: 2/09/26

CRFD 1: Reduce avoidable delays due to patient choice				
Activity	Lead	Expected Completion	Progress Status	Delivery Status
1.1 Ensure the development of a Choice Policy for BSMHFT which is signed off through the appropriate internal governance routes. Choice Statement to be shared with Jo Lowe to ensure aligns to Care Act.	Jason Nash	August 2026	Completed – August 2026	
1.2 Escalation route to support Choice Policy	Jason Nash	August 2026	In Progress	Delayed – Sept 26
1.3 Ensure that there is a clear communications plan in place to disseminate to operational staff working in patient settings who are part of the discharge planning to ensure awareness of Choice Policy and implementation as part of Admission Process.	Jason Nash	Sept-Oct 2026	In Progress	On Track
1.4 Investigate opportunities for a system wide approach to Choice across the BSOL Cluster.	Jenny Watson	March 2027	In Progress	On Track
1.5 Review of Admissions Policy requires a review (date has passed)	Jason Nash	Dec 2026	In Progress	On Track
1.6 Development of patient leaflet on choice to be included in EBE developed Information Pack for patients on admission.	Jason Nash Aisha Kauser Joanne Lowe	August 2026	Completed- August 2026	
Indicators of Success: - Choice Policy Statement agreed and in place - Staff aware of and following the Choice Policy – suggest a 3 month check point review to ensure being followed. - Reduced number of delays as a result of choice Potential areas of Risk: - Patients/Families/Carers/Staff may not be satisfied with the choices made available on discharge despite placements being identified to meet needs.				
Update: 1.1 Choice SOP approved at PDMG – Aug 26 1.2 A clear escalation process is required to support staff with implementation of the Choice Policy Statement. This will require support from the legal team on what needs to be put into place. 1.4 Conversation with Louise Carter in ICB regarding System Wider approach to Choice commenced. 1.5 Admission policy requires a review – Jason Nash taking forward with support from David Cameron. 1.6 EBEs supported development of patient leaflet.				

CRFD 2: Improve access to social care capacity and strengthen joint working				
Activity	Lead	Expected Completion	Progress Status	Delivery Status
2.1 Realign and strengthen the Rapid Discharge Team (proposal to be shared with Vanessa)	Joanne Lowe	Mobilise Sept 26	In Progress	On Track
2.2 Undertake a desk top review for Younger Adults and Older Adults with BCC colleagues (inline with the approach taken with St Andrews Northants).	Joanne Lowe Vanessa Devlin Jenny Watson Aisha Kauser	17 th July Younger Adults 22 July Older Adults	Completed	Complete
2.3 Develop and Agree on a core set of response timelines which can be monitored weekly by Health & Social Care and aligned to both admission and discharge pathways, Care Act Requirements and Red to Green. Link to 12 point discharge plan.	Joanne Lowe Vanessa Devlin Aisha Kauser Jason Nash	15 July 2026 meeting 30 August 2026 completion	In Progress	Revised date for completion– Oct 26
2.4 Ensure that the weekly data on CRFDs issued to LA's is built from the weekly deep dive to ensure accurate, up to date information being issued to partners.	Dan Webster Joanne Fieldhouse	20 July 2026	In Progress	Update to be provided.
2.5 Ensure monthly reporting into Strategic Commissioning Groups for oversight of CRFD delays	Jenny Watson Jason Nash	30 July 2026	Not Started	Delayed meeting cancelled.
2.6 Review of current patient flow and escalation pathways to reduce duplication and maximise efficiencies.	Jenny Watson Vanessa Devlin Joanne Lowe Caroline Potter	1 September 2026	In Progress	Delayed – Oct 26
2.7 Review of Discharge Co-ordinator Function	Jenny Watson Vanessa Devlin	1 September 2026	In Progress	Delayed – Oct 26
2.8 Ensure the implementation of the AMHP Review across the trust	Dan Webster	July 2026	Completed	Complete
2.9 Pilot Trusted Assessor role in BSMHFT	Joanne Lowe	June 2026	Completed	Complete
2.10 Ensure Care Co-ordinators are in reaching into inpatient settings	Jenny Watson Renu Bhopal-Padiar	31 August 2026	In Progress	Revised date for completion – Dec 26
2.11 NEW ACTION – review digital innovation to support data visibility across Health & Social Care.	Jenny Watson Carl Beet	December 2026	In Progress	On Track
Indicators of Success:				

- Timely response to key activities to be undertaken post admission
- A renewed pathway for managing CRFD's jointly agreed and implemented
- Accurate information sharing with LA's with appropriate system level oversight.

Potential areas of Risk:

- Resistance to agreeing to 'response times'
- Risk of the trusted assessor pilot not being supported leading to continuous social care delays.

Update:

2.2 A workshop has been organised for the 3 July 2026 at 1pm. Outcome led to additional actions above.

2.9 Confirmation from BCC that they are unable to support a trusted assessor pilot due to contractual changes which would be required and BCC are unable to accommodate these.

02/09/26

2.1 A meeting with BCC (Joanne Lowe) confirmed the review of the Rapid Discharge Team in progress. Business case in development for a further 2 social workers is in development by BSMHFT.

2.2 Desk Top reviews completed, however recurrent reviews required and process to do this under review with BCC.

CRFD 3: Reduce delays caused by funding decisions and pathways				
Activity	Lead	Expected Completion	Progress Status	Delivery Status
3.1 Work with BCC to agree a mandatory funding split for Packages of Care (117) and the subsequent revision to local funding pathway.	Jenny Watson Joanne Lowe Vanessa Devlin	Phase 1 – May Phase 2- July/August Phase 3- September Phase 4 – March 2027	In Progress	On Track
3.2 Develop a clear protocol to support staff identify 'Host Commissioner 'responsibilities upon admission.	Tracy Smith	December 2026	In Progress	On Track
3.3 Ensure training is made available to all staff on the new funding split and application process.	Jenny Watson Dan Webster	Roll out of training Aug/Sept 2027	Not started/not due till 2027	
3.4 Implement a 'Gold' Escalation Call with the Chief Nurse	Lisa Stalley-Green Sophia Fletcher Jenny Watson	June 2026 commencement	Complete	Complete
Indicators of Success:				
• Mandatory Funding split approved and implemented • Reduced delays on the funding pathway as clearer process for applications made clearer				

Potential areas of Risk:

- Potential delays if BCC or ICB do not approve the move to a mandatory funding split based on due diligence
- SMBC excluded from mandatory funding splits.

Update:

3.1 Strategic Intent Document developed in partnership with BCC and approved by Execs from both BSMHFT and BCC – June 2026

- Review of key due diligence actions to support the mandatory split underway.

CRFD 4: Improve market management and access to appropriate accommodation and support				
Activity	Lead	Expected Completion	Progress Status	Delivery Status
4.1 Identify gaps in housing and accommodation needs upon release.	Robert Devlin	September 2026	In Progress	On Track – requires escalation
4.2 Complete a review of required bed capacity across BSMHFT	Robert Devlin	September 2026 – Dec 2026	In Progress	On Track
4.3 Attend Independent Provider Meetings	Aisha Kauser Robert Devlin	Ongoing	In Progress	On Track
4.4 MHLDA PC to work with BCC on a Housing Project which focus' on MHLDA specialist providers, commissioning expectations, quality and pricing tariffs.	Aisha Kauser Robert Devlin Sumyra Ul-Hasan (BCC)	September 2026-Dec 2026	In Progress	On Track
4.5 Explore with BCC the re-opening of the framework – include timeframes around adaptations and position on insurances for properties to be accessed for complex patients – understand barriers for providers wishing to join the framework	Jenny Watson Alison Malik (BCC)	Dec 2026	In progress	On Track
4.6 Re-open inpatient framework for acute and picu beds	Jenny Watson Robert Devlin Neil Barnett	Sept 2026	In Progress	On Track
4.7 Facilitate delivery of a rehab framework across Cluster	Robert Devlin Tracy Smith	Dec 2026	In Progress	Off Track
4.8 Develop a training and awareness plan for staff around homeless pathways, No Recourse to Public	Tracy Smith Aisha Kauser	October 2026	Not started	

Funds and brokerage of appropriate housing and support.	Joanne Lowe			
4.9 Service Mapping for housing pathway to support discharge pathway (pre 72 hour OT assessment)	Jason Nash	Dec 2026	In Progress	On Track
Indicators of Success: • Greater diversity of market provision • Levelling up of cost of care • Staff awareness of housing pathways on discharge Potential areas of Risk: • Time commitment and time delays to delivering the required activities. • Potential financial impact to level up on cost of care				
Update: 4.5 Draft letter to Stuart Lackenby prepared for issue, requesting support to join the BCC framework. 02/09/26 update: 4.2 Meetings have commenced with divisional managers regarding the bed stock review. 4.5 Letter issued to Stuart Lackenby regarding a request to join the BCC Framework. A meeting with Stuart has led to monthly 1:1s. 4.7 Market Engagement Event 20/08/26. Cabinet Office Approvals required. Mobilisation will be from April 2027.				

Appendix F – Board Assurance Statement

To be submitted separately.

Committee Escalation and Assurance Report

Name of Committee	Audit Committee
Report presented at	Board of Directors
Date of meeting	7 October 2026
Date(s) of Committee Meeting(s) reported	30 September 2026
Quoracy	Membership quorate: Y
Agenda	• Committee Escalations • Board Assurance Framework • Corporate Risk Register • Internal Audit Progress Report • Internal Audit Action Tracking Report • Internal Audit Review: Compliance with Anti-Racism Policy • External Audit Progress Report • Risk Management Policy • Risk Management Group Assurance Report
Alert:	The Committee highlighted continuing concerns regarding organisational capacity and capability, particularly the capacity to deliver the Trust's transformation agenda and respond to demand pressures within Children and Young People's services. The Committee agreed this remained an important area for oversight and triangulation across committees.
Assure:	• The Committee considered the Internal Audit review of compliance with the Trust's anti-racism policy, which provided partial assurance and identified six medium and four low-priority management actions. The Committee heard that actions were being progressed and noted the absence of high-risk recommendations. The Committee agreed that this should be reported to Board as an area of assurance and monitored through People Committee as part of continuous improvement. • The Committee received assurance from progress against the 2026/27 Internal Audit Plan. The draft Clinical Audit review had received a positive reasonable assurance opinion, with further reviews planned across EPRR, IT physical access, risk management/BAF, sexual safety and key financial controls. • The Committee received positive assurance regarding the operation of the Risk Management Group, including strong engagement from operational directorates and senior leadership and improved linkage between operational and strategic risk discussions. The Committee reflected that this demonstrated increasing organisational maturity in risk management. • The Committee supported the refreshed Risk Management Policy, noting its alignment with current national guidance and the Trust's new strategic priorities.
Advise:	The Committee noted that consolidated reporting on single tender waivers, framework exemptions, losses and special payments, SFI breaches and relevant employment overpayments was not yet available. Concern was expressed that this



	information had been outstanding across several Committee meetings. Some assurance was received that work was underway to establish a consolidated reporting approach, with the Committee emphasising the importance of timely reporting to support good governance, transparency and identification of potential systemic issues. The Committee received overall assurance from the Corporate Risk Register but was not able to conclude that all high-level operational risks were being appropriately mitigated, particularly given a number of long-standing high-scoring risks. Further work continued to review, challenge and rationalise these risks, including consideration of a more thematic presentation to improve strategic oversight and triangulation. The Committee noted progress against the Internal Audit action tracker but reinforced the need for revised implementation dates to be realistic and deliverable. Particular challenge was raised regarding the action relating to purchase-order authorisers within Integra, with further assurance requested before agreeing the proposed revised timescale.	
Reducing Health Inequalities impact:	The Committee considered how effective risk management and assurance arrangements supported the Trust's approach to reducing health inequalities. In particular, discussion highlighted pressures within Children and Young People's services, including increasing demand and workforce capacity, alongside the importance of understanding how these pressures may affect service delivery. The Committee also agreed that future Risk Management Group assurance reports should more explicitly demonstrate the relationship between identified risks, associated mitigations and their potential impact on reducing health inequalities.	
Board Assurance Framework	The Committee welcomed the refreshed Board Assurance Framework and agreed to introduce a rotational strategic deep dive into selected BAF risks, working alongside the relevant assurance committee and executive lead and avoiding duplication. SR8, concerning the ability to maintain secure digital infrastructure and systems, was agreed as the first deep dive. New risks identified: No new risks were identified. The Committee continued to highlight organisational capacity and capability, transformation delivery and demand pressures as areas requiring ongoing oversight and triangulation through the relevant assurance committees.	
Report compiled by:	Winston Weir, Non-Executive Director	Minutes available from: Kat Cleverley, Company Secretary



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Committee Escalation and Assurance Report

Name of Committee	Caring Minds Committee
Report presented at	Board of Directors
Date of meeting	7 October 2026
Date(s) of Committee Meeting(s) reported	21 September 2026
Quoracy	Membership quorate: Y
Agenda	The Committee considered an agenda which included the following items: • Charity Update Report • Trust and Foundations Update • Caring Minds Strategy Update • Financial Update • Cazenove SMAF Update • Letter of Engagement - Caring Minds BSMH NHS Foundation • Discussion relating to terms of reference and Trustee Board
Alert:	• Dementia clocks remain unfunded, with no dedicated funding source identified. The proposal will rely on future fundraising and the new Match My Project scheme, which has not yet been tested and has uncertain timescales for delivery. • Hospital Rooms project carries a potential future financial liability. Whilst the project is viewed positively, the Committee was concerned about committing to a £45,000 match funding arrangement without sufficient certainty regarding future charitable income, fundraising success or Trust support. A final decision was deferred pending additional information. • Regulatory compliance risk was noted relating to previous late submission of the charity's Annual Report and Accounts. Mitigating actions have been implemented to prevent recurrence and protect future funding opportunities. • Members acknowledged that Board-wide understanding of Corporate Trustee responsibilities may be limited, with no formal trustee training programme currently in place and varying levels of trustee awareness across the Board. • Current charity governance processes rely heavily on information provided by applicants, creating a risk of duplication of funding requests and insufficient validation of alternative funding routes.
Assure:	• The Committee was assured that Caring Minds continues to successfully generate income and support service improvement and wellbeing projects across the Trust through fundraising, donations, grants and charitable activity. • The charity has secured significant fundraising income, including the "In Memory of Rosin" appeal (£10,664) and continued growth of the staff lottery, generating approximately £721 per month. • The Committee received assurance that governance arrangements are being strengthened, including improved communication with Trust



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	governance groups and stronger validation of funding requests before charitable consideration. • Members were assured that a strong programme of grant applications is in development, with an application pipeline valued at approximately £143,561 to support veterans, sensory environments, chronic fatigue services, children and young people, and other initiatives. • The Committee was assured that all available external funding opportunities would be explored before committing charitable funds to major projects such as the Hospital Rooms proposal. • Assurance was received that the Cazenove investment portfolio remains diversified and has delivered positive returns, achieving a 15.4% annual return over the previous 12 months. • The Committee was assured that appropriate independent examination arrangements are in place following approval of the appointment of Shruti Soni Ltd as Independent Examiner. • Members received assurance that work is underway to strengthen the governance relationship between Caring Minds and the Board of Directors acting as Corporate Trustee, improving oversight, accountability and strategic alignment.
Advise:	• Fundraising campaigns should be carefully timed and coordinated with major Trust activities, particularly the Staff Survey, to avoid competing communications and maximise engagement. • Future funding applications should include evidence of consideration through relevant Trust governance routes before submission to Caring Minds, including use of committee minutes where appropriate. • Communication with applicants should avoid describing proposals as "rejected" where alternative funding routes remain available, and instead emphasise ongoing support and fundraising opportunities. • The Committee advised that the Ardenleigh shower proposal would only be suitable for charitable consideration if it formed part of a wider staff wellbeing initiative rather than a standalone estates improvement. • Members advised that future financial forecasting should include contingency planning for match-funded projects such as Hospital Rooms to better understand potential long-term financial commitments. • The Committee supported establishing a dedicated Corporate Trustee meeting and trustee development programme to improve Board engagement, understanding and oversight of Caring Minds. • A Board Strategy Session should be used to establish a baseline understanding of trustee duties, governance expectations and the relationship between Caring Minds and the Trust before implementing wider governance changes.
Reducing Health Inequalities impact:	Members recognised that health inequalities continue to impact access to services, patient experience and outcomes. While progress is being made through a range of improvement initiatives and partnership approaches (including PCREF and PSIRF), further work is required to strengthen the use, and cross population, of data and targeted interventions, and to work collaboratively with system partners to reduce inequalities and improve outcomes for local communities.
Board Assurance Framework	



	New risks identified: no new risks were identified.	
Report compiled by:	Monica Shafaq, Non-Executive Director	Minutes available from: Hannah Sullivan, Corporate Governance Manager

Report to Board of Directors						
Agenda item:	21					
Date	7 October 2026					
Title	Risk Appetite Framework					
Author/Presenter	Kate Smith, Risk Manager Kat Cleverley, Company Secretary					
Executive Director	David Tomlinson – Executive Director of Finance	Approved	Y	✓	N	
Purpose of Report		Tick all that apply ✓				
To provide assurance		To obtain approval	✓			
Regulatory requirement		To highlight an emerging risk or issue				
To canvas opinion	✓	For information				
To provide advice	✓	To highlight patient or staff experience				
Summary of Report						
Alert	✓	Advise		Assure		
Executive Summary The Risk Appetite Framework was reviewed and discussed at the Board Strategy Session on 30 September 2026. The session enabled the Board to consider the Trust's proposed appetite across the principal categories of organisational risk and to confirm the balance between enabling strategic ambition, innovation and transformation and maintaining appropriate caution in areas where exposure could result in avoidable harm, material financial loss or significant security concerns. The proposed position reflects that discussion and is presented for formal Board approval. To strengthen alignment with the Trust's annual planning, financial and Board Assurance Framework cycles, the Board is also asked to agree that future reviews of the Risk Appetite Framework are realigned to the start of each financial year. Subject to approval, the next review will therefore take place in April 2027, enabling the agreed appetite to inform strategic priorities, decision-making and risk oversight from the outset of 2027/28.						
Recommendation						
- The Board is asked to approve the Risk Appetite Framework for 2026/27. - The Board is asked to agree that the Framework will be reviewed in April 2027, to align with a refreshed position for the new financial year.						
Enclosures						
N/A						

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

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

The risk appetite framework sets out the tolerance for the whole of the organisation, and will be used throughout all risk management processes.

The Board had been asked to complete a risk appetite survey for discussion at the Board Strategy Session in September. Following the session, the following the following was agreed for formal approval at Board of Directors:

Risk Type	Recommended Appetite	Board principle
Quality & Safety	CAUTIOUS (6-8)	The Trust will support proportionate, evidence-led innovation where there is a clear potential to improve outcomes. Innovation may involve managed risk and uncertainty, but it must not reduce patient or staff safety below agreed minimum standards, statutory requirements or defined safety tolerances. Appropriate safeguards, clinical oversight, monitoring and clear criteria to pause or stop activity must be in place.
Reputational	OPEN (9-10)	The Trust may accept proportionate, time-limited reputational exposure where decisions are transparent, evidence-based and support better outcomes.
People	EAGER (12)	The Trust will actively test new workforce models where staff involvement, equality impact, wellbeing and safe staffing controls are demonstrated.
Finance	CAUTIOUS (6-8)	The Trust will accept financial risk only within agreed controls, tolerances and delegated authority, with a credible benefits case and recovery route.
Regulatory	OPEN (9-10)	The Trust may adopt a reasoned, transparent interpretation or challenge where it remains lawful, engages regulators early and can manage the consequences.
Strategy	EAGER (12)	The Trust will actively pursue calculated strategic opportunities where alignment, benefits, dependencies, controls and exit criteria are clear.
Operations	EAGER (12)	The Trust will test and scale operational improvements where continuity, capacity, workforce and patient-safety impacts are actively managed.
Data &	OPEN	The Trust will use data to improve care only where purpose, lawful

Information Management	(9-10)	basis, quality, access, retention and accountability are explicit
Governance & Legal	OPEN (9-10)	The Trust may simplify or adapt governance where decisions remain lawful, documented, transparent, appropriately delegated and subject to effective assurance.
Digital Improvement	EAGER (12)	The Trust will actively invest in and test digital solutions where user need, clinical safety, interoperability, inclusion, information governance and measurable benefits are addressed.
Cyber Security	CAUTIOUS (6-8)	The Trust has a low appetite for preventable cyber compromise; innovation must meet defined security, resilience, recovery and assurance requirements.
Transformation / QI	EAGER (12)	The Trust will actively support controlled experimentation, rapid learning and scaling of effective changes, with clear measures, ownership and stop criteria.
Security	CAUTIOUS (6-8)	The Trust will maintain a low appetite for preventable security harm; any departure from controls must be risk-assessed, authorised and time-limited.
Property	OPEN (9-10)	The Trust may pursue new estate models where safety, accessibility, service continuity, affordability, sustainability and whole-life value are demonstrated.
Environment	OPEN (9-10)	The Trust will pursue proportionate environmental action where benefits, statutory duties, affordability, resilience and impact on care are understood.
Commercial	OPEN (9-10)	The Trust may enter commercial arrangements where due diligence, conflicts, value, quality, legal compliance, exit arrangements and protection of public resources are assured.
Partnerships & Provider Collaboratives	EAGER (12)	The Trust will actively pursue partnership opportunities where shared outcomes, governance, accountability, risk allocation, data arrangements and benefits are explicit.

Overarching Board principle:

A higher risk appetite does not mean that high risk is acceptable in every circumstance. BSMHFT will take calculated and managed risks where there is a clear potential benefit, the risks are understood, appropriate mitigations are in place, and the level of exposure is proportionate to the expected benefit.

Overarching Risk Appetite statement:

BSMHFT has an appetite to take calculated and managed risks where this is necessary to deliver its strategy, improve outcomes for patients, communities and staff, reduce health inequalities, transform services and strengthen organisational capability. The Trust will be more cautious where risks could result in avoidable harm, material financial loss, serious security exposure, inappropriate use of information or failure to meet statutory and regulatory obligations.

Report to Board of Directors						
Agenda item:	22					
Date	7 October 2026					
Title	Risk Management Policy					
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 The Risk Management Policy has been reviewed and updated according to its review period (last reviewed in 2024). Updates have been made to align the Policy to the new strategic priorities. Changes have also been made to update reference to national and professional risk management guidance. Purpose The Policy has been endorsed and recommended to the Board by the Audit Committee.						
Recommendation						
The Board is asked to approve the Risk Management Policy.						
Enclosures						
Risk Management Policy						

RISK MANAGEMENT POLICY

POLICY NO & CATEGORY	RS 01	Risk & Safety
VERSION NO & DATE	17	September 2026
RATIFYING COMMITTEE	Board of Directors	
DATE RATIFIED	7 October 2026	
NEXT REVIEW DATE	2 years after ratification	
EXECUTIVE DIRECTOR	Executive Director of Finance	
POLICY LEAD	Company Secretary	
POLICY AUTHOR <i>(if different from above)</i>	As above	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	Yes	

Policy Context

This policy establishes the Trust-wide framework for identifying, assessing, recording, escalating and managing strategic and operational risks. It supports consistent, proportionate and timely decision-making, links risk management to the Trust's objectives, risk appetite, Corporate Risk Register and Board Assurance Framework, and clarifies accountability from service level to the Board.

POLICY REQUIREMENT

The Policy applies to all staff - including HMP Birmingham Healthcare staff, BSOL MHPC & Reach Out, agency staff, TSS/Bank staff, trainees, contractors, Trade Union colleagues, students and persons engaged in doing business or providing services on behalf of the Trust. This Policy will be reviewed every two years; however, it could be reviewed earlier if significant changes occur within the Trust risk management landscape.

All staff members are responsible for:

- ensuring that risks are identified, assessed and managed.
- highlighting identified risks to their manager where they are unable to manage the risk as part of their legitimate role/responsibilities.

All operational service areas and Executive Directors should systematically review risks on their risk registers, in a timely, dynamic and proportional way, those scored 15 or more, on a monthly basis as a minimum while those scored 12 or less quarterly as a minimum, identify controls for mitigation and evaluate their effectiveness.

The Risk Management Group (RMG) will ensure effective working arrangements and controls are in place to proactively manage the escalation of risks. Risk moderation will take place at the RMG to determine appropriateness of risk scores, approve risks for escalation and ensure operational risks do not compromise the delivery of the Trust's operational objectives and business plan.

All risks which could significantly compromise the Trust's ability to deliver its operational and strategic objectives will be reviewed on a monthly basis as a minimum via the Corporate Risk Register and Board Assurance Framework respectively, by the Quality, Patient Experience and Safety Committee, People Committee, and the Finance, Performance and Productivity Committee, as a tool for driving their agendas, discussions and debates.

The Audit Committee will review the effectiveness of the system of internal control including assurance that effective arrangements are in place for risk management and make recommendations to the Board as appropriate regarding the Trust's risk management arrangements.

Change Record

Date	Version	Author (Role)	Reasons for review / Changes incorporated	Ratifying Committee
August 2026	17	Kat Cleverley, Company Secretary	Updates have been made to align the Policy to the new strategic priorities. Changes have also been made to update reference to national and professional risk management guidance.	Audit Committee

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1 Introduction

1.1 Rationale

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

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

(Adapted from ISO 31000:2018, Risk management Guidelines)

Risks will always be present in the things that we do. The aim of this policy is to ensure that all staff actively understand risk, recognise risk, and know how to identify, assess, report, review, and manage risks to support the overall aims of the organisation. This means that we look at risk at all levels ranging from the risks to delivery of our strategic priorities/aims, through to the day-to-day delivery of team-based objectives which in turn contribute to the bigger picture.

This is demonstrated in the pictorial diagram below: -

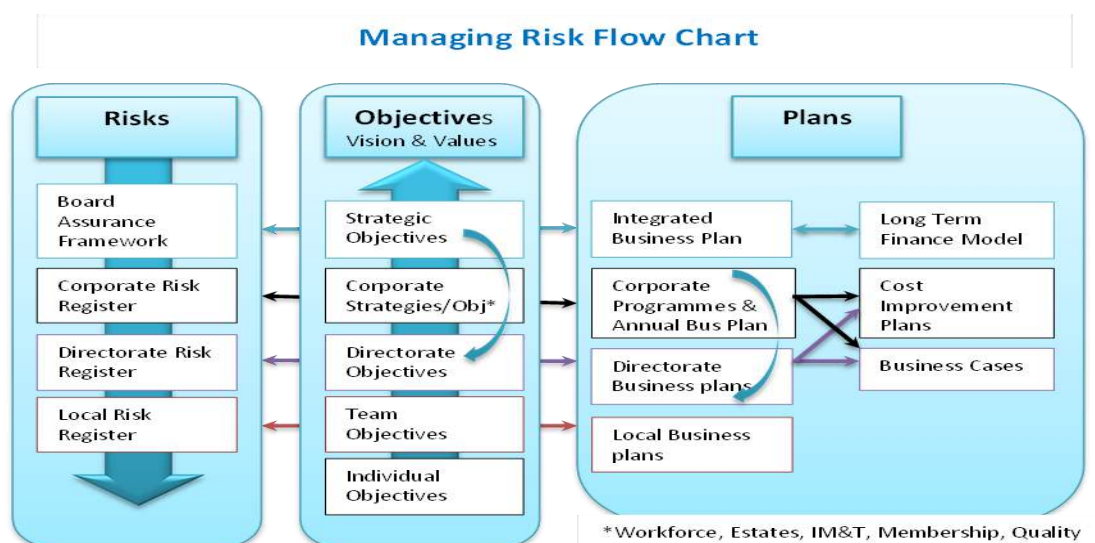


Figure 1 – Managing risks flow chart.

Good risk management is at the heart of everything we do in the Trust. We need to be open, honest, and aware of the risks we are facing on a day-to-day level as well as strategically. BSMHFT is committed to implementing an agile, dynamic, integrated and Trust-wide proactive approach to risk management – i.e. to identifying, assessing and managing potential risks/threats to the delivery of its operational objectives and strategic priorities.

In large complex organisations, managing risk could seem a daunting task. Risks are, however, inherent in everything that we do as the provision of healthcare

entails some uncertainty, hence, that uncertainty brings new opportunities and risks. How we manage existing and emerging risks is important in helping us meet our objectives, improve service delivery, achieve value for money and reduce unwarranted variations, fire-fighting and unwelcome surprises.

This Risk Management Policy provides a framework for the effective, proactive and timely management of risks. Sound recording and escalation mechanisms are described for departmental risks, wider locality service area risks and Trust wide risks. This policy also sets out the roles and responsibilities of individuals in delivering good risk management as well as the overarching governance structure for reporting of risks.

1.2 Scope

The Policy applies to all staff, including HMP Birmingham Healthcare staff, BSOL MHPC & Reach Out, Agency, TSS/Bank staff, agency staff, trainees, contractors, Trade Union colleagues, and students and persons engaged in doing business or providing services on behalf of the Trust.

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

1.3 Principles

The Trust's approach recognises:

- The need to ensure that risks are openly discussed and reported within a culture of improvement, honesty, and reality.
- The implementation of the risk management arrangements must be proportionate, timely, dynamic, aligned to the delivery of the Trust's goals, comprehensive and embedded into business as usual as well as responsive to changes within the Trust's business environment.
- The need to strike a balance between stability and innovation. In a changing and challenging environment, risk management helps to create and seize opportunities in a managed way e.g. by considering alternative actions to those originally intended. Some risks will always exist and will never be eliminated; all staff must understand the nature of risk and accept responsibility for the management of risks associated with their area of authority.
- The Trust explores an integrated approach to risk management that combines a top-down strategic view with a complementary bottom-up operational process.

2 Policy

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

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

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

All local service areas, managers and Executive Directors should systematically review risks on their risk registers or within their portfolio on a monthly basis as a minimum, for those scored 15 or more and on a quarterly basis as a minimum, for those scored 12 or less as well as provide assurance that the risks are being managed thoroughly and through their local governance arrangements. Local service areas, Directorates and corporate support teams are expected to escalate any risks with a score of 15 or more that have been approved at their local governance meeting, signed off at the Directorate level and by the relevant Executive Director. Such risks will then be presented at the RMG for consideration and approval for inclusion onto the CRR, please see section 5 for more details on risk escalation.

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

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

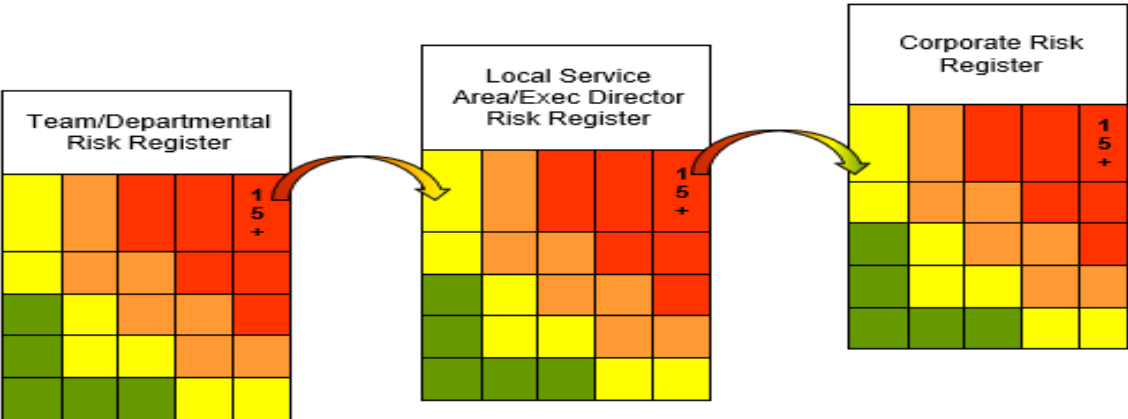


Figure 2 - Escalation in the Risk Register Hierarchy

BSMHFT’s Risk Management Policy provides a comprehensive framework to underpin how staff in all Services and Directorates across the Trust should timely and proactively identify, assess, manage and mitigate any potential risks that

could compromise the achievement of their local operational objectives/goals. It thus seeks to foster standardisation, engagement, consistency and galvanise leadership in fostering effective risk management and risk escalation from 'Ward to Board'.

3 Procedure

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

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

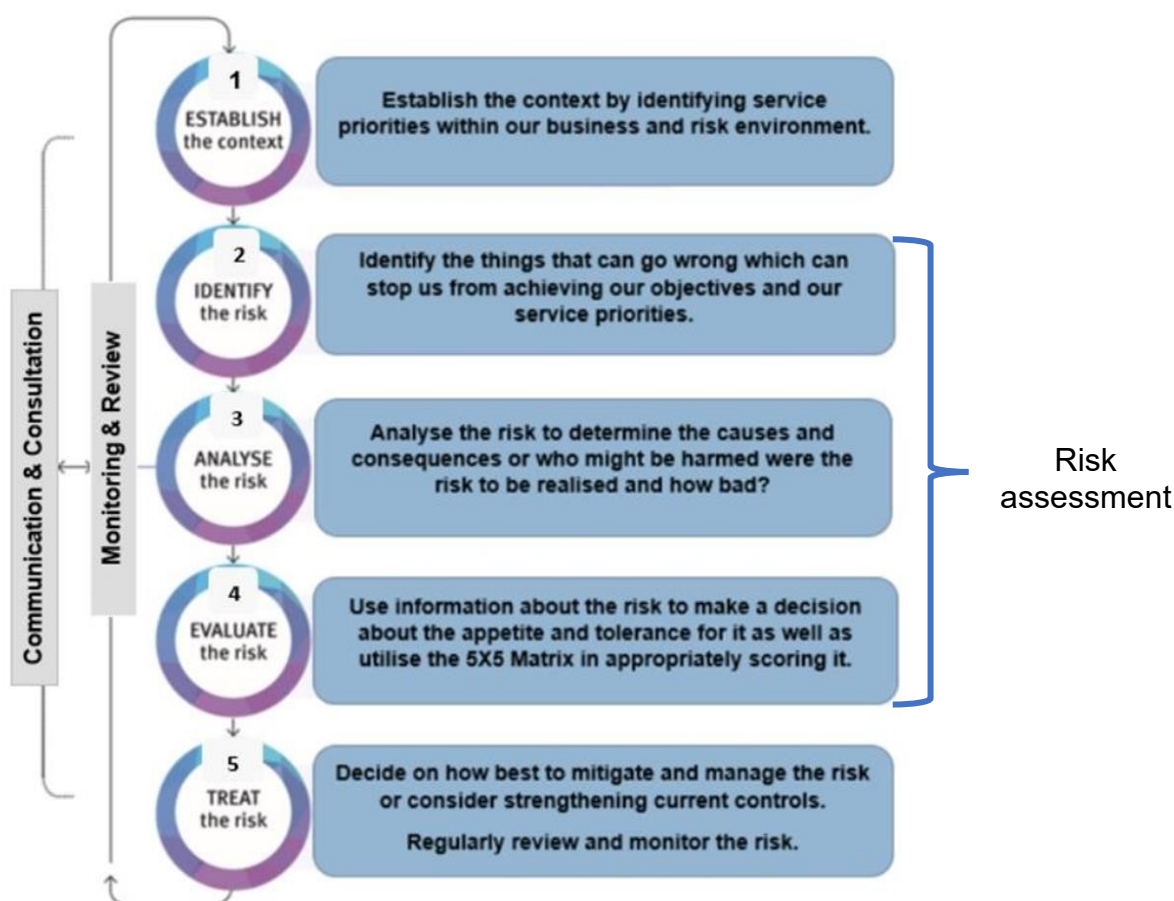


Figure 3: BSMHFT's approach to risk management - Five steps

3.1.1. Step 1: Establish the context

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

3.1.2. Step 2: Risk identification

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



Figure 4 - Sources of Risk Identification

Any managed change generated within the Trust should be risk assessed before, during and after the change occurs. Significant projects are managed through the Project Management Office where risk & issue logs and Clinical Quality and Equality impact assessments are documented, assessed, and managed by the project teams.

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

Major Incident plans should be tested on a regular basis, and risks identified from any learning are communicated back to the relevant groups to ensure processes are refined. All risks relating to EPRR and BC are captured on the Trust risk management information system (Eclipse), reviewed monthly as a minimum for those scored 15 or more and quarterly as a minimum for those scored 12 or less, as well as reported to the Business Continuity & Emergency Preparedness

Committee which has responsibility for scrutinising, communicating and escalating such risks through the relevant Trust governance channels.

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

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

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

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

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

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

3.1.3. Step 3: Risk analysis

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

3.1.4. Step 4: Risk Evaluation

Evaluate, assess and quantify the risk by deciding on how bad (consequence) and if the risk were to be realised (likelihood). The Trust uses a standard 5 × 5 risk-scoring matrix to support consistent assessment of consequence and likelihood. The matrix and associated descriptors are set out in Appendix 3. The matrix is a decision-support tool and must be applied using professional judgement, available evidence and consideration of the relevant operational, clinical and strategic context. Decide on the most appropriate risk response option. The following three risk scores will have to be identified during a risk assessment process: -

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

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

3.1.5. Step 5: Risk Treatment & Prioritisation

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

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

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

Where further actions are required to avoid, eliminate or reduce the risk, these actions must be entered onto the risk register along with the date by which the action will be implemented and the individual responsible for assuring delivery of the action.

3.2. Risk Review and Monitoring

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

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

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

3.3. Types of control: Risk control techniques

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

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

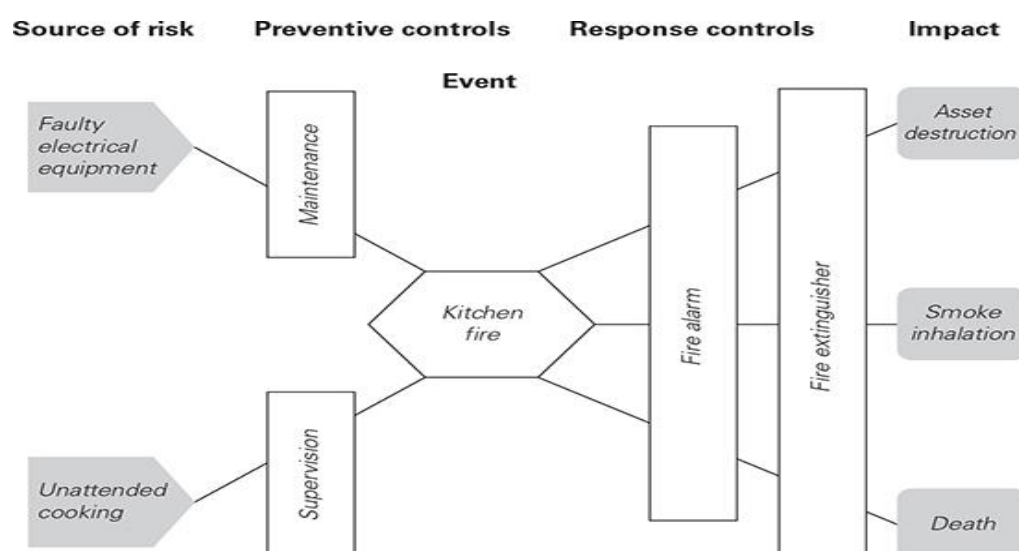


Figure 5. Types of control

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

- The risk must be scored 15 or more and must be approved for escalation by the Service, Departmental or local governance meeting and/or management team, supported by the Directorate Governance meeting and/or senior management team and the relevant Exec Director.
- The risk must be appropriately assessed, and all fields completed prior to presentation for escalation.
- Once a risk has been approved for escalation by the Directorate Governance meeting and/or management team, the risk Manager should be notified so they could liaise with the Service and/or Directorate to ensure the risk is appropriately captured on the CRR template and included onto the agenda for the RMG. Please see appendix 2b for details of the Trust's risk escalation flow chart.

3.5. Risk Escalation:

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

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

3.6. Board Assurance Framework (BAF)

- The BAF also provides a structured framework for identifying and mapping the main sources of assurance across the Trust and co-ordinating them to best effect.
- The BAF is a mechanism that should enable the Board to gain assurance that principal risks to the achievement of the Trust's strategic goals have been identified, assessed and are properly managed in line with best practice. It is thus a robust tool, which the Board uses to reinforce strategic focus and better management of risks and in gaining assurance.
- It thus provides a structure and process through which the Trust could focus on those principal risks which may undermine the achievement of its strategic goals as defined in the Level 1 priorities in its updated Strategy.

- Executive Directors and their ADs are responsible for ensuring that risks within their portfolio captured on the CRR and BAF are timely and regularly updated prior to presentation at the relevant Board Committees.

3.7. Linking the CRR to the BAF

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

3.8. Collaborative and shared Risk Management

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

3.9. Risk Management Training:

- BSMHFT recognises that developing staff capacity and capability in risk management is critical for fostering engagement and embedding its risk management culture.
- The Risk Manager with the support of the relevant AD, Senior Professional Lead or Exec will design and deliver bespoke risk management training that will be available to all staff and managers as well as to contractors delivering services on behalf of BSMHFT. Staff will be regularly signposted to log onto the learning zone to book onto the Trust's risk management training programme.

3.10 Risk Management Annual Improvement Plan:

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

4. Responsibilities

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

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

	The Director of Finance has delegated responsibility for internal financial controls and the implementation of financial risk management, procurement, information management systems, information governance, communications, the programme management office, and estates and facilities (managed within the subsidiary organisation SSL). The Medical Director and the Director of Nursing have joint delegated responsibility for clinical risk management and for the effective management of risks within their portfolios. The Director of Operations has overall responsibility for the management and co-ordination of all operational risks including business continuity and emergency planning. The Director of Strategy, People and Partnerships has overall responsibility for risks relating to People, Organisational Development and Capability, Learning and Development, Business and Strategic Planning and Strategic Partnerships.	
Clinical Directors	Clinical Directors are responsible for ensuring that there are robust systems and processes in their Directorates to support the effective identification, assessment, mitigation, monitoring and management of risks. They are responsible for ensuring that risk management and especially high-level operational risks in their directorates are periodically reviewed and scrutinised at their Directorate Clinical Governance Meetings. Clinical Directors will be responsible for timely reviewing and approving high operational risks scoring 15 and above from their directorates being put forward for escalation to the RMG prior to their presentation at the RMG.	

Corporate Governance/Clinical Governance	Clinical Governance will be responsible for ensuring all clinical and patient safety related risk are appropriately added onto the Trust risk management information system. They will liaise with the Risk Manager in ensuring Services and Directorates escalating risks to the RMG for consideration, approval and inclusion onto the corporate risk register are appropriately supported. Corporate Governance has overall responsibility for the designing and regularly refreshing Risk Management Policy and through the Company Secretary for the management of the Board Assurance Framework. They shall also work closely with ADs, Non-Executive Directors, Executive Directorates and the Company Secretary in designing, regularly refreshing and implementing the BAF.	
Associate Directors / Corporate Senior Professional Leads	All Associate Directors and Corporate Senior Professional Leads have delegated responsibility for the effective management of risks within their portfolios and for ensuring that significant risks to the achievement of their local operational objectives are escalated in line with this Policy. ADs and Corporate Senior Professional Leads are responsible on behalf of their Executive Directors, for BAF and CRR risks that are assigned to their portfolio, ensuring these are regularly reviewed and updated as well as all related actions appropriately implemented and evidenced.	
Senior Leaders and Managers (including Senior Directorate Teams).	• Implementing Trust policies, standards, guidelines, and procedures within their area of responsibility and ensuring these are understood by staff. • Ensuring that risk assessments are undertaken liaising with appropriate professionals as appropriate. • Ensuring that an up-to-date record of staff's attendance at, and compliance with, statutory and mandatory training is maintained as per the Risk Management Training Policy. • Implementing and monitoring any identified, and appropriate, control measures to	

	mitigate risk within their scope of responsibility. - Ensuring that identified risks are recorded on the risk register as appropriate within their domain and reported through local governance structures to the Clinical Governance Committee on a quarterly basis. - Overseeing the development and monitoring of an action plan to mitigate identified risks on the risk register. - It is fundamental that risk management is accepted as a line management responsibility. Managers at all levels must adopt this approach, own the process, and act, both proactively and retrospectively, to identify, assess, and manage any risk issues affecting their unit, departments, wards or services.	
Risk Manager	- They are responsible for ensuring the Trust has effective risk management arrangements in place, populating the Trust's risk management policy, raising the profile, visibility and supporting Services and Directorates across the Trust to embed risk management into business as usual. - Creating space for a risk aware-culture to flourish across the Trust and the provision of risk management-related assurance to the Board and its sub-committees. - Act as an adviser to the Trust on all aspects of risk management and lead on the development of a dynamic, comprehensive, proactive, agile, sustainable Trust-wide risk management infrastructure. - Support local services and Directorates in reviewing and keeping their local risk registers up-to-date and in pulling risk registers for local governance meetings if requested including servicing the RMG. - Designing and delivering the Trust's risk management training. - Provide admin support to the RMG including, servicing, minuting and ensuring	

	all reports and papers are collated and timely circulated.	
Board of Directors	Responsible for: - • overall risk oversight, scrutiny, gaining assurance, setting the tone and culture that underpins the Trust's risk management approach. • ratifying the Trust's Risk Management Policy including the Risk Appetite Statement. • reviewing the Board Assurance Framework and the Corporate Risk Register.	
Audit Committee	Responsible for: - • reviewing the effectiveness of the system of internal control including assurance that effective arrangements are in place for risk management. • making recommendations to the Board as appropriate regarding its risk management arrangements.	
Quality, Patient Experience and Safety Committee	Responsible for: - • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect quality, safety, and patient experience risks and that there are effective controls, assurance and mitigation to manage these.	
Finance, Performance and Productivity Committee	Responsible for: - • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect performance, sustainability, financial and governance risks and that there are effective controls, assurance, and mitigation to manage these.	
People Committee	Responsible for • reviewing the Board Assurance Framework and the Corporate Risk Register to ensure that they accurately reflect workforce related risks and that there are effective controls, assurance, and mitigation to manage these.	

Caring Minds Committee	Responsible for developing and reviewing charity risks to ensure they accurately reflect risks relating to the delivery of the charity strategy and to ensure that there are effective controls, assurance, and mitigation for these.	
Risk Management Group	Responsible for: - - seeking assurance on the effectiveness of the Trust's risk management systems. - developing and overseeing the implementation of the Risk Management Policy. - reviewing and approving risks escalated to it and ensuring that those rated 15 or above are properly recorded in the Corporate Risk Register. - Considering evidence and approving the closure of risks on the Corporate Risk Register. - Supporting the Board with the development and maintenance of the Risk Appetite Statement and the CRR. - Receive, review the BAF twice a year and offer advice and recommendations to the Board via relevant Board Committees.	
Transformation and Delivery Group	Responsible for: - Providing scrutiny, assurance, governance and oversight, of all risks and impact assessments relating to change programmes and projects.	
Local management and assurance groups	Responsible for: - - maintaining risk registers relating to their area of responsibility. - systematically reviewing relevant risks, seeking and providing assurance that they are being managed through their local governance arrangements. - escalating risks with a score of 15 or above through their Directorate meetings to the Risk Management Group.	

5. Development and consultation process

Consultation summary	
Date policy issued for consultation	August 2026
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	Date(s)
Staff and reps from Services/ Directorates - Workshops	
Policy Development Management Group (PDMG – for noting)	
Local Governance Committees	
ET	
Risk Management Group	
Audit Committee	
Board	

6. Reference documents

- ISO 31000:2018 — Risk management: Guidelines.
- NHS England Risk Management Framework, 2025.
- National Quality Board, Principles for Assessing and Managing Risks Across Integrated Care Systems, 2024.
- The Institute of Internal Auditors, The IIA's Three Lines Model, 2020.
- BSMHFT Risk Appetite Framework — current Board-approved version.
- BSMHFT Board Assurance Framework — current approved version.

7. Bibliography

None

8. Glossary

Risk Description		There are 3 main components will need to be considered when articulating the risk description (cause, event and effect):
		- There is a risk of...if
		- This may be caused by
		- Which could lead to an impact / effect on
Risk Rating	Inherent	This is the score of a risk without taking into consideration any controls which may be in place to mitigate it. This is also referred to as gross risk, initial risk, uncontrolled risk or absolute risk.

	Current	This is the score of the risk taking into consideration the controls and mitigation measures in place. This is also referred to as net risk, residual risk, current risk, or managed level of risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk was to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high).
Risk Likelihood		The probability if the risk were to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is 'rare' which denotes it will probably never happen, with a 5 being 'almost certain' which indicates that it will undoubtedly or possibly happen.
Risk Score		Risk score is derived by multiplying the Impact by Likelihood.
Risk Appetite		Is defined as the amount and level of risk that the Trust is willing to pursue or accept in order to achieve its priorities.
Controls or risk mitigations		These are measures/interventions implemented by the Trust to reduce either the likelihood of a risk and/or the impact were it to be realised. Controls could include strategies, policies, procedures, systems, SOPs, Checklists etc being implemented to reduce either the likelihood and/or impact of the risk were it to crystallise. A control is also a measure that maintains and/or modifies risk (ISO 31000:2018(en)).
Three Lines Model	1 st Line of Defence	Services, teams and operational functions that own and manage risks as part of day-to-day delivery. The first line is responsible for identifying, assessing, controlling, monitoring and escalating risks within its area of responsibility.
	2 nd Line of Defence	Functions that provide specialist expertise, support, oversight, monitoring and constructive challenge in relation to risk management and compliance. These may include the Corporate Governance and Risk Management Team and other specialist corporate functions.
	3 rd Line of Defence	Functions that provide independent and objective assurance on the adequacy and effectiveness of governance, risk management and internal control. This includes Internal Audit and may include other independent external assurance providers.

9. Audit, assurance & monitoring implementation.

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

Monitoring implementation of this Risk Management Policy

- BSMHFT will undertake regular Risk Management Self-assessments, annual internal audits, Snapshot Audits and/or an annual health check of its risk management culture using key performance indicators (KPIs – please see appendix 2a for details) in measuring the effectiveness of risk management arrangements across its services. These will explore a sample of 10 risks randomly selected from each Directorate risk registers and 5-10 from the Corporate Risk Register in measuring the following KPIs as set out on the table below: -

Element to be monitored	Lead	Tool	Frequency	Reporting Committee	Culture of Care Alignment
Compliance	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C'ttee, FPP, AC & Board.	Safety Quality of Care Avoiding harm
Maturity	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C'ttee, FPP, AC & Board.	Safety Quality of Care Avoiding harm
Data Quality	Risk Manager & ADCG (BAF)	Annual self-assessment audits	Yearly	RMG, QPES, People C'ttee, FPP, AC & Board.	Safety Quality of Care Avoiding harm

10. Appendices

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

Appendix 1: Equality Impact Assessment

Equality Analysis Screening Form

Title of Proposal	Risk Management Policy		
Person Completing this proposal	Kat Cleverley	Role or title	Company Secretary
Directorate	Finance	Service Area	Corporate Governance Team
Date Started	July 2024	Date completed	August 2026
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy is designed to ensure that the Trust has effective systems in place to identify, report, mitigate and assure itself of any risks to the effective delivery of all its strategic priorities. These are: Care; Communities; Culture; Creativity.			
Who will benefit from the proposal?			
The robust identification and management of risk will benefit, staff, service users, visitors and partners across all services and sites.			
Does the policy affect service users, employees or the wider community? <i>Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward</i>			
The Policy may directly affect service users as its effective implementation may have positive impacts the Trust's safety culture and enhance the delivery of high-quality patient-centred safe care.			
Does the policy significantly affect service delivery, business processes or policy? <i>How will these reduce inequality?</i>			
N/A			
Does it involve a significant commitment of resources? <i>How will these reduce inequality?</i>			
N/A			
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)			

N/A				
Impacts on different Personal Protected Characteristics – Helpful Questions:				
<i>Does this proposal promote equality of opportunity?</i> <i>Eliminate discrimination?</i> <i>Eliminate harassment?</i> <i>Eliminate victimisation?</i>			<i>Promote good community relations?</i> <i>Promote positive attitudes towards disabled people?</i> <i>Consider more favourable treatment of disabled people?</i> <i>Promote involvement and consultation?</i> <i>Protect and promote human rights?</i>	
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	No/Minimal Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.
Age	✓			It is anticipated that age will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their age.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	✓			It is anticipated that disability will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of any disclosed disability. The Trust have the Disability and Neuro Diversity Staff Network Group who currently support staff with disability. We also support staff with Reasonable adjustment with the Government 'Access to Work' Grant. This is dependent if the individual feel comfortable about being open about their disability especially where this may be a hidden disability or mental health issues. The current WDES is showing the Trust is ranked in the top 10% nationally in Recruitment and Reporting of harassment, bullying and abuse.

Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	✓			It is anticipated that gender will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their gender identity. Currently gender is collated and there is a disparity around gender pay gap overall with an increase from 6.99% to 11.17%. The Trust has now set up a Women's Network and Men's Network who meet on a monthly basis.
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	✓			It is anticipated that marriage or civil partnership will not have an impact in terms of discrimination as this policy ensures that the staff group who affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of their marriage or civil partnership. This is dependent on staff feeling comfortable about being open about their Marriage or Civil Partnership.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	✓			It is anticipated that pregnancy and maternity will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. However, the Trust will provide necessary support and reasonable adjustment for an employee who is pregnant or on maternity, paternity or adoption leave and this may be pausing the procedure for a temporary time. This is dependent on staff feeling comfortable about being open about their or their partners

				pregnancy, including miscarriage. We also have started the Women's Network where these matters can be discussed and shared there.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	✓			The Trust is working towards a Anti Racist organisation and will be launching the Anti Racist Framework. It is anticipated that Race or Ethnicity will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. We also have the Race Equity Network and Anti Racist Campaign to support those who are facing racial discrimination.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	✓			Although this is a protected characteristic, we have some recorded data and this is subject to staff completing this. The Trust will provide necessary support and reasonable adjustment for employees, and we also have the Spiritual Care Team. It is anticipated that religion or belief will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair, reasonable and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their religion or belief.
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	✓			Although this is a protected characteristic, we have some recorded data and this is subject to staff completing this. We currently have LGBTQ Staff

				Network who meet regularly where information is shared. It is anticipated that sexual orientation will not have a negative impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair discrimination, reasonable and consistent manner irrespective of this. The Trust has also launched the LGBTQ+ campaign to support staff and training.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	✓			Although this is a protected characteristic, this is not recorded. It is anticipated that Transgender or Gender Reassignment will not have an impact in terms of discrimination as this policy ensures that the staff group who are affected by this policy should be treated in a fair discrimination, reasonable and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their being Transgender or undergoing Gender Reassignment. The Trust is currently offering Trans Awareness training to support staff.
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	✓			This policy is written to promote equality and remove any discrimination to ensure that everyone can fulfil their full potential within a Trust that is inclusive, compassionate, and committed. This is keeping in line with our Trust values, the NHS People's Plan commitment to equality, diversity and inclusion and reflects the provisions of the Equality Act 2010. This policy applies to all, including applicants applying for a job, staff including agency, bank and volunteers, services users and carers, visitors, stakeholders, an any other third-party organisations who work in partnership with the Trust

Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	No		
What do you consider the level of negative impact to be?	High Impact	Medium Impact	Low Impact	No Impact
				✓
If the impact could be discriminatory in law, please contact the Equality and Diversity Lead immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.				
If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the Equality and Diversity Lead before proceeding.				
If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the Equality and Diversity Lead .				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
Discussions took place with colleagues in the development of this policy. EDI Leads will work with the organisation to reduce impact of any detriment experienced by reports of concerns.				
How will any impact or planned actions be monitored and reviewed?				
Via the Directorate CGCs, RMG, Board and Board Committees. Feedback from reporters of concerns, escalating concerns through governance routes. Regular audits and policy updates.				

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
This is not relevant. The policy is applicable to all members of the Trust regardless of their personal protected characteristics.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at bsmhft.hr@nhs.net The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Directorate or Service planning and monitored on a regular basis.

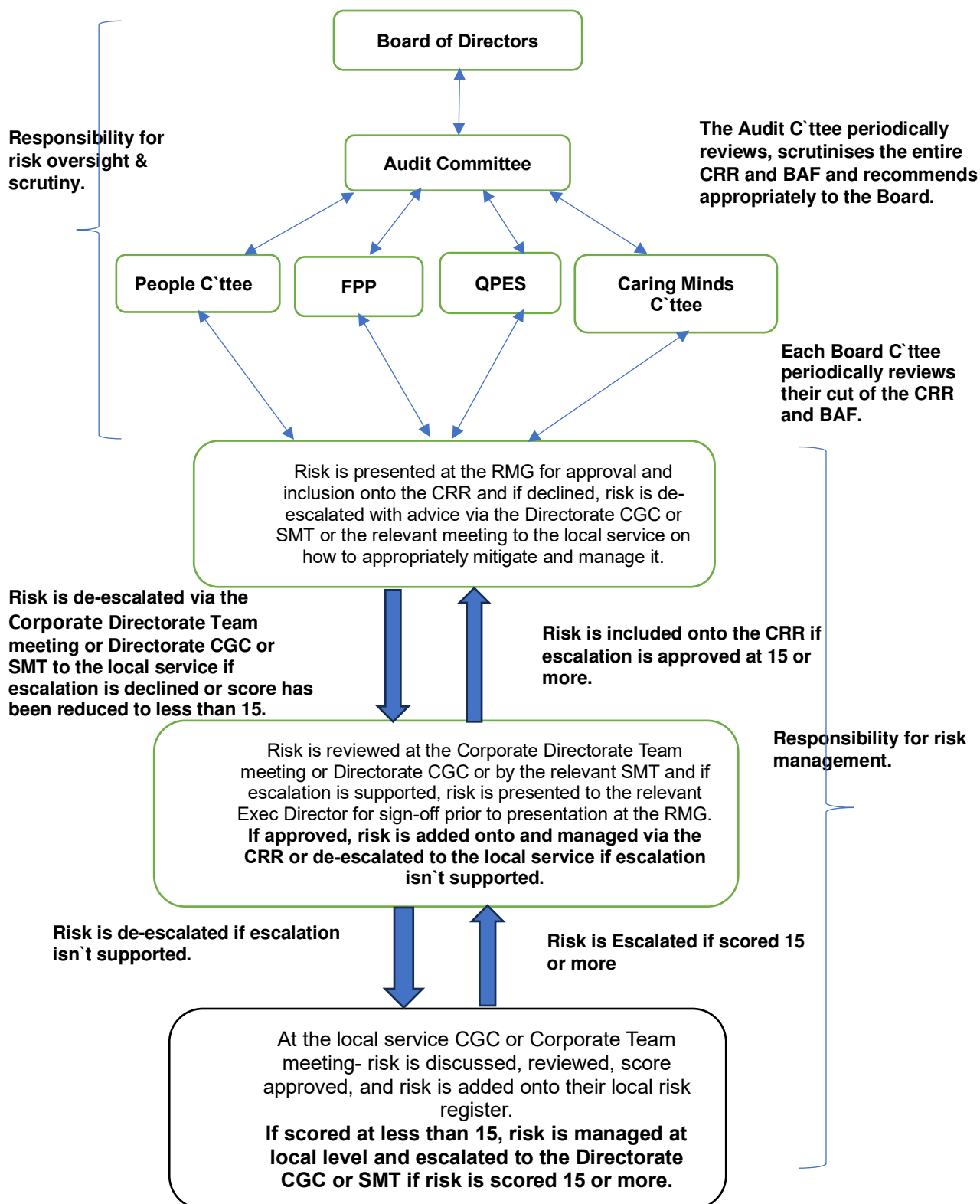
Note: Whilst the mechanism of risk registration, mitigation and assurance is silent on equality and inclusion, it does offer a vehicle for the recognition and mitigation of specific risks to equality and inclusion. The effective use of risk registers and their reporting and oversight can offer a positive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

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

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

Appendix 2b: Risk Management Flow Chart

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



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

Appendix 3: Risk Scoring

RISK SCORING

The prioritisation and allocation of risk

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

- **The Trust's 5 × 5 Risk Scoring Matrix will be used to support the consistent assessment and prioritisation of risks. The matrix forms part of the Trust's risk-management arrangements, which are informed by ISO 31000:2018, Risk management — Guidelines.**

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

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

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

Measures of Likelihood – likelihood scores (financial risks):

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

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

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no or minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention. Requiring time off work <3days. Increase in length of hospital stay by 1-2days.	Moderate injury requiring professional intervention. Requiring time off work 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity / disability Requiring time off work >14days. Increase in length of	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
			An event that impacts on a small number of patients	hospital stay by >15days. Mismanagement of patient care with long term effects.	number of patients.
Quality Complaints Audit	Peripheral elements of treatment or service sub-optimal Informal complaint or inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards. Minor implications for patient safety if unresolved Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if not resolved. Multiple complaints / independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment or service. Gross failure of patient safety if findings not acted on Inquest / Ombudsman inquiry Gross failure to meet national standards.
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (<1 day).	Low staffing level that reduces service quality	Late delivery of key objective / service due to lack of staff. Unsafe staffing level or competence (>1day). Low staff morale Poor staff attendance for mandatory / key training.	Uncertain delivery of key objectives / service due to lack of staff. Unsafe staffing levels or competence.	Non-delivery of key objectives due to lack of staff On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training / key training on an ongoing basis.
Statutory duty / Inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved.	Single breach in statutory duty Challenging external recommendations / improvement notice.	Enforcement action Multiple breaches in statutory duty Improvement notices. Low performance rating Critical report.	Multiple breaches in statutory duty Prosecution Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below	National media coverage with >3days service well below

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

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

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise or graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse side effects Physical attack such as pushing, shoving or pinching causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling – no time off work required	Wrong drug or dosage administered with potential adverse side effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2-3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information / communication on transfer of care Vehicle carrying patient involved in road traffic accident Slip / fall resulting in injury such as sprain	Wrong drug or dosage administered with adverse side effects Physical attack causing serious injury Grade 4 pressure ulcer Long-term HCAI Slip / fall resulting in injury such as dislocation, fracture, blow to the head Loss of limb Post-traumatic stress disorder	Unexpected death Suicide of a patient known to the services within last 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Incident leading to paralysis Incident leading to long-term mental health problem Rape / serious sexual assault

Trust 5 x 5 Risk Scoring Matrix

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

Appendix 4: Risk Thresholds/Risk Level Monitoring

RISK THRESHOLDS / RISK LEVEL MONITORING

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

Appendix 5: Risk Appetite Statement

RISK APPETITE STATEMENT

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

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

BSMHFT Risk Appetite Framework

NB: Please note that this Risk Appetite Framework is subject to change as the Board will approve its risk appetite framework in October 2027

Risk Type	Statement & definition of the preferred risk appetite category	Risk appetite category	Target risk score range
Quality & Safety	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	Cautious	6 - 8
Reputational	Appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation.	Minimal	2 - 4
People	Innovation pursued – desire to ‘break the mould’ and challenge current working practices. High levels of devolved authority – management by trust rather than close control.	Eager	12
Finance	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Open	9 – 10
Regulatory	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	Cautious	6 - 8
Strategy	Guiding principles or rules in place that are receptive to considered risk taking in organisational actions and the pursuit of priorities. Organisational strategy is refreshed at 2-3year intervals.	Open	9 – 10

Operations	Innovation supported, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	Open	9 – 10
Data and Information Management	Accept need for operational effectiveness in distribution and information sharing.	Open	9 - 10
Governance & Legal	Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions.	Minimal	2 - 4
Digitalisation/ Technology	Systems / technology developments considered to enable improved delivery. Agile principles may be followed.	Open	9 – 10
Transformation/ Projects and Quality Improvement	Innovation supported, with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance.	Open	9 – 10
Security	Risk of loss or damage to Trust property, assets, information, Staff, Patients or the public. Stringent measures in place, including: • DBS checks where applicable. • Staff vetting maintained at highest appropriate level. • Controls limiting staff and visitor access to information, assets and estate. • Access to staff personal devices restricted for official tasks etc.	Minimal	2 - 4
Property & Environment	Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	Open	9 – 10
Commercial	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	Open	9 – 10
Partnerships & Provider Collaboratives	Receptive to taking difficult decisions to support the achievement of the Partnership or Provider Collaborative when benefits outweigh risks. Processes, oversight / monitoring and scrutiny arrangements in place to enable considered risk taking.	Open	9 – 10