Birmingham and Solihull Mental Health NHS Foundation Trust

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Board of Directors Public Meeting
09.00, Wednesday 2 April 2025
Uffculme Centre
AGENDA

Ref	Item	Purpose	Report type	Time
	Service User Story 09.00-09.30			
1	**Chair's Welcome and Introduction**			09.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of meeting held on 5 February 2025**	Approval	Enc	09.35
5	**Matters arising from meeting held on 5 February 2025**	Assurance	Enc	
6	**Chair's Report** *Phil Gayle, Chair*	Assurance	Enc	09.40
7	**Chief Executive and Director of Operations Report** *Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Executive Director of Operations*	Assurance	Enc	09.50
8	**Board Assurance Framework** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	10.10
9	**Integrated Performance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	10.15
	Quality and Clinical Services			
10	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	10.20
11	**Health Inequalities Report** *Fabida Aria, Executive Medical Director*	Assurance	Enc	10.30
	People			
12	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	10.45
13	**Staff Survey Results Report** *Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships*	Assurance	Enc	10.55
14	**Guardian of Safe Working Hours Q3 Report** *Hari Shanmugaratnam, Guardian of Safe Working*	Assurance	Enc	11.05
15	**Freedom to Speak Up Guardian Annual Report 2024/25** *Emma Randle, Freedom to Speak Up Guardian*	Assurance	Enc	11.15
	Sustainability			
16	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.25
17	**Finance Report** *Dave Tomlinson, Executive Director of Finance*	Assurance	Enc	11.35
18	**Digital and AI Assurance Report** *Carl Beet, Chief Information Officer*	Assurance	Enc	11.40
19	**Trust Strategy 2025/26 Goals Report** *Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships*	Assurance	Enc	11.50
20	**Caring Minds Committee Report** *Monica Shafaq, Non-Executive Director*	Assurance	Enc	12.00
21	**Trust Seal Report** *Kat Cleverley, Company Secretary*	Approval	Enc	12.10
	Reflections			
22	**Living the Trust Values**		Verbal	12.15
23	**Board Assurance Framework reflections**		Verbal	12.20
24	**Any other business**		Verbal	12.25
25	**Questions from Governors and members of the public**			

Close by 12.30
Date and Time of Next Meeting: Wednesday 4 June 2025, 09.00-12.30

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST Minutes of the Public Board of Directors Meeting Wednesday 5 February 2025, 09.00, Uffculme Centre			
Members	Philip Gayle	PG	Chair
	Fabida Aria	FA	Executive Medical Director
	Bal Claire	BC	Deputy Chair/Non-Executive Director
	Linda Cullen	LC	Non-Executive Director
	Vanessa Devlin	VD	Executive Director of Operations
	Roisin Fallon-Williams	RFW	Chief Executive Officer
	Thomas Kearney	TK	Non-Executive Director
	Patrick Nyarumbu	PN	Executive Director of Strategy, People and Partnerships
	Monica Shafaq	MS	Non-Executive Director
	Lisa Stalley- Green	LSG	Executive Director of Quality and Safety/Chief Nurse
	Dave Tomlinson	DT	Executive Director of Finance
	Winston Weir	WW	Non-Executive Director
Attending	Shane Bray	SBr	Managing Director SSL (item 16 only)
	Kat Cleverley	KC	Company Secretary (minutes)
	Paige Harrison	PH	Business Partner/Assistant to CEO and Chair
	Nicola Nixon	NN	Community Matron ICCR (item 1 only)
	Emma Randle	ER	Freedom to Speak Up Guardian (item 13 only)
	Hannah Sullivan	HS	Governance and Membership Manager
	David Tita	DTi	Associate Director of Corporate Governance
Observers	Three governors and one member of staff/the public observed the meeting in person.		

Ref	Item
1	**Staff Story** NN attended to share her story of her career development with the Trust. NN had worked in the Trust since completing her nurse training in 2009, initially in Forensic services at Reaside and assisted in the opening of the Tamarind Centre, then moved to Assertive Outreach as Clinical Lead, and now working as Matron for half of the Community Mental Health Teams across Birmingham and Solihull. NN reflected that she enjoyed working for the Trust and was thankful for the various opportunities it had provided, including currently completing a Chartered Manager Degree Apprenticeship. NN was passionate about staff wellbeing and was a qualified Professional Nurse Advocate. There had been some issues embedding and raising the profile of this role, and informal café events had been held to try and improve awareness of it. NN noted that she was also attending preceptorship sessions. NN commented that she had been supported by her manager to develop further in her role and been given the opportunity to complete some backfill duties as Head of Nursing and AHPs. NN reflected on some challenges within the service: • High caseload numbers across Community Mental Health Teams, which meant that teams were often holding a high level of risk within the community. A caseload stratification approach had been taken to review cases and ascertain the most appropriate pathways to meet service user needs. • Care coordinators were a finite resource and there were significant pressures to allocate coordinators, balancing clinical need and staff wellbeing. • Clinical and team office space was an issue. Lack of space impacted on clinical input and team cohesion • Across ICCR as a whole there were not enough Matrons in the community to assure quality and safety across all of the services.

	The Board thanked NN for attending and sharing her story.
2	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting.
3	**Apologies for absence** Sue Bedward, Non-Executive Director
4	**Declarations of interest** No new interests were declared. DT noted his interest as a Director of Summerhill Services Ltd.
5	**Minutes of meeting held on 4 December 2024** The minutes were approved as a true and accurate record.
6	**Matters arising from meeting held on 4 December 2024** All actions were updated.
7	**Chair's Report** The Board received the report for information. PG particularly highlighted his ongoing service visits that were undertaken across the Trust's different sites; PG thanked the Corporate Governance team for providing the visits schedule for 2025/26 and encouraged continued site visits from members of the Board. PG noted that he had been pleased to visit the Homeless Health Exchange service at their new base.
8	**Chief Executive and Director of Operations Report** The Board received the report for information and noted the following key points: • VD advised the Board that there was a continued focus on key performance indicators and outcomes, with data utilised to inform improvements and ongoing transformation. This information was reshaping the way the Trust worked and how changes were being driven forward with partners, staff, service users and carers. • A number of vacancies had been filled recently, particularly psychological professions. • There had been positive work undertaken on peer support workers within the ICCR team. • There had been a lot of focused work on CMHT caseloads, which was beginning to have a positive impact on service users. • Low Secure Child and the whole CAMHS service has achieved their Autism Spectrum Disorder accreditation for another three years. • The Tamarind Centre had recently received an outstanding peer review and CQC Mental Health Act compliance for Sycamore Ward. • An investment from Caring Minds Charity had been received to improve the environment at HMP Birmingham. • An implementation plan for primary care dementia specialty services was underway and the Trust was working with voluntary partners to support service users in the memory assessment service. Waiting Well sessions had been successful and were well received by service users and the CQC. • In December 2024 the Solihull Perinatal team formally opened its new team base at Maple Leaf Centre. • There had been improvements seen in the number and timeliness of closing employee relations cases, with some traction being made on new processes. • RFW noted that there was a lot of good practice happening around People processes, including the People Promise which had been commended by NHSE. The Trust had made significant improvements in terms of bank and agency spend against the total pay spend. • The Mental Health Provider Collaborative was involved in some key pieces of work including currently developing its new strategy, and supporting the transfer of the children and young people's service.

- The Trust continued to work towards an all-age model of care provided by a single provider. A due diligence process was underway to ensure a smooth transition.
- Integrated neighbourhood teams had been developed in line with the Community Care Collaborative implementation plan.
- The recent CQC inspection of Community Mental Health Teams had resulted in the S29 being lifted. This was testament to the right leadership and support in place, that tangible differences could be made to quality and safety.
- The CQC inspection report into Zinnia had been published last week, with a number of areas of work to focus on. The senior leadership team had developed and implemented an action plan which had been recognised by the CQC.
- Reaside was receiving dedicated cultural support through the Culture of Care programme.
- RFW advised that there was an expectation that all organisations would move to the NHS Federated Data Platform over the next two years.
- NHS Planning Guidance had been provided on 30 January and was significant in its ramifications for the NHS generally, and for mental health services. Mental health had been mentioned as one of the four key priority areas in the guidance, and there was commitment to continue the rollout of school mental health support teams. RFW advised that the Trust would review the guidance and what it meant for the organisation. There would be some difficult discussions and decisions to be made, but the key would be utilising strong working relationship with the system and internally.

LC asked about the all-age model of care for children and young people, noting the current demand and what the resource would look like when the service was transferred. LC commented that this was both an opportunity and a challenge. RFW advised that the due diligence process was currently taking place, and it was clear that there would be some assets and estate that transferred as part of the move.

WW asked about the Community Care Collaborative and whether this was in line with national planning guidance. RFW commented that the Trust had been in discussion with partners before the initiative was launched, and partners continued to review its alignment.

BC asked if there was a risk that trusts would become inward focused. RFW advised that whilst it was a risk, there was a change in behaviours and executive teams across the system were meeting together regularly.

PG congratulated colleagues at Tamarind following the positive feedback from the CQC. PG was also pleased to note that investment for HMP Birmingham from the Caring Minds charity. PG asked if the level of risk withi the community had been assessed, with the high caseload numbers and lengthy waiting times. FA advised that most teams were looking to protect slot to be able to provide support for urgent escalations. There was a significant amount of work ongoing to provide more appointments within the community. RFW added that this was a daily consideration, and priorities were considered when slots were organised each day.

PG asked if the high use of bank staff in acute and urgent care was reducing. VD advised that there was a plan in place to manage this and understand the context for bank use, considering whether the staffing establishment was correct in relation to the level of acuity on the wards. RFW noted that there was a focus on e-rostering to ensure good planning of annual leave.

PG recognised that colleagues were experiencing high acuity at Meadowcroft PICU and asked how the Trust was supporting staff wellbeing during this time. RFW advised that a service was available for staff who were experiencing trauma at work and was provided by psychologists. The team was very supportive of each other and was a consistent team that helped to build bonds.

PG commented on the CQC inspection report into Zinnia and asked how confident the Trust was that cultural issues and risk assessment issues were addressed and similar issues were not occurring in other areas. LSG advised of the plan to implement MHOST, looking at identifying gaps and reviewing bank staff use and substantive staff establishments. LSG advised that the key issue was arrangements for annual leave, noting that specific communication had been made with clinical leads to ensure a good cultural practice.

9	**Board Assurance Framework** The Board received the BAF for information. DTi advised that SR7 had undertaken additional development and would be included in the next iteration of the BAF. Risk scores had been aligned to the agreed risk appetite for each area. DTi also advised that the planning guidance and development of the Trust's strategy would be reflected throughout the BAF. Risks were reviewed and scrutinised regularly by Executives, and at each Committee meeting. WW noted that the BAF had been received at Audit Committee alongside the Corporate Risk Register and the Committee had been fully assured by the approach, the process and the clear links. PG asked how confident the team was that there was appropriate understanding ownership of the BAF across the organisation. DTi noted that Executives had full ownership and there was confidence that Associate Directors across the Trust were aware of the new risks and helped to shape and address actions. The team was working on sharing the risks widely across the organisation.
10	**Integrated Performance Report** The Board received the report for information. DT advised that he, KC and DTi had met with the Associate Director of Performance and Information to discuss the format and improvements that could be made. Key highlights included: • There had been a significant reduction in Community Mental Health Team waits over a period of time. • Performance measures were included within the NHS Oversight Framework. • There had been some encouraging progress in some areas, with improvements reported through on Out of Area beds, however non-contracted beds remained a significant financial pressure. LSG advised that a task and finish group had been established to review how the well-led framework could be reported through the Integrated Performance Report. TK commented on the PICU and outpatient numbers which were quite high and did not seem to be reducing. VD advised that there were daily considerations of inappropriate and appropriate bed placements, managed in collaboration with clinicians and managers. FA added that bed management was a dynamic situation, with the position changing daily. BC noted that the deep dives providing useful information, and felt that the Finance, Performance and Productivity Committee should be receiving services to showcase their work. BC asked about the plan for Clinically Ready for Discharge patients, noting the ongoing deterioration; with some elements outside of the Trust's control, what was the Trust's plan to manage this as much as possible. RFW advised that the Trust had recently received some support from the ICB through strategic commissioning to review longest stays. The review had highlighted a number of actions for the Trust, and an action plan was being developed. BC asked if the Trust was reluctant to place individuals back into community settings. RFW advised that patients would often be retained due to concern over housing and social elements, however planning discharges in advance would contribute significantly to the pathway. The team would also conduct follow-up appointments, which were measured as a key performance indicator.
11	**Quality, Patient Experience and Safety Committee Report** The Board received the report from January's Committee meeting. LC highlighted the following key points: • The Committee had been assured by the actions planned in relation to the S64 issued to Zinnia. • The Committee had discussed significant concern relating to the cultural and leadership issues within Reaside, but had acknowledged the work on the Culture of Care programme that was taking place. • There was ongoing work to determine nurse establishment on wards that were most affected by acuity.

	• The Committee had been assured by the quality and safety framework, which aligned with governance and regulatory requirements. The Committee felt that the Bronze, Silver and Gold approach would encourage ward to board oversight. • Assurance had been received on the progress and achievements of the Right Care Right Person programme.
12	**People Committee Report** The Board received the report from January's Committee meeting. MS highlighted the following key points: • Concern had been raised in relation to Values Based Appraisals, which remained below compliance target across the Trust. • Concern was noted in relation to the number of nursing vacancies. • The Committee acknowledged challenges across the system with sickness absence rates. • The Committee had been assured by the Freedom to Speak Up Guardian report, which highlighted increased contacts and an embedded approach. • The Committee had received comprehensive feedback from the Race Equity Network. • MS advised that the Committee would be interested in receiving benchmarking data to understand how BSMHFT compared to other trusts. RFW commented that the System Workforce Board would be happy to provide the benchmarking data pack for information, and PN advised that the Committee was keen to take an appreciative enquiry approach to identified issues. PG asked how confident the Trust was that the appraisal target would be achieved. PN commented that he was fully confident that compliance would be achieved in line with the workforce plan. WW commented that the Audit Committee had received an adverse internal audit review into Medical Job Planning and asked about the assurances on how this would improve. FA advised that this was an improvement journey, and the target was expected to be reached as it was a contractual requirement.
13	**Freedom to Speak Up Guardian Quarterly Report** The Board received the report for assurance. ER highlighted the following key points: • Clinical support staff, including bank, were the highest category of staff contacting Guardians during the reporting period. ER noted that there was a high proportion of bank staff accessing Freedom to Speak Up. • The key reason for contacts was behaviour and incivility. • ER noted that the Pulse survey results had highlighted Freedom to Speak Up Guardian contacts for the first time, which was positive as it reflected that colleagues were using their local arrangements, including line managers, as a first step to resolving issues. • Concern had been highlighted in relation to colleagues from Reaside removing name badges when approaching Guardians. • The Guardians were working to improve investigation processes, including training more investigation officers and reviewing casework. • The team had provided intelligence for recent CQC inspections. DT asked if the Freedom to Speak Up Guardians had links to the Staff Networks. ER confirmed that the team worked with some Networks more than others, but the offer would reintroduced to all. RFW thanked ER for the report, noting that the team did a significant amount of work with all of the different areas of the Trust at all different hours. RFW commented on the low uptake of training offers and asked if there was any support in place to increase the numbers of people undertaking the training. LSG noted that this would be a quality objective.

	ER commented on the significant piece of proactive work that was underway to utilise the Guardians across the organisation. A review was being taken into Freedom to Speak Up Guardians which could result in revised guidelines.
14	**Finance, Performance and Productivity Committee Report** The Board received the report from January's Committee meeting. BC highlighted the following key points: • The Committee alerted the Board to the systemwide challenges in relation to cost plans and sustainability for the next financial year. • Non-Trust bed overspend continued to be a significant challenge. • There had been significant improvements in agency spend, but bank spend needed continued focus to reduce, and the balance understood in relation to the increased number of substantive staff. • The Committee had received a comprehensive report on the Taskforce for Climate Related Financial Disclosure recommendations. PG asked about the amount of information the Committee had received into Digital and AI. BC advised that the Committee had recently agreed the forward plan for 2025/26 and had noted the increased regularity of Digital and AI reports that would be received. DT added that an overview report would also be received at Board twice yearly. RFW commented on the positive overview of digital opportunities that had been presented at Senior Leaders' Forum in February.
15	**Finance Report** The Board received the report. DT advised that the Trust would achieve the targeted surplus by the end of 2024/25. There was a significant financial challenge for the BSOL system, but there had been a lot of progress made in relation to planning for 2025/26. DT confirmed that the Trust had received its NHS Oversight Framework segmentation letter and would remain in Segment 3.
16	**Summerhill Services Ltd (SSL) Overview Report** The Board received the report and SBr highlighted the following key points: • Reaside was a key challenge for SSL, but the team was working closely with LSG to mitigate issues. Additional funding had been identified to upgrade bathrooms facilities at Reaside, but it remained an aged building which would continue to be challenging. SBr confirmed that funding options continued to be investigated. • Highcroft was a key capital project that was in progress, and was moving into the planning stage. • An improved food management system had been implemented. • SSL was currently in the process of purchasing a new pharmacy robot, which had been through a procurement process and hoped to be completed by the end of the year. SBr advised that the Children and Young People's service would impact on the pharmacy service, with an anticipated 30% increase in prescriptions. • SSL was planning its Staff Awards event for June. PN noted that the staff story at the beginning of the meeting had mentioned the utilisation of space, specifically clinical spaces and asked what the feedback had been from the UBook system trial. SBr commented that the full report into the trial was available, with findings indicating that people were booking larger than necessary rooms for their meetings, and booking repeat meetings just in case. SBr noted that the trial had resulted in improved utilisation of rooms at Northcroft, and the data would be used to look at resources needed to manage this across other buildings. PG asked how long the Reaside refurbishment would take. SBr commented that some work is taking place now, and SSL was working closely with clinical staff to ensure minimal disruption.
17	**Audit Committee Report**

	The Board received the report from January's Audit Committee meeting. WW advised of the following key points: • The Committee had received an internal audit report into Medical Job Planning, which was given a partial assurance rating. • The Committee had been encouraged by the advisory internal audit report into Discharge Management. • The Committee had been fully assured by positive assurance ratings into the Key Financial Controls: General Ledger and Budgetary Control internal audit review and the follow-up Bank Staff Management review. • A full review of the Corporate Risk Register had been received, and the Committee had been assured by the clear links to the Board Assurance Framework. PG asked whether Committee Chairs had the opportunity to influence the internal audit plan. WW confirmed that the draft plan was received each year and all chairs could contribute and make suggestions.
18	**Living the Trust Values** VD reflected on how the Trust values were always tangible when visiting and talking with staff, noting that colleagues really did understand the values and reflected on the Trust as a great place to work. VD advised that she had delivered the executive director slot at induction during the week and commented that the values were strongly felt from new members of staff. VD had particularly experienced the Compassionate value during her work on the urgent and emergency care pathway, noting that she had seen how people had worked closely together during a critical period of bed management and how well people had managed the pathway. VD felt that colleagues always seemed to come together and support each other during difficult times. VD had particularly experienced the Inclusive value during her work with other partners at Rookery Gardens, with Birmingham Healthy Minds, the 24/7 pilot, and the reflection of this value in health inequalities reports. VD noted George and Eden wards for their display of the Commitment value in their work to manage patient flow. VD also commented on the Commitment value at Reaside with the launch of the Culture of Care programme.
19	**Board Assurance Framework reflections** No further reflections.
20	**Any other business** PG thanked TK for his hard work and contributions over the last year. VD noted that it was LGBTQ+ History Month, and an event was being held on 14 February to celebrate. KC reminded the Board that there was an International Women's Day conference organised for 7 March.
21	**Questions from Governors and members of the public** The following questions were posed to the Board: • The Board was asked if there had been progress made in perinatal services for different communities. RFW commented that a lot of work had been undertaken to understand gaps and service users who were missing out on care. There were new Experts by Experience in place to support service users to access they care they needed. PN noted that the Trust had seen proactive work where the team had been discussing improvements with communities and service users, including work with the Nishkam Centre. • A question was asked about the children and young people's service. RFW clarified that Trust was establishing an all-age model with one provider delivering the whole service. • NN commented on the medical PICU issues that had been raised during the meeting, noting that her team would hold a support café in the area. RFW commented that the team could also link in to the Freedom to Speak Up Guardians.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
None.			

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors							
Agenda item:	**6**						
Date	2 April 2025						
Title	Chair's Report						
Author/Presenter	Phil Gayle, Chair						
Executive Director	Phil Gayle, 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**	✓

Purpose

The report, for information and accountability, with overview and key events, is presented to the Board, highlighting areas of involvement during the month and to report on key local and system wide issues.

Recommendation
The Board is asked to note the contents of the report.
Enclosures
N/A

CHAIR'S REPORT

INTRODUCTION

On 13 March, I attended an NHS briefing for Chairs and Chief Executives of NHS organisations, in London, where verbal and power point presentations were delivered emphasizing our collective responsibility to meet growing demands. A major reset in national and system-wide oversight and governance was highlighted, with a strong focus on maintaining public confidence while operating under tight financial constraints. Boards were urged to enhance productivity and efficiency without compromising patient access or quality of care. By October the forthcoming 10-year NHS plan is expected to introduce new regional and local operating frameworks. NHSE and the Department of Health will merge, targeting 50% efficiency savings, while ICBs, including Birmingham and Solihull, must cut running costs. Local providers like BSMHFT are expected to increase productivity and reduce back-office spending in the new financial year. These challenges will remain a key focus for the Board and Trust leadership. However, alongside financial and operational pressures, we must continue fostering a positive culture, improving staff morale, and building on recent progress and upward encouraging trajectory, as reflected in our latest staff survey results.

GOVERNANCE MATTERS

The Board can be assured our committees continue to provide oversight and assurance related to quality and safety, patient experience, finance productivity performance, people and culture, including as audit and internal controls continue. Looking forward, the Lead Governor's tenure is due to expire in June 2025 and a review of the process for nominations is taking place and a timeline agreed for launching the process in line with confirming the appointments at this year's AGM. It is with sadness to note that in February, our Deputy Lead Governor, Mustak Mirza, sadly passed away. I was pleased that some BSMHFT senior staff were able to attend his funeral. We have planned a celebration of his life on Wednesday 2 April at our Trust HQ, Uffculme Centre. There will be the planting of a tree in Mustak's honour in our memorial garden, and the opportunity for colleagues to sign the memory book and share our memories of Mustak together. The spiritual care team will be on site to offer support.

SERVICE VISITS

Visits to our Trust services are ongoing and both the NEDs and Governors are joining us on these visits over the coming months. Our Non-Executive board members continue to engage with the site visits across key service areas to improve their understanding of what is happening at the front line as well as the visibility of Board members. This is a really important element of our role as NEDs, as we are keen to see and listen to staff, patients and service users about our services – both positive aspects and areas of improvement.

LISTENING TO STAFF AND STAFF ENGAGEMENT

My visits to the different services continue. Most recently, I have been pleased to visit the Tamarind Centre where I spent half a day shadowing staff and gaining a greater understanding of the work and challenges the staff have. I attended several different meetings, visited different wards, and had some great conversations with staff and service users. It was great to see the services that the Tamarind Centre offers to our service users. I also visited the Zinnia Centre and had the opportunity to visit inpatient units and spend some time with the ward staff and inpatient service users, listening to feedback, good news events and activities and the challenges they at times face. I met with the CMHT and AOT teams and had a productive morning at the centre. I look forward to the visits that I have planned over the next couple of months.

These visits provide me with an opportunity as Chair to see the great work we provide across both Birmingham and Solihull.

PARTNER AND SYSTEM DEVELOPMENT / STAKEHOLDERS

In recent months I have attended the NHS Confed Chairs Group, an NHSE Chairs meeting around planning guidance, the BSOL Integrated Care Partnership and the ICS System Leadership Event. I regularly attend meetings to ensure involvement and relationship building are maintained and enhanced with our system partner's and Stakeholders locally and regionally. I continue to attend the BSOL Chairs meeting every month discussing system challenges and how we can work in a more streamlined way as partners.

STAKEHOLDER ENGAGEMENT

I continue to Chair the Council of Governors meetings where we dedicate time to receiving assurances from the Non- Executive Director colleagues on key areas of focus for the Trust and engaging in productive discussions and development. I maintain my regular monthly meetings with Shane Bray from SSL which are informative and valuable. I also continue to meet bi-monthly with Rebecca Farmer, Director of System Co-ordination and Oversight for NHS England where we discuss key areas of focus for the Trust.

PEOPLE/QUALITY

I chair the Board Strategy sessions where important discussions are held, and information shared. Progress is discussed with a collective focus to enable and ensure continuous progress Trust-wide. Regular 1:1's are held with Roisin, Chief Executive, and the Executive and Non-Executive Directors.

PHIL GAYLE
CHAIR

Report to Board of Directors							
Agenda item:	**7**						
Date	2 April 2025						
Title	Chief Executive Officer and Director of Operations Report						
Author/Presenter	Vanessa Devlin, Executive Director of Operations Roisin Fallon-Williams, Chief Executive Officer						
Executive Director	Roisin Fallon-Williams, CEO	**Approved**	**Y**	✓	**N**		

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

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

Purpose

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

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

Recommendation

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

Enclosures

N/A

CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT

PEOPLE

Operational Team and Learning and Development

The pilot on "Stay Conversations" has now expanded from the Strategy, People and Partnerships directorate to include Acute and Urgent Care.

As part of the BSOL presentation to NHSE in relation to Trust's progress with the People Promise framework, the Trust received very positive feedback and have been asked to showcase this work nationally.

The People Masterclasses continue to go from strength to strength and currently have a waiting list, specific areas, and professional groups will be prioritised within the Trust. The masterclasses are underpinned by the newly launched management essential workshops which has just completed its pilot and with plans to launch a new module over the next quarter.

Several revised People policies are due to be launched over quarter one to align with best national and regional practice and to align to the Trust values and strategic direction.

Work is underway to extend the system coaching offer into a Trust bespoke offer.

Workforce, Recruitment and Temporary Staffing Service

The vacancy rate for January was 10.6%. **We have now achieved our target of reducing the vacancy rate to 11%.** In January, our WTE increased by 22.49WTE. The vacancy rate for band 5 nurses is now 5.8% which is has seen a significant drop in the last 12 months (in January 2023 it was 43.6%).

Efforts now move to our band 6 vacancies with a rate of 21.6%. Over the following months, we will be exploring ways of recruiting and retaining experienced, qualified nurses.

Turnover also continues to remain stable, with 397 leaving the Trust in the last 12 months. The turnover rate in February was 8.1% which was the lowest in this financial year. We are focussing on particular hot spot areas.

Bank and agency usage continues to be monitored. In February, we saw a further drop in our agency usage which is now 1.6% of our total pay bill and is below target.

The Trust no longer has 'over cap' nurse assignments and we are now actively working with NHS Professionals to move current agency nurses over to NHP by the end of March.

The Trust has been regionally recognised for successfully generating over £160,000 in agency net savings across our Medical workforce. Demonstrating the effectiveness of our strategy and commitment to financial efficiency. In addition to this, our high level of Direct Engagement compliance has been commended for reflecting our dedication to ensuring the best possible outcomes for both staff and the Trust.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

Dialog+ Uptake: Increasing Dialog+ uptake across community teams remains a priority. Ringfenced sessions are supporting Neighbourhood Mental Health Teams (NMHTs) and medical staff. Ongoing troubleshooting and peer support are provided through monthly reflective practice sessions, led by the Dialog+ Clinical Trainer.

Community Mental Health Teams (CMHTs)

CMHTs continue to prioritise reducing long waits. Weekly/fortnightly monitoring by Clinical Service Managers, Associate Director (AD), and Heads of Service has led to a decrease in first appointment waits from 1,223 in June 2024 to 1,087 in December 2024. Daily A&E reviews of known service users are underway, in collaboration with Acute and Urgent Care, to understand attendance patterns and prevent future visits.

The CMHT out-of-hours duty line remains operational daily until 9 pm, including weekends and bank holidays, supporting known adult service users in CMHT's. Since January 2025 to date, we have taken 703 calls, main reasons for individuals calling have been feelings of anxiety and needing reassurance as well as medication queries. These concerns have been resolved by the duty clinician and where additional medication is needed, the duty worker has liaised with the on-call doctor for support and advise. Out of these 703 calls, only 33 were referred to Home Treatment. The duty line has also supported with stepping down called ambulances by taking calls from the Ambulance service.

Homeless Services

Following the closure of the Salvation Army service at William Booth Centre, the Homeless Health Exchange relocated to Attwood Green Health Centre on 2 December 2024. The team and service users have settled in well. Despite the closures of both William Booth and Washington Court services, the teams continue to collaborate with partners to support the homeless population.

Solihull Integrated Addictions Service (SIAS)

SIAS has partnered with BSMHFT Safeguarding to strengthen clinical governance, enhancing both service user support and staff resources. SIAS has exceeded Q1-Q3 discharge KPIs across all substance domains and remains on track for Q4. To reduce engagement barriers, SIAS has secured additional community spaces in Solihull Family Hubs, increasing treatment participation.

COMPASS Dual Diagnosis Team

Following a review with Steps 2 Recovery, COMPASS has established a regular presence across their sites to strengthen relationships and improve dual diagnosis and substance use guidance. This aims to boost referrals and direct work with service users. COMPASS is finalising Level 2 Dual Diagnosis training, with venue bookings underway for spring/summer 2025.

ICCR Psychological Services

Recent successful recruitment has brought several teams to full capacity, reducing waiting lists and improving access to a stepped care model. Creative strategies, including split posts, have helped overcome previous recruitment challenges.

Solar CAMHS

Capacity and demand work is progressing alongside near-complete job planning. Clinicians are

receiving funded training to meet evolving needs of Children and Young People. A 12-month embedded position with Autism West Midlands is enhancing the service's neurodiversity expertise through consultation and environmental assessments.

Early Intervention in Psychosis

The service continues to meet waiting time standards for referral to treatment. Physical activity programmes remain successful, with new activities being assessed for inclusion.

ADHD Services

The Trust are addressing high demand through a redesign of internal processes, improving assessment and treatment pathways.

Several innovative projects are underway to further enhance services, including:

- A digital review of processes, both administrative and clinical pathways, which have now been fully implemented.
- Introduction of job plans for all clinical staff to ensure standardisation across the service and full utilisation of capacity.
- Introduction of reasonable adjustment clinics, providing additional support to those with a diagnosis of ADHD who are on the waiting list for treatment.
- One of the pilot sites testing the use of AI for clinical recording, with the aim of significantly reducing the amount of time spent on clinical admin and will increase the number of appointment we can offer.

Steps to Recovery

The service has implemented Peer Review for Quality Standards and introduced new service user surveys on restrictive practice and experience. Strategic objectives now include a co-production strategy to tackle health inequalities. Waiting lists remain low, and the Intensive Community Rehabilitation Team partnership, with Birmingham Mind continues to reduce inpatient stays and facilitate step-downs from out of area (OOA) High Dependency Unit placements.

ICCR is so pleased to see eight finalists in the Values Awards.

Acute and Urgent Care

Workforce and Recruitment

Encouraging progress has been made in staffing across our inpatient areas, with substantive recruitment of newly graduated student nurses and additional Internationally Educated Nurses filling Band 5 vacancies. The North Over-Recruitment Team is now operational and will reduce bank spend, the next step is to ensure that all inpatient localities are working in a consistent way contributing to the directorate's financial recovery plan.

Staff Wellbeing and Development

Reflective practice in the North has been successfully launched, with strong attendance. Plans are in place to enhance clinical supervision and improve regular management supervision figures. Action plans with expected improvement will be reported into the Provider Collaborative System Quality Group next month.

Financial Recovery Plan

The Acute and Urgent Care Financial Plan remains focused on cost reduction, particularly in inappropriate out-of-area and non-contracted bed placements and staffing. A reduction in current overspend is targeted, with ongoing monitoring of financial performance. Reducing reliance on

temporary staffing and identification of the cost savings plans will be presented through sustainability board with focus on tangible controls on bank use and implementation of a process to cease use of non-contracted inpatient facilities from April.

Recovery House Procurement

The procurement process is on track, with an anticipated contract award in March 2025. This initiative will enhance crisis alternatives and reduce the pressure on inpatient services.

Clinical Services ward oversight and monitoring

All three wards on the North continue to participate in daily touchpoint meetings focused on patient safety and quality of care, and positive progress is being made against the plan. However, concerns remain, particularly regarding care plans and risk assessments following a recent compliance visit to Eden Acute Ward. An action plan has been developed to address these challenges.

Admissions audit and alternative responses

The admissions audit action plans are progressing, providing insights into admission trends and identifying alternative responses to reduce unnecessary admissions. Findings will be presented at the Patient Flow Improvement Programme.

Mental Health Front Door Triage at Queen Elizabeth Hospital Emergency Department

Early indications suggest positive outcomes, with further evaluation ongoing. A formal report will follow in the next reporting cycle through the System Urgent Emergency Care Board.

Psychiatric Decisions Unit (PDU)

We have established a robust set of key metrics, regularly reviewed in collaboration with University Hospitals Birmingham (UNB) colleagues. These metrics include Referral Outcome, Referral Source, Average Duration of Stay in the PDU, Average Occupancy, and Discharge Reasons. Our analysis indicates that while there is progress, there remains work to be done to enhance staff acceptance rates and response times, thereby reducing delays. The increased average duration of stay in the PDU highlights the challenges in bed flow and the high demand for this resource. To address these issues, we have scheduled staff training and a review of case snapshots to improve consistency in acceptance and effective utilisation of the PDU to support the Urgent and Emergency Care (UEC) pathway.

Out of Area in-reach Standard Operating Procedure

A draft SOP has been developed, incorporating feedback from ICCR and Discharge Managers. An engagement session was held in March, with a formal review planned at the Clinical Governance Committee (CGC) in April. This will ensure robust clinical oversight of service users in the placements and outline clear expectations of the providers.

The division is undertaking focused work on stakeholder engagement and Quality Improvement (QI): these include. A workshop with ICCR, Urgent Care, and Home Treatment Teams (HTT) was held in late March to strengthen joint pathway working and collaboration. The Urgent Care Pathways Group continues to evolve, engaging key partners such as MIND and Talking Spaces to improve service access. A new Quality Improvement (QI) project has been launched to assess the impact of out-of-area placements, with Experts by Experience (EBE) providing valuable input on the admissions process.

Primary Care, Dementia Services and Specialties

The Community Dementia and Frailty Service is developing a dedicated department page on the

Trust website, scheduled to launch in April 2025. The page will offer a range of information on dementia and frailty services, along with helpful videos and webinars accessible to all. The service recently participated in a study led by the National Institute of Health Research (NIHR) Dementia and Neurodegeneration Policy Research Unit at Queen Mary, University of London (DeNPRU-QM). The study aims to explore national variations in service design over the past decade, with the goal of informing more equitable care in the future. Part of this work is exploring how we can work more collaboratively with primary care to move forward with shared care arrangements.

The inpatient teams at our Juniper and Barberry sites are actively implementing the Culture of Care approach — a national programme designed to enhance ward culture and improve patient experience. A recent CQC Mental Health Act visit to Bergamot Ward yielded positive feedback. Service users and their families praised the quality of care and treatment, with staff described as "mini miracle workers." Additionally, the service has joined the Enhanced Therapeutic Observations Committee (ETOC), a national programme aimed at improving therapeutic observations. Through ETOC, we are sharing data on observations, incidents, and staffing, allowing us to compare practices nationally and adopt best approaches to enhance patient care.

Birmingham Healthy Minds recently received confirmation from the Department of Work and Pensions (DWP) and Department of Health and Social Care (DHSC) Joint Work and Health Directorate that additional funding has been secured for Senior Employment Advisors (SEAs) and Employment Advisors (EAs) for the 2025/26 period. This is a welcome development, as the service plays a vital role within talking therapies. A recent service user shared the following feedback: "Thank you for all your help over the past 16 weeks. I have felt myself change and be excited about life in ways I didn't imagine possible. I will always hold a very important place in my heart for you and all your advice. Thank you for being there for me when it felt nobody else was. I promise to do me and you both proud and always take care of me!"

The Bipolar Service continues to strengthen partnerships with other NHS Trusts. This spring, they will provide Mood on Track intervention training to another Trust, expanding access to this psychological support. In May, the service will offer four new group interventions in Birmingham and Solihull, further improving access for service users.

The Meridan Family Programme is awaiting confirmation on whether its contract with NHS England for family intervention training will be extended. An international workshop on family intervention in forensic settings is scheduled for April 2025.

The Veteran Voices patient group recently held a successful face-to-face event at Birmingham City Football Ground. The session, delivered in partnership with third-sector organisations, focused on improving regional services for service users with substance misuse challenges.

Secure Care and Offender Health (SCOH)

Overall staffing levels continue to improve, with vacancies decreasing month-on-month (turnover: 6.7%, vacancies: 8%)

At Ardenleigh, the increased acuity of new admissions has led to the need for enhanced staffing to maintain safe, high-quality care. The Women's Service secured £2.4m funding to develop Dawn House as a step-down facility in partnership with Anawim, aiming to improve the experience in women's secure care and support provision of least restrictive care.

At Reaside Clinic, a February 2025 CQC inspection provided positive feedback, recognising improvements were beginning to be made. The Culture of Care programme is being embedded and creating an energy and commitment from everyone in the service to make improvements and set standards.

At HMP Birmingham, rising activity levels and the impact of illicit substances remain a challenge, that we are working collaboratively on with prison colleagues, police, commissioners and NHSE to explore how we can tackle these challenges. The Health & Justice Vulnerability Service has filled all community vacancies, boosting outreach engagement. The Custody/Court pathway are experiencing some challenges as a consequence of the Right Care, Right Person (RCRP) approach (i.e. high levels of inappropriate remands without mental health support) this has been escalated at strategic RCRP group for action.

The FIRST team's Winter Fayre was a major success, uniting service users, families, carers, and partners, with service user recovery stories highlighting the impact of person-centred care. In February 2025, CQC praised the team's co-production culture and patient-focused approach. The team is supporting ICCR community colleagues with a pilot community forensic liaison service, enhancing early support and prevention.

The division continues to improve in key performance areas, with high compliance in appraisals (91.7%), clinical supervision (88.2%), management supervision (88.8%), and fundamental training (96%). The staff survey saw improved uptake (62%), with a 6% improvement in People Promise variables including staff engagement and staff morale. The Health & Justice Vulnerability Service (+18%) and Reaside Clinic (+9%) showed the greatest year-on-year improvements, while Women's Services are receiving additional Organisational Development Team support to improve their staff engagement.

SUSTAINABILITY

Funding and Finances

The Trust has been working with the Mental Health Provider Collaborative and other system partners to meet the requirements of the annual planning round, which culminated in an Extraordinary Board meeting to approve our submission.

For the new financial year, the Trust faces an enormously challenging position which includes a savings target of over £36million so we all have an important role to play in delivering services in the most cost-effective way.

The single largest element of this plan relates to the work that is being done across the system to reduce our need to use non-contracted inpatient beds in adult acute and psychiatric intensive care unit PICU services, we know this will enhance the experience of service users, ensure better quality support as well as deliver financial savings.

There are also a number of other plans based on the same principles of first and foremost improving quality and experience that we have developed that will enable us to reduce our spend as a consequence and will require the support of colleagues across the organisation and in some case the partnerships we have to deliver.

BSoL Community Care Collaborative

A first draft 'locality operating model' was endorsed by the Steering Group in December 24. Feedback has informed further development into version 3 of a draft operating model for integrated care in neighbourhoods and localities across Birmingham and Solihull. It is expected that full implementation of this large-scale, multi-organisation change programme will take three years (2025/6 to 2027/8). It focuses at present on adults.

A financial plan has recently been put forward which primarily includes the roll out of the Integrated Neighbourhood Teams, (INT's). We are working with partners to agree the model and consider how their workforce plan aligns to this, alongside other initiatives such as the mental health neighbourhood teams and 24/7 project.

The Collaborative's Implementation Plan detailed the expectations of the benefits of working together, our approach as a Collaborative, and initial impact measures. It committed to understanding and demonstrating the Collaborative's impact and embedding this into the work programmes and services. The proposed approach to evaluation is split into two main areas:

Collaborative Programme Evaluation – reviewing the process of implementation, the effectiveness and benefits of the Collaborative, and the extent to with the Collaborative delivers on NHSE's guiding principles.

Evaluation of work programmes – this will build on initial evaluation in the INT programme.

Mental Health Learning Disability and Autism (LDA) Provider Collaborative

The following key activities have taken place over the last quarter:

The MHPC has continued to seek the views of stakeholders and partners on the high-level blueprint of the Mental Health Strategy. This has included a community event held on the 25/2/25 in Solihull, a community event in Birmingham on 28/2/25 and an online event held on the evening of the 06/03/25. An engagement event with members of the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) Collective took place on the 25/3/25 providing a space for community leaders to share their views on the proposed transformation priorities. Engagement with stakeholders will be continued throughout March to inform the strategy to be finalised by 30 April 2025.

Following the release of the NHS Planning Guidance for 2025/26 the MHPC has been working through the commissioning intentions and priorities for next year based on the funding that will be available to commission services.

An evaluation of the adult inpatient acute and PICU bed procurement is currently underway. This procurement will result in a framework arrangement which will go live in May 2025 and a contracted block arrangement/s which will go live in October 2025.

Key developments for the MHPC include:

The MHPC will be facilitating an engagement session with Black Leaders from across BSOL on 11 April 2025 to review the needs assessment and strategy priorities for mental health.

A Co-Production Event will be taking place on 30 April 2025 to bring together key stakeholders, partners and communities to develop a co-production framework for the MHPC.

On the 28th of March 2025 the MHPC attended the Birmingham Health & Wellbeing Board alongside Public Health colleagues to present on both the draft Creating a mentally health city strategy and the mental health strategy blueprint. It is proposed that both strategies have detailed plans which underpin the transformation priorities and demonstrate synergies across the vision for Birmingham.

The MHPC will continue to seek assurance and have oversight of the transition of the Birmingham Women's and Childers mental health services into BSMHT during 2025 ensuring the appropriate due diligence and impact assessments are undertaken and reported into Board.

24/7 Neighbourhood Centre Pilot Site

Our pilot site programme is developing well and has been seeing service users for some weeks now.

We continue to link with colleagues from the other 5 national pilots to share learning and support continuous evaluation.

Experiences of all involved have been very positive and relationships with our local community partners have very much strengthened.

QUALITY

Section 29A and Focused Inspections

The most recent action plan associated with the Zinnia Focused inspection shows positive progress with all identified actions and the team continue to review this at their bronze and silver meetings.

During the CQC Focused inspection at Reaside in February, the CQC noted positive progress compared to their previous visit. The improvement noted in the action plan for the site supports this finding. CQC colleagues considered whether or not to lift the current section 29a as part of this latest visit and their decision will be confirmed on publication of this report.

We have continued to see improvement with compliance rates for clinical and management supervision albeit focus needs to remain for some specific teams. At the end of February, clinical supervision was at 84% and management supervision at 67%. This quality metric continues to be monitored at the Safer Staffing and Trust Clinical Governance Committees.

The focused work to review Emergency Departments has now been completed and included a specific focus on the Place of Safety and the Psychiatric Decisions Unit. There is a plan in place to implement more responsive post assessment and develop pathways to align with localities across the Trust to support patients on caseloads to better access local help and support. Additionally, there is participation in system-wide quality summits on improving responsiveness and care for people with a mental health condition who present at local Emergency Departments.

Reducing Restrictive Practice

The Reducing Restrictive Practice Steering Group meets monthly with good representation by Directorates/Service Areas and ongoing active involvement of our Experts by Experience.

Health Inequalities and Learning Disability and Autism have been added as Standing Agenda items for 2025 meetings and onwards to support ongoing discussions of how the Reducing Restrictive Practice work can support these priorities as well.

At the end of 2024 there was a Stocktake Session to review outcomes of improvement work and set priorities and the RRP Workplan for 2025 to incorporate the Quality management system principles into the RRP Work. Some of the priorities for the 2025 Workplan include, setting up the regular Admission and Seclusions Panels, improving the Rapid Tranquilisation training to support proactive use of medication, re-audit of Seclusion across all service areas.

Notable achievements have been the Seclusion posters developed with EBEs which will be rolled out across all inpatient areas, the Inpatient Service User Survey Results and adopting key themes from these results into the 2025 workplan and development of a Staff Assault Tracker to support ongoing liaison with Teams and the Police.

A key area of focus has also been embedding the routine use of the Restrictive Interventions Dashboard to ensure that the data available is being discussed and reviewed regularly by teams and service areas and the Steering group to inform the Improvement work.

LOCAL NEWS

Children and Young People's (CYP) Services Transfer to BSMHFT

Monday 10th March marked the launch of the TUPE consultation at Birmingham Women's and Children's NHS Foundation Trust (BWC), as the detailed preparations continue for the transfer of children and young people's mental health staff and services to Team BSMHFT on the target date of 1 July 2025.

The first session was attended by our Director of Operations, Vanessa Devlin, along with other BSMHFT senior leaders and a Trade Union representative, with more formal and informal sessions planned for BWC staff over the coming weeks.
Executive teams from both BSMHFT and BWC also met earlier this week, to review the programme mobilisation plan and the status of the due diligence work that is being compiled for each workstream.

Looking ahead, we will be sharing an invite with our BWC mental health colleagues to join our Listen Up Live on Tuesday 27 May which is dedicated to the CYP services joining the Trust. This will be a session where we will encourage all attendees to have their cameras on to see each other's faces and to give BWC colleagues the opportunity to familiarise themselves with the process and energy of our Listen Up Lives.

New Out of Hours Mental Health Service – Talking Space Service, St Paul's Square, Central Birmingham

Opened on 7 March, this fourth Crisis Intervention space is available to offer support for young adults aged 18–25 and will be open every Friday through to Monday, from 1pm till 9pm, providing essential services to help those in need.
The services at this new venue include:

- Wellbeing support
- Comfort
- Safe space to talk
- Crisis care
- Preventative care
- Signposting and advice
- Practical support
- Clinical support (if needed)

The Talking Space service is designed to offer in person mental health support in a safe, welcoming environment. Whether individuals are seeking emotional comfort, crisis care, or guidance, the service is there to listen and help.

We can learn more about all MINDs Talking Space venues, via https://birminghammind.org/what-we-do/talking-space-inc-crisis-support/

NATIONAL NEWS

10 Year Plan

Work has continued nationally to inform the 10 Year Plan and establish the means by which its themes of the 3 shifts from Hospital to Community, from Analogue to Digital and Sickness to Prevention will be achieved.
Tom Kibasi has been announced as the lead author for the plan and the intention is that it will be published later in the spring.

NHS Changes Announced

Since our last Board meeting, a number of changes have been announced both within the NHS and other Government Departments that will impact of the NHS.

These announcements include, Sir James Mackey being appointed as Transition CEO of NHS England, the 'abolition' of NHSE, the requirement for Integrated Care Boards (ICBs) to make a 50% reduction in costs and a number of other requirements associated with living within the funding allocation the NHS has received.

We are continuing to consider with colleagues in both the BSoL system and more widely to determine, the implications of the changes, how we need to respond and work together and where we will need to strongly advocate for mental health.

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

VANESSA DEVLIN
EXECUTIVE DIRECTOR OF OPERATIONS

Report to the Board of Directors							
Agenda item:	**8**						
Date	2 April 2025						
Title	Board Assurance Framework						
Author/Presenter	David Tita – AD Corporate Governance						
Executive Director	David Tomlinson – Executive Director of Finance	**Approved**	**Y**		**N**	✓	

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

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

Alert		**Advise**		**Assure**	✓

1. **Purpose:**

This report aims to present the Board Assurance Framework (BAF) to the Board of Directors for oversight and assurance following its review and scrutiny by Board Committees at their February meetings.

2. **Introduction:**

A BAF sets out and pulls together all strategic risks linked to the delivery of the Trust strategy while leveraging assurance that such risks are robustly and efficiently mitigated and managed in line with best practice and the Trust`s risk management arrangements.

Members of Board Committees after reviewing their BAF at their February meetings, made the following recommendations which are still being worked through due to completion of the business case for the CYP transfer and associated documents taking priority. These will, however, be timely completed in view of Board Committee meetings in April: -

I. While noting the progress that has been made with mitigating some of the BAF risks, members advised that BAF risk scores be reviewed to ensure they appropriately reflect the level of residual risk.
II. Members of the FPP advised for the language in the titles for SR6 and SR7 to be reviewed, reframed and aligned with the body of the risk entries.
III. Members of the People Committee on the other hand, recommended joint committee oversight for BAF risks with joined Executive ownership.

3. **Key issues and risks:**

The main issue worth noting is: -
The fact that BAF risks will be further reviewed and re-aligned once key planning priorities for 2025/26 which are currently being discussed through ongoing series of workshops will be agreed on.

Strategic Priorities

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

Recommendation

The Board of Directors *is requested to:*

1. ***NOTE*** *the content of this report.*
2. ***REVIEW, SCRUTINISE*** *and* ***GAIN ASSURANCE*** *that BAF risks linked to the delivery of the Trust`s `strategic priorities` are appropriately mitigated and managed in line with best practice and the Trust`s risk management Policy arrangements.*

Enclosures

Table 1: Summary of the Board Assurance Framework.
Table 2: Heat Map of the BAF.
Appendix 1: Details of the People Committee Board Assurance Framework
Appendix 2: Details of the QPES Board Assurance Framework.
Appendix 3: Details of the FPP Board Assurance Framework.
Appendix 4: Details of the QPES Board Assurance Framework – continuation

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

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. People: Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users							
SR1	Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care.	June 2024	October 2024	DSPP	**3x3 = 9**	N/A	**5x4=20**
SR2	Inability to attract, retain or transform a resilient workforce in response to the needs of our communities.	June 2024	October 2024	DSPP	**3x3= 9**	N/A	**5x4=20**
2. Quality: Delivering the highest quality services in a safe inclusive environment where our services users, their families, carers and staff have positive experiences, working together to continually improve							
SR3	Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.	Sept 2024	October 2024	CN	**4 x 2 = 8**	N/A	**4 x 4 = 16**
SR4	Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.	Sept 2024	November 2024	CN	**4 x 2 = 8**	N/A	**4 x 3 = 12**
3. Sustainability: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population							
SR5	Failure to maintain a sustainable financial position.	Sept 2024	October 2024	DOF	**5 x 2 = 10**	N/A	**5 x 4= 20**
SR6	Failure to maintain acceptable governance and environmental standards.	Sept 2024	October 2024	DOF / COO	**3 x 3 = 9**	N/A	**5 x 4= 20**
SR7	Failure to deliver optimal outcomes with available resources.	Sept 2024	October 2024	DOF / COO	**3 x 3 = 9**	N/A	**4 x 4 = 16**
4. Clinical Services: Transforming how we work to provide the best care in the right way in the right place at the right time, with joined up care across health and social care							
SR8	Failure to continuously learn, improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.	Sept 2024	October 2024	MD	**3 x 3 = 9**	N/A	**4 x 4 = 16**
SR9	Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.	Sept 2024	October 2024	COO	**3x 3 = 9**	N/A	**4 x 4 = 16**

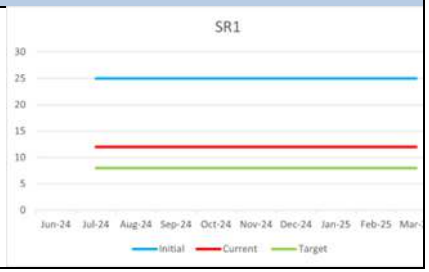
Table 2: Board Assurance Framework - Heat Map

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

Appendix 1: Details of the People Committee Board Assurance Framework.

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**Failure to create a positive working culture that is anti-racist and anti-discriminatory to enable high quality care.**	• **Shaping our future workforce** • **Transforming our culture and staff experience** • **Modernising our people practice**	• Increased FTSU contacts. • Lack of early local resolution • Staff survey results • Colleague feedback	• Sickness and recruitment challenges. • Lack of engagement. • Loss of trust and confidence with communities. • Services that do not reflect the needs of service users and carers. • Inequality across patient population. • Workforce that is not culturally competent to support populations and colleagues.	People Committee	Executive Director of Strategy, People and Partnerships	SR2

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 5x Likelihood 4=20	Poor staff experience, low morale, feeling less valued and listened to, unable to speak up and develop trusting relationships with colleagues, all contribute to the Trust's inability to retain its skilled workforce.	**Impact 3 x Likelihood 3= 9**	A number of workforce plans focused on improved culture would have a positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce.	
		DATE OF LAST REVIEW	21st October 2024	

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Develop and implement a clear reducing health inequalities programme, moving from programmes approach to BAU.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	September 2025	All Divisions now have reducing inequality plans, milestones are currently being reviewed. Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed.

Develop and implement infrastructure to identify and address Racism and Discrimination across the Trust.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	March 2026	Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed. Policy awaiting final confirmation at TCSE in March 2025. Anti Racist practitioner and leader remaining to be rolled out.
Take PCREF from pilot to full implementation.	Associate Director of Equality, Diversity, Inclusion and Organisational Development	March 2026	Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed. PCREF to be incorporated into HI plans and also key corporate frameworks i.e. PSIRF.

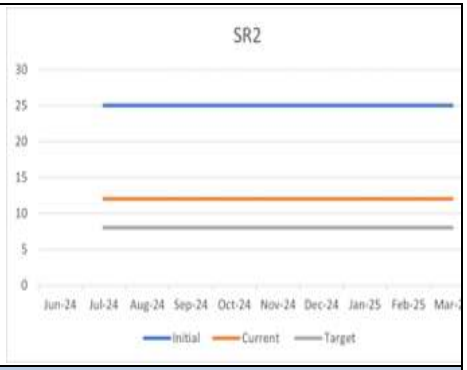
POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Ability to offer flexible working arrangements. • Values-based recruitment. • Workforce Race Equality Standard. • Workforce Disability Equality Standard. • Model Employer • NHSE High Impact Actions. • Pay Gap • Public Sector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

• Management essential and people related training. • Improved experience scores on staff survey Improved retention rates. • EDI Improvement plan.			
Update since last review:			
30 Jan 2025 Risk newly assessed with inputs from the team and presented for Exec sign-off.			
31/01/2025 BAF risk has been updated to reflect the recommendations from the last People Committee as specific action due dates have also been included**.**			
15 Feb 2025 Gaps in assurance have been added.			

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

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY

Impact 5 x Likelihood 4=20	On a platform of increased operational pressures, rapid demand, a competitive marketplace, reduced pipelines, challenged training places and funding, the risk to the Trust is significant for filling its workforce gaps and developing its services. Staff shortages and deteriorating staff experience will impact further on the Trust's ability to attract and recruit to the organisation.	**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.	
		DATE OF LAST REVIEW	29 January 2025	

CONTROLS/MITIGATIONS	**GAPS IN CONTROL**
▪ International recruitment pipeline. ▪ Safer Staffing model ▪ MHOST ▪ E-Rostering compliance. ▪ Training Needs analysis. ▪ Leaver's questionnaires. ▪ Stay conversations ▪ Staff Survey ▪ Pulse survey ▪ Values and Behavioural framework. ▪ Robust People processes. ▪ Robust temporary staffing processes. ▪ Retention plan ▪ Health & wellbeing offer. ▪ Flexible retirement options ▪ To support and implement system priorities such as 4 Rs (Reconnect, Recruit, train and Retain, Resilience and reform).	▪ Delays in time to hire. ▪ No formalised marketing and attraction strategy / plan. ▪ Inability to match recruitment needs (due to national and local shortages). ▪ High dependency on temporary staffing. ▪ Poor establishment controls. ▪ Not using E-Rostering to full ability. ▪ Not following values and behaviours framework. ▪ People processes not being adhered to.

ACTIONS PLANNED

Action	Lead	Due date	Update
Decrease use of bank in line with growth of substantive workforce.	Head of Workforce Transformation	Ongoing	Bank has decreases but at a slower rate than the substantive workforce had increased.

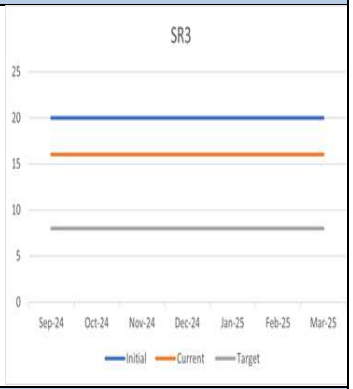
To complete divisional workforce plans for 25/26 to feed into the overall submission.	Head of Workforce Transformation	14/03/2025 Request extension of action due till 31/03/2025 to allow two-week review and feedback on divisional workforce plans.	Templates have been provided to divisions and support sessions set up. Still Awaiting National guidance.
To complete a self-assessment against the People Promise domains and agree priorities for 25/26	Head of workforce Transformation	31/03/2025	Two workshops planned to undertake the assessment and agree priorities

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Ability to offer flexible working arrangements. • Values based recruitment • Flexibility with the targeted use of Bank incentives and Trust-wide reward. • Improving vacancy and turnover performance. • Customer satisfaction survey positively improving. • Values based recruitment • Stay conversation data • Comprehensive health & wellbeing offer. • Increased % of staff recommending BSMHFT as a place to work. • Improved staff engagement scores. • Improved recruitment timeline. • HR KPI reports	• Diversity gaps in senior positions. • Gender pay gap • Significant workforce gaps • Cost of living increases with AfC pay-scales not as competitive as some private sector roles. • WRES and WDES indicator 2 (likelihood of appointment from shortlisting). • Colleagues not adhering to flexible working initiatives. • Non-adherence to values-based recruitment principles.	Internal audit reviews 2024-25: • Race Equality Code • Recruitment and Retention. • Complaints • Bank and agency • Disciplinary Process • Sickness Absence Management.	• Data quality concerns for all demographics. • Changes not translating into change of experience at the pace and levels of sustainability we would require.

• Increased use of social media to attract.			
Update since last review:			
21st October 2024 Risk newly assessed with inputs from the team and presented for Exec sign-off.			
29 January 2025 Risk newly assessed. Has not achieved target score due to the following - Hot spot areas remain in terms of vacancies, turnover and temporary staffing usage. Issue with culture, bullying harassment, increasing sickness and ER cases are still impacting staff experience, team effectiveness and resilience.			
15 Feb 2025 Gaps in assurance have been added.			

Appendix 2: Details of QPES Board Assurance Framework

SR3	**Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.**	• **Quality** ❖ Preventing harm ❖ Patient safety culture ❖ Quality improvement and assurance ❖ Improving service user experience ❖ Using our time more effectively	• Lack of implementation & embedding of QI processes. • Unwarranted variation of quality of care. • Insufficient focus on prevention and early intervention. • Poor management of the therapeutic environment. • Limited co-production with services users and their families.	• Failure to meet population needs and improve safety. • Variations in care standards and outcomes. • Unwarranted incidents • Failure to reduce harm. • Poor patient experience.	QPES	Executive Director for Quality & Safety/ Chief Nurse	SR4 SR8 SR9
RISK APPETITE		**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. ***Target risk score range 6-8.***		**INHERENT RISK SCORE**	Impact 4	Likelihood 5	Risk score 20
				DATE RISK WAS ADDED	18th October 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 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	5th March 2025	
CONTROLS/MITIGATIONS			**GAPS IN CONTROL**	

• Process in place to review and learn from deaths • Clinical Effectiveness process including Clinical Audit, NICE • Implementation of PSIRF • Trust Safety Huddle • Safer Staffing Committee • Transition to LFPSE • Patient safety education and training • Implement a culture of continuous learning and improvement. • Mental Improvement Programme work as defined in the Patient Safety Strategy. • Development and application of RRP Dashboard. • Process in place to for staff, service users and families to raise concerns • Programme of external audit. • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Internal adoption of a transparent Quality/assurance process AMaT implementation. • QI Resources and projects in place • CQC Insight Data and regular joint meetings. • Healthcare Quality Improvement – NCAPOP (National Clinical Audit and Patients Outcome Programme). • Coroner's Reports • QSIS compliance • Shared Care Platform • Capital prioritisation process • Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation. • Bronze Silver Gold Escalation/Resolution Process. • Agreement on process for sharing information and providing assurance to stakeholders in place with MHPC, ICB, NHSE and CQC.	• Gaps in MHA Action Plan oversight arrangements from CQC inspections. • Clinical Governance structures from Ward/Team to Board. • Structure of recording on Rio means duplication and gaps – high admin burden. • Usability of ESR and documentation framework for RMS highlighted as a challenge. • Levels of training and support for supervision, protected time for all substantive registrants. • The action plan amnesty thematic review has highlighted a gap in staff understanding of the importance of RMS/Clinical Supervision. • Inability to embed a culture of continuous learning and improvements, sharing learning across the organisation • Clinical Audit Framework and full implementation of the audit framework on AMAT. • Full implementation of Dialogue+

ACTIONS PLANNED

Action	Lead	Due date	Update
Review of Trust Clinical Governance and implementation of recommendations from internal audit and review to ensure	DQS/CN	31st March 2025	Review and workshop completed. Paper to QPESC, CGC TOR revised and published, agenda updated, and forward planner revised in light of reporting arrangements to QPESC, reported at Audit Committee. Final workshop planned with

Ward/Team to Board governance is fit for purpose.			Clinical Services in March to complete Chairs Training for local Clinical Governance Groups.
One year in review of PSIRF to ensure the process is meeting statutory responsibilities and ensuring continuous improvement in quality through an embedded safety culture.	DQS/CN	31st March 2025	Review of PSIRF started, scope to include reporting, after action reviews, Structured judgement reviews and safety panels, supporting staff, relatives and demonstrating learning. Coroners masterclass held. Workshop March and final report to QPESC in April 2025.
Alignment of policy and audit processes and reporting schedule through CEAG.	IDCN	31st March 2025	Completion of review of audit frameworks contained in policies for assurance and reporting arrangements agreed to go through updated Clinical Effectiveness and Assurance Group, this has been completed and the final action will be to add all audits to AMAT for regular completion in clinical services.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
Learning for improvement: • Structured Judgment Reviews reviewed at local safety panels. • Corporate led learning from deaths meeting. • Executive Director's Assurance Reports to QPES Committee and Board. • NHS Digital Quarterly Data • Commissioner and NED quality visits. • CGC Local review has been completed and actions implemented. • Action in place in respect of the learning from	• Reaside regulatory notice environment and governance. • Reaside FTSUG Regional escalation. • Reaside CQC Report • Zinnia Centre CQC Sec 64 Letter. • External Audit Clinical Governance Review (18 recommendations). • Zinnia Section 29A warning notices – training, sharing learning, supervision, governance, observation.	• CQC planned and unannounced inspection reports. • Reaside commissioned support programme and Culture of Care Programme. • Door alarm implementation programme. • Internal and External Audit reports. • Triple A reporting to QPES from CGC. • Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting. • QMS update reporting to QPES • QI reporting to Trust and Local CGC's, STMB and requested for regular QPES/Board- This has been embedded from June 2024 with regular reports built into committee planning structures. • Incident reporting and learning is included in the Patient Safety Report to Trust CGC, QPES, and Board.	• The availability of real time safety data to triangulate information. • Strengthening of processes is required for assuring that the learning from PFD, external reviews, incidents, and complaints is embedded. • Analysis and triangulation of data across different sources needs is weak and inconsistent. • Lack of an accountability framework in place for how actions from Ligature and Environmental risk assessments are overseen/managed at Divisional level with stratification of associated risk at trust level.

Greater Manchester and Nottingham. • Physical Health Strategy	• Zinnia CQC report • PFD on learning identification through internal investigations.	• Independent annual assessment against the 68 NHS Core Standards for EPRR. • Safety Huddles review staffing on a daily basis • DIPC/IPC/Estates monthly escalation Meeting. • Submission made to the CQC in response to the Sections by the required deadline in December 2024, showing improvement in the areas that were highlighted.	

LINKED TO RISK REGISTERS/CRR RISKS	
1545	There is a risk to patient safety, the quality of care and patient experience due to high waits across all Older Adult CMHTs, this includes waits for new assessments, follow ups and patients awaiting care coordination.
868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc due to the lack of AMHP availability, particularly out of hours.

Update since last review:

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

5th March 2025

Local CGC (LCGC) Review completed. TOR adjusted and standardised across all directorates. LCGC Agenda also updated, refreshed, and used similar TCGC style template for agendas (3 as per theme months). Consultation exercise undertaken with executive colleagues. Consultation exercise undertaken with Directorate SLT – concluded 6th of January. Final amendments to be made and new LCGC process rolled out. New LCGC process has been augmented with improved, bespoke reporting on quality, safety and experience, with learning from death reporting due to be rolled out in March.

Transition of senior leadership roles in Nursing and Quality Directorate in support of new structure.

Review and consolidation of learning to date and next steps in respect of Greater Manchester and Nottingham, learning to link in with steps to develop integrated community working in addition to review of Paranoid Schizophrenia Pathway.

Bronze Silver Gold escalation Protocol implemented for patients waiting in Emergency departments for assessment or admission for treatment.

Review of transfers to Acute Trust due to physical health needs.

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR4	**Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.**	• **Quality** ❖ Patient safety culture ❖ Quality improvement and assurance ❖ Improving service user experience ❖ Using our time more effectively.	• Inability to effectively collate, share and understand intelligence from incident data in improving patient experience. • A workforce that requires greater knowledge about recovery and personalised care. • Increased turnover • Overreliance on bank and agency staff. • Difficulties with sharing good practice and duplicating it. • The lack of a central hub to capture all engagement activities which could be accessed by services once they`re designing services. • Increased waiting list time affecting care and support for patients and their families and carers. • Families and carers not always engaged in care planning. • Estate /environment not fit for purpose in some areas. • Poor food choices and opportunities in some settings. • Lack of understanding of sphere of influence for clinical facing teams.	• A reduction in quality care. • Service users not being empowered • Services that do not reflect the needs of service users and carers. • Service provision that is not recovery focused. • Increased regulatory scrutiny, intervention, and enforcement action. • Failure to think family • Inequality across patient population. • Workforce that is not equipped or culturally competent to support populations and colleagues. • Failure to provide resources that support health, wellbeing, and growth. • Lack of engagement from staff and patients, families and carers. • Reactive rather than proactive service model • Increased service demand.	QPES	Executive Director for Quality & Safety/ Chief Nurse	SR3 SR8 SR9

RISK APPETITE	**Cautious** - Accept need for operational effectiveness with risk mitigated through careful management limiting distribution. ***Target risk score range 6-8.***	INHERENT RISK SCORE	Impact	Likelihood	Risk score
			4	4	16
		DATE RISK WAS ADDED	18th October 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 3 = 12	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	5th March 2025	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Community transformation • The design of a Community Engagement Framework being led by the ICBQI Programmes with our EBE`s/ HOPE Strategy. • IPEAR representation • Recovery for all team • Trust induction sessions • EBE educator programme • Recovery College • Participation & Experience team members in each division. • HOPE (Health, Opportunities, Participation, Experience) action groups. • LEAR action groups • EBE recruitment panel programme. • Carer strategy • QPESC Visits • Chair and Non-Executive and Executive Director Visits. • Board and QPESC Stories • Healthwatch reports • PALS and Complaints access, resolution and learning.	• Challenges around workforce as genuine engagement requires sufficient and consistent staff. • Turning off part of CPA where family and carers were being recorded and offered family engagement tool – risk that Dialog + won't always capture family and carers needs / support Ongoing work around preventative needs and stigma A stretched workforce that hasn`t always got the capacity to make these relationships. Difficulties with sharing good practice and duplicating it. The lack of a central hub to capture all engagement activities which could be accessed by services once they`re designing services The diversity of our communities means Communities can find us hard to reach Lack of consistency and burnt-out workforce in some of the services use of bank and agency staff can impact on our capacity to build relationships with families. • Implementation of 'In Mustak's Steps' 15 steps for BSMHFT. • Framework for aligning reporting to QPESC using 'I statements'.

ACTIONS PLANNED

Action	Lead	Due date	Update
Need to review how Community engagement and patient experience data is captured and reported.	AD for AHP and Recovery/ Head of Community Engagement	31st March 2025	• Review in scope working with MHPC. • Definition required for the interface between community engagement and patient experience.
Development of Fifteen Steps Model 'In Mustak's Steps'	AD	31st March 2025	Coproduction of this in development with EBE's. Model to commence in April 2025 and project plan to be presented at PEAR in December 2024 and shared with QPES in January 2025.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• FFT • Healthwatch • EbE Observer project • Patient councils in Secure Care. Urgent care, CMHT and D&F.	• Community Mental Health survey	• Monthly reports on participation and engagement presented QPES • QI Reports • Participation and Experience team provide quarterly reports to divisional teams. ICCR have requested bi-monthly reporting to support with actions related to negative comments in Community Mental Health survey. • Executive oversight of the engagement activities. • Participation worker visits to clinical areas reported via Participation & Experience Team monthly meetings and escalated through PEAR.	• Lack of regular and frequent governance reporting and oversight – divisional teams to provide assurance through clinical governance committee. • Inability to integrate and effectively use data in reporting – Inability to integrate and triangulate data from patient experience and PALS/Complainants effectively. • Patient safety partners are new to the organisation and at early stages of implementation – there is an absence of defined strategy for how they will be utilised Clear reporting structure and attendance at safety meetings Project overview available.

LINKED TO RISK REGISTERS/CRR RISKS	
Risk 824	Failure to ensure that patient information leaflets and posters are available in a range of languages would result in a breach of regulation 10(2)(c) and the Equality Act 2010.
Risk 1023	Risk that families and carers are not consistently involved in risk history, risk assessment and care planning for patients, resulting in the potential for inadequate support and avoidable harm to patients.

Update since last review:	
5th March 2025 Additional actions being taken to align capture of patient experience data with 'I statements' Addition of EBEs to Culture of Care Programmes in services	

Appendix 3: Details of the FPP Board Assurance Framework.

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR 5	**Failure to maintain a sustainable financial position** **NB In this context, a sustainable financial position means an in year AND underlying breakeven over next 2 years and sufficient cash headroom.**	• **Sustainability** ❖ **Balancing the books**	• *Poor financial management by budget holders.* • *Inadequate financial controls.* • *Cost pressures are not managed effectively.* • *Savings plans are not implemented.*	• Trust not meeting its financial targets limiting available funds for investment in patient pathways.	FPP	Executive Director of Finance	SR6 SR7

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact: 5 x Likelihood 4= 20	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 5 * Likelihood 2 = 10**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	
		DATE RISK WAS ADDED	18th October 2024	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Governance controls (SFIs, SoD, Business case approval process) Financial Management supporting teams Reporting to FPP and Board on Trust performance. • Continued review and utilisation of balance sheet flexibility. • Savings Policy • Sustainability Board review. • ICS expectations and reporting requirements.	• Consequences of poor financial performance do not attract any further review. • Requests for cost pressure often made without following agreed process. • Attendance at Sustainability Board variable.

			• Trust has not been able to develop a pipeline for delivery of savings.
ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
To roll out of new finance reports – work is ongoing to identify the capability within the ledger system, the training and resource requirement including specialist expertise.	Deputy Director of Finance	Ongoing	Finance teams have adjusted their local level reporting, and have a session with an external partner to share learning around Power BI finance tools. The changes to the ledger, and chart of accounts from the imminent changes as a result of BSMHFT receiving services currently provided by BWCH means that all financial reporting arrangements will need to be reviewed.
To develop a financial management policy – work is underway to progress this	Deputy Director of Finance	31/10/2024	Financial Management Policy has now been adopted by the Sustainability Board and has been in use by the Finance Department since the beginning of October.

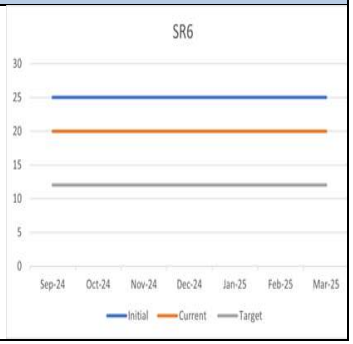
POSITIVE ASSURANCES	**NEGATIVE ASSURANCES**	**PLANNED ASSURANCE**	**GAPS IN ASSURANCE**
• Ability to deliver planned financial position dependent on sufficient controls – Trust continues to meet its statutory financial obligations, including any shortfall in savings delivery.	•	• Ability to deliver planned financial position dependent on sufficient controls – Trust continues to meet its statutory financial obligations. • Internal and External Audit review. • Audit Committee and FPP oversee financial framework and monthly reporting of financial position and any deviation from plans for 23/24 to 24/25.	• Trust continues to be given assurance through audit reports. • HFMA sustainability audit has identified a number of development areas that would improve controls and performance. • HFMA sustainability audit has identified a number of development areas that would improve controls and performance.

LINKED TO RISK REGISTERS/CRR RISKS	
108	Savings schemes are not delivered in full meaning the Trust may fail to meet its financial plan leading to a deficit in year, a fall in financial risk rating or inability to fund capital programme.
112	The Trust does not secure the growth funding we require.
Update since last review:	
21st October 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**	

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS

SR 6	Failure to maintain acceptable governance and environmental standards.
	
	• **Progress in delivering national standards including:**
	  • **Reducing Inappropriate Out of Area Placements in line with agreed reduction targets (0 for acute and 10 for PICU) and maintenance.**
	  • **Service users followed up within 3 days of discharge.**
	  • **Reducing long waits for accessing CMH and CYP services.**
	  • **Achieving and maintaining national waiting time standards for accessing Talking Therapies services.**
	  • **Achieving and maintaining Reliable Improvement and Recovery rates for service users**
		• **Operational Strategies and Transforming Care Programmes covering Acute & Urgent Care, ICCR, Specialties and Secure Services.**	• Low number of adult and older adult beds per weighted population, below national average
			• High levels of admissions under the mental health act
			• Acuity of patients impacting on having longer lengths of stay
			• Available bed capacity in adult and older adults constrained by high number of Clinically Ready for Discharge (CRFD) patients also impacting on increasing length of stay.
			• Availability of timely access to discharge destinations for CRFD patients including impacts of social worker
				Service users being placed in OOA placements moving patients away from local networks/support and incurring additional increased expenditure.
				
				Agreed national reduction targets for inappropriate OOA placements not being met and impacting on patient experience.
				
				Patients not being admitted to a local bed in a timely way, service users waiting for admission and being managed in the community.
				
				Patients who are CRFD remaining in inpatient care longer than is required impacting on increasing length of stay.
				
				Long waits for ADHD assessments affecting CYP waiting times
				
				Financial impact on Trust if Talking therapies activity levels not met
				
				Increased risk to service users not followed up with 3 days of discharge.
				High DNA rates in CMH services.
					FPP / QPES	Executive Director of Finance
						
						&
						
						Chief Operating Officer
							SR5
							SR7

	accessing Talking Therapies services.		availability, funding of placements, availability of appropriate placements. • High bed occupancy levels reducing bed availability. • High CMHT caseload numbers – maintain contact and engagement with service users.	Impact on ability to manage patient flow across services from early intervention/prevention, reducing escalation in service user's needs and reducing admission/reducing need for crisis support.			
RISK APPETITE		**Eager** - Application of dynamic environment-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that ensures meeting organisational requirements. ***Target risk score range 12.***		**INHERENT RISK SCORE**	Impact	Likelihood	Risk score
					5	5	25
				DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 5 x Likelihood 4 = 20	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 4 x Likelihood 3 = 12**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	
		DATE OF LAST REVIEW	10th February 2025	

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Trustwide Sustainability/ Green Group. With representation Corporate and Clinically.	Trust/ SSL	Ongoing	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'.

Development of Business cases and securing of major capital to address Reaside functional suitability.	Trust/ SSL	Ongoing	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
Development of Action Plan to address under performance in Talking Therapies.	AD for Specialties	Ongoing	
Productivity Improvement Plan developed and implemented within Acute & Urgent Care.	AD for Acute & Urgent Care	Ongoing	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Multi-disciplinary Trust Sustainability Group including SSL, Finance, Procurement, Clinical/ Nursing Teams, etc. • Performance reported to FPPC.	•	• Inspection reports. • Compliance audits. • Self-assessment, accreditation and self-certification reports. • External visit reports. • Peer Reviews • Board Assurance Framework Report.	• Lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply. • Lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply. • Poor learning from previous regulatory inspections. • Self-assessment, accreditation and self-certification culture not strong enough to be relied upon for assurance. • Peer review not very regular. • The culture of BAF not fully developed and embedded.

LINKED TO RISK REGISTERS/CRR RISKS	
1049	Failure to recruit and retain staff to enable safe staffing levels could result in a breach of HCSA regulation 18 (staffing). Risk of increasing reliance on agency and temporary workforce, will result in poor continuity of care and impact on safer staffing requirements.
85	Non-compliance with E and F statutory standards in external landlord-controlled buildings.
1459	Reaside- backlog condition and clinical functionality.
950	There is a risk that CMHT caseloads will continue to be above 35 which will breach regulation 18 HSCA (RA) Regulations 2014 Staffing. Caused by CMHT having 3 workstreams being: primary care talking therapies, memory drug prescribing & monitoring and core secondary mental health

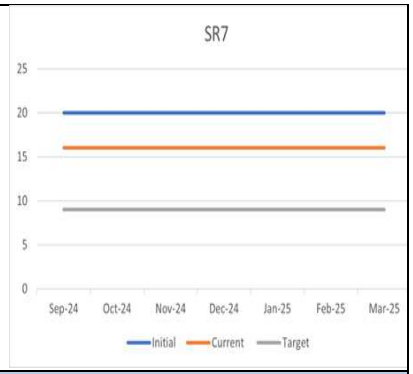
	provision. This may result in higher risk of clinical incidents, increase in staff sickness, poor work-home-life balance, service users not receiving a quality service and increased waiting lists and waiting times for service users.
Update since last review:	
21st October 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**	
10th February 2025 **SR6 reviewed and new entries captured.**	

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR 7	**Failure to deliver optimal outcomes with available resources**	• Achieving and maintaining delivery of 'Culture of Care Standards for Mental Health Services', comprising: ❖ Lived Experience — We value lived experience. ❖ Safety — People feel safe and cared for. ❖ Relationships — High-quality and trusting. ❖ Staff support — Present alongside distress. ❖ Equality — We are inclusive, value difference and promote equity. ❖ Avoiding Harm — Actively avoid harm and traumatisation. ❖ Needs Led — We respect people's own understandings. ❖ Choice - Nothing about me without me. ❖ Environment — Spaces reflect the value we place on our people ❖ Things To Do — Requested activities every day. ❖ Therapeutic Support — We offer a range of therapy. ❖ Transparency — We have open and honest conversations	• Inadequate resources • Staff do not understand or commit to the standards • Competing priorities • Variation in performance between teams • Shortage of suitably qualified and experienced staff and leaders • Lack of meaningful data and evidence. • Unwarranted variation of quality of care.	• Patient outcomes and satisfaction are less than optimal • Services are not responsive or consistent	FPP / QPES	Executive Director of Finance & Executive Director for Quality & Safety/ Chief Nurse.	SR3 SR4 SR5 SR6 SR8

RISK APPETITE	**Open** - Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control. ***Target risk score range 9-10.***	INHERENT RISK SCORE	Impact	Likelihood	Risk Score
			4	5	20
		DATE RISK WAS ADDED	September 2024		

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY

Impact 4 * Likelihood 4 = 16	We are developing measures to demonstrate these outcomes in a systematic way, or focus our resources on their achievement, so there is currently no way 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	9th March 2025



CONTROLS/MITIGATIONS	GAPS IN CONTROL
▪ Process in place to review and learn from deaths. ▪ Clinical Effectiveness process including Clinical Audit, NICE. ▪ Implementation of PSIRF ▪ Implement a culture of continuous learning and improvements. ▪ Mental Health Improvement Programme work as defined in the Patient Safety Strategy. ▪ Development and application of RRP Dashboard ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. ▪ Internal adoption of a transparent Quality/assurance process AMaT implementation. ▪ CQC Insight Data and regular joint meetings ▪ Healthcare Quality Improvement – NCAPOP (National Clinical Audit and Patients Outcome Programme). ▪ Use of workforce resources; e-roster compliance, reduction in temporary staffing. ▪ Coroner's Reports ▪ Capital prioritisation process ▪ Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation.	▪ Lack of aligned comprehensive assessment of delivery against culture of core standards. ▪ Lack of process that explicitly prioritises process against culture of care standards.

ACTIONS PLANNED

Action	Lead	Due date	Update
External Culture of Care and Leadership Review of Reaside.	Executive Director	April 2025	External review launched and underway at Reaside Clinic, involvement of staff and service users, initial launch with leaders

	Quality & Safety		completed, launch with staff and service users in April with 'sort our site out' event, external reviewers reporting excellent cooperation.
Agree a set of metrics aligned to the programme.	EDQ&S	May 2025	Work underway with National Programme to develop metrics.
Programme to be scaled up from four wards across the Trust to all wards from April on a rolling programme.	EQD&S	April to August 2025	Programme plan now agreed with prioritisation of areas, Phase 1 - Secure and Offender Health, Phase 2 -Steps 2 Recovery, Phase 3 – Specialities and Older People, Phase 4- Acute Wards.

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

LINKED TO RISK REGISTERS/CRR RISKS	
1023	Risk that families and carers are not consistently involved in risk history, risk assessment and care planning for patients, resulting in the potential for inadequate support and avoidable harm to patients.
1545	There is a risk to patient safety, the quality of care and patient experience due to high waits across all Older Adult CMHTs, this includes waits for new assessments, follow ups and patients awaiting care coordination.
868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc due to the lack of AMHP availability, particularly out of hours.

Update since last review:

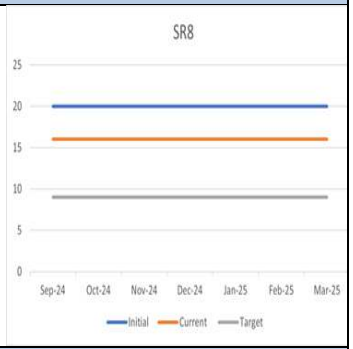
9th March 2025
Programme plan in place, all divisions signed up to participate, External review of Reaside Clinic has started and CQC re-inspection has taken place.

Appendix 4: Details of the QPES Board Assurance Framework – continuation

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

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

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
Impact 4 x Likelihood 4 = 16	Current score demonstrates the controls in place and level of assurance evidenced.	**Impact 3x Likelihood 3 = 9**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.	
		DATE OF LAST REVIEW	21st October 2024	

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

• Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity. • Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Implementation of Learning from Excellence (LFE). • PSIRF Implementation Strategy including PSIRF Implementation Group and PMO support. • Freedom to speak up processes. • Cultural change workstreams including Just Culture. • BSOL Provider Collaborative Development Plan. • Experience of Care campaign. • Health, Opportunity, Participation, Experience (HOPE) strategy. • Family and carer strategy. • Implementation of Family and carer pathway. • BSOL peer support approaches. • Expert by Experience Reward and Recognition Policy. • EbE educator programme. • EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • Divisional inequalities plans. • PCREF framework • Synergy Pledge. • Provider Collaborative inequalities plans. • System approaches to improving and developing services. • Community Transformation Programme – now in year 3 of implementation. • Community caseload review and transition. • Out of Area programme. • Transforming rehabilitation programme, including new of Intensive. Community Rehab Teams. • Reach Out strategy and programme of work.	• 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 finalized for all areas. • Availability of sufficient capital funding for developments. • Capacity within teams to deliver transformation and service developments alongside day job.

• Redesign of Forensic Intensive Recovery Support Team. • BSOL MHPC Commissioning Plan. • BSOL MHPC Development Plan. • Joint planning with BSOL Community Integrator and alignment with neighbourhood teams. • Development of community	

ACTIONS PLANNED

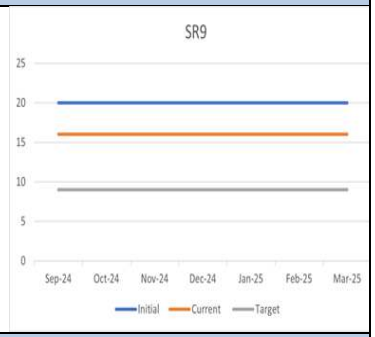
Action	Lead	Due date	Update
Support for development and implementation of divisional health inequalities plans from EDI team.	Jas Kaur / Associate Directors of Operations	February 2025	Plans will be finalised based on feedback.
Patient Carer Race Equality Quarterly submissions to NHSE – Linked to the activities highlighted in the framework.	Jas Kaur / Associate Directors of Operations	Ongoing	Regular reports to NHSE.
To audit health inequalities footprint within the Trust`s governance and reporting arrangements from `Ward to Board`.	David Tita / AD Corporate Governance	30th November 2025	This will facilitate an evaluation and understanding of the extent to which governance reports are written and presented through the lens of health inequalities.
Review and refresh of the family and carer pathway	AD for Allied Health Professions and Recovery	March 31st 2025	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• Learning from Peer Review/National Strategies shared through PSAG. • Serious Incident Reports. Increased scrutiny and oversight through SI Oversight Panel. • Executive Chief Nurse's Assurance Reports to CGC, QPES Committee and Board.	• Highlight and escalation reporting to Strategy and Transformation Board. • Reports to QPES Committee.	• Updates on PSIRF Implementation to QPES and Board. • Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • BSOL MHPC Executive Steering Group. • Health Inequalities Project Board. • Community Transformation governance structures. • Out of Area Steering	• The Trust currently has no baseline to understand the organisations view on safety culture. An options appraisal on how this could be undertaken is being prepared for the Board. • Senior leader session/Board meeting- to discuss how to use QI methodology-driver diagrams, plan, and risk asses, etc. Check knowledge. New First line

• New processes have been devised to improve learning from deaths including improved oversight of Structured Judgement Reviews (SJR's) and associated learning/actions. • Participation Experience and Recovery (PEAR) Group. • Community collaboration with system partners. • Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme.		• Performance Delivery Group "deep dives". • Highlight and escalation reporting into BSOL MHPC Executive Steering Group. • Each division has its own health inequalities action plans that feed to Inequalities board.	manager QI training now in place: QI methodology in day-to-day leadership- using process mapping, driver diagrams, read data etc. • The Safety Summits are in their early conception and may not be adopted well by Divisions/services. • Work to be undertaken to embed human factors/just culture. • Inability to engage with all parts of the Trust.

LINKED TO RISK REGISTERS/CRR RISKS	
868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc due to the lack of AMHP availability, particularly out of hours.
CRR04/453	Potential delays in timely inpatient admissions from both A&E and general wards onto Acute beds.
CRR05/1929	Lack of AMHP availability resulting in delays in timely mental health act assessments.
Update since last review:	
21st October 2024 **Risk newly assessed with inputs from the team and presented for Exec sign-off.**	
14th October 2025 ***Divisions have now completed their divisional health inequalities plans.***	

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

			service transformation. • Lack of support for and involvement of families and careers. • The difficult financial landscape.				
RISK APPETITE		**Open** - Receptive to taking difficult decisions to support the achievement of the Partnership or Provider Collaborative when benefits outweigh risks. Processes, oversight / monitoring and scrutiny arrangements in place to enable considered risk taking. **Target risk score range 9-10.**		**INHERENT RISK SCORE**	Impact 4	Likelihood 5	Total score 20
				DATE RISK WAS ADDED	September 2024		
CURRENT RISK SCORE	**RATIONALE**		**TARGET RISK SCORE**	**RATIONALE**		**RISK HISTORY**	
Impact 4 x Likelihood 4 = 16	Current score demonstrates the controls in place and level of assurance evidenced.		**Impact 3 x Likelihood 3 = 9**	Aligns with the Trust`s risk appetite and reflects the threshold at which risk could be tolerated as it can`t be eliminated and due to controls being embedded.			
			DATE OF LAST REVIEW	21st October 2024			

CONTROLS/MITIGATIONS	**GAPS IN CONTROL**
• Inpatient Bed Strategy and Inpatient quality transformation programme. • Digital transformation programme. • Partnership working with the Voluntary Sector. • Inpatient flow improvement programme. • Patient initiative follow-up work. • Urgent care and Community transformation. • Better prioritisation and triaging of patients of waiting lists. • System approaches to improving and developing services. • Solihull Children and Young People Transformation. • System approaches to improving and developing services.	• Not enough beds for population when compared nationally. • Lack of the right model of care that is suitable for our patients. • Capacity within teams to deliver transformation and service developments alongside day job. • Family and carers pathway not consistently applied or suitable for all services. • Partnerships strategy is currently being refreshed – containing gap/opportunity analysis of current pathways. • Needs assessment for BSOL is not up to date, which weakens our intelligence about our population and needs.

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Implementation of 3rd phase of the Community transformation.	Renu Bhopal-Padhiar / Associate Director Specialties (Keisha Dell)	31st March 2025	On track -
Implementation of the 1st phase of the Urgent Care transformation and Winter Plan.	Associate Director of Operations- Acute and Urgent Care	31st March 2025	On track -

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE	GAPS IN ASSURANCE
• BSOL MHPC Executive Steering Group. • Participation Experience and Recovery (PEAR) Group.	• The new 24/7 MH neighbourhood Community service is still in its early stages.	• Two weeks wait review. • Piece of work around Clinical Governance. • Financial plans that have just been signed. • Reports to the Strategy & Transformation Boards.	• Having a strong service user/carer voice across all of our governance forums. • Variations in inputs across pathways.

• 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.		• System trajectory around 104 and 78 weeks wait. • Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • Reports to QPES Committee. • Co-produced Trauma informed recovery focussed training rolled out (NMHT). • Physical health connectors pilot.	• Gaps in the CYP Pathways.

LINKED TO RISK REGISTERS/CRR RISKS

CRR Risk IDs	Risk Descriptions
CRR02/1924	Potential insufficient capacity across Acute Care pathway to manage patient demand.
CRR04/453	Potential delays in timely inpatient admissions from both A&E and general wards onto Acute beds.
CRR05/1929	Lack of AMHP availability resulting in delays in timely mental health act assessments

Update since last review:

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

4TH Feb 2025
Implementation Plan of 1st Phase of Inpatient Bed Strategy – this has been completed as Policy has been developed and shared with NHSE. New entries have been captured.

12th March 2025
Risk updated and new controls added noting the following progress:

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

Report to Board of Directors

Agenda item:	9						
Date	2 April 2025						
Title	Integrated Performance Report						
Author/Presenter	Richard Sollars, Deputy Director of Finance Sam Munbodh, Clinical Governance Team Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information						
Executive Director	Dave Tomlinson, Director of Finance	**Approved**	**Y**	**x**	**N**		

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

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

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

- Dashboard now contains links to relevant measures for each Division and services.
- Four new metrics have been added in January under the Quality Domain at the request of the Acting Deputy CNO covering physical patient harm, psychological patient harm and physical staff/third party harm incidents.
- Two new metrics have been added under the Sustainability Domain at the request of the Deputy Director of Finance covering bank and agency spend.
- Both Talking Therapies waiting times targets are sustainably being achieved.
- Inappropriate and Appropriate Out of area placements, remains key priority area for improvement. A separate Productivity Plan update was reported to January 2025 FPPC on progress and action plans.
- Clinically ready for discharge is a major contributor to this and remains high. System level escalations being undertaken.
- CPA 3 day follow up largely being met, improvements in late data entry required, this is being followed up with service managers to improve timeliness of recording contacts on RIO.
- Formal review within last 12 months now reliably upper 90s.
- Referrals over 3 months with no contact remains high, but mitigations are in place to avoid risks and waiting times are being covered at the service area deep dive meetings.
- Vacancies – Vacancy data at 8.6% reduction from last month
- Fundamental Training reached 95% target this month
- Incidents of Self Harm have decreased from 224 to 205
- Ligature incidents with anchor point – 2 incidents this month
- Rolling programme of service area deep dives continuing, including benchmarking and waiting times where appropriate
- Being supplemented by review of leadership team approach

Following the recent January 2025 Trust Board development session on the Insightful Provider Board, feedback will be utilised to review the Integrated Performance Report, working with lead Executives and teams where appropriate to take forward.

FPPC members are asked to note the improvements made to the Trust's Performance Management

Framework, including:

- Tighter, more formalised approach with alignment of assurance to committees
- Wider Executive involvement through the service area deep dives and more recently the introduction of divisional leadership review meetings.
- Bringing all performance management matters (People, Quality, Performance, Finance) through a single set of forums via the Performance Delivery Group (PDG) to support.

FPPC is asked to note that the service area deep dive framework has been in place since March 2024 and supports the implementation of a more granular level service specific approach focusing on the four domains of Quality and Safety, Workforce and Culture, Operational Performance and Finance. A service line RAG rating assessment covering each of the domain areas is also agreed with the service area senior leadership team at each meeting.

In addition, and building on the service line review meetings, from November 2024 Divisional Leadership review meetings have been introduced. These take place with the Executive Team on a quarterly basis. The discussions are focusing on jointly reviewing team working, management and delivery of the Trust's finance, people, quality and performance priorities and understanding dependencies across the team to support.

Since the last FPPC meeting in February 2025, there has been no Performance Delivery Group meeting, and one Deep Dive meeting held. Updates and outcomes are provided in the report.

Members are reminded that at the request of FPPC, there is a continued focus on selected metrics. Table 1 provides a summary of the progress related to these metrics in line with plans and trajectories provided by the relevant service leads. Tables 2-4 includes all the other domain metrics within the IPD where there is either a deteriorating trend or a requires improvement trend.

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

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

Domain and metric	On Track	Plan in Place	Progress	Pages
Performance				
Inappropriate out of area Number of placements			Deterioration in last month in last month and remains above trajectory	2-3, 10-12
National Waiting times – Long waits – Adult CMHTs			Improvement in performance in last 4 months. Ahead of 104 week waits trajectory.	3
National Waiting Times – Long waits - CYP			104 weeks trajectory has declined in last 2 months, small number of patients. 78 week has improved in last month but remains above trajectory	3
People				
Vacancies			Reduction in last 4 months February at 8.6%	4
Sickness			Reduction in last 2 months. February at 5.5%.	4, 19-20
Appraisals			Small improvement in month at 80.4% and remains below the 90% standard	4, 21-22
Sustainability				
Monthly Agency costs				4

Table 2: Performance

	On Track	Plan in Place	Progress	Page
Talking Therapies - Service users moving to recovery			Improving Trend in last month (49.83%) just below 50% target	
Talking Therapies Reliable Recovery Rate			Improving trend in last month (45.97%) below target of 48%	3, 17-18
Talking Therapies Reliable improvement rate			Deteriorating trend in last month (59.27%) below target of 67%	3, 15-16
Clinically Ready for Discharge: percentage of bed days			Deteriorating trend in last month. Feb at 13.33%	3-4, 14-15
Clinically Ready for Discharge: Number of delayed days			Improving trend in last 2 months. Feb at 1968 bed days.	3-4, 14-15
Eating Disorders National Access standard - Routine			Small deterioration in last 2 months to 87.5% below 95% target (small numbers)	3

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Improving trend in last 5 months (95.37%). Now above target of 95%	4, 23-24

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Incidents resulting in self harm			Decreasing trend in last month. Reviewed via QPES.	4, 25
Physical Patient harm incidents (New metric)			Has remained at 21 this month	4,26
Psychological patient harm incidents (new metric)			Increasing trend in last 2 months. February at 19 (from 17)	4,27
Physical staff/ third party harm incidents (new metric)			Has remained at 6 for last 5 months	4,28
Ligature with anchor point			2 cases this month (from 0)	4, 29

Strategic Priorities

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

Recommendation

FPPC is asked to note the latest performance position, update on areas identified for improvement and feedback following the service area deep dive meetings held for Specialties along with a summary of outcomes.

Enclosures

FPPC March 2025 Performance Report and Integrated Performance Dashboard

Appendix I FPPC March 2025 FPPC Performance Improvement Metrics

Appendix II FPPC March 2025 Performance Framework update

Appendix IIa Specialties (Focus on Care Home Liaison and CERTS)

Integrated Performance Report

Context

The Integrated Performance Report, the associated Dashboard and supporting detailed reports, including the background to all, were discussed at the Board development session in July 2024 and committee chairs were asked to consider how best to use and develop them to support their committees in providing assurance to the Board. If they require any further discussion or support, they should contact Dave Tomlinson or Tasnim Kiddy.

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.

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.

- Active Inappropriate Adult Mental Health Out of Area Placements (Previously Inappropriate Out of Area Bed Days)
- People metrics – Vacancies, Sickness absence, Appraisals and Bank & Agency fill rates

Committees are asked to note that the improvement plan metrics are discussed at Performance Delivery Group and service area deep dive meetings to assess progress and action plans to support delivery. Appendix 1 outlines an update on improvement plans provided by relevant Leads. This includes an update on the 2024/25 trajectory and related action plans.

Due to the level of detail within the overall IPD, at the October 2023 FPPC meeting, members asked that summarised detail on the key issues is provided. The report content below has therefore been included to address this feedback.

Since the last FPPC there has not been no Performance Delivery Group meeting and one service area deep dive meetings focusing on Specialties.

Performance in February 2025

FPPC is asked to note that the that new metrics have been added to the quality and Sustainability Domains as follows.

- Four new metrics have been added under the Quality Domain at the request of the Acting Deputy CNO covering physical patient harm, psychological patient harm, physical staff/third party harm incidents and Psychological staff/ third party harm incidents.

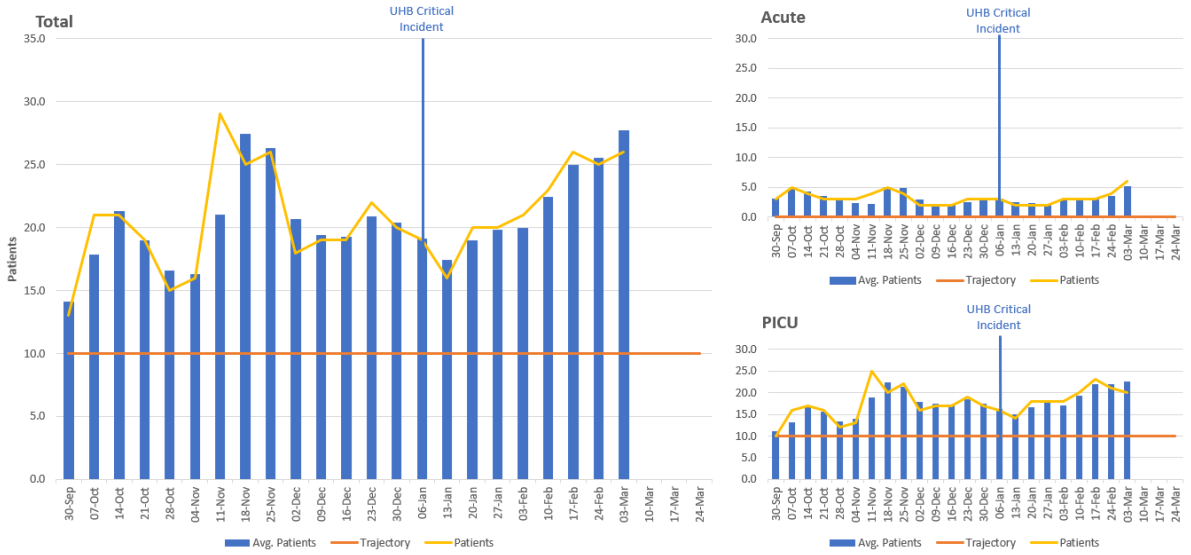
- Two new metrics have been added under the Sustainability Domain at the request of the Deputy Director of Finance covering bank and agency spend.

In summary, the key performance issues facing us as a Trust have changed little over the last 2 years, although there have been some improvements against some of the metrics in recent months:

Active Inappropriate Out of Area placements

A Trust trajectory has been agreed with NHSE as part of the 2024/25 national planning requirements. The trajectory is for zero acute inappropriate placements from April 2024 and to reduce and not exceed 10 PICU inappropriate placements from June 2024 onwards.

Process improvements as part of the Productivity action plan are continuing to be implemented and have helped to address some underlying issues, however in the last month there has been a continuing number of service users requiring admission and this together with increased Clinically Ready for Discharge patients continues to impair our ability to eliminate inappropriate out of area placements. Performance remains above trajectory for February 2025. The granular level weekly data is outlined below. As at the end of February 2025, there were 4 acute (target 0) inappropriate placements and 21 PICU (target 10) patients. This is 5 higher than the previous month.



A separate update on the productivity plan and actions was provided to January 2025 FPPC by the Acute and Urgent Care Associate Director. A summary of the areas for continuing focus include:

<u>Clinical Oversight</u>

- Establishing a Clinical Oversight Group to lead assertive case management, improve flow for high volume users, and create diversion pathways for CMHT patients.
- Focused actions to reduce bed usage from 160+ to 110 beds.
- Embed Quality Improvement into the Clinical Oversight Group to support tracking of performance at locality level and reporting into the Patient Flow Improvement Program governance structure.

Gatekeeping

- QI project to shift gatekeeping metrics from conversations recorded to measurable admission avoidance outcomes.

Pathway improvements

- Develop and enhance pathways for earlier intervention within urgent care. Service Development funding has been secured which will support admission avoidance, ensure purposeful admission and that the discharge is effective. Pilots include:
    - CMHT pilot- responsive support for known patients attending ED.
    - Urgent Care pilot - Dedicated medical support in Bed Management and PDU.
    - Psychological support in HTT for patients on the bed waiting list.

System Collaboration

- Address external challenges by engaging with local authorities and progressing the procurement of a Crisis House (recovery house) to reduce socially driven crisis overwhelming ED.

Talking Therapies Recovery rates

The 2024/25 NHS planning guidance introduced 2 new metrics, reliable recovery and reliable improvement. These are in addition to the current recovery rate. All the rates are below the national targets with the Reliable Recovery rate showing an improving trend this month. The service leads are discussing these metrics with teams and new starters to enable an understanding about what is required and utilising data to identify service users who require additional appointments to improve the position.

National Community Waiting Times – Both Adult and Older Adult CMHTs have made progress against their improvement plans which have focussed on reducing long waits. Challenges in both services remain in particular around managing high caseload levels and pressures arising from staffing levels.

In line with the national 2024/25 operational planning guidance, trajectories were submitted to NHSE via the ICB to improve and reduce long waits in adult CMH and CYP services. The initial focus is to review all long waiters over 104 weeks within adult CMH and 104 weeks and 78 week reduction for CYP services. The detail of these improvement plans has been added to Appendix 1. CMH adults service - performance as at February 2025 is in line with agreed trajectory and CYP services are marginally over the 104 and 78 week wait trajectory, both include small volume of patients. The CYP waiting times includes those waiting for ADHD assessment.

The informatics team have developed supporting waiting times reports at patient and staff level to enable teams to manage and monitor compliance going forwards.

Eating Disorders National Access Standard – Routine – Performance has dropped below the 95% target this month to 87.5%. It should be noted that due to small volumes of patients in this cohort, this reduction relates to one patient who was assessed and admitted as an inpatient.

Clinically Ready For Discharge (CRFD) - bed days lost to CRFD have been on an increasing trend, with the latest Trust position at 13.3%. The main drivers for this are

delays in both adult and older adult acute services. CRFD in February 2025 in Adult Acute & Urgent Care was at 18% (53 patients) and in Older Adult Services at 25.2% (19 patients). The number of delays in Acute and Urgent Care and Older Adults has decreased this month. The main reasons for the delays in adult acute are allocation of a social worker, supported accommodation and lack of public funding and in older adults is due to waits for nursing home placements and social worker allocation.

Trust and partnership wide discussions to support the identification of plans to assist discharge continue to be prioritised by weekly meetings and daily reviews discussing individual patient needs, however, traction to improve the position remains challenging. Barriers have also been escalated to senior system wide level discussions.

Quality the detailed position on these metric areas is discussed at QPES committee. A summary of the metric changes is outlined below. This month a number of new metrics relating to harm have been added:

- Incidents of Self harm have reduced from 224 to 205 this month (decrease in adult acute inpatients and Secure inpatients).
- New metric: Physical patient harm incidents – remained at 12 for last 2 months
- New metric: Physical staff/ third party harm incidents – Remained at 6 for last 5 months.
- New metric: Psychological patient harm incidents - increasing trend in last 2 months. February at 19 (from 17)
- Ligature with anchor point – has increased to 2 this month (from 0)

People workforce measures – The detailed position on these metrics is discussed at the People Committee. FPPC is asked to note that there is an adverse variance against most of the set performance standards although there have been improving trends in fundamental training and reduction in staff turnover.

2024/25 action plans - The HR Leads have reviewed the metrics and provided updated trajectories for 2024/25 together with an outline of the key areas of action referenced in Appendix 1.

- Bank and Agency WTE reduction – There have been small increases in both bank and agency WTE this month. Both remain below trajectory
- Staff Appraisals at 80.4% as at February 2025 below improvement trajectory and below the 90% Trust standard.

- L&D continuing to provide support interventions to staff and hot spot areas and planning Values Based Appraisal sessions with services. Identified a small number of students who need to be excluded from the cohort.

- Staff vacancy levels Vacancy rate at 8.6% ahead of trajectory

- Mandatory Training at 95.37%, improved position this month and now above the 95% target.

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Sustainability – (Please see details in finance report)

Integrated Performance Dashboard

February 2025

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Performance

Bed Occupancy	92 ↓
Clinically Ready for Discharge: Bed Days	1968 ↓
Clinically Ready for Discharge: Bed Days (%)	13 ↓
CPA 3 Day Follow Up (%)	81
CPA 7 Day Follow Up (%)	92
Eating Disorders: Waiting Time - Routine (%)	88 ↓
Eating Disorders: Waiting Time - Urgent (%)	100 ↑
First Episode Psychosis: Waiting Time (%)	100 ↑
Out of Area: Inappropriate Placement Bed Days	646 ↑
Out of Area: Inappropriate Placements Active	25
People on CPA with a Formal Review in last 12 Months (%)	97 ↑
Referrals over 3 Months with no Contact	3959 ↓
Talking Therapies: Reliable Improvement Rate (%)	59 ↓
Talking Therapies: Moving to Recovery (%)	50
Talking Therapies: Reliable Recovery Rate (%)	46
Talking Therapies: Seen in 18 Weeks (%)	100 ↑
Talking Therapies: Seen in 6 weeks (%)	93 ↑

People

Bank & Agency Fill Rate (%)	94 ↑
Fundamental Training (%)	95 ↑
Staff Appraisals (%)	80 ↑
Staff Sickness (%)	5
Staff Turnover: Rolling 12m (%)	6 ↑
Staff Vacancies (%)	9 ↑

Quality

Absconsions from Inpatient Units	2
Commissioner Reportable Incidents	0
Community Confirmed Suicides	0
Community Suspected Suicides	0
Failure to Return	13 ↑
Harm (physical) – patients	21 ↓
Harm (physical) – staff/third party	6 ↓
Harm (psychological) – patients	19 ↓
Harm (psychological) – staff/third party	2 ↓
Incidents of Self Harm	205
Incidents Resulting in Harm: 1 - Patients (%)	0
Incidents Resulting in Harm: 2 - Other (%)	0
Inpatient Confirmed Suicides	0
Inpatient Suspected Suicides	0
Ligature no Anchor Point	11 ↑
Ligature with Anchor Point	2 ↓
Patient Assaults	27 ↑
Patient Assaults / 1000 OBDs	1.5 ↑
Physical Restraints	291
Physical Restraints / 1000 OBDs	16.7 ↓
Prone restraints	66
Prone restraints / 1000 OBDs	3.8 ↓
Reported Incidents	2304
Staff Assaults	79 ↑
Staff Assaults / 1000 OBDs	4.5

Sustainability

Agency as % of Pay Spend	2 ↑
Agency Staff Spend	£372k ↑
Bank as % of Pay Spend	11
Capital Expenditure	£1,705k ↗
Cost Improvement Programmes	£2,102k
Group Cash Balance	£87,860k ↑
Info Governance (%)	96
Operating Surplus	£1,016k

Last refreshed 12th March 2025

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

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Measure	Latest Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Clinically Ready for Discharge: Bed Days		1933	1909	2117	2300	2140	1968 ↓
Clinically Ready for Discharge: Bed Days (%)		12	12	13	14	13	13 ↓
CPA 3 Day Follow Up (%)	80	80	85	80	84	80	81
CPA 7 Day Follow Up (%)	95	91	93	88	91	87	92
Eating Disorders: Waiting Time - Routine (%)	95	100	100	88	100	92	88 ↓
Eating Disorders: Waiting Time - Urgent (%)	95		100			100	100 ↑
First Episode Psychosis: Waiting Time (%)	60	100	100	100	100	50	100 ↑
Out of Area: Inappropriate Placement Bed Days	328	536	560	658	631	591	646 ↑
Out of Area: Inappropriate Placements Active	10	14	17	27	21	20	25
People on CPA with a Formal Review in last 12 Months (%)	95	97	97	96	97	97	97 ↑
Referrals over 3 Months with no Contact		3758	3671	3707	3851	3920	3959 ↓
Talking Therapies: Reliable Improvement Rate (%)	67	59	59	63	61	61	59 ↓
Talking Therapies: Moving to Recovery (%)	50	43	45	48	50	48	50
Talking Therapies: Reliable Recovery Rate (%)	48	40	40	44	45	45	46
Talking Therapies: Seen in 18 Weeks (%)	95	96	98	98	98	98	100 ↑
Talking Therapies: Seen in 6 weeks (%)	75	90	90	93	93	92	93 ↑

Integrated Performance Dashboard

February 2025

Measure	Latest Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Bank & Agency Fill Rate (%)		91	91	91	91	91	94 ↑
Fundamental Training (%)	95	93	94	94	94	95	95 ↑
Staff Appraisals (%)	90	80	80	80	80	80	80 ↑
Staff Sickness (%)	4	6	6	7	7	6	5 ↑
Staff Turnover: Rolling 12m (%)		7	7	6	6	6	6 ↑
Staff Vacancies (%)		10	11	10	9	9	9 ↑

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

Integrated Performance Dashboard

February 2025


HOME


PERFORMANCE


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SUSTAINABILITY

Trust | Acute & Urgent Care | ICCR

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Measure	Latest Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	
Absconsions from Inpatient Units		4	8	1	3	5	3	
Commissioner Reportable Incidents		0	0	0	0	0	0	
Community Confirmed Suicides		2	1	0	0	0	0	
Community Suspected Suicides		1	3	1	0	0	0	
Failure to Return		22	18	17	16	15	11	↑
Harm (physical) – patients		20	19	22	16	21	21	↓
Harm (physical) – staff/third party		6	6	6	6	6	6	↓
Harm (psychological) – patients		17	16	18	14	17	19	↓
Harm (psychological) – staff/third party		1	1	2	2	1	2	↓
Incidents of Self Harm		218	234	192	114	224	205	
Incidents Resulting in Harm: 1 - Patients (%)		0	0	0	0	0	0	
Incidents Resulting in Harm: 2 - Other (%)		0	0	0	0	0	0	
Inpatient Confirmed Suicides		0	0	0	0	0	0	
Inpatient Suspected Suicides		0	0	0	0	0	0	
Ligature no Anchor Point		17	25	23	14	20	11	↑
Ligature with Anchor Point		1	1	0	1	0	2	↓
Patient Assaults		43	38	52	36	33	27	↑
Patient Assaults / 1000 OBDs		2.3	2.0	2.7	1.9	1.7	1.5	↑
Physical Restraints		285	343	266	232	227	291	
Physical Restraints / 1000 OBDs		15.2	17.6	14.0	12.1	11.7	16.7	↓
Prone restraints		43	74	49	42	56	66	
Prone restraints / 1000 OBDs		2.3	3.8	2.6	2.2	2.9	3.8	↓
Reported Incidents		2337	2708	2675	2332	2550	2281	
Staff Assaults		97	88	123	128	91	79	↑
Staff Assaults / 1000 OBDs		5.2	4.5	6.5	6.7	4.7	4.5	

Integrated Performance Dashboard

February 2025

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

Measure	Latest Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	
Agency as % of Pay Spend		2	1	2	1	2	2	↑
Agency Staff Spend		£389k	£337k	£416k	£323k	£372k	£372k	↑
Bank as % of Pay Spend		12	11	12	12	11	11	
Capital Expenditure		£1,080k	£397k	£342k	£874k	£1,333k	£1,705k	↗
Cost Improvement Programmes		£2,826k	£1,306k	£1,201k	£1,449k	£2,586k	£2,102k	
Group Cash Balance		£97,993k	£98,784k	£94,821k	£91,629k	£88,234k	£87,860k	↑
Info Governance (%)		93	96	86	94	94	96	
Operating Surplus		£187k	£685k	£127k	£458k	£378k	£1,016k	
System Oversight Framework (SOF) Rating		3	3	3				

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

Out of Area: Inappropriate Placements Active

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Question	Answers
A: What has happened?	From April 2024 the 2024/25 NHS planning guidance has introduced a revised metric for assessing the reduction of Inappropriate Out of Area Placements. This will now be based on the number of inappropriate out of area placements at each month end. A Trust trajectory has been agreed with NHSE as part of the 2024/25 national planning requirements. The trajectory is for zero acute in appropriate placements from April 2024 and to reduce and not exceed 10 PICU inappropriate placements from June 2024 onwards. Inappropriate out of area placements has fluctuated since January 2024 with large peaks and troughs. February is showing an increase in the last month at 25 placements with 4 in acute beds and 21 in PICU beds above the trajectory of 10 for February 2025. These all relate to adult acute/PICU patients. There were 17 inappropriate admissions during February with 4 acute and 13 PICU a small increase compared to January. The 2024/25 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE. This enables a reclassification of such beds as being 'appropriate' as they meet the qualitative requirements of an 'appropriate' placement. Internal reporting reflects those currently identified as 'appropriate'. However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHSE currently does not recognise these bespoke SOP arrangements agreed via NHSE. NHSE and Commissioners are aware of these issues and acknowledge that until this issue is resolved, there will be differences between national reporting using MHSDS as the data source and local Trust reporting.
B: Why has it happened?	NHS Benchmarking data for 2023/24 confirms that BSMHFT has a low number of inpatient beds per 100,000 weighted population indicating the need for additional capacity to meet the needs of the BSOL population. The service continues to face pressure on its inpatient capacity, with bed occupancy levels consistently at 95%, the inpatient admission and discharge ratio largely on a 1:1 basis, lengths of stay are above the national average due to high levels of acuity requiring a higher number of observations. The number of patients clinically ready for discharge has been increasing over the 12 months with circa 86% delay reasons attributed to community which is not in the Trust's immediate control. CRFD at 1968 overall in February with adults at 1,111 lost bed days which equates to 18%. Adult bed occupancy has remained at 97% and length of stay has increased to an average of 105 days in february The bed waiting list for service users being managed by Home Treatment Teams in the community are a further added pressure to capacity requirements. The combination of these challenges and the inter dependencies continually impact on creating sufficient flow within the acute and urgent care pathway in particular to allow repatriation of out of area placements. Demand for PICU beds remains high resulting in patients being placed in units further away from Birmingham. Staffing has also remained a challenge in terms of sickness and vacancies levels.
C: What are the implications and consequences?	Without a system wide approach and a review of patient flow across MH pathways, demand will continue to exceed available Trust capacity and risks to patients and staff potentially increasing without the reconfiguration of services needed to manage demand and manage patients in community teams that also have the staffing and skill mix levels to support. The bed waiting list identifies patients who are waiting to be admitted and are being risk managed in the community. Action plans continue to receive national and commissioner scrutiny which remain at a high level due to performance being above trajectory.

D: What are we doing about it?	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 are : Demand Management/Gatekeeping • Managing demand, localities are now gatekeep all admissions and ensure that alternatives to hospital admission are offered. Further meetings arranged to review how gatekeeping can be more thoroughly implemented across all 'doors' to inpatients. SDF funding has been secured to fund pilots in CMHT/HTT and urgent care High volume users project to identify high volume users and employ management plan to prevent admission and support/enable these users to avoid inpatient bed referral • Clinical Oversight Team - senior medical cover to have oversight of patients on the bed list, meeting with Kings Norton medical team and Bed Management to discuss placement of patients in area. • QI project to shift gatekeeping metrics from conversations recorded to measurable admission avoidance outcomes • Progressing the procurement of a Crisis House Locality model development • The locality model is now in place across all acute areas and a new bed management function to support the locality model being developed. CRFD Workstream and length of stay • Renewed focus on Clinically Ready for Discharge. Action plan in place, and suggestions of how to improve internal management of CRFD being presented via OOA Steering Group. • weekly internal bed management, ICB deep dive weekly, Estimated Discharge Date confirm and challenge process (more proactive approach being taken for patients with longer Length of Stay. Reducing gaps in CRFD recording and plans to increase the usage of ICRT as an alternative to care packages • Social workers have been appointed who will work across adult acute/ older adults and with the homeless team. The first 2 will commence in January 2025 • Strategic level conversations are also being planned with the Local Authority Work has been undertaken to extend the current contracts for appropriate placements with the number of beds available increasing for 2024/45, this should help reduce the number our of area placements in the future A new trajectory has been agreed with commissioners for reductions in inappropriate out of area placements for 2024/25. This is based on the new national metric introduced in April which will look at the number of OOA placements at month end.
E: What do we expect to happen?	Monthly use of inappropriate out of area beds is expected to continue but reducing as the range of actions being taken forward get implemented and embedded and progress is made toward achieving the agreed trajectory of using only 10 or less PICU placements.
F: How will we know when we have addressed issues?	When the numbers of inappropriate OOA placements reduce in line with the trajectory submitted in the action plan. Actions being taken forward by the workstreams begin to impact on creating capacity and flow to support repatriation of out of area placements.

Clinically Ready for Discharge: Bed Days

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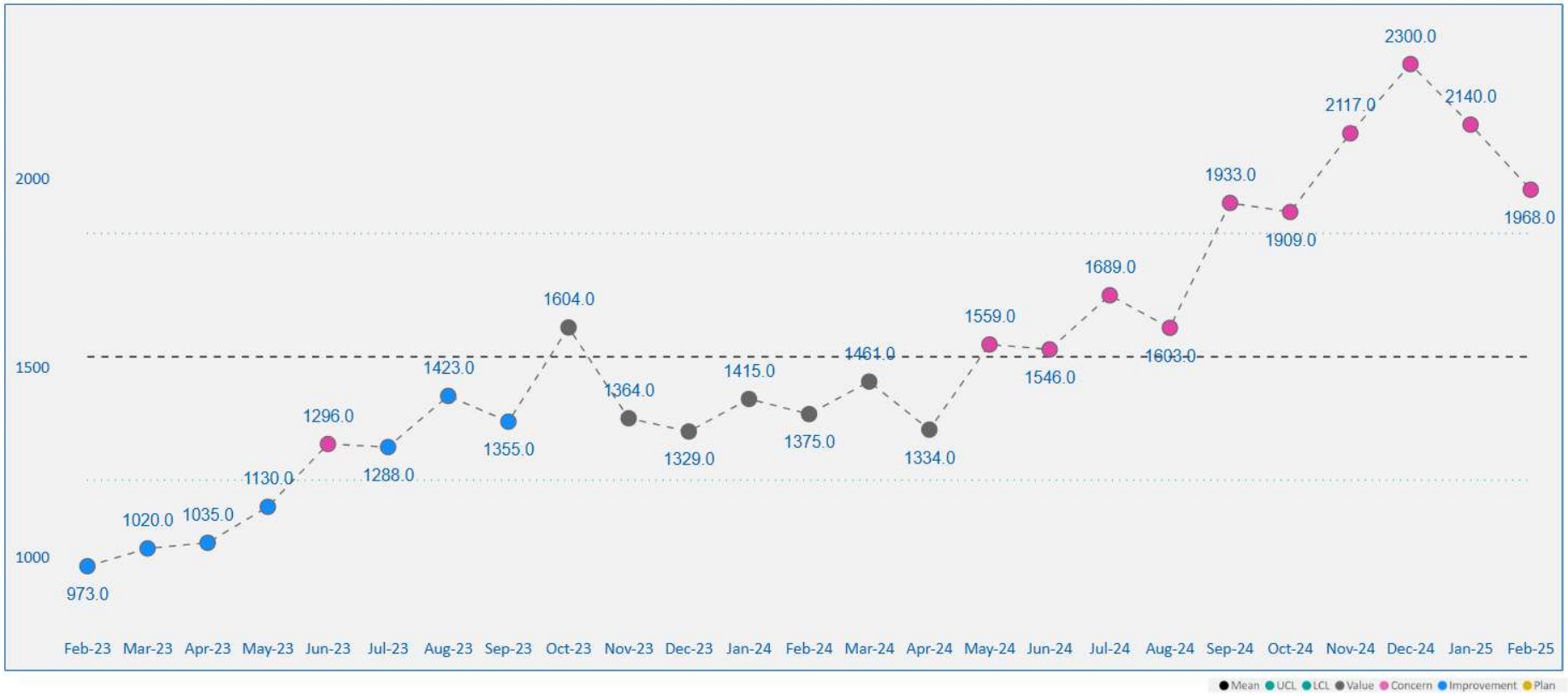

Question	Answers
A: What has happened?	The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. The number of CRFD bed days has been on an increasing trend since May 24 and reached a peak in December to 2236 bed days. This has fallen for the last 2 months with February at 1968. Adults moved from 1164 days in January to 1,111 days in February, which related to 53 patients, with a main delay reason of Social Worker allocation, suported accomodation and awaiting public funding and older adults moved from 697 days in January to 482 in February and related to 19 patients, who were waiting for care home placements and social worker allocation.
B: Why has it happened?	The main reasons for the delays across both services include awaiting of a social worker, funding 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?	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. Weekly meetings with ICS colleagues to review those CRFD. Discussions with the ICS and local authorities to assist in addressing the 'system' wide challenges and identifying alternatives to aid discharge for service users waiting for social care and nursing home placements. 8 Social workers have been appointed by the Local Authority and the first of these will commence in January 2025 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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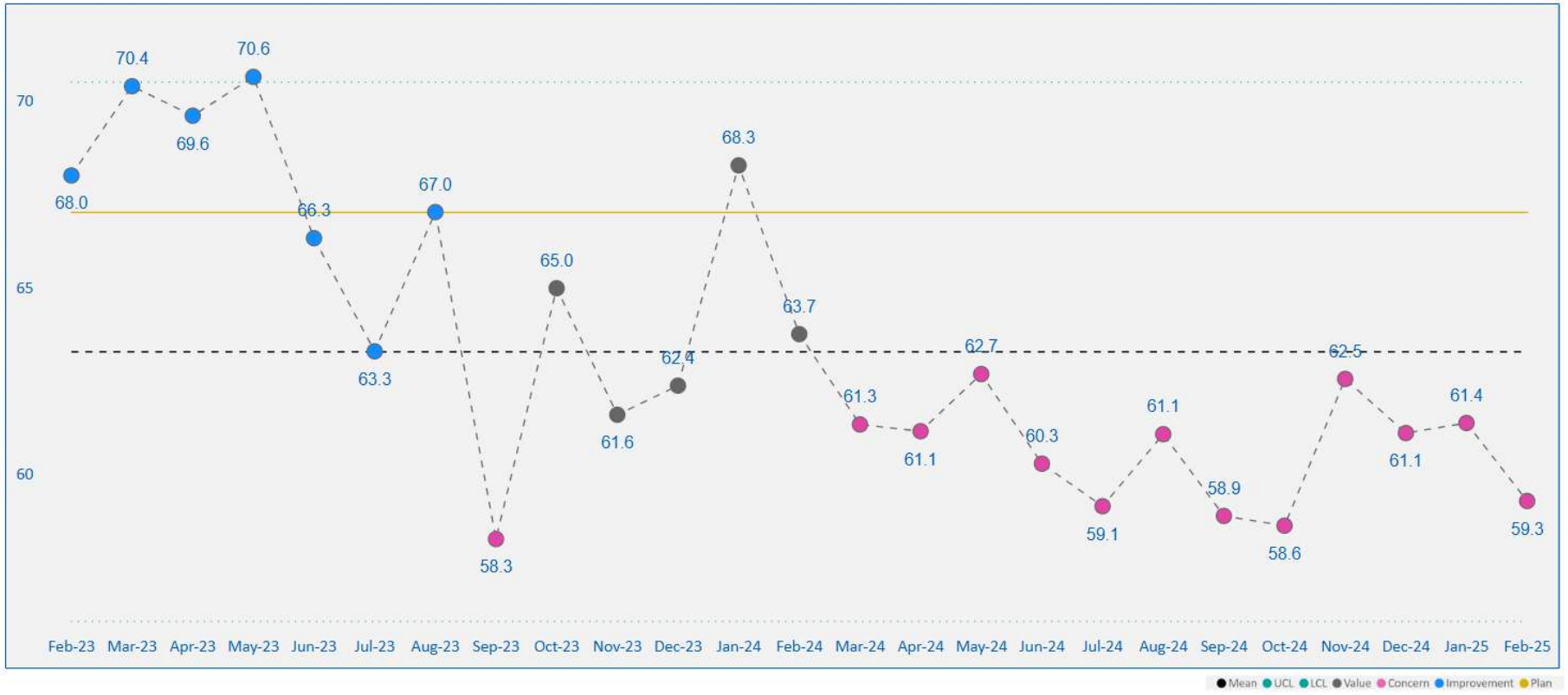

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. February 2025 has shown a reduction to 59.27% and remains below the 67% target and below the lower control limit. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression has reliably improved at the end of their treatment.
B: Why has it happened?	A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria. A person has shown reliable improvement if their scores on the depression and/ or the relevant anxiety/ medically unexplained symptoms measure have reduced by a reliable amount, whether or not they met caseness at the start of treatment. The service is providing sessions to new starters so understand the expectation and key milestones within the service and the business intelligence team has created a report which indicates the number of people contributing to recovery and which ones have not yet recovered so they know which people to offer further appointments to.
C: What are the implications and consequences?	Service users needs are not being met and the national 67% standard is not being met.
D: What are we doing about it?	The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable improvement rate.
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 67% Reliable Improvement rate.

Talking Therapies: Reliable Recovery Rate (%)

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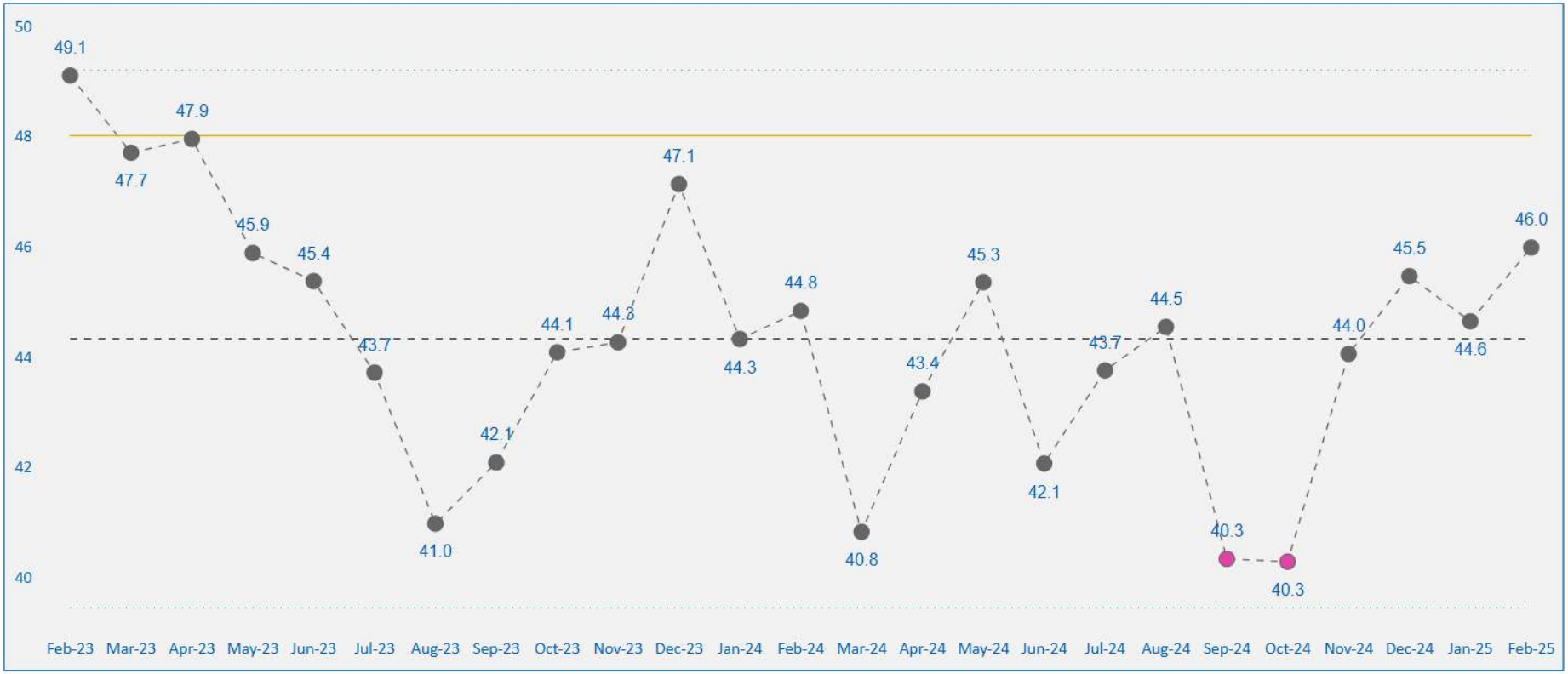

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. The Reliable Recovery rate has fluctuated and is not meeting the 48% target. February 2025 position has increased to 45.97% and remains below target. Reliable Recovery Rate is the outcome 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 48% of all patients who complete a course of therapy. A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria that met caseness at the start of treatment. Patients are considered reliably recovered if they meet both criteria for reliable improvement and for recovery. The service is providing sessions to new starters so understand the expectation and key milestones within the service and the business intelligence team has created a report which indicates the number of people contributing to recovery and which ones have not yet recovered so they know which people to offer further appointments to. These actions have contributed to an increase in the reliable recovery rate this month.
C: What are the implications and consequences?	Service users needs are not being met and the national 48% standard is not being met.
D: What are we doing about it?	The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable recovery rate.
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 48% Reliable Recovery rate.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness (%)

February 2025

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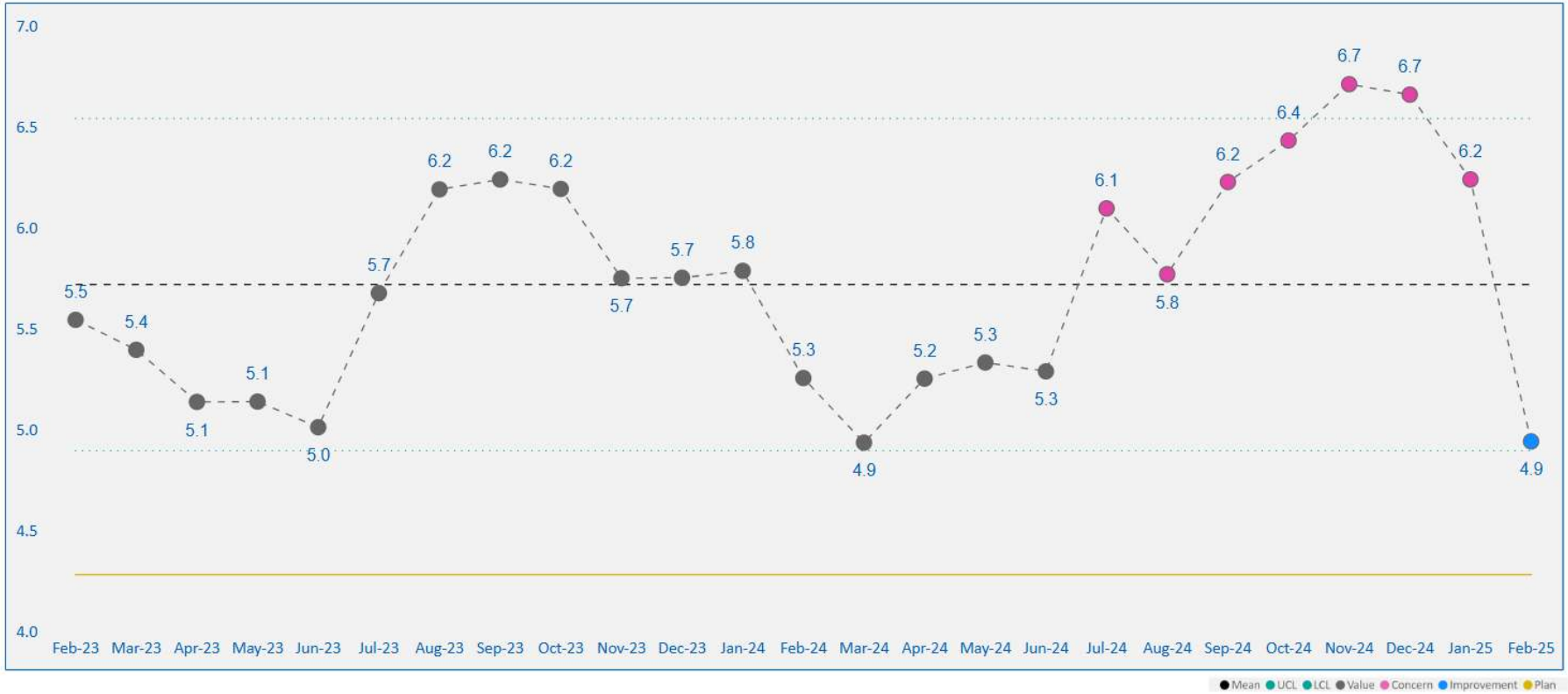
Commentary

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



Question	Answers
A: What has happened?	Trust wide sickness absence rate for January 2025 was 6% against 6.6% in December 2024 and 6.5 % in November 2024 . Of all absences across the Trust, 2.56% were Short Term and 3.4% were long-term. Across the divisions, the following services had the highest absence rates: - Secure Services and Offender Health 7.3% (3.1% Short Term and 4.2% Long Term) - Acute and Urgent Care 6.1% (1.7% Short-Term and 4.5% Long-Term) - PCDS 5.2% (1.9% Short Term and 3.3% Long Term) All divisions were showing as having a below target rate of Return to Work Interview completion, standing at 69% across the Trust.
B: Why has it happened?	Chronic Long-Term Sickness in some areas with high sickness absence rates are accoutable for these hot spots. Persistent long-term sickness in high-stress teams, are be due to underlying health conditions and job-specific pressures. Limited RTW contact completion may indicate resource limitations Long term sickness in some teams are due to a number of reasons such as pregnancy related and related to employee relations case management. Stress, anxiety and depression continue to be the top reasons for sickness absence.
C: What are the implications and consequences?	1. Operational Inefficiencies: • High sickness rates in teams could lead to delays and added workload for remaining staff, potentially impacting service quality and efficiency. 2. Increased Risk of Burnout: • Ongoing vacancies and low RTW contact rates mean that some employees may experience greater strain, increasing burnout risk and potentially leading to a cycle of recurring sickness.
D: What are we doing about it?	Continued Development of HR Clinics and Insight Action is ongoing to refine the structure and underlying data discussed in HR Clinics, so that these insight and action driven conversations can support confident and early manager intervention and support in the event of staff absence. Sucessful HR Clinics will both support manager confidence, enhance people management practices and ensure compassionate, timely support for colleagues (both unwell and their teams). HR Case Management Developments Action is ongoing to refine the management of People Relations cases, supporting prompt action and wellbeing intervention should a colleague become unwell during a formal process. Proposed developments include case operational risk ratings - identifying where discussion and support planning may be needed with critical cases. Renewed People Management Masterclasses A range of new Masterclasses have been introduced for managers and aspiring managers, to support people management competency development and confidence across the Trust. These include Health and Wellbeing Masterclasses, which focus on practical employee support and processes. Delivery routes for these courses are being reviewed to identify whether localised delivery would reach a wider audience and how eLearning tools may provide further reach.
E: What do we expect to happen?	The areas with high levels of sickness absence cases have an impact on service provision as fewer staff are available to provide service and it also ultimately impacts on the health of the 'remaining staff who are well and who continue to provide service. This can result to fatigue for the remaining staff. The sickness absence cycle continue, if we do not deal with the root causes of sickness absence.
F: How will we know when we have addressed issues?	Sickness absence levels will improve; outcomes will be achieved within parameters set by Trust Policies, reduction of high levels of stress and anxiety across the Trust.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Appraisals (%)

February 2025

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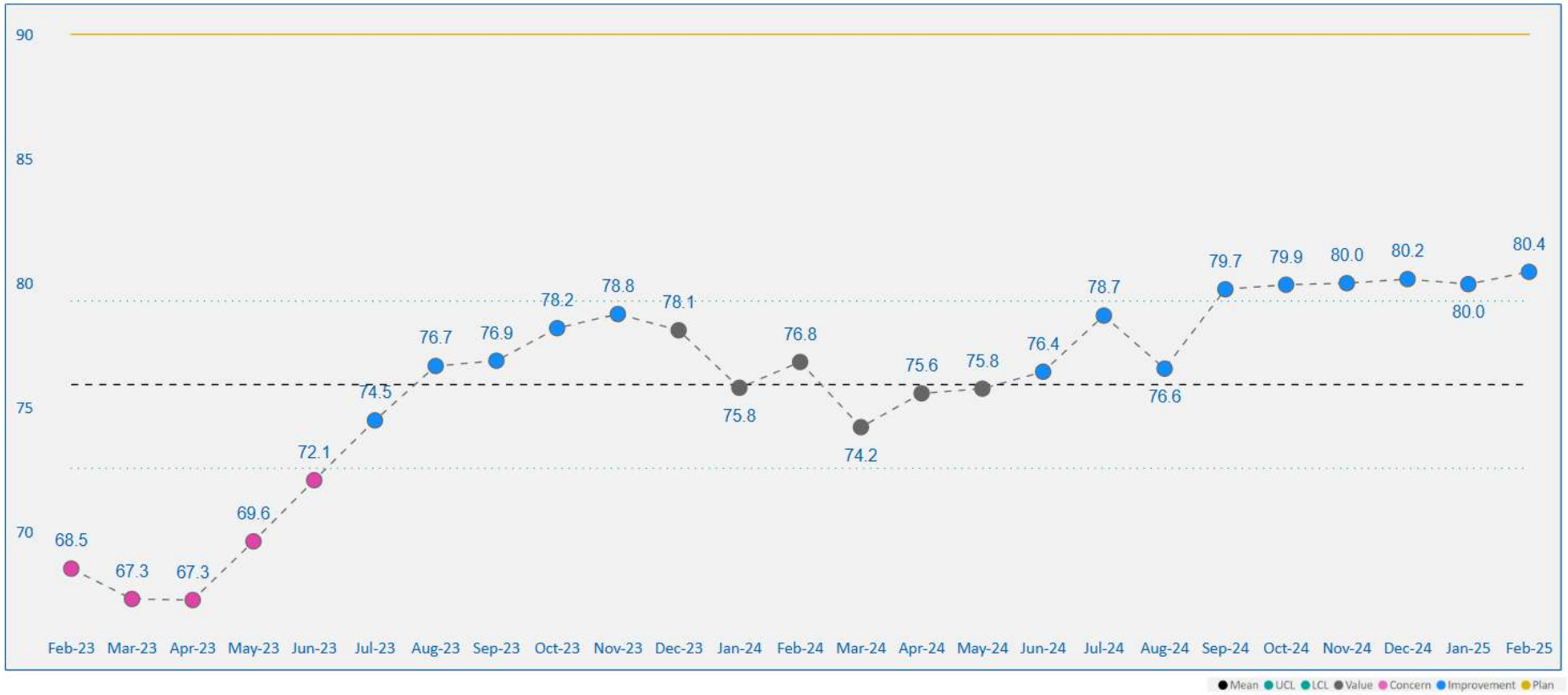

Question	Answers
A: What has happened?	The trust's Appraisal compliance is 79.9% which is a small decrease from December which was 80.3%. The trust remains below the Trust target of 90% and commissioner's target of 85%.
B: Why has it happened?	The teams within the Trust are below 75% compliance are: Acute and Urgent Care 70.8%, Exec- Medical 46.6% Exec-Nursing 61.7%, Exec - Resources - 57.4% and New Care Models 38%. Please note we have understood that there are staff identified (trainee clinical psychologists) that are negatively impacting our compliance figures and will need to be excluded.
C: What are the implications and consequences?	We are not meeting our commissioner target of 85%
D: What are we doing about it?	Quality- The QI project has increased it's frequency to weekly meetings to support timely actions discussed with the working group, e.g. Induction change ideas, VBA sessions etc. Compliance- In addition to BAU activities, VBA sessions are being planned/scheduled with services. As discussed above we have identfied that trainee clinical psychologists will need to be excluded from VBA compliance as this is negatively impacting compliance. A meeting has been arranged to support this work.
E: What do we expect to happen?	The QI appraisal project and 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?	The review of appraisal compliance data (Insights reports), Ms forms survey data and staff survey data. The appraisal QI project also provides staff feedback from a qualitative perspective from the working group. Our aim is to ensure all staff will receive a values based appraisal, empowering staff to take ownership for their personal development and the trust will be able to demonstrate a holistic approach to staff members personal development.

Fundamental Training (%)

February 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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Commentary

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

Question	Answers
A: What has happened?	The overall Fundamental Training compliance increased from 94.3% in December to 94.9% in January. Overall, the trust has surpassed the Commissioners' target; nevertheless, we remain slightly below of the 95% Trust target for substantive staff. Every area is still below the 95% Trust target except for Exec Director - Medical, Nursing and Resources - Chief Exec - 83%, - Exec Ops - 94.9% (Only Acute and Urgent Care is below 95%), - New Care Models - 89.1%, - Strategy, People and Partnerships - 93.9% Temporary Staffing Compliance has increased from 88.9% in December to 90.3% in January, it remains above the Trust Target of 75%
B: Why has it happened?	The grace periods for SRS's Fundamental Training and Oliver McGowan's e-learning have ended. Since SRS compliance is classroom-based, it is not possible to achieve 95% compliance in a short period of time given the availability of trainers, in addition to this the DNA rate remains higher than average due to the course being required but only a few select wards. We expect overall compliance to stay above 90% however because of the addition of new training to the traffic lights in August, including Mask-Fit-Testing, Oliver-McGowan Tier1 webinar, and Tier2 face-to-face, we are taking steps to approach 95%. On the 1st of December Dual Diagnosis will only be completed once every year instead of once only (grace period in place until the 3rd of June 2025), and Patient Safety Level 1 and Level 2 have also been added to the traffic lights(they have a grace period until the end of May 2025)
C: What are the implications and consequences?	• Low FT compliance is a risk to patient safety and the safety of our staff. There is a risk staff will not have the competence required to practice safely in clinical areas. • Breach of commissioners' compliance contracts which can result in financial penalties that can cost in excess of £210,000 per subject for every month that BSMHFT remains non-compliant. • The Trust is adding more FT training on traffic light, and the majority of these trainings are face-to-face, which depends on the trainer's availability. Additionally, DNA rate is an issue for face-to-face training, as we have experienced so the L&D team won't be able to increase the Trust's overall compliance to 95% at the end of this year. • TSS are not included in overall Trust compliance however are required to undertake training. The required training needs to provide TSS staff on time to be practice safely. If TSS staff cannot undertake the necessary training they will be unable to book to work on inpatient wards.
D: What are we doing about it?	• For Fundamental Subjects with less than 95% compliance, a recovery plan with monthly trajectories is in place. • ILS spaces have been purchased for April - June 2025 • Regular business operations, with L&D persistently chasing staff to fill spaces in order to maintain compliance at the necessary percentages. • Extra notifications about upcoming training are being sent out by the Fundamental Training staff. • Each staff member assigned to complete the new training receives an email from the FT team at least one month before it goes live on the traffic light. Staff will have more time to complete the training because new courses added to traffic light will have a six-month grace period as well. • ILS courses have been organised out in the hot spot areas to target compliance
E: What do we expect to happen?	Based on the recovery plans and trajectories we expect compliance to reach 95% overall compliance by February 2025. The expectation is that the DNA emails, reminder emails to staff and reports for AD and CDs will decrease DNA rates. Increasing the grace period for the new Fundamental Training subjects will not affect the overall Trust compliance in that give period as it will enable staff to become compliant before the grace period expires.

Incidents of Self Harm

February 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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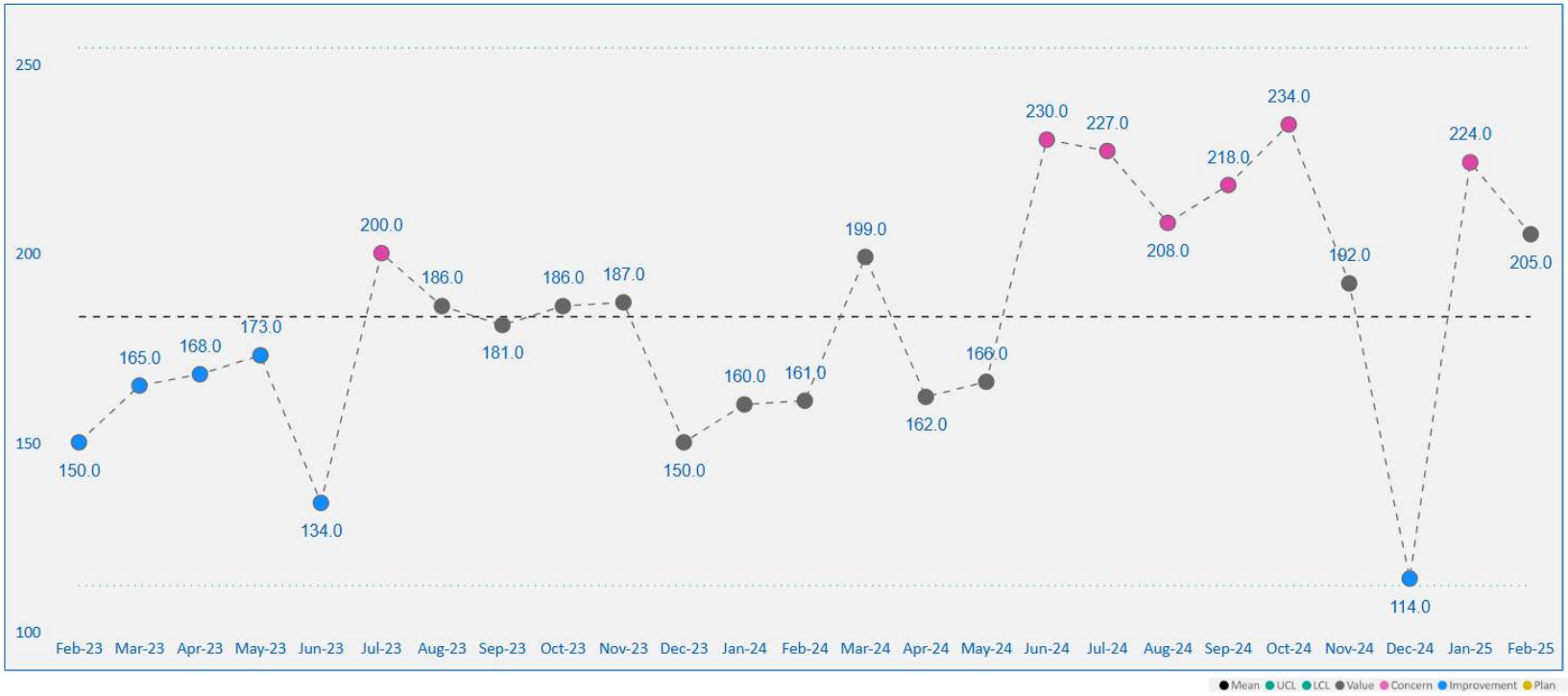

Harm (physical) – patients

February 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

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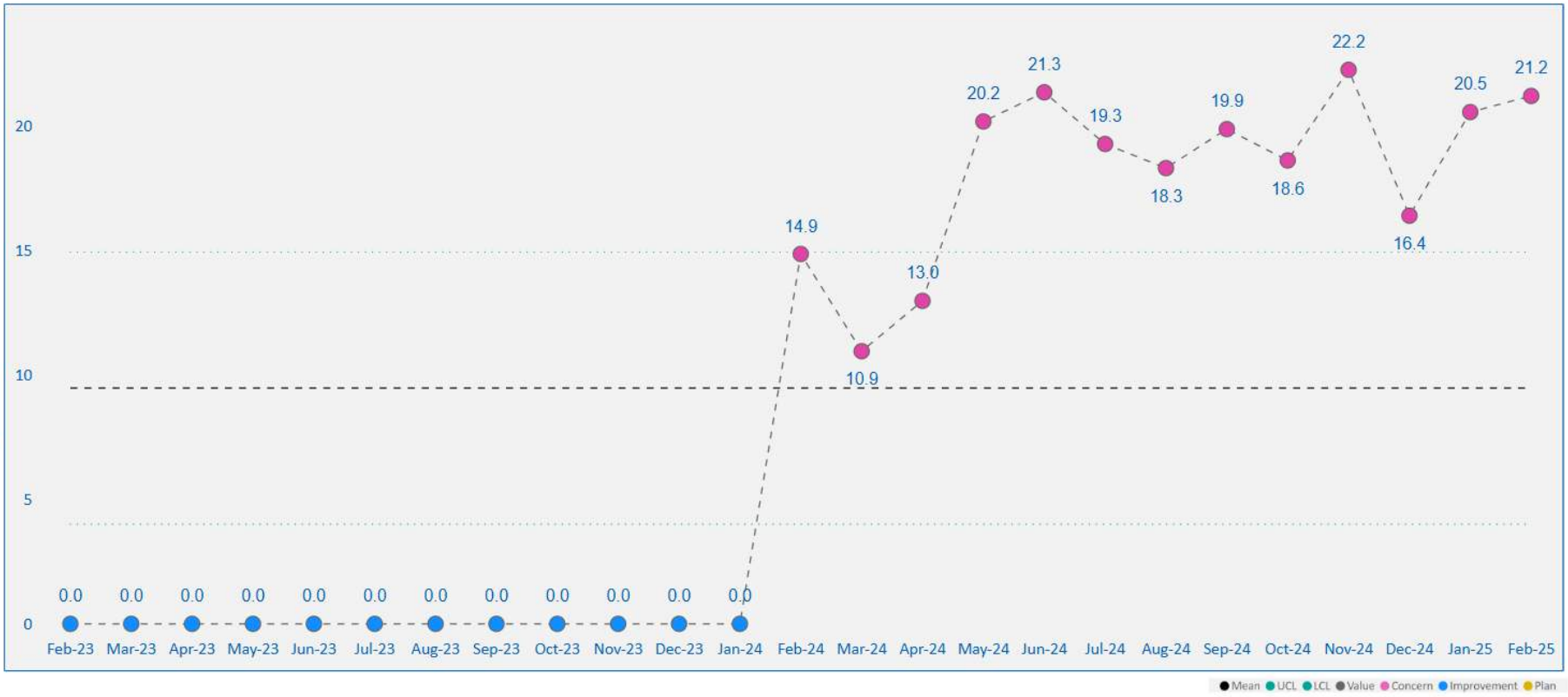

Psychological Patient Harm Incidents

January 2025

Birmingham and Solihu
Mental Healt
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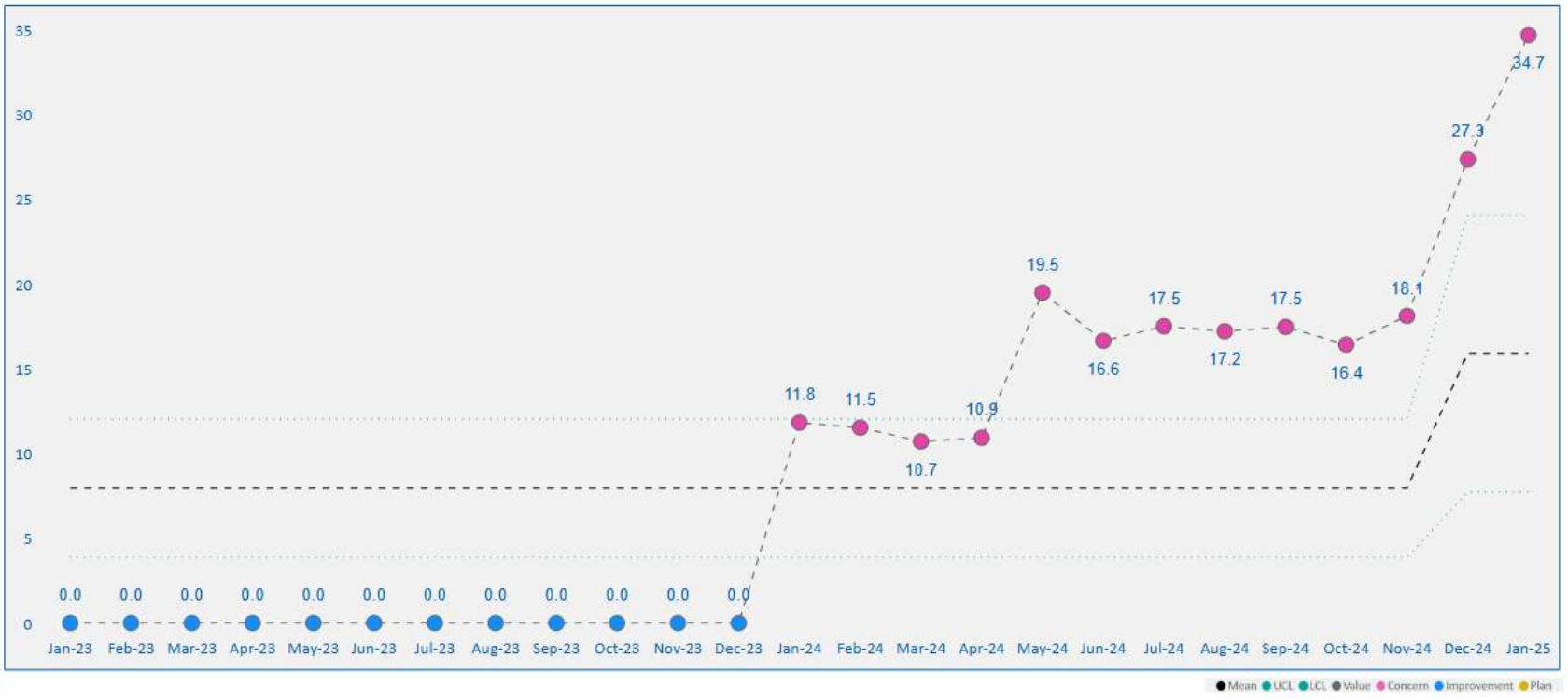

Birmingham and Solihu
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Harm (psychological) – patients

February 2025

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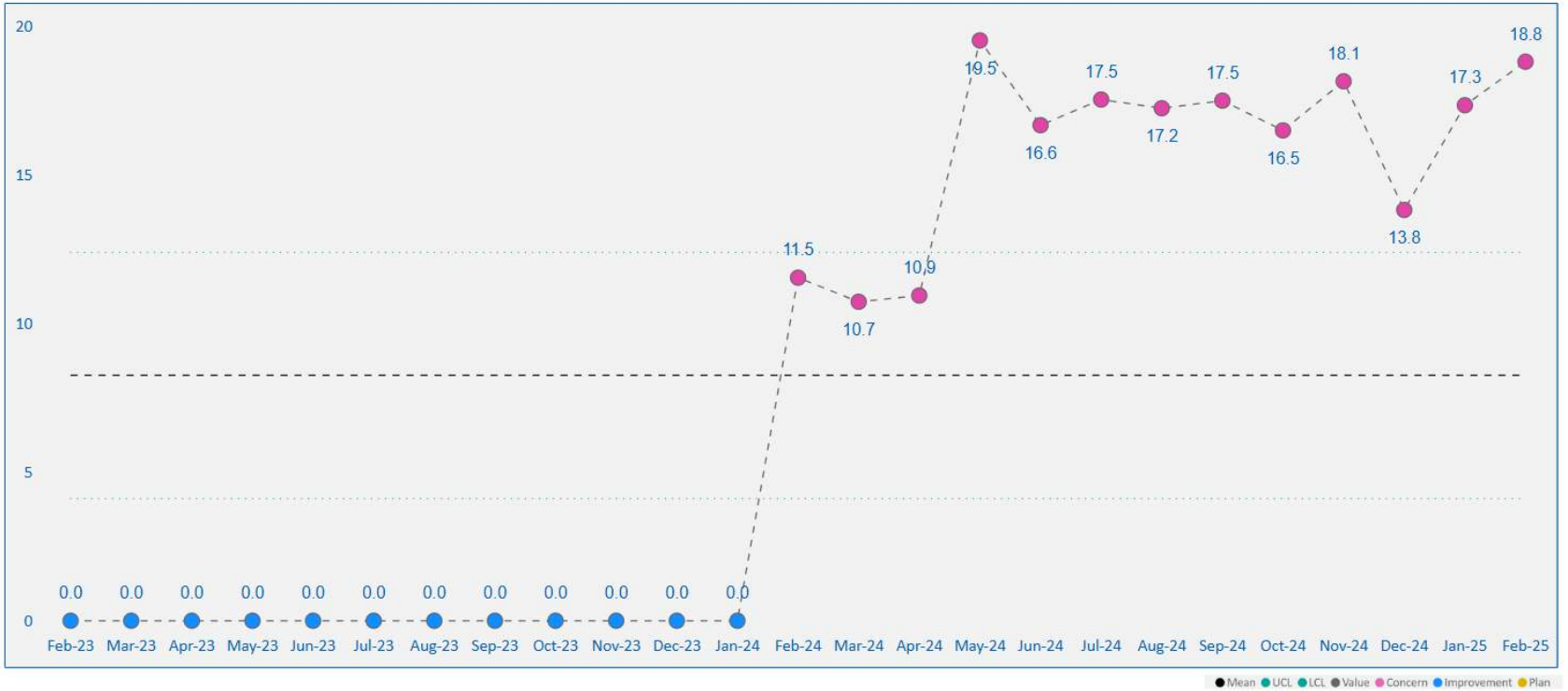
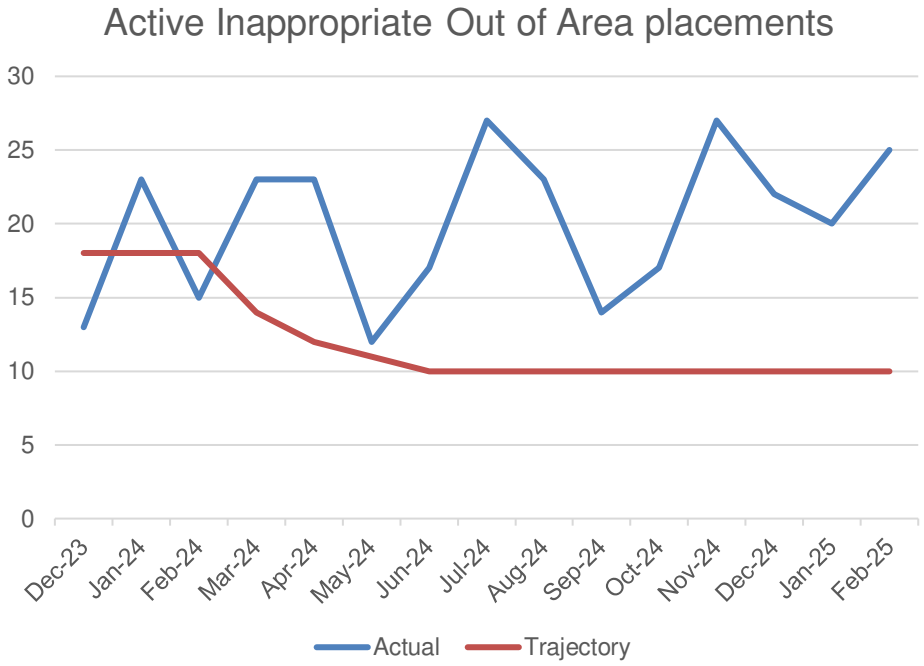


Appendix I - FPPC 19th March 2025

2024/25 Performance metric Improvement Trajectory update

During 2023/24 the following metrics were identified by FPPC for improvement. Action plans and trajectory updates have been provided.

Active Inappropriate Out of Area Placements

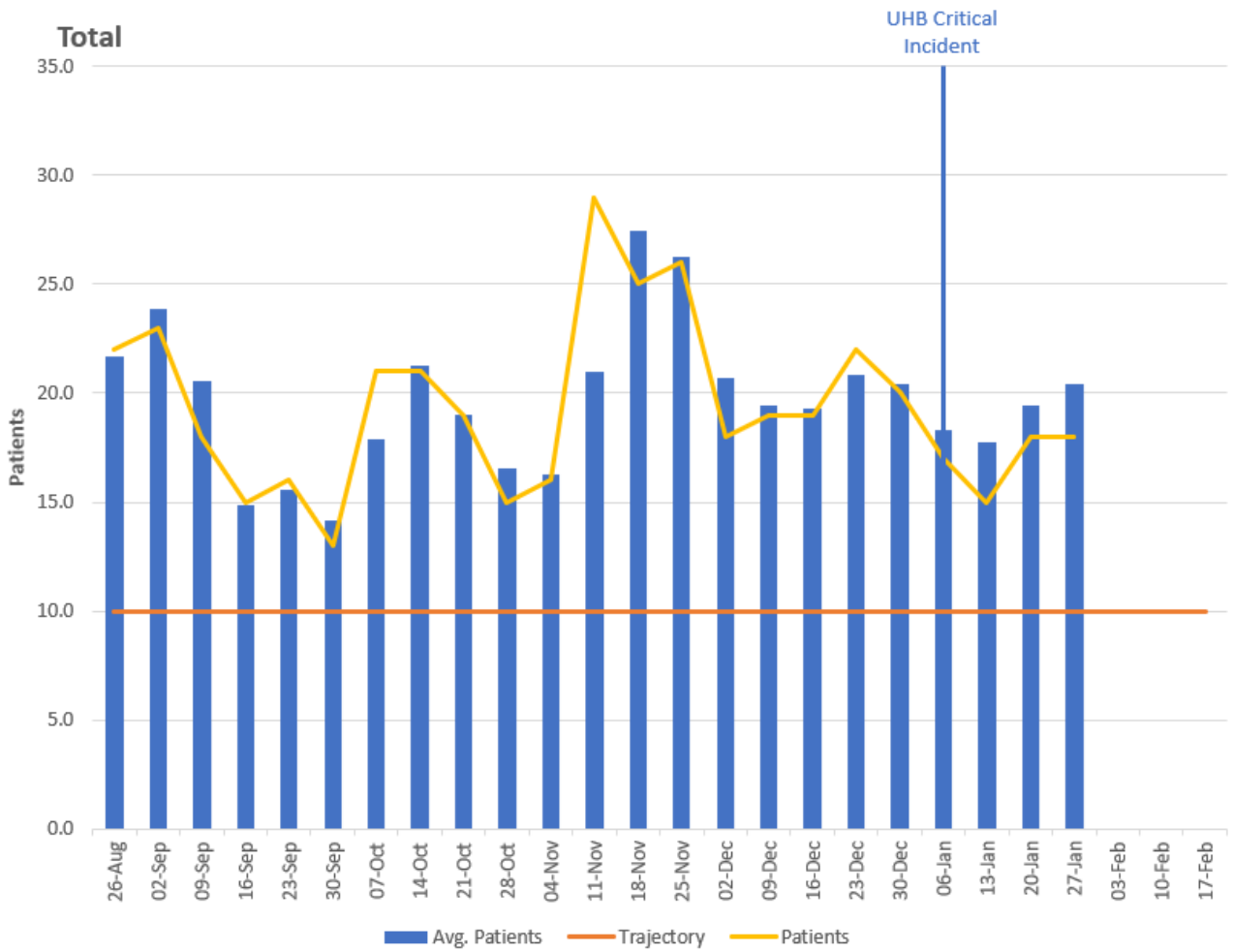


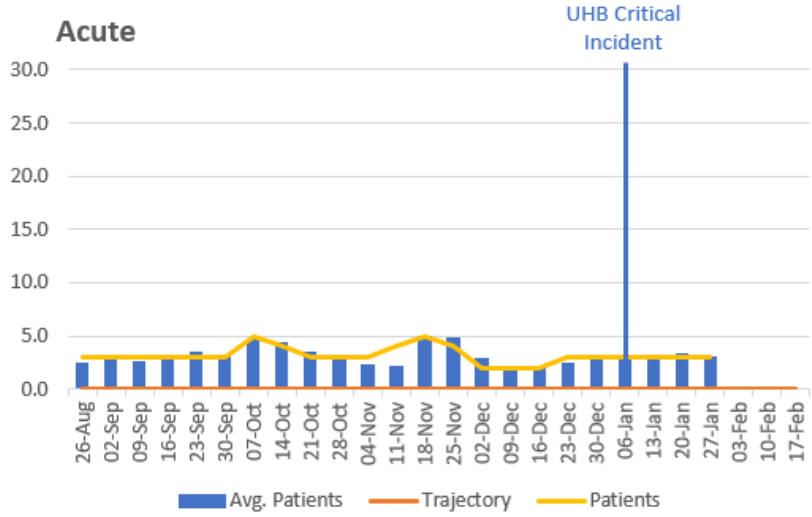
A Trust trajectory has been agreed with the ICS and NHSE as part of the 2024/25 national planning requirements to reduce and not exceed 10 PICU placements from June 2024 onwards. The target for inappropriate acute placements is zero from April 2024.
February 2025 shows a deteriorating performance – Total inappropriate number of placements at 25 (target 10), 4 acute (target 0) and 21 PICU (target 10).

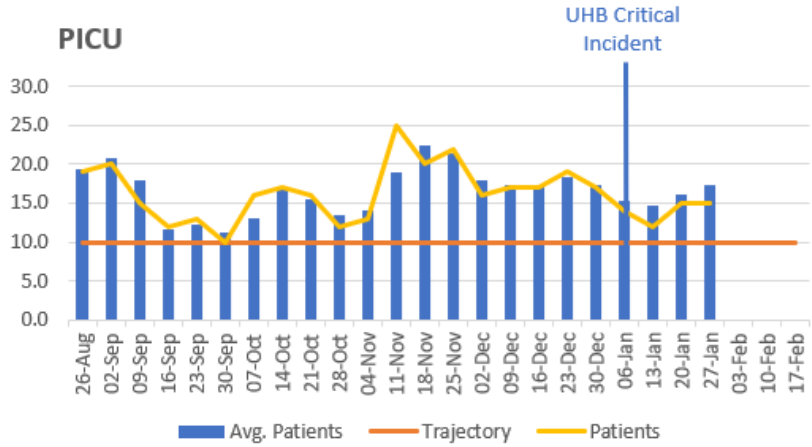
The Trust's productivity action plan continues to focus on workstreams to better manage demand, focus on reducing CRFD patients, reduce all OOA placements and related costs, improve patient experience and optimise services within the resources available.

Slide 4 below highlights the weekly progress being achieved, monitored via the Patient Flow Steering Group.
A key pressure point remains the impact of Clinically Ready for Discharge (CRFD) patients that are not within Trust control, particularly social care and housing impacting on reducing the available Trust capacity to support repatriation and reduce the number of all out of area placements.

2. Inappropriate Out of Area Placements - BSMHFT







Slides 4 outlines next steps for the productivity plan.

Productivity Plan – update

FPPC is asked to note that a detailed update on the Productivity Plan was been provided by the AD for Acute & Urgent Care at January 2025 FPPC.

Next Steps:

Clinical Oversight

- Establishing a Clinical Oversight Group to lead assertive case management, improve flow for high volume users, and create diversion pathways for CMHT patients.
- Focused actions to reduce bed usage from 160+ to 110 beds.
- Embed Quality Improvement into the Clinical Oversight Group to support tracking of performance at locality level and reporting into the Patient Flow Improvement Programme governance structure.

Gatekeeping

- QI project to shift gatekeeping metrics from conversations recorded to measurable admission avoidance outcomes.

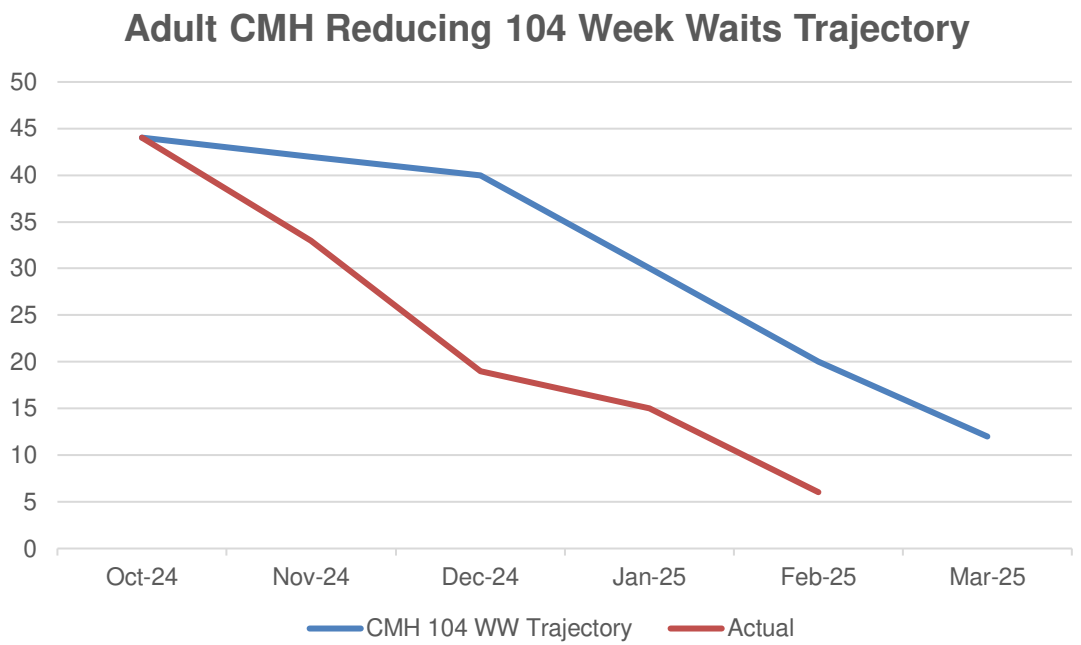
Pathway improvements

- Develop and enhance pathways for earlier intervention within urgent care. Service Development funding has been secured which will support admission avoidance, ensure purposeful admission and that the discharge is effective. Pilots include:
    - CMHT pilot- responsive support for known patients attending ED.
    - Urgent Care pilot - Dedicated medical support in Bed Management and PDU.
    - Psychological support in HTT for patients on the bed waiting list.

System Collaboration

Address external challenges by engaging with local authorities and progressing the procurement of a Crisis House (recovery house) to reduce socially driven crisis overwhelming ED.

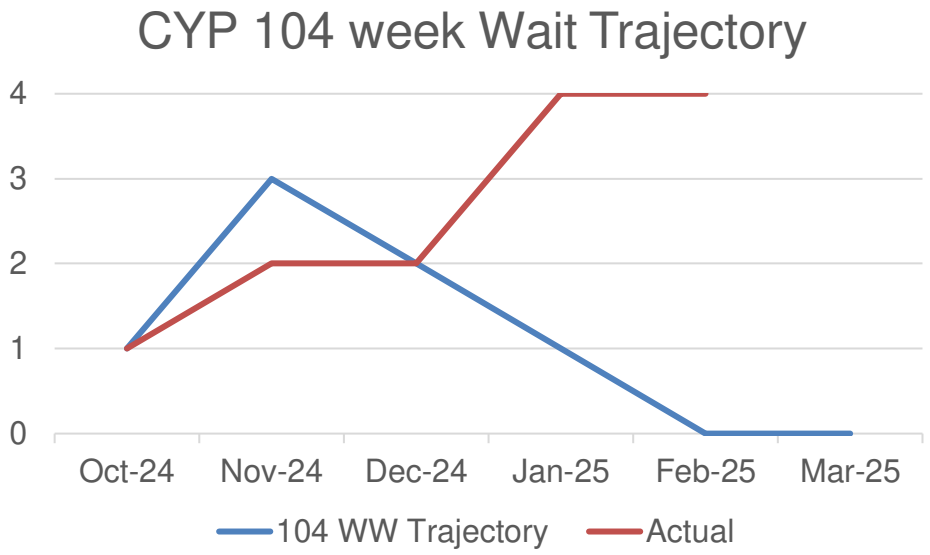
Adult CMHTs - Reducing Long Waits
Progress against national reduction trajectories

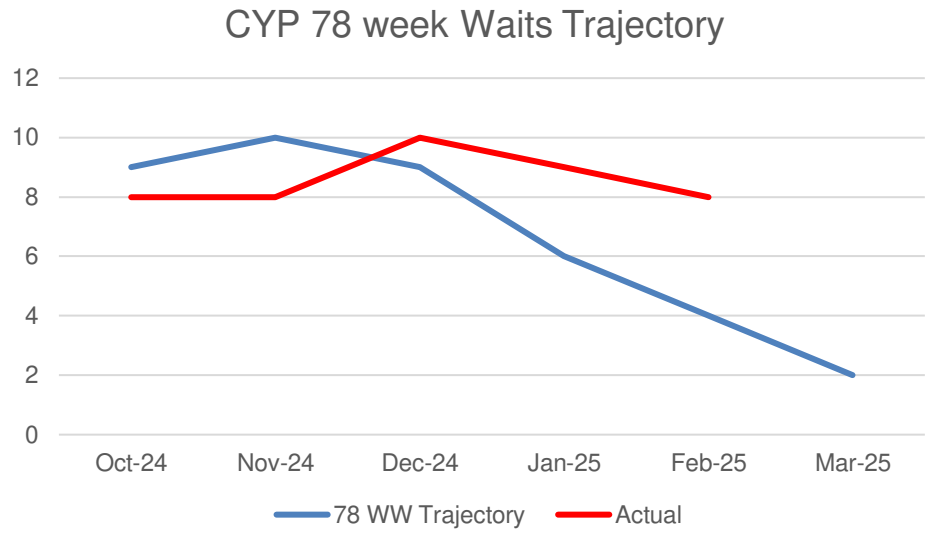


- Following the national planning guidance for 2024/25, a trajectory was agreed with service leads and submitted to NHSE to reduce long waits in community mental health services for adults and CYP by March 2025.
- For Adult services, the Trust's focus is on reducing long waits over 104 weeks by March 2025 moving from 45 service users to 12 by end March 2025.
- February 2025 position is ahead of trajectory with a continuing reducing trend observed, and 6 service users now waiting more than 104 weeks.

Birmingham and Solihull Mental Health NHS Foundation Trust

CYP - Reducing Long Waits
Progress against national reduction trajectories





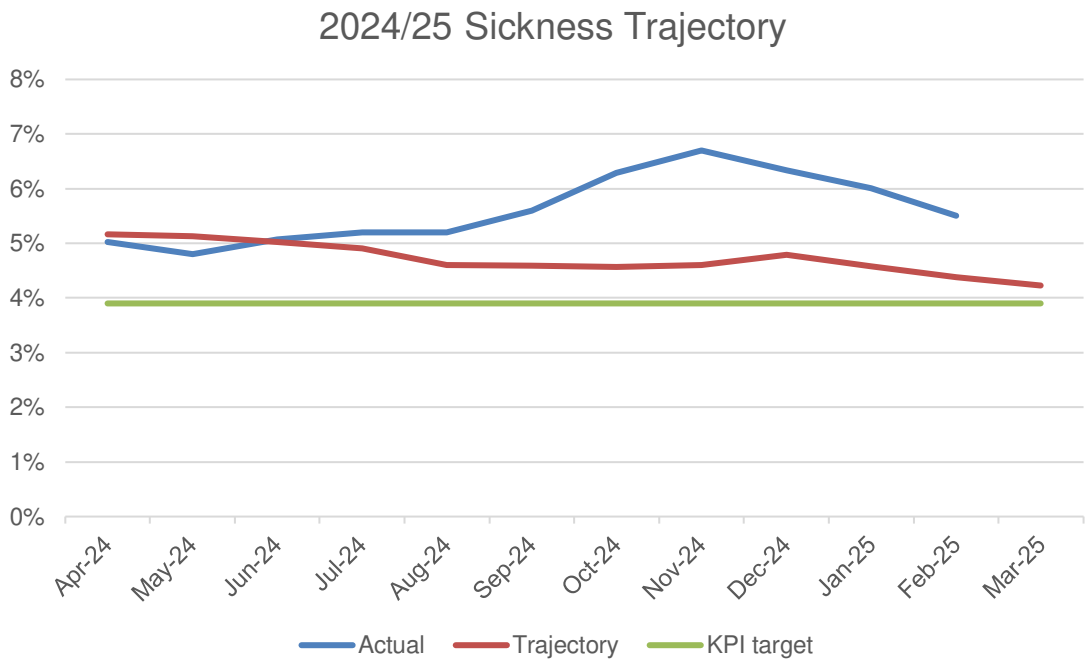
- For CYP services (Solar and ADHD), as the number of service users waiting for first contact over 104 weeks is small in volume, further improvement is required to reduce long waits over 78 weeks in line with national guidance. As a result, improvement trajectories have been agreed for both areas.
- For CYP the Trusts focus is to reduce long waits over 104 weeks to 0 and to reduce waits over 78 weeks from 10 to 2 service users by end March 2025. As at February 2024 – 104 week waits has remained at 4 and 78 week waits have reduced to 8 still over trajectory. Service leads are continuing to review patient needs and planning for the appointments required.

Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce trajectories – 2024/25 update

Sickness Absence

Updated 2024/25 Sickness trajectory in line with the workforce plan



Sickness levels decreased to 4.9% in February 2025 but remains above the improvement trajectory of 4.58%. Long-term sickness has increased to 3.5% and short-term sickness decreased to 2.0%.

Action Plan:

Focus Reporting: A focus report has been prepared, exploring the overall and localised trends of sickness across the Trust to support targeted and intervention.

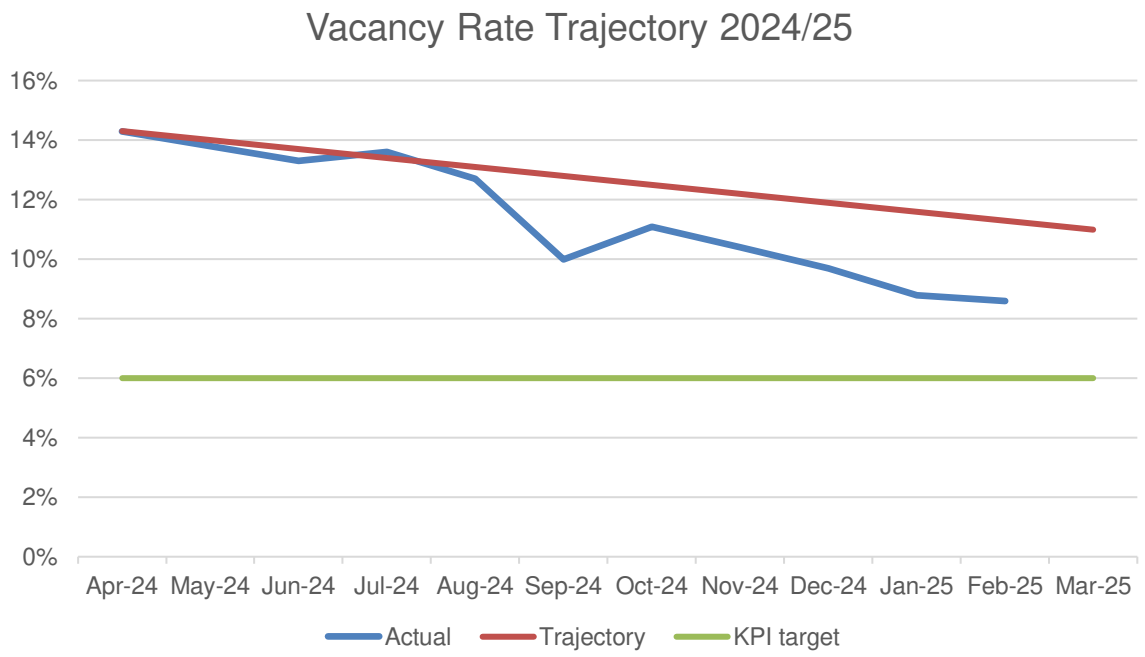
Return to Work Compliance: Exploration led by the People Partners is ongoing with areas with lower than 50% RTW compliance to understand barriers and identify interventions to support data management and colleague support.

Occupational Health: A new occupational health provision is due to launch in April 2025 and implementation activity is ongoing, with a renewed focus on management referral processing and access to the range of support services on offer.

Note - Trajectory and commentary provided by People team

Vacancies

Updated 2024/25 vacancy trajectory in line with the workforce plan



The target to reduce the vacancy rate for 2024/25 is based on a reduction of 3.3% to reach 11% by March 2025. The KPI target is 6%. Improving trend observed. February at 8.6%

Following on from presenting to Nursing Students at the University of Birmingham and hosting stands over the last year at the Birmingham City University Nursing Careers event, University of Wolverhampton Nursing Careers Recruitment Event, and the RCNI Birmingham Recruitment event, the students in their final year who had offers made to them pending completion of their studies and them acquiring of their PIN's, are being slotted into our vacancies successfully. Furthermore, following a considerable centralised recruitment event for band 5 nurses across the year and international recruitment, multiple offers have been made, again with them being manoeuvred into our vacancies successfully.

Note - Trajectory and commentary provided by People team

Vacancies

Action Plan update:

The trust, in conjunction with universities, education facilities, and with the assistance of ICB members, is currently rolling out actions from its eighth working group meeting for the Careers Event Process for the Psychological Professions.

The ICB and NHSE have introduced instruction on vacancy levels and agency reduction - A by-product of the weekly vacancy control panel is the highlighting of if the correct processes and procedures are being used to ensure like for like permanent / fixed term vacancies are being requested and put in place.

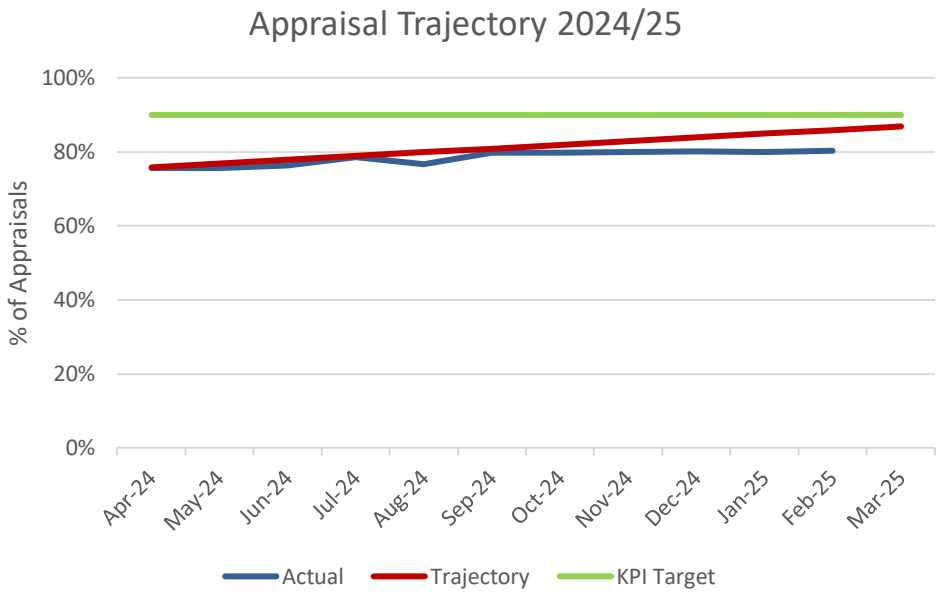
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- Ensure flexibility is promoted in internal advertisements and vacancy information.
- Enhance training for hiring managers to equip them to discuss flexible working at interview.
- Update recruitment processes and training to ensure that the drop down menu for different types of flexible arrangement are used on NHS Jobs / TRAC when vacancies are created.
- Upskill hiring managers / resourcing teams to be able to identify which forms of flexibility are appropriate for roles.
- Draft and get sign off on an organisational statement about openness to flexible working arrangements, to be included in all vacancy packs.
- Start monitoring number of new joiners who are recruited flexibly and collate this centrally.

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

Appraisals

Updated 2024/25 Appraisal trajectory



A revised trajectory has been agreed for 2024/25 to increase appraisal performance by 1% each month moving from 75.9% to achieving the Trust 90% standard in March 2025.

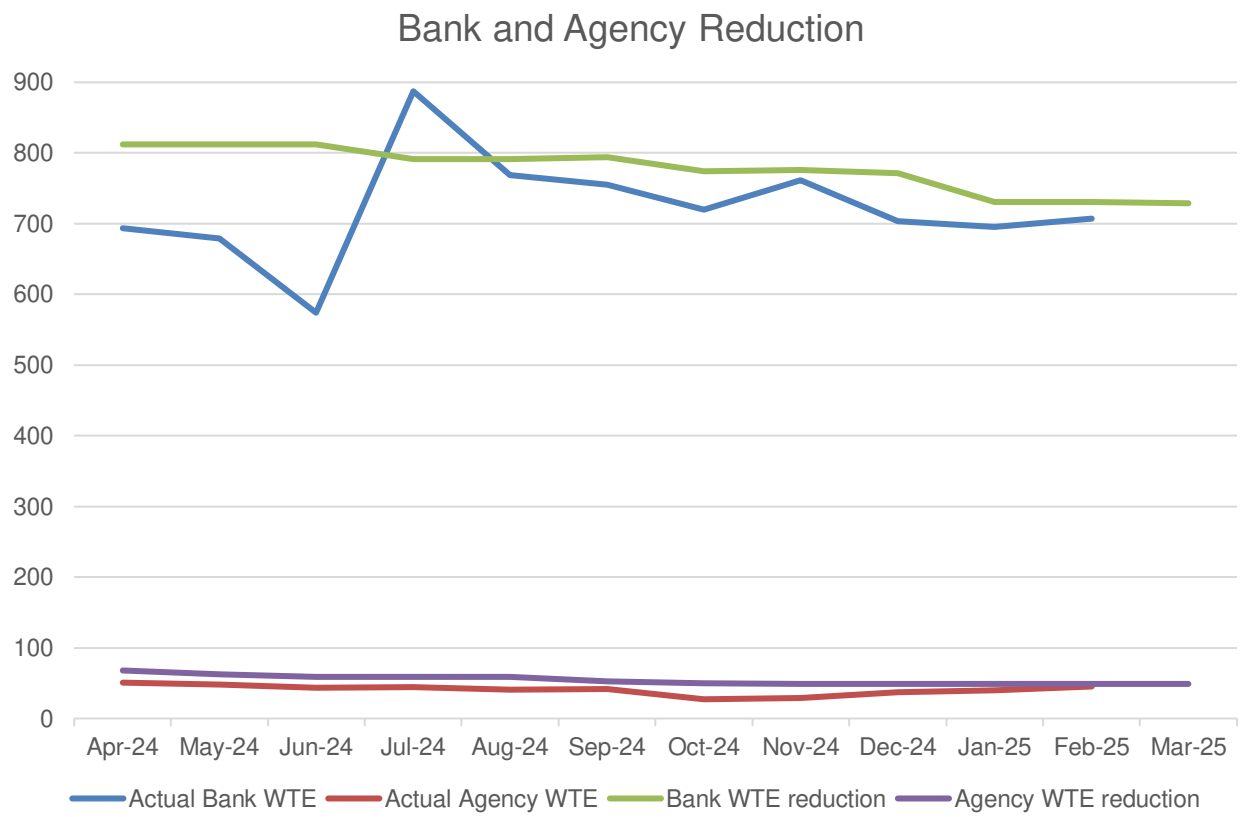
February 2025 appraisal performance has increased to 80.4% just below trajectory.

Actions:

- QI appraisal project - Working group meeting held alongside regular project group to discuss and support the implementation of change ideas.
- In addition to the BAU activities, L&D are continuing to provide VBA support interventions to staff/hot spot areas.
- VBA sessions are being planned with services.
- Noted that the appraisal rate is being affected by a group of trainees who require to be excluded and this is being followed up.

Note - Trajectory and commentary provided by People team

Bank and Agency Reduction



The focus for 2024/25 has moved from monitoring the bank and agency fill rate to reducing the numbers of Bank and agency used within the Trust. The target is to reduce the use of bank workers by 85 WTE and 20 WTE in agency workers by March 2025.

February 2025 data showed an increase of 9 for bank users and an increase of 5 WTE for agency staff. Both figures remain below the trajectories.

Note - Trajectory and commentary provided by People team

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability

Monthly Agency costs

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

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

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

- In February 24 bank workers started with the trust, helping to alleviate the need for agency.

FPPC is asked to note that from March 2024, a revised framework is being implemented with a monthly Performance Delivery Group meeting and granular level service area deep dive meetings. The process remains developmental and learning from the meetings is utilized to shape future meetings. As part of this framework, a service line RAG rating assessment covering each of the four domains of Quality and Safety, Workforce and Culture, Operational Performance and Finance is agreed with the service area senior leadership team.

FPPC members are asked to note that since the last FPPC meeting in February 2025, a Performance Delivery Group meeting has not been held and therefore no update has been provided this month. and the following service area deep dive has taken place:

- Specialties – 6th March focusing on Care Home Liaison and Community Enablement and Recovery Team (CERTS)

Service Area Deep Dive Meetings – Update

1. Specialties – 6th March 2025

The service focused their deep dive on the Care Home Liaison and CERTS services. The related service area presentation is included as Appendix IIa. A summary of the agreed service line RAG rating is outlined in the table below:

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
Care Home Liaison	Green	Green	Green	Green	Green	Green
CERTS	Green	Green	Green	Green	Green	Green

i) Overview

Care Home Liaison team - work with care homes to enable staff to develop strategies to support service users in the community with their mental health needs, the majority of whom have dementia.

CERTS team – work to enable service users to remain in the community where possible and also work with the inpatient services from admission to begin process of the discharge options that may be required working to a ‘home first principle’ and providing support to carers as part of the transition.

It was noted that both services provide effective care, treatment and support to service users and carers demonstrated by the work and good practise shared covering all the domain areas of Quality & Safety, People, Finance and Performance. Examples include:

- Good service user and carer feedback for both services.
- Staff survey has one of the strongest positive results in the Trust.
- High levels of RMS and clinical supervision rates.
- Staff retention is excellent with minimal to no turnover experienced which has contributed to effective team working and provision of consistent practises. Small number of psychology posts are currently being advertised.

- CERTS team also promote joint working with CMHTs to offer continuity of care for service users who have been inpatients and also attend bed management meetings to have early sight on pending referrals.
- CHL are part of a national pilot to use DIADEM, an assessment tool for dementia within care homes which supports the Memory Assessment Service who have long waiting times and helps with advanced care planning to make placements more sustainable.

ii) Clinically Ready for Discharge and creating patient flow

It was noted that 38% of service users are currently Clinically Ready for Discharge (CRFD) and as well as the impact on patient experience, the cost of this to the service/trust based on using national average bed cost figures has been undertaken to identify the financial impact this also has. The work undertaken to triangulate the data to understand the impact was commended.

- The largest reason for delayed discharges is placements in care homes and social worker allocation. On a positive note, it was confirmed that a Social Worker will be commencing from 10th March.
- A meeting is in place with social care to see if the Care Match process can be improved and discussions to reduce delays in funding agreements for 117 aftercare packages.
- A Capacity Utilisation manager for P2 beds (community) funded by SDF commenced in January 2025 to support the flow into step-down beds which has been successful, facilitating 9 discharges in the last month. However a constraint to increase this relates to the limited availability of step down beds for those with functional mental health needs and complex behaviours as the current provider mainly supports dementia patients.

iii) Areas raised by service leads for discussion/support:

- For the P2 pathway consideration requested for permanent funding by commissioners given the success in impacting on patient flow, creating inpatient capacity with positive patient experience with service users being in a less restrictive environment.
- Work to improve communication between HTT and the CMHTs is ongoing, this continues to be a pressure area as CERTS only work in a supportive role post discharge as they have no medical cover.
  Service leads are planning to proactively provide training to HTTs regarding the needs of older adult service users as a means to enable HTTs to support older people post discharge.
- HR support for an ongoing casework was highlighted to see if it can be expedited to prevent delays.

2. Deep Dive Summary RAG ratings across all service areas

The overall RAG ratings summary across all service areas that have taken place to date has been updated for the above deep dive meeting and outlined below for reference.

Appendix II Performance Management Framework

Date	Division	Service	Overall	Quality & Safety	Operational Performance	Workforce & Culture	Finance	Strategy, Transformation & External
31-May-24	Acute & Urgent care	Eden Acute		Red	Amber	Red	Red	
31-May-24		Eden PICU		Amber	Amber	Amber	Red	
31-May-24		Endeavour House		Green	Amber	Green	Red	
31-May-24		George ward		Red	Green	Red	Red	
31-May-24		Larimar		TBC	Green	Amber	Red	
19-Jul-24		All HTT	Amber	Amber	Amber	Red	Amber	Red
19-Jul-24		HTT West	Green	Amber	Green	Green	Green	Red
19-Jul-24		HTT North	Green	Green	Green	Amber	Green	Red
19-Jul-24		HTT South	Amber	Amber	Amber	Amber	Amber	Red
19-Jul-24		HTT Zinnia	Red	Amber	Red	Red	Amber	Red
19-Jul-24		HTT Solihull	Amber	Amber	Amber	Green	Red	Amber
20-Sep-24		Central & East Inpatients	Amber	Amber	Amber	Amber	Red	Green
17-Jan-25		Urgent Care: Psychiatric Liaison/Bed Management	Amber	Amber	Amber	Amber	Green	Amber
21-Mar-25		Home Treatment						
12-Mar-24	ICCR	SOLAR						
4-Jun-24		Homeless CMHT	Green	Green	Amber	Amber	Green	Green
4-Jun-24		Rough Sleeper MH Team	Green	Green	Green	Amber	Green	Amber
4-Jun-24		Health Exchange	Amber	Green	Amber	Amber	Green	Amber
20-Aug-24		Neighbourhood MH Teams	Amber	Amber	Amber	Amber	Amber	Green
20-Aug-24		Adult CMHTs	Amber	Amber	Amber	Amber	Amber	Amber
10-Sep-24		SIAS	Green	Green	Amber	Amber	Green	Amber
10-Sep-24		Recovery Near You	Green	Green	Amber	Amber	Green	Green
10-Sep-24		COMPASS	Green	Green	Green	Green	Amber	Green
1-Nov-24		S2R Wards	Amber	Green	Green	Green	Amber	Green
14-Jan-25		SPS	Green	Green	Green	Green	Green	Green
11-Mar-25		AOT						

Appendix II Performance Management Framework

Date	Division	Service	Overall	Quality & Safety	Operational Performance	Workforce & Culture	Finance	Strategy, Transformation & External
25-Oct-24	Secure	Secure CAMHS	Amber	Red	Green	Amber	Green	Red
25-Oct-24		Womens Secure Blended Service	Amber	Amber	Green	Amber	Green	Amber
25-Oct-24		Youth First	Amber	Amber	Amber	Amber	Green	Amber
25-Oct-24		Offender Health	Amber	Red	Green	Amber	Green	Amber
25-Oct-24		Health Justice Vulnerability Service	Green	Green	Green	Amber	Green	Green
20-Dec-24		Reaside	Green	Amber	Green	Amber	Green	
20-Dec-24		Tamarind	Green	Green	Green	Green	Green	
20-Dec-24		FIRST	Green	Amber	Green	Green	Green	
2-Apr-25		Ardenleigh/Offender Health/Liasion and Diversion						
7-Mar-24	Specialties	MAS	Amber	Amber	Red	Green	Red	Amber
7-Mar-24		Clinical Health Psychology	Red	Amber	Amber	Red	Red	Red
2-May-24		Deaf		Amber	Amber	Amber	Red	Red
2-May-24		Neuropsychiatry		Amber	Amber	Green	Red	Amber
25-Jul-24		Perinatal		Green	Amber	Green	Amber	Green
25-Jul-24		Mother and Baby & Outreach		Green	Amber	Green	Green	Green
5-Sep-24		Eating Disorders	Green	Green	Green	Amber	Green	Green
7-Nov-24		Art Psychotherapy	Green	Green	Green	Green	Green	Green
7-Nov-24		Veterans	Green	Green	Green	Green	Green	Green
21-Jan-25		Dementia and Frailty Inpatients		Amber	Red	Amber	Red	Green
6-Mar-25		Care Home Liasion/CERTS	Green	Green	Green	Green	Green	Green

Community Enablement and Recovery Team (CERTs):

Working in collaboration with community mental health teams and inpatient units, the aim of this service is to treat and support service users with primarily complex needs and their carers in their local communities to avoid admission to hospital and, where admission is unavoidable, to reduce the duration of stay.

Care Home Liaison:

The team offers interventions, using a co-ordinated holistic approach that helps care staff develop strategies and build competence and confidence to support residents with mental health needs. Each care home has a designated community mental health nurse who works directly with the residents (as clinically appropriate) if they are a current service user of the Trust. We can also advise residents, not currently our patients, as to whether a referral to the Trust would be appropriate.

Knowledgeable.

Very supportive and helpful

Staff were very good to my wife and very helpful and informative i have learnt a lot form the staff.

Staff were very pleasant and explained their service and helpful

Staff were very polite to my mother very informative.

FEEDBACK

staff were always on time very polite, and we worked together to help me understand my journey.

I felt I was listened to and supported on my road to recovery.

Helpfulness.

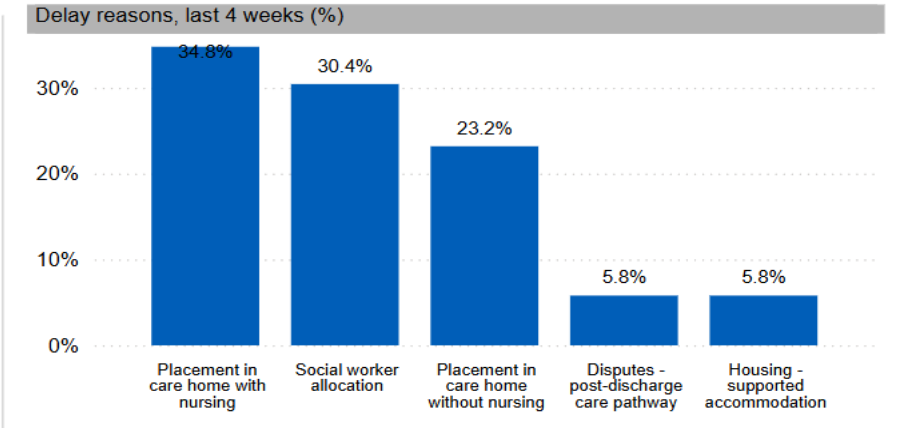
- Staff retention: CERTs (Last recruitment was 4 years ago this was due to retirement) CHL: 2 Years ago, due to created post.
- Joint working with CMHT – Attendance at CMHT to discuss CMHT case loads and support with identifying referrals.
- Continuity of care from in-patients.

- Joint working with HTT – Difficulty when patients are discharged to the CMHT (Limited communication / Handover).
- Medic responsibility for patients on the Bed Waiting List.

OA Discharge team:

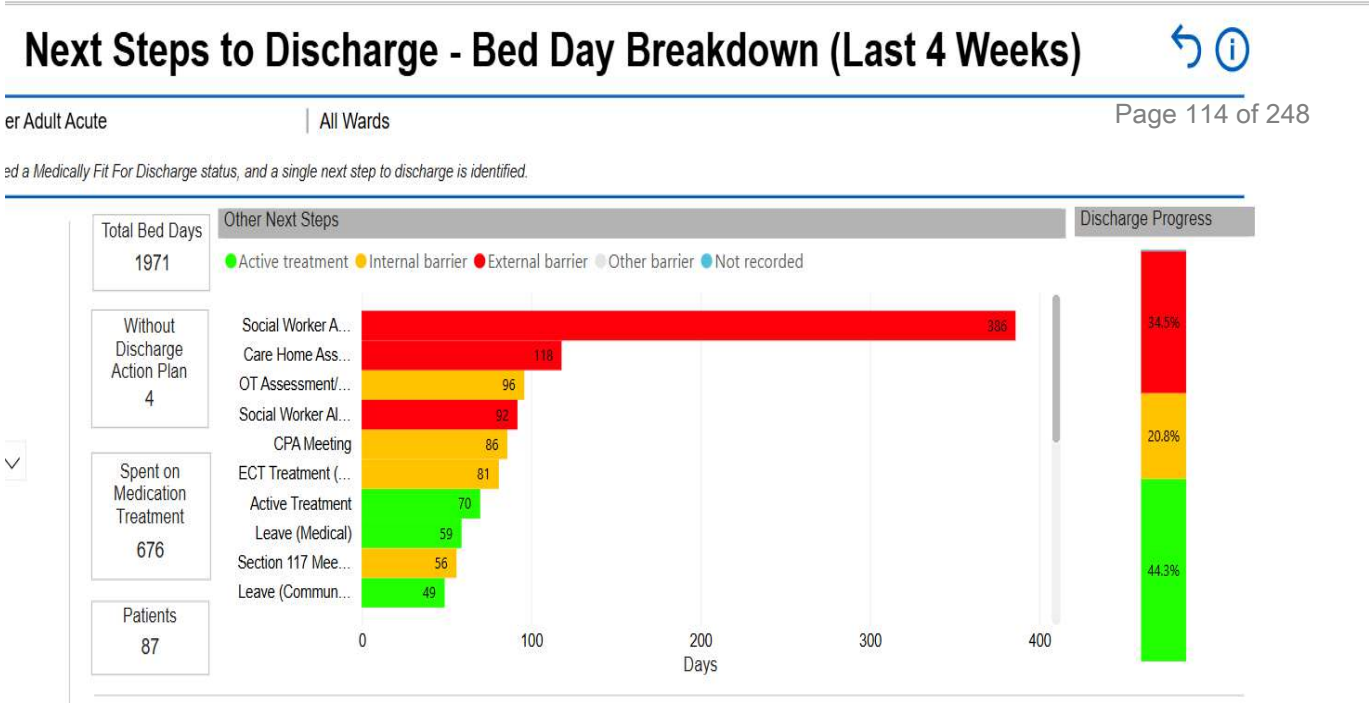
4 Wards (X3 Juniper Centre) and X1 Reservoir Court.
Beds: 71 (36 Female Beds & 35 Female Beds).

CRFD: 27 (38% bed occupancy).
Bed cost per day £335 (National Figure)
Patient 1: 219 Days (£73,365) – Bids via Care Match.
Patient 2: 172 Days (£57,620). – Bids via Care Match.
Attribution: Social Worker allocation, Social Worker assessments and Bids via Care Match.



Allocated Social Worker for OA commencing – Start Date ?This week.
Attendance at weekly Deep Dive Meeting & Fortnightly CRFD meeting

Allocated Social worker: This will support with current social care delays however there will still be Social Care Attribution delays when the social worker is in place.



Capacity Utilisation Manager – P2 beds (Community):

Role commenced: 30th January 2025 (9 Discharges).

Supporting with flow in P2 beds (BLCC, Kenrick Centre & Supporting with Long Stays at Connaught Care Home).

Creating flow will support with availability for in-patient step down (However, There is currently 10 commissioned MH step down beds at BLCC).

Limited step-down availability for Functional MH with complex behaviours.

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	
Date(s) of Committee Meeting(s) reported	**19 March 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Regulatory Compliance Report • Reducing Restrictive Practice • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Freedom to Speak Up Report • Health Inequalities Report • Integrated Performance Report • Clinical Governance Committee Assurance Report • Clinical Services Strategic Goals 2025/26 Report • Quality Strategic Goals 2025/26 Report
Alert:	The Committee wished to alert the Board of Directors to the following: • Ardenleigh is a hot spot with ongoing concerns in relation to Adriatic Ward where two young people are responsible for a high number of reportable incidents. Options are being reviewed with Reach Out partners to consider the most appropriate model of care including the transfer of services for CYP. Ardenleigh will be an area of focus going forward. • IPR waiting times for emergency departments and CMHT remains a key concern. Emergency departments and transfer of care between teams has seen an increase in incidents. A full review of the risk management framework has been commissioned with support from Healthwatch and other partners. • A deep dive into psychological harm incidents has been scheduled for June 25, this will allow the Committee to focus on the impact for staff and ensure wellbeing offers are being promoted and utilised.
Assure:	The Committee was assured on the following areas: • Reaside improvement plans have made significant progress and the culture of care external support has been positive with the senior leadership team taking responsibility for developing plans for improvements and engaging with staff and service users. Estates have supported the initiative for decorating Reaside to improve the environment and service users will be involved in painting. The Committee were assured by the ongoing improvements. • Zinnia improvement plans have been embedded with the door works being completed. Staff training is in place and all staff are fully compliant alongside the introduction and roll out of Dialogue+.

	• Reducing Restrictive Practice work continues to showcase improvements, with data being inclusive of health inequalities, LDA, Age; Ethnicity; Gender; Disability Status and Deprivation Index. Data for incidents by Time of Day and Weekday has supported staff identify when specific activities should be planned and this is seen a positive reduction in incidents. Data is being used to improve the overall culture. • Freedom to Speak Up has seen a positive increase in contacts with Speak up Guardians and Champions receiving 157 speaking up concerns in quarter 3. The team achieved our 2024 goal of over 20 Champions and now have 21 FTSU Champions who have received the National Champions training.	
Advise:	• The Governance team will support a review of how health inequalities can be embedded into Board and Committee reporting. The Committee noted the importance of ensuing this becomes business as usual. • A business case has been drafted for the safer staffing model. The Committee noted the need to evidence a significant reduction in the use of bank staff before the business case can be enacted. This will be through a phased approach over four quarters. The student pipeline remain strong through universities and therefore no concerns in relation to the ability to recruit have been raised. • The Integrated Care Board have commissioned a quality summit to review the pressures and access to services through emergency departments. • Quality assurance audits for planning priorities for the next financial year will be a key focus.	
Board Assurance Framework	The Committee was assured the Board Assurance Framework is reflective of the associated Committee risks.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Dr Linda Cullen Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance Manager

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	
Date(s) of Committee Meeting(s) reported	**19 February 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Regulatory Compliance Report • Reaside Report • PEAR Group Assurance Report • Patient Safety Incident Responses Framework, SI Reviews, Patient Safety Alerts, Complaints and PALS Report • Valdo Calocane - independent investigation • Integrated Performance Report • Clinical Governance Committee Assurance Report • Staffing Review • Mental Health Legislation Committee • Safeguarding Management Board Assurance Report
Alert:	The Committee wished to alert the Board of Directors to the following: • The Committee received the Valdo Calocane review and noted the Trust is committed to learning from the failures identified through a structured and proactive response. By strengthening risk assessment processes, enhancing multidisciplinary oversight, improving family and carer engagement, and embedding a culture of shared learning, the Trust aims to deliver safer, more effective care. The implementation of robust oversight arrangements and clear accountability mechanisms will ensure that lessons from this review lead to meaningful and lasting improvements in patient safety. The Committee acknowledged there is significant work ongoing to mitigate the associated risks. • The Committee received the Safety Staffing review and proposal for a phased approach to increase substantive staffing with a focus on increasing the establishment within Acute and Urgent Care due to the high level of acuity. The proposal requires substantial investment as a long-term solution to the utilisation of bank staff. The Committee noted their concerns in relation to affordability and induction processes. • The Committee received and were assured by the Mental Health Legislation Committee report. The Committee were altered the report has not been received by the Board of Directors for over 12 months.
Assure:	The Committee was assured on the following areas:

	• Reaside improvement plan has been implemented and positive feedback has been received from the CQC following a recent inspection on site with notable improvements in relation to the introduction of the Culture of Care Framework. The Committee will receive monthly progress reports.	
Advise:	The Committee were advised the PEAR Group continues to evolve with increased attendance. The group continue to focus on collating feedback from families and carers to improve service users experience.	
Board Assurance Framework	The Committee were assured the Board Assurance Framework is reflective of the associated Committee risks.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Winston Weir Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance Manager

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors						
Agenda item:	**11**					
Date	2 April 2025					
Title	Health Inequalities Report					
Author/Presenter	Jas Kaur, Associate Director EDI and Organisational Development Fabida Aria, Executive Medical Director					
Executive Director	Fabida Aria, Executive Medical Director	**Approved**	**Y**	✓	**N**	

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

Summary of Report

Alert		**Advise**	✓	**Assure**	

At BSMHFT, reducing Health Inequalities is everybody's business, ward to Board. With that intention this report is presented to the Board of Directors to outline key programmes of work that contribute to reducing Health inequalities for our service users and carers.

The report has been discussed at Quality, Patient Experience and Safety Committee, Finance, Performance and Productivity Committee and People Committee on 19 March 2025. Each Committee was posed a series of questions to consider and to reflect on how health inequalities would be reflected throughout all discussions and governance arrangements in the future.

Recommendation

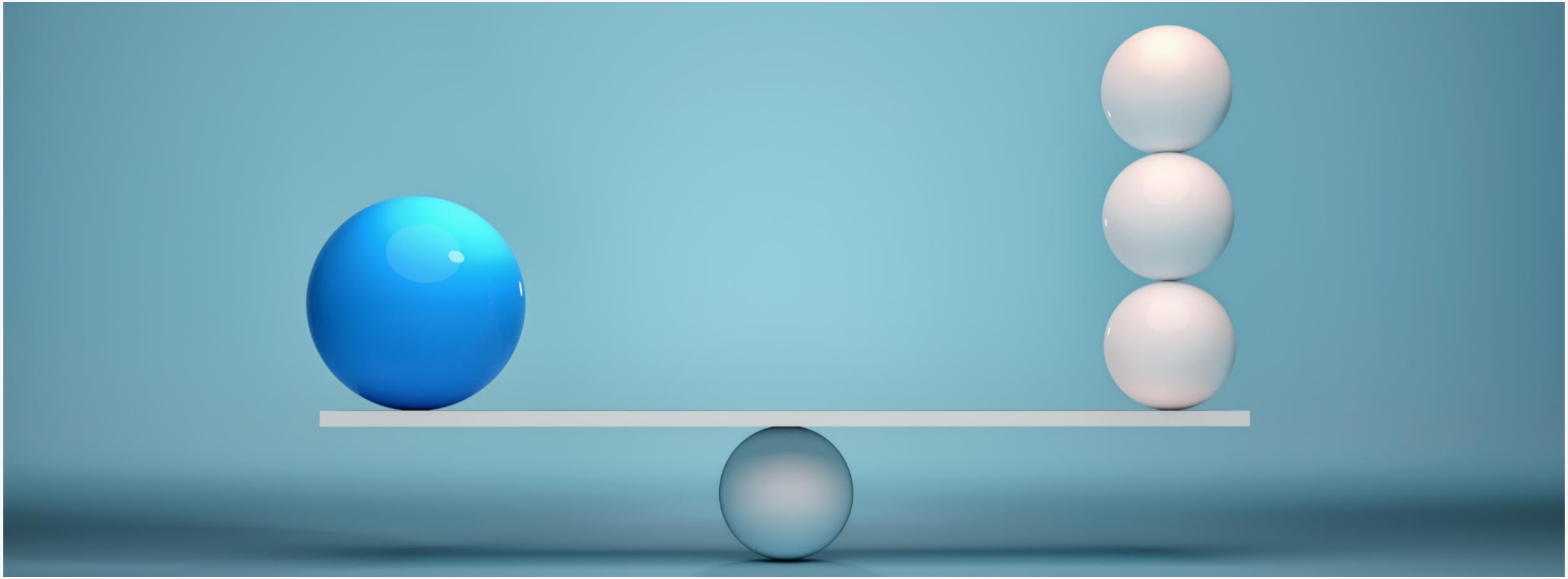
The Board is asked to receive the overview report for assurance.

Enclosures

Health Inequalities Overview

Birmingham and Solihull Mental Health NHS Foundation Trust

Value Me to Reduce Inequality
Heath Inequalities April 2025



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What are Health Inequalities

Health inequalities are **unfair** and **avoidable** differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

-Kingsfund

The BIGGER Why…

To enable the right ingredients for an

Inclusive culture

which is…

Anti racist

and

Anti discriminatory for **all**

to

Improve access, experience

and

outcomes

for

our people

NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

Value Me to Reduce Inequality

What..

Every person to be valued and understood

Why...

So that I have a fair opportunity to take the next step-*whatever that looks like for me*

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https://www.etransx.com/wellbeing-care-community-addressing-social-determinants/

The System view: Addressing health inequalities

- The NHS now has a duty to address health inequalities across its work: this includes monitoring take up of elective and emergency activity, immunisations and vaccination, NHS Talking Therapies, key measures of CVD detection and management, pre-term birth, take up of LD&A health checks etc by deprivation and ethnicity
- Designed to focus the NHS more explicitly on the inequalities impact in 'business as usual'
- BSOL's inequality strategy sets out our strategic approach to tackling health inequalities.
- This is complemented by more localised work at 'Place' level, including local Health and Well-being Boards
- System CEOs have committed to focus on cancer screening, LD&A/ SMI health-checks, elective care & imm & vac

Maternity Care & Infant Mortality

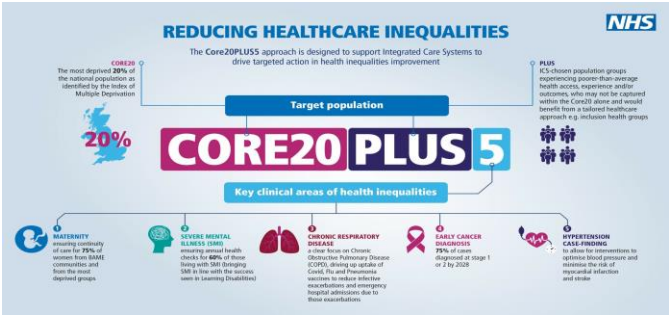
- Improve the experience and outcomes for mothers, parents, and babies and reduce the number of infants who die before their first birthday

Better Start for our Children

- Improve the health of children from our most deprived communities by supporting them to get the best start in life, focusing first on increasing uptake of vaccination and improving school readiness.

Better Prevention, Detection & Treatment of Major Diseases

- Improve the prevention, early detection and treatment of the diseases that drive early mortality for people, focusing first on cardiovascular disease, respiratory disease, cancer screening and diabetes.



Better Outcomes for People with Mental Illness

- Improve the experience and outcomes for people living with serious mental illness and improve their health and wellbeing to achieve their potential in life.

Better Outcomes for People with Disabilities including Learning Disability

- Improve the experience and outcomes for people living with a disability across the life course, starting with a focus on learning disability.

Improved Outcomes for Inclusion Health Groups

- Improve health and care outcomes for our most vulnerable citizens in inclusion health groups including new migrants, refugees and asylum seekers, homeless people, people with substance misuse difficulties and other "hidden populations".

NHS E Health Inequalities statement:

NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)

Domain	Indicator	Deprivation	Ethnicity	ICB	Trust
Elective recovery	Waits; >18weeks / 52 weeks / 65 weeks	√	√	√	
	Activity rates: elective and emergency admissions, outpatient, virtual outpatient, emergency attendances	√	√	√	
	Elective activity vs pre-pandemic for under and over 18s	√	√	√	√
Urgent and emergency care	Emergency admissions for under 18s	√	√	√	√
Respiratory	Uptake of COVID and flu vaccination	√	√	√	
Mental health	Overall number of severe mental health (SMI) physical health checks		√	√	
	Rates of total MHA detentions	√	√	√	√
	Rates of restrictive interventions	√	√	√	√
	NHS Talking Therapies recovery	√		√	√
	CYP mental health access	√	√	√	√

Embedding Health Inequalities at QPES - Points for Discussion

- Do we monitor
  - Equitable access to Mental Health Services?
  - Culturally Competent & Trauma informed care?

- Are we data –driven in our decision making?
  - Do we gain assurance, and promote the use of, Health Inequality dashboards?
  - Do we use and gather representative service user and carer feedback?

- Are we driving evidence based and Inclusive services?
  - Are we tailoring services to disproportionately effected groups?
  - Are we actively advocating and testing digital inclusion and accessibility

- From a safety perspective are we reducing inequalities in care pathways?
  - Do we seek assurance against the fair and equitable use of Mental Health Act Powers?
  - Do we seek assurance in relation to RRP with a focus on demographics?

Embedding Health Inequalities at FPP - Points for Discussion

- Do we monitor
  - Finance: allocating resources to address inequalities?
    - Targeted investment?
    - Fair Tariff adjustments?
    - Monitoring spend on HI?
  - Performance: measuring impact on HI?
    - Incorporate Inequality metrics in performance reviews?
    - Health inequality dashboards?
    - Patient outcomes by IMD (Index of multiple deprivations -39 indicators)
  - Productivity: Embedding equity in efficiency measure?
    - Reducing unwarranted variations?
    - Prevention investments to reduce long term costs?
  - Embedding HI in FPP agendas?
    - Dedicated agenda item?
    - Equality Impact assessments?
    - Annual reporting on HI spend and outcomes?

Embedding Health Inequalities at People Committee - Points for Discussion

- Do we monitor
  - Workforce representation and Diversity?
  - Health & Wellbeing?
  - Culturally Competent Care & Training?

- Are we Data –driven in our decision making?

- Are we actively involving the voice of communities and Lived experience?

HI Priority Streams

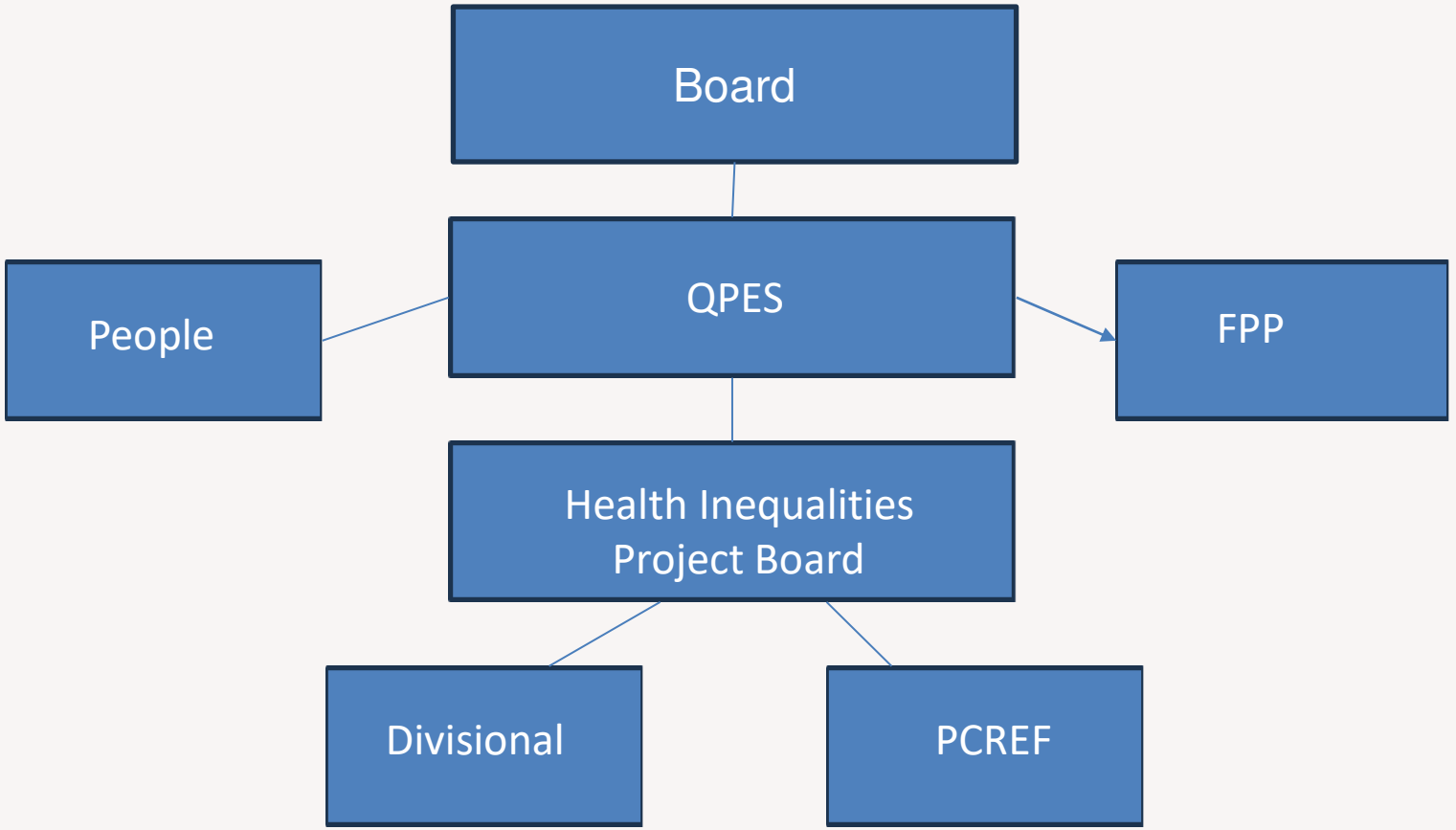
Patient Carer & Race Equality Framework

+

Birmingham & Lewisham African and Caribbean Health Inequalities Review

Governance

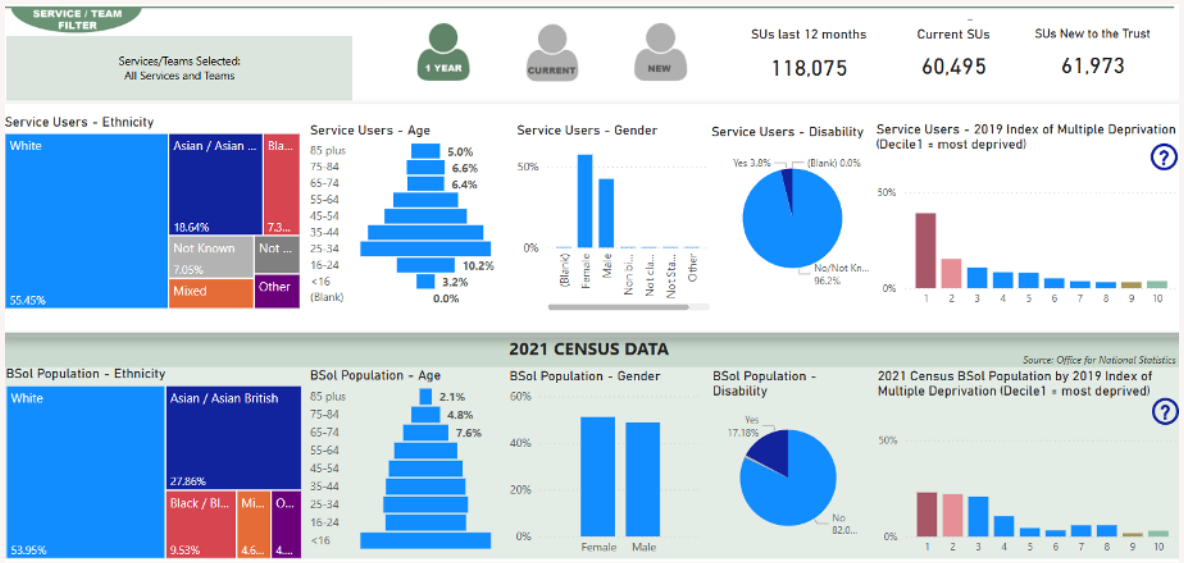
FPP



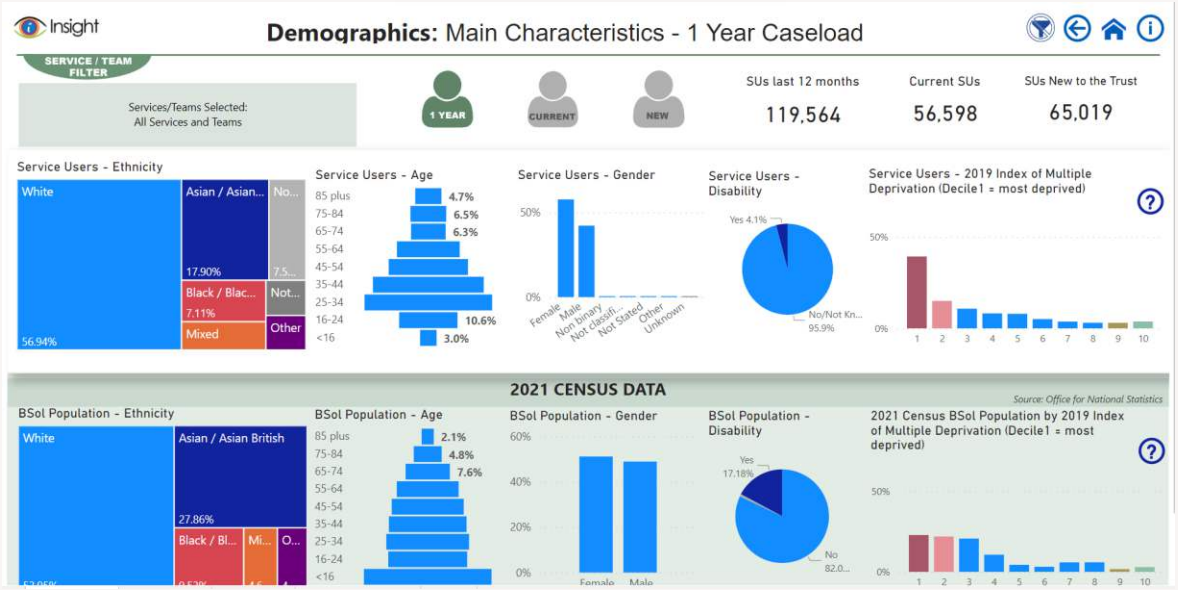
Birmingham and Solihull Mental Health NHS Foundation Trust

BSMHFT Service User Data

March 2025



November 2024



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Current Position

- All priority workstreams have milestone plans
- Operational Divisions:
  - All Operational Divisions have finalised Health Inequalities plans in the same format with identified leads and milestones identified
- Culture of care being socialised across services
- BSMHFT identified as Expert Lead to progress on behalf of region
- BSMHFT site for BCC Cultural Humility, Safety and Competence Pilot with external evaluation
- Culturally Appropriate Advocacy being evaluated
- New service model pilot 24/7 (featured as spotlight)

Key Achievements in reducing Health Inequalities

- Focussed interventions relating to DNA's across the Specialties Division
- Applied Nurse Practionner physical health in post across Ardenleigh to support improved physical health
- Solar have over 90% coverage of schools in Solihull with our Mental Health Support Teams
- Mental Health staff now located in British Transport Police control rooms to support enhanced response
- Active engagement with eclipse data to support and respond to colleagues experiencing discrimination from service users

- ‘This is Me’ tool developed in ICCR being rolled out pan Trust within Rio, emphasising identity and culture
- Quality Improvement Programmes
  - **Project Aim:** To reduce to zero the percentage of patients waiting over 40 weeks for High Intensity Cognitive Behavioural Therapy (HI CBT) by the end of March 2024 (from joining the waiting list to being allocated a clinician)- completed.
  - **Project Aim:** To develop a discharge process which reduces delays in discharge referrals for Solihull Early Intervention Psychosis service users by 20% from January to May 2024. (completed)
  - Readmission rates in FIRST Team, ensuring the continuity of appropriate care in the community to decrease readmissions
  - **Environments which meet sensory needs of people who are neurodiverse:**QI Project at Forward House which is part of the Culture of Care RCPysch QI programme.

Key Achievements in reducing Health Inequalities-PCREF Focus

- PSIRF & PCREF marrying
  - PSI recommendations proactively identify Health Inequality considerations
    - Saffron Ward PSI included active use of Google translate in everyday communications & increased engagement with Culturally appropriate advocacy
- RRP training materials revised to focus on disproportionate impact
- Google translate endorsed as a legitimate tool in improving everyday communication
- Trauma informed care training actively incorporates racism as trauma

- Perinatal Services
  - 3rd sector referral routes: Maternity Engagement Action Approachable Parenting, Nishkam, Acacia, BCT Leaving Care teams.
  - Perinatal Risk Training: A section on health inequalities that lead to increased risk of death in perinatal period for women of colour. Reference to MBRRACE reports
- Psychological Professions
  - Cultural Competencies Framework
  - Development of salaried Graduate Internships for colleagues from racialised minority backgrounds aspiring to careers in Psychology
  - Championing Anti-Racism & Inclusion in Clinical Practice workshops for Psychological Professions Trust and BSol system

Birmingham and Solihull Mental Health NHS Foundation Trust

Communities Transformation communities of focus

- Chinese Community ✓
- South Asian Community ✓
- Somalian Community ✓
- African Caribbean Community ✓
- LGBTQ+ Community ✓
- Gypsy Traveller Community ✓
- Asylum Seekers / Migrants ✓
- Sex Trafficked / Sex Workers ✓

Outline of Community Transformation Engagement

- Peer Support Training
- Managing Risk Training
- Co-production Workshop – Confirm collaborative Goals
- Pop Up Mental Health Clinics – Community locations
- Mental Health & Suicide First Aid Training
- Specialist Pathway Process Mapping with COF
- Accessible Communications
- Bespoke Activities

Mental Health Inequality Outcomes

- Alleviate loneliness & Isolation via engagement, Learning & Support
- Raising the awareness of Mental Health to Community Members
- Challenging stigma that leads to barriers of access, improving access
- Improving knowledge of Services, Pathways & how to access them
- Build skills & competences of community champions, increasing MH volunteers, peer support and workforce opportunities
- Deliver bespoke MH support at a community level promoting self help

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Birmingham and Solihull Community Mental Health Transformation Programme

Birmingham and Solihull Mental Health NHS Foundation Trust

Communities of Focus in Community Transformation	Outline of Bespoke Projects in Community Transformation
Chinese Community	Menu Of Activities to improve MH understanding identify gaps and barriers and improve Access
South Asian Community	EOI coming out on framework to deliver creative approaches to combat mental health inequalities
Somalian Community	All age celebration event imbedding MH support & agencies. Celebrating the Wisdom & Experience of Elderly Somali People
African Caribbean Community	EOI coming out on framework to deliver creative approaches to combat mental health inequalities
LGBTQ+ Community	Wellbeing self care support groups that promote self-care for mental health
Gypsy Traveller Community	Mental Health support imbedded into GRT working group outcomes in partnership with NNS & ASC
Asylum Seekers / Migrants	Working with Migration Policy and BCC Commissioning to deliver support to AS/M with no recourse to public funds in hotels
Sex Trafficked / Sex Workers	Co-produced MH professionals training on engaging and relationship building with vulnerable sex workers – recommendation from SWAN

Underpinning Support for All

- Animation Video & resources explaining MH Service Offers
- Podcasts
- Alignment and facilitation /relationship building of Communities Of Interest to Community Mental Health Services
- Peer Support/ & Co – Production Workshops
- Managing Risk Training
- Mental Health & Suicide First Aid Training
- Pop Up Mental Health Clinic
- Co – Location Opportunities with Neighbourhood Mental Health Teams

Next Steps

- Directorate HI plans embedded in governance (current plans in appendix)
- Better use of data and AI
  - Embedding google translate as everyday communication tool
- Embedding PCREF principles in Culture of Care
- Connecting roles & HI purpose through Anti Racist Practionner
- PCREF Partners to be developed in line with PSIRF Partners
- Community Collaborative to be embedded in Health Inequalities governance
- Health inequalities (PCREF) embedded through goals for 2025

Birmingham and Solihull Mental Health NHS Foundation Trust

Risks

- PCREF not featured in planning guidance or NHS Contracts
- Data quality variable across services
- Low levels of Health Inequality literacy
- High levels of discrimination, bullying, harassment and victimisation from Service Users
- Health Inequalities not explicitly in Job Plans
- Representation of community assets in organisational governance not fully embedded

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**2 April 2025**
Date(s) of Committee Meeting(s) reported	**19 March 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Board Assurance Framework • People Dashboard • Shaping our Future Workforce Group Assurance Report • Transforming our Culture and Staff Experience Group Assurance Report • People Strategy Goals 2025/26 • Workforce Plan Overview • Staff Survey Results Report • Gender Pay Gap Report • Race Equality Code Assessment Report • Health Inequalities Report • Safer Staffing Report
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • The Gender Pay Gap Report highlighted that, overall, there was a mean gap of 7.87% which was a decrease from 2023. Although this was positive in relation to the overall gender pay gap, increases in pay gaps were reported in ethnicity (8.49% in 2024 from 6.82% in 2023) and sexual orientation (-4.25% in 2024 from -2.98% in 2023). • The staff survey results highlighted some remaining concerns in relation to bullying, discrimination ad negative behaviours from the public.
Assure:	• The Committee was assured by the improvements reported in vacancy and turnover rates. • Fundamental training compliance had increased to 94.4% which was slightly below the 95% target, however there was confidence that the target would be achieved by year-end. • The Committee noted the excellent progress in areas of the staff survey, particularly highlighting that the Trust's key people goal measure of whether colleagues would recommend working at the Trust to friends and family had significantly increased to 65.7%. • The "stay" conversation pilot had been successful and would be rolled out to a clinical area. An evaluation of the pilot would be presented to the Committee in May. • The Committee approved the People strategy goals for 2025/26.

	• The Committee received a detailed Health Inequalities Report, noting the ongoing work that would ensure health inequalities was a regular reflection in all reports.	
Advise:	There had been some improvement in sickness absence rates, with an overall reduction reported at 6.4%. The Committee noted the plans in place to improve the recording of return-to-work conversations following periods of sickness. The Race Equality Code Assessment was received and it was noted that auditors were currently reviewing the submission. The Committee acknowledged additional work to do to ensure optimal staff mix on wards and noted that international nurses had settled well into the organisation.	
Board Assurance Framework	The Committee had identified the following revised risks: • Failure to create a positive working culture that is anti-racist and anti-discriminatory. • Inability to attract, retain or transform our workforce in response to the needs of our communities. Scrutiny of the risks would continue to ensure the risk scores correlated to rationale and the mitigations and plans in place.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Bal Claire, Deputy Chair/Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**2 April 2025**
Date(s) of Committee Meeting(s) reported	**19 February 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee held a development and strategy session on Workforce Transformation.
Alert:	There was concern that the scale of the staff sickness absence issue was not fully realised, particularly in relation to staffing establishments and the budgets required. This would continue to be closely monitored to understand the root causes. The Committee considered the need for corporate benchmarking to support the workforce transformation plans from a systems comparator perspective, i.e. how is the Trust's sickness absence related to other comparator Trusts. The session highlighted the call to action that was required, and encouraged participation in the planning process and support of the transformation efforts. The Committee acknowledged that it needed to consider digital and modern solutions within its workforce transformation strategy.
Assure:	• The Committee was assured by the number of successes that had been achieved during 2024/25, including increase substantive recruitment, successful international recruitment campaign, medical recruitment, improved retention, and improved staff survey results. • The Committee was particularly assured by the significant reduction in agency use which had made a difference to spend during the year. • The Trust's commitment to wellbeing and work/life balance was demonstrated through high levels of flexible working, in alignment with the Trust's People Promise. • The Committee noted the importance of team cohesion in making changes and contributing to the transformation required. • The Trust would continue to highlight and celebrate good practice and look to replicate across the organisation.
Advise:	The Committee acknowledged that improvements were needed and would hopefully be addressed by the workforce transformation plans. These areas included: • Focus on hot spot areas across the organisation and addressing issues. • Increasing productivity in teams. • Increasing oversight of corporate areas. • Awareness that bank reduction was not happening at pace, and supporting this key piece of work.
Board Assurance Framework	The Committee had identified the following revised risks:

	• Failure to create a positive working culture that is anti-racist and anti-discriminatory. • Inability to attract, retain or transform our workforce in response to the needs of our communities. The risks would continue to be reviewed and scrutinised to ensure that they reflected key issues and actions in place to mitigate areas of concern.	
	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:	**13**					
Date	2 April 2025					
Title	Staff Survey Results Report					
Author/Presenter	John Travers, Staff Experience and Engagement Lead & Nageeta Paul, Senior Organisational Development Business Partner					
Executive Director	Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships	**Approved**	**Y**	**x**	**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**	

NHS Staff Survey Results 2024

Situation

We achieved a 57% response rate, exceeding our People Goal of 55% and remaining above the mental health trust average. More importantly, we have increased team participation, 130 teams met the 10-response threshold, surpassing our target of 120 teams.

One of our key measures, whether colleagues would recommend working here to friends and family, has risen significantly to 65.7% (up from 62.6%), surpassing our People Goal target of 65% and approaching our highest-ever score of 66.4% (2020). In contrast, the average score for mental health trusts has remained largely unchanged at 65.21% (previously 65.57%).

Thematic analysis shows significant progress in three of the seven "People Promise" themes: "Always Learning" has seen the most improvement. "We Work Flexibly" and "We Are Safe and Healthy" have also progressed positively.

- "Always Learning" has seen the most improvement by 0.14 (5.98 in 2023 vs 6.12 in 2024)
- "We Work Flexibly" by 0.12 (6.79 in 2023 vs 6.91 in 2024)
- "We Are Safe and Healthy" by 0.09 (6.33 in 2023 vs 6.42 in 2024)

Morale has increased and is now above average (6.34 vs 6.20), however, our staff engagement score has not improved over the past five years, and the greatest year-on-year decline is in the local question assessing the effectiveness of senior leader communication, 40.2% in 2024 compared to 44.6% in 2023.

Positive appraisal ratings have driven improvements in the "we are always learning" theme. Our trust score for this theme in 2023 was 5.98 and for 2024 it is 6.12 which is significantly above the mental health average of 5.93.

The score for the people promise element "We are safe and healthy" has improved year on year from 6.33 in 2023 to 6.42 in 2024, however we are below the mental health average for whether staff would be happy with the standard of care provided by this organisation (Q25d) - 2023 was 56.2% and 58.63% in 2024 against the mental health average of 64.83%

Additionally, safety-related scores (e.g. staffing numbers) have also shown progress. Q3i details "There are enough staff at this organisation for me to do my job properly" 36.26% (2023) vs 40.95% (2024) and the mental health average is 37.16%.

Out of 104 questions (including local questions):

- 22 questions have shown significant year-on-year improvement.
- Only 4 questions have declined.
    - This organisation offers me challenging work (Q24a)
    - In last 3 months, have not come to work when not feeling well enough to perform duties (11d)
    - Communication between senior leaders and staff is effective. (Local question)
    - Do managers demonstrate the values at work? (Local question)
- The vast majority (78 questions) have remained unchanged.

The declining scores are not concentrated in one specific theme. This marks the second consecutive year where improving scores outnumber falling scores. Last year saw a major step forward, with improvements across most scores and themes. This year, that positive trend continues.

Despite these improvements, bullying, discrimination and other negative behaviours from the public remain a major concern, with scores unchanged and significantly worse than the mental health average. This is quantified in the "negative experiences" where our trust score is 7.81 compared to the mental health average 7.98. A significant gap persists in the perception of discrimination, this year the trust score is 85.3% and the mental health average is 91.4%.

While concerns remain about bullying and discrimination involving colleagues at the Trust and there is more work to do, we have seen the bullying scores have fallen numerically for the fifth consecutive year. People are more likely to report bullying than ever before.

- In 2020 13.86% of colleagues said they had experienced bullying, harassment or abuse by managers in the previous year, falling to 9.58% in 2024.
- In 2020 22.47% of colleagues said they had experienced bullying, harassment or abuse, falling to 17.23% in 2024. Of those experiencing bullying, 66.96% of colleagues in 2024 said they or a colleague had reported this compared to 61.02% in 2020.

We have prioritised early communication of the results. Key findings were shared with Associate Directors ahead of the Senior Leaders' Forum in February, enabling discussions at leadership level.

- Teams are now receiving their results, followed by a corporate-wide rollout after the embargo lifts on March 13th.
- All teams are expected to share results with frontline colleagues and discuss actionable changes.
- The OD team will support teams in these discussions and next steps.

We have recently received a breakdown of free-text responses. Additional data will provide deeper cultural context, allowing us to refine communications and messaging accordingly, analysis is underway. However, our overarching themes and insights remain consistent with the findings outlined in this report.

Recommendation
The Board is asked to formally receive the report for assurance and note that next steps and actions will be discussed at the People Committee development session in April.

Enclosures
N/A

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services		
People		
Quality		
Sustainability	✓	**Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population.**

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	**14**					
Date	2 April 2025					
Title	Guardian of Safe Working Hours Q3 Report					
Author/Presenter	Hari Shanmugaratnam, Guardian of Safe Working					
Executive Director	Fabida Aria, Executive Medical Director	**Approved**	**Y**	✓	**N**	

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

Summary of Report

Alert		**Advise**	✓	**Assure**	

Quarterly reports to the Trust Board are mandated by the Terms and Conditions of the Junior Doctor Contract. Safer Staffing and issues related to rotas and training are under the remit of Medical Workforce and Education.

- No immediate safety concerns were raised during this quarter.
- Exception reporting rates have decreased during this quarter. 11 unique exception reports were raised during this quarter, of which 9/11 related to overtime working.
- 2 fines were levied against the Trust for breaches in safe working hours.
- The number of outstanding reports carried forward has decreased to 1.

The number of vacant shifts continues to be high but stable.19% of the gaps were due to post vacancies. 190/191 on call locum vacancies during this period were filled.

Recommendation

The Board is asked to receive the report for assurance, noting that there is oversight of safe working hours for junior doctors in the Trust and that appropriate actions are being taken in response to concerns raised.

Enclosures

N/A

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

April – June 2024

High level data

Number of doctors / dentists in training (total):148 in October and November, 149 in December

Number of doctors / dentists in training on 2016 TCS (total): 148 in October and November, 149 in December

Amount of time available in job plan for guardian to do the role: 1 PA per week

Admin support provided to the guardian (if any): No specific admin support provided.

a) Exception reports

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	1	0	1	0
F2	0	0	0	0
CT1-3	3	9	11	1
ST 3-6	0	2	2	0
GPVTS	0	0	0	0
Total	4	11	14	4

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY2 – CT3 (Rotas 1-6)	3	9	11	1
ST North	0	1	1	0
ST South	0	1	1	0
ST Forensic	0	0	0	0
Total	3	11	13	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	1	0
F2	0	0	0	0
CT1-3	1	7	3	1

ST3-6	0	1	1	0
GPVTS	0	0	0	0
Total	1	8	5	1

b) Type of exceptions in the quarter:

There were no immediate safety concerns raised. 11 exception reports were raised in total.

Of the 11 exception reports; 9 related to working overtime. 1 was related to breaches of natural breaks and 1 was related to working pattern.

c) Work Schedule Reviews

Status;

Work Schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST3-6	0
GPVTS	0
Total	0

d) Locum bookings and vacancies

Locum bookings OCTOBER 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	7	7	78	78
Rota 2	0	0	0	0
Rota 3	6	6	57.50	57.50
Rota 4	4	4	40.50	40.50
Rota 5	4	4	34.00	34.00
Rota 6	7	7	70.00	70.00
ST4-6 North & East	2	2	16.50	16.50
ST4-6 Rea/Tam	3	3	56.00	56.00
ST4-6 South & Solihull	12	12	92.00	92.00
Total	45	45	444.50	444.50
Locum bookings NOVEMBER 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	8	8	66.50	66.50
Rota 2	4	4	49.00	49.00
Rota 3	6	6	65.00	65.00
Rota 4	5	5	38.50	38.50
Rota 5	12	12	92.50	92.50
Rota 6	10	10	106.00	106.00
ST4-6 North & East	4	4	41.00	41.00
ST4-6 Rea/Tam	3	3	64.00	64.00

ST4-6 South & Solihull	10	10	107.00	107.00
Total	62	62	629.50	629.50

Locum bookings DECEMBER 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	13	13	134.00	134.00
Rota 2	8	8	74.50	74.50
Rota 3	4	4	41.00	41.00
Rota 4	11	11	126.50	126.50
Rota 5	9	9	85.50	85.50
Rota 6	12	12	129.50	129.50
ST4-6 North & East	13	13	137.00	137.00
ST4-6 Rea/Tam	4	4	72.00	72.00
ST4-6 South & Solihull	10	10	115.00	115.00
Total	84	84	915.00	915.00

**It might also be useful to include a narrative explaining how the work left uncovered by unfilled requests was delivered. For example: Were clinics cancelled? Were teams left to cope with fewer staff? Did consultants pick up the slack? Did non-resident on-call staff have to come in and so breach rest requirements?*

Locum bookings OCTOBER 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	28	28	280.00	280.00
ST4-6	17	17	164.50	164.50
Total	45	45	444.50	444.50

Locum bookings NOVEMBER 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	45	45	417.50	417.50
ST4-6	17	17	212.00	212.00
Total	62	62	629.50	629.50
Locum bookings DECEMBER 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	57	57	591.00	591.00
ST4-6	27	27	324.00	324.00
Total	84	84	915.00	915.00

Locum bookings OCTOBER 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	0	0	0	0
Vacancy	16	16	124.50	124.50

Sickness	18	18	174.00	174.00
Off Rota	8	8	90.00	90.00
Emergency Leave / Compassionate	0	0	0	0
Maternity / Paternity Leave	0	0	0	0
Exam Leave	0	0	0	0
Acting Up Consultant	3	3	56.00	56.00
Total	45	45	444.50	444.50

Locum bookings NOVEMBER 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	0	0	0	0
Vacancy	13	13	113.00	113.00
Sickness	32	32	302.00	302.00
COVID	4	4	48.00	48.00
Off Rota	8	8	97.00	97.00
Comp Leave / Bereavement	2	2	25.00	25.00
Maternity / Paternity Leave	0	0	0	0
Emergency Leave	1	1	4.50	4.50
Acting Up Consultant	2	2	40.00	40.00
Total	62	62	629.50	629.50

Locum bookings DECEMBER 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Maternity/Paternity	3	3	36.00	36.00
Vacancy	8	8	89.00	89.00
NEW DEC INTAKE	10	10	75.00	75.00
Sickness	24	24	267.50	267.50
Off Rota	23	23	263.00	263.00
Comp Leave / Bereavement	6	6	65.00	65.00
Emergency Leave	1	1	4.50	4.50
Actg up Consultant	6	6	85.50	85.50
Pre-Booked Leave Agreed	2	2	17.00	17.00
NOT FILLED	**1**	**1**	**12.50**	**12.50**
Total	84	84	915.00	915.00

Fines levied

Two fines have been levied in Q3. Ideas for disbursement of previously accrued fines will be discussed and agreed at the Junior Doctor Forum.

Issues arising

The overall number of exception reports has decreased, with 11 unique reports submitted during the quarter. Similar to Q1 and Q2, the majority of exception reports related to overtime (working beyond scheduled hours) or not achieving natural breaks rather breaches of core rest requirements overnight.

The number of vacant shifts continues to be high but stable.19% of the gaps were due to post vacancies. 190/191 on call locum vacancies during this period were filled.

Liaison Psychiatry at the Queen Elizabeth Hospital

The Guardian of Safe Working, Dr Hari Shanmugaratnam has discussed with Dr Krishnamurthy that the number of exception reports from the liaison psychiatry team at Queen Elizabeth hospital has significantly decreased. The Guardian of Safe Working will continue to monitor this.

Actions taken to resolve issues

See above.

Summary

No immediate safety concerns were raised during this quarter. Exception reporting rates have increased. 11 unique exception reports were raised during this quarter, of which 82% related to overtime working.

The number of exception reports being raised is likely to represent the exception report system being under utilised by resident doctors.

Two fines were levied against the Trust for breaches in safe working hours.

Out of the reports closed, only 7% were within 48 hours and a further 57% were within 7 days.

The number of vacant shifts continues to be high but stable.19% of the gaps were due to post vacancies. 190/191 on call locum vacancies during this period were filled.

Questions for consideration:

Ongoing support from senior leaders in encouraging raising concerns through use of exception reporting system is appreciated.

Report to Board of Directors

Agenda item:	**15**					
Date	2 April 2025					
Title	**Freedom to Speak Up Guardian Report 2024-25**					
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		**Advise**		**Assure**	☒

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:

Colleagues throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up

Speaking up policies and processes are effective and constantly improved

Senior leaders role model effective speaking up

All colleagues are encouraged to speak up

Individuals are supported when they speak up

Barriers to speaking up are identified and tackled

Information provided by speaking up is used to learn and improve

Freedom to speak up (FTSU) is consistent throughout the health and care system, and ever improving

Recommendations

The Board is asked to receive the Annual Report for assurance.

Enclosures

N/A

FREEDOM TO SPEAK ANNUAL GUARDIAN REPORT

1. INTRODUCTION AND BACKGROUND

1.2. The role of Freedom to Speak Up guardians and the National Guardian were established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and recommendations from Sir Robert Francis' Freedom to Speak Up (FTSU) Inquiry.

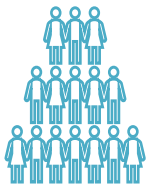
1.3. The Trust's FTSU service was established in 2019 and has expanded to become a team of 3 guardians, a team administrator, and is supported by a network of 21 Champions.

1.4. This report brings together the **432** voices of workers and creates a picture of who is speaking up to the guardian and what they are speaking up about.

1.5. It provides an opportunity for the Trust to learn from these speakers who may not have otherwise been heard.

1.6. The infographics below provide headline activity from 1 January 2024- 31 December 2024:

Headlines 2024



TOTAL

432 cases were raised
with the Freedom to Speak Up Guardians.

PATIENT SAFETY AND QUALITY

14.1% included an element
of patient safety and quality.

compared to national average of 19.4% *

BULLYING AND HARRASSMENT

16.4% of cases reported included an element of bullying or harassment.

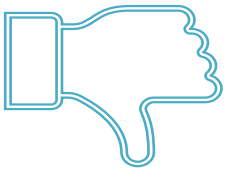
compared to national average of 19.8%

WORKER SAFETY AND WELLBEING

Over one in three cases raised (35.6%) involved an element of worker safety and wellbeing.

The most reported theme in 2024, national average is 32.3%

INAPPROPRIATE BEHAVIOURS



Over one in three cases raised (34 %) involved an element of inappropriate attitudes and behaviours.

ANONYMOUS CASES

The percentage of cases which were raised anonymously is four percent (3.7%).

Less than half the national average of ten percent

DETRIMENT

Detriment for speaking up was indicated in 1% of cases.

Less than the national average of four percent

FEEDBACK

Nearly four-fifths (77.7%) of those who gave feedback said they would speak up again.

The national average is 79.8%

PROFESSIONAL GROUPS

Workers from a range of professional groups spoke to the Freedom to Speak Up Guardians.

Nurses
accounted for the biggest portion (26.8%) of cases raised

The national figure is 28.3% for Nurses and Midwives

* FTSU-Case-Data-Annual-Report-23-24-1.pdf

2. THE IMPACT OF FREEDOM TO SPEAK UP ON SAFETY, CULTURE AND ORGANISATIONAL IMPROVEMENT

2.1 For patient safety concerns we have fed emerging risks intelligence into PSIRF; into the national quality improvement work for George and Eden wards and the enhanced framework plan for Eden PICU. With other surgery work we have contributed towards the Ardenleigh restorative action plan, have been instrumental in initiating action plans for improvements in safety and culture at Warstock Lane, Newington CMHNS CMHT, Maple Leaf, and West Hub CMHT.

2.2 For culture, by sharing feedback, we have influenced improvements in formal HR casework processes, investigation practice and timelines, roles and responsibilities of stakeholders, and casework deep dive analysis. Working alongside colleagues in the People team we received commendation from NHSE for progress made against the “Voice that Counts” People Promise goals.

2.3 High level themes are routinely shared in reports and with leaders across the organisation enabling them to act, learn and improve. Behind these themes are the human experiences of workers wanting to do their best for their patients and colleagues. One of these stories was featured nationally by the National Guardian’s Office as part of their 100 Voices

initiative which showcases the difference which Freedom to Speak Up can make to people patients and organisations 100 Voices: Listening to trainees - National Guardian's Office

2.4 Other examples of national exposure were during speaking up month; Lucy Thomas is working towards reducing the barriers faced by our deaf staff and recorded a video using British sign language Here To Listen. We have also featured in the Annual Report laid before Parliament - National Guardian's Office.

2.5 We are firmly embedded into the Trust's induction programme for corporate, student nursing and newly qualified staff undertaking their preceptorship. We also have a strong presence in the supervision arrangements for our Internationally Educated Nurses. Likewise, we can be confident that our Resident Doctor representatives know how to respond when someone raises a concern.

2.6 Our business volumes and feedback demonstrate that a range of professional groups and those with protected and intersecting characteristics access the service. We know that certain groups of staff face unique and cultural barriers to speaking up and or contacting a guardian. Our analysis reveals that on average in 2024 and for those we knew about, 30% of our speakers identified as being black and minority ethnic; ten percent identified as having a disability/long term health condition/neurodiverse; and three percent identifying as belonging to the LGBTQ+ community.

2.7 As guardians we are invested in and prioritise inclusive listening spaces. Improving our skills and cultural competency through continuous professional development, training and through speaker feedback is of on-going importance.

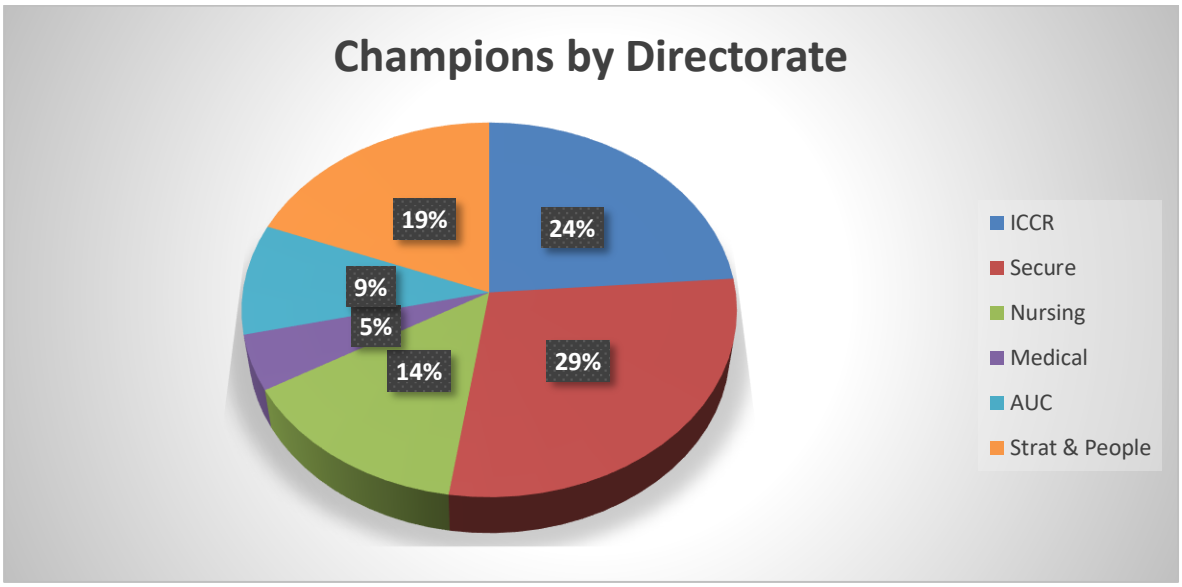
3. THE DEVELOPMENT OF THE FREEDOM TO SPEAK UP CHAMPION NETWORK

3.1 We surpassed our 2024 goal of over 20 champions and now have 21 FTSU Champions who have received the national champions training. We continue to grow this network.

3.2 In Quarter 2 (July-September) we started collecting rudimentary data from our champions in terms of their contacts. We ask them to submit this information anonymously and it is included in our reports

3.3 Most champions elect to support their colleagues in their local areas. However, this isn't always possible and is context dependent and the champions have autonomy in terms of who they are most comfortable supporting.

3.4 The chart below shows the percentage of champions that sit in each directorate:



3.5 There is not too much difference across directorates. However, we do need to focus our recruitment in the Nursing, Medical and Acute and Urgent Care areas. We have asked our leaders in these areas to promote their local champions and to use the 2024 Staff Survey data to identity gaps where champions could be recruited, improving their local speak up arrangements.

3.6 In terms of the location of our champions we are confident that we have a reasonable representation across geographical areas with a diversity of substantive role profiles. A number of our champions are also members of the Staff Networks and are also visible through these forums as other potential sources of support.

3.7 Our champion network is inclusive. Collectively our champions have lived experiences of mental health and recovery, of speaking up themselves, diversity in their backgrounds, and in their protected characteristics. They are committed, passionate and uphold our values in driving behavioral change, empowering their colleagues. Forty seven percent have one or more protected characteristics (Black and minority ethnic, LGBTQ and Disability and Health and Wellbeing).

4. MAKING SPEAKING UP BUISNESS AS USUAL

4.1 Working with our Chair and AD for Corporate Governance we made improvements to our governance arrangements and the FTSU governance framework for reports. This instrument is in place as a safeguard to protect the independence and integrity of the FTSU Guardian from any undue influence and/or pressure or requests to amend their reports or direct work.

4.2 For speaking up month we visited and engaged with over 40 teams and services. The theme for speak up month was "Listening Up" and the importance of listening to understand. We asked colleagues what their experiences of being listened to by managers and leaders was like. Some said that they felt safe and heard but many more told us that that there was a tendency to be signposted to other leaders "in their area". Colleagues fed back that this initial experience made them feel that what they had to say was unimportant and "that it was someone else's job to listen". This discouraged them from speaking up again.

4.3 Equipping our leaders and managers to gain the skills, knowledge and confidence to consistently respond well when someone speaks up to them, to speak up themselves and to create a healthy speak up culture in their area has been a long-standing objective and forms part of the FTSU improvement plan. It is disappointing that take up of the three e-learning modules has been extremely low.

4.4 However, we are pleased to report that for the first time, we have been included in the Trust's Five -Year Strategy 2025/26 in terms of goals and deliverables. Likewise, the new BAF risk "A failure to listen and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services" has also been crafted, enabling further scrutiny and raises the priority of the Trust's speaking up arrangements.

5. LOOKING FORWARD, NEXT STEPS AND THE WIDER SPEAKING UP LANDSCAPE

5.1 We are currently refreshing the Trusts speaking up policy which incorporates the new Speak Up policy for the NHS. This version will be significantly streamlined and more user friendly.

5.2 An early analysis of the 2024 NHS Staff Survey results reveal that we remain persistently below average in having "A Voice that Counts" compared to the mental health average. However, when you look at the sub- themes, we score highly on offering colleagues autonomy and control but far lower when it comes to creating an environment where staff feel comfortable

raising concerns. Conversely, for our bank staff, the "Voice that Counts" score has increased from last year.

5.3 Informed by the Staff Survey and WRES /WDES findings we will be producing an action plan highlighting our priority areas of focus for the year ahead whilst continuing to offer targeted support and intervention to our operational directorates.

5.4 Working alongside the Interim Deputy Director of Quality, Safety & Experience we will be developing our goals and deliverables for improving patient safety, further developing leadership and support for staff to speak up.

5.5 We will actively contribute to the on-going Culture of Care programme at Reaside and are having early discussions with Dr Helen Smith and stakeholder colleagues on how to embed the speaking up and safety culture agenda within the current programme work. Future board reports will provide regular updates on progress.

5.6 One of the outputs from the ICB "Open Conversation" engagement was to strengthen the system guardian arrangements working collaboratively to adopt an evidence -based approach to delivering our FTSU services across the BSOL patch. We meet monthly with our system guardian colleagues.

5.7 We are aware that NHS England is working to implement the Kark review recommendations and has firmly included speaking up as a component of its competency framework for leaders and Chairs.

5.8 We await the publication of the Thirlwall enquiry which is due to be published in the autumn. Amongst other questions, the enquiry has sought to understand the efficacy of existing processes and procedures for raising concerns at the Countess of Chester Hospital (including whistleblowing and Freedom to Speak up Guardians) and whether they were adequate Terms of reference | The Thirlwall Inquiry. The recommendations may potentially impact the role and function of Freedom to Speak up Guardian.

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**2 April 2025**
Date(s) of Committee Meeting(s) reported	**19 March 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Integrated Performance Report • Finance Report • Budget Setting 2025/26 Report • Digital and AI Assurance Report • Cyber Assurance Framework • Emergency Preparedness, Resilience and Response Report • Sustainability Strategic Goals 2025/26 • Clinical Services Strategic Goals 2025/26
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Committee received the proposed 2025/26 financial plan, which set out a breakeven position. This comprised a significant level of risk for the Trust, including a £36m savings plan. The Committee raised concern about the ability to deliver the plan, and requested a delivery and governance framework that would support execution of the plan during the financial year. • The Trust Group position at Month 11 was a reported surplus of £2.6m. This was a £556k improved position from the original year-to-date plan. Following work across the BSOL system to address the significant system deficit, non-recurrent benefits had been identified to increase the Trust forecast from a £2m surplus to £10.7m surplus. • The current financial position was positive, however the Trust's underlying deficit was significant at c£16m, mainly driven by non-Trust beds expenditure and insufficient recurrent savings.
Assure:	• The Committee received a detailed Health Inequalities Report, noting the ongoing work that would ensure health inequalities was a regular reflection in all reports. The Committee would review the 24/7 pilot as part of its future agendas. • The Committee approved the Sustainability strategic goals for 2025/26.

	• The Committee approved the Clinical Services strategic goals for 2025/26. • A positive assurance report into Cyber, Digital and ICT was received. The Committee noted the ongoing work to ensure effective cyber measures to protect the organisation and the Trust's leading position in the ICS in this area. The Committee noted the systems that were being put in place to launch digital change over the next three years.	
Advise:	An outstanding internal audit recommendation for additional Emergency Preparedness, Resilience and Response resource was acknowledged, and the Committee noted that a business case had been developed. The Committee was advised that the Trust may not be fully compliant with Cyber Assurance Framework standards by the final submission date of 30 June 2025, but noted the actions and mitigations in place to ensure compliance by the second year of the CAF.	
Board Assurance Framework	The Committee was assured by the revised Board Assurance Framework and discussed the draft detail of the three new risks: • Failure to maintain a long-term, sustainable financial position • Failure to maintain acceptable governance and environmental standards • Failure to deliver optimal outcomes with available resources The Committee requested further review of the risks to ensure strategic terminology and succinct language was utilised to strengthen framework.	
	New risks identified: No new risks were identified.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	
Date(s) of Committee Meeting(s) reported	**19 February 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Integrated Performance Report • Finance Report • Budget Setting 2025/26 Report, inc. Capital Programme Report • Business Development and Partnerships Report • Right Care Right Person Overview Report • Internal Audit Requirement: Cyber Assurance Framework Data Security Protection Toolkit
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Trust have now received the 2025/26 priorities and operational planning guidance from NHS England. The Committee discussed in detail the national priorities that Integrated Care Boards and providers must achieve and noted the Trust saving plans remain committed and focussed on effective change through transformational long-term planning. Staff engagement remains a priority and finance colleagues will work with the communications team to develop clear communications for wider sharing across the organisation to strengthen staffs understanding and highlight the importance of the challenges for 2025/26. The Committee recognised the significant challenge internally and across the system noting the associated risks. The Trust will make an interim submission on 26 February 2025 in line with national timelines.
Assure:	The Committee were assured in relation to Right Care, Right Person progress and the notable reduction of section 136s since the mobilisation in November 2024. The Committee were assured relationships with West Midlands Police continue to improve and work continues to explore additional partnerships. The Committee received the Business Development and Partnerships Report and were assured overhead margins are being fully considered in relation to the overall impact and benefits of all tenders and other business

	developments. The Committee noted positive progress in relation to all business cases and the benefits in supporting the overall savings plans.	
Advise:	The Committee endorsed the Going Concern review in line with International Accounting Standard 1 Presentation of financial statements and note a review has been undertaken to assess the ability to use the going concern basis of accounting for the preparation of the 2024/25-year end accounts. The Committee endorsed the statutory backlog and maintenance works.	
Board Assurance Framework	The Committee was assured by the revised Board Assurance Framework and current scoring of risks.	
	New risks identified: No new risks were identified.	
Report compiled by:	Winston Weir Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

Report to Board of Directors							
Agenda item:	**17**						
Date	2 April 2025						
Title	Month 11 2024/25 Finance Report						
Author/Presenter	Emma Ellis, Head of Finance & Contracts / Richard Sollars, Deputy Director of Finance						
Executive Director	David Tomlinson, Executive Director of Finance	**Approved**	**Y**		**N**		

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

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

Revenue position:

The month 11 consolidated Group position is a surplus of £2.6m. This is £556k better than the original year to date plan. The original plan for 2024/25 was an outturn of £2m surplus. Following work across the BSOL system to address the significant system deficit, non-recurrent benefits have been identified that move the BSMHFT forecast from a surplus of £2m to a surplus of £10.7m.

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

- **BSMHFT Underlying deficit** – Although the BSMHFT 2024/25 financial position appears positive as described above, the underlying position is a significant deficit of circa £16m, with key drivers being non-Trust bed expenditure and insufficient recurrent savings (see below).

- **Non-Trust Beds overspend** – The 2024/25 non Trust beds expenditure plan is £14m. Year to date expenditure at month 11 is £20m. The current full year forecast is £22m (£8m overspend). Bed day usage has increased to the highest usage of the year to date in February.

- **Savings** – The 2024/25 savings target is £17.8m. The month 11 savings achieved is £16m year to date, this is in line with plan. It is currently forecast that the full target will be achieved but with £8m being via non recurrent means.

Capital position:

The month 11 Group capital expenditure is £5.5m year to date, this is £3m behind year to date forecast. The total revised forecast expenditure for 2024/25 is £14.2m.

Cash position:

The Group cash position at the end of month 11 was £88m.

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services		
People		
Quality		
Sustainability	✓	**Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population.**

Recommendation

It is recommended that the Committee review the month 11 financial position and discuss the key alerts noted.

Enclosures

Month 11 finance report

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2024 to 28thFebruary 2025

Month 11
Group financial position

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Annual Budget	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Patient Care Activities	661,355	605,842	612,664	6,822
Other Income	21,117	19,357	26,850	7,492
Total Income	**682,472**	**625,199**	**639,513**	**14,314**
Expenditure				
Pay	(300,247)	(275,069)	(272,309)	2,760
Other Non Pay Expenditure	(341,092)	(312,272)	(331,889)	(19,617)
Drugs	(7,150)	(6,554)	(7,099)	(545)
Clinical Supplies	(539)	(494)	(631)	(137)
PFI	(14,388)	(13,189)	(12,742)	447
EBITDA	**19,056**	**17,621**	**14,843**	**(2,778)**
Capital Financing				
Depreciation	(9,765)	(8,951)	(8,815)	136
PDC Dividend	(16)	(15)	(15)	-
Finance Lease	(8,479)	(8,126)	(8,170)	(45)
Loan Interest Payable	(972)	(891)	(894)	(3)
Loan Interest Receivable	1,899	1,740	4,916	3,176
Surplus / (Deficit) before taxation	**1,722**	**1,379**	**1,864**	**485**
Taxation	(380)	(348)	(304)	44
Surplus / (Deficit)	**1,342**	**1,031**	**1,560**	**530**
Adjusted Financial Performance:				
Remove capital donations/grants/peppercorn lease I&E impact	5	4	4	-
Adjust PFI revenue costs to UK GAAP basis	722	1,011	1,038	27
Adjusted financial performance Surplus / (Deficit)	**2,069**	**2,046**	**2,602**	**556**

Month 11 2024/25 Group Financial Position

The month 11 consolidated Group position is a surplus of £2.6m This is after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 (£1m year to date).
The month 11 outturn is £556k better than the original year to date plan. The original plan for 2024/25 was an outturn of £2m surplus. Following work across the BSOL system to address the significant system deficit, non-recurrent benefits have been identified that moved the BSMHFT forecast in month 10 from a surplus of £2m to a surplus of £10.7m. The month 11 position is in line with this revised trajectory. For further detail, see page 4.

The Group month 11 position is mainly driven by a surplus of £2.4m in the Trust, £371k surplus for Summerhill Services Limited (SSL), a break even position for the Mental Health Provider Collaborative (MHPC) and a surplus of £232k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

Birmingham and Solihull ICS position

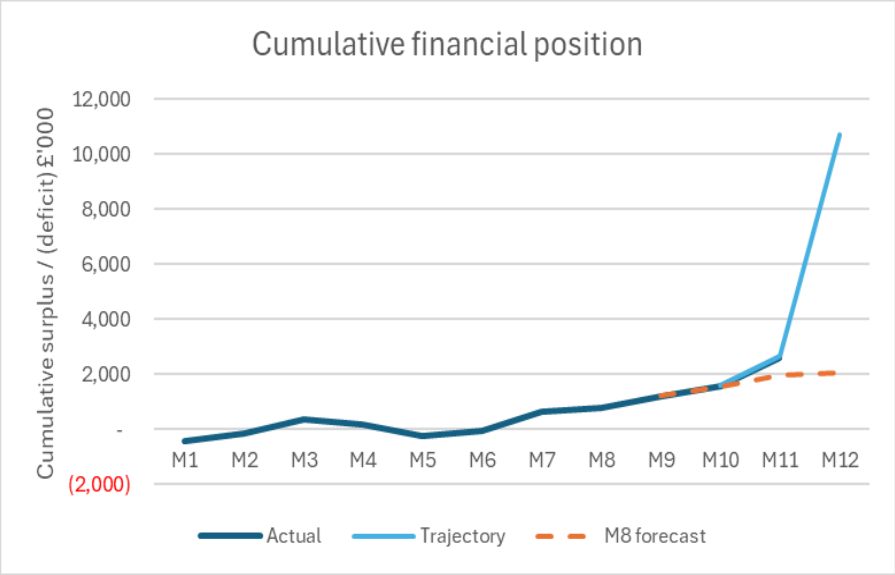
The draft month 11 BSOL system position is a deficit of £42m which is £38m adverse to plan but is an improvement of £45m compared to month 9, mainly driven by UHB. The draft UHB position is now £56m deficit, with £4m deficit for ROH and £13m surplus for BSOL ICB.

Month 11 Group position
Segmental summary

Group Summary	Trust	SSL	Reach Out	BSOL PC	Consolidation	Group
	Actual	Actual	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	344,555	-	157,562	404,852	(294,305)	612,664
Other Income	26,435	26,600	-	-	(26,185)	26,850
Total Income	**370,990**	**26,600**	**157,562**	**404,852**	**(320,491)**	**639,513**
Expenditure						
Pay	(256,535)	(11,450)	(1,924)	(2,660)	261	(272,309)
Other Non Pay Expenditure	(81,224)	(7,729)	(156,980)	(403,538)	317,583	(331,889)
Drugs	(7,419)	(1,970)	-	-	2,290	(7,099)
Clinical Supplies	(631)	-	-	-	-	(631)
PFI	(12,742)	-	-	-	-	(12,742)
EBITDA	**12,438**	**5,450**	**(1,343)**	**(1,346)**	**(356)**	**14,843**
Capital Financing						
Depreciation	(5,849)	(2,604)	-	-	(363)	(8,815)
PDC Dividend	(15)	-	-	-	-	(15)
Finance Lease	(8,146)	(350)	-	-	326	(8,170)
Loan Interest Payable	(894)	(1,843)	-	-	1,843	(894)
Loan Interest Receivable	3,818	22	1,575	1,345	(1,843)	4,916
Surplus / (Deficit) before Taxation	**1,352**	**675**	**232**	**(1)**	**(393)**	**1,864**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(304)	-	-	-	(304)
Surplus / (Deficit)	**1,352**	**371**	**232**	**(1)**	**(393)**	**1,560**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	4	-	-	-	-	4
Adjust PFI revenue costs to UK GAAP basis	1,038					1,038
Adjusted financial performance Surplus / (Deficit)	**2,394**	**371**	**232**	**(1)**	**(393)**	**2,602**

2024/25 Group Forecast

Birmingham and Solihull Mental Health NHS Foundation Trust



	£'000
Original BSMHFT plan/forecast	**2,069**
Distribution of Reach Out Provider Collaborative surplus	2,000
Distribution of Tier 4 CAMHS Provider Collaborative surplus	674
SSL Vat provision release	4,893
Balance sheet flexibity release	1,100
Revised BSMHFT forecast surplus	**10,736**

2024/25 Forecast

The original financial plan for 2024/25 was to achieve a surplus of £2m. The month 11 year to date position is £556k ahead of this plan. As reported at month 10, following work across the BSOL system to identify opportunities for significant financial improvement in quarter 4, additional non-recurrent financial improvements totalling £8.7m have been identified for BSMHFT. This moved the forecast for 2024/25 from a £2m surplus to a surplus of £10.7m as set out in the table opposite. This includes the following unplanned benefits:

- a share of in year surplus from the Reach Out and Tier 4 CAMHs provider collaboratives
- release of a provision held pending review, relating to SSL VAT treatment.
- Further release of balance sheet flexibility

The month 11 year to date position is in line with the revised forecast.

Although the revised forecast for 2024/25 is a substantial surplus, the BSMHFT underlying financial position continues to be a significant challenge given the non-recurrent nature of the in-year benefits.

Commissioning overview

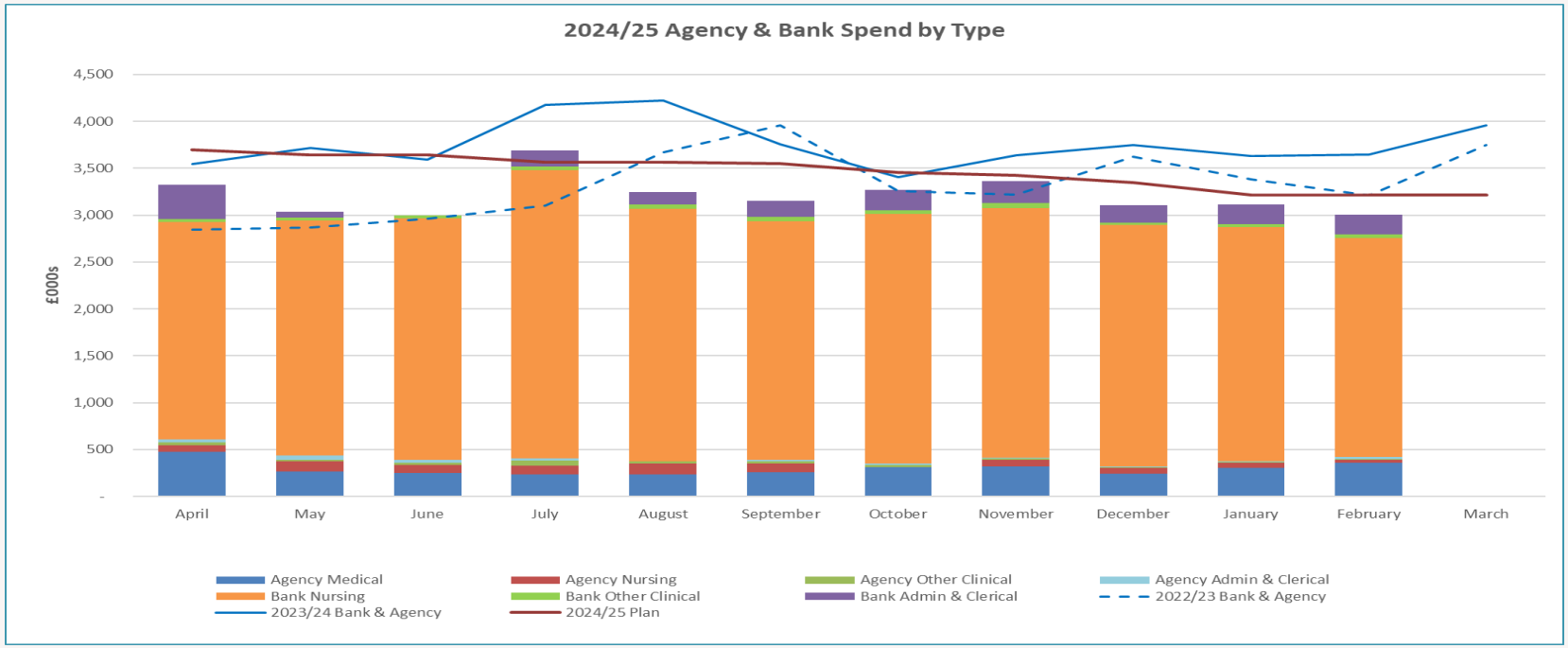
Mental Health Provider Collaborative (MHPC)

- Commissioning responsibility for Learning, Development & Autism (LD&A) transferred from BSOL ICB to MHPC from 1.6.24.
- Current expected income, including LD&A is £446m
- Month 11 position break even
- Month 11 cash balance £27m.
- Key risks:
- Infrastructure costs
- Packages of care (inflation and growth in numbers).

Reach Out

- £165m annual income in current plan
- Month 11 position £232k surplus – in line with agreed contribution to Trust overheads.
- Month 11 cash balance £33m.
- Key risks:
- Clinical concerns around expected growth in out of area numbers and EPC costs.

Temporary staffing expenditure



Bank

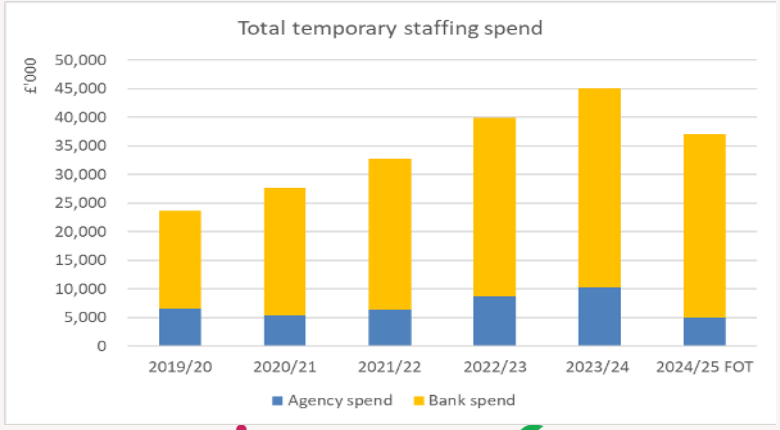
Agency

Month 11 temporary staffing expenditure is £35.2m, this is £3m less than plan.

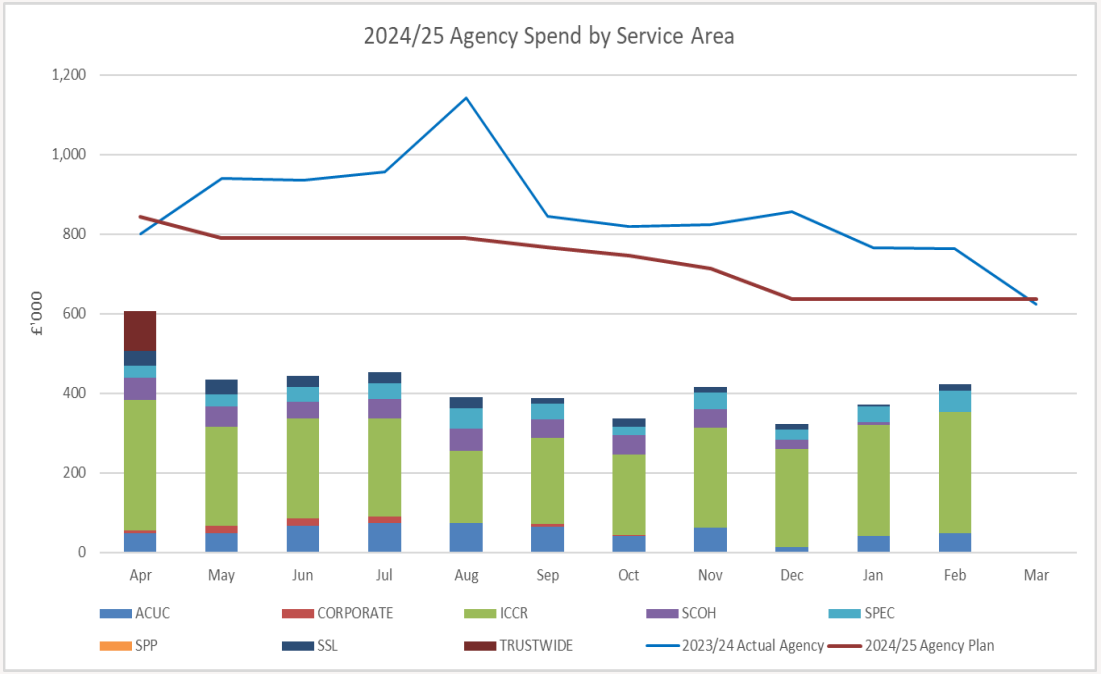
Bank expenditure £30.7m (87%) – the majority of bank expenditure relates to nursing bank shifts - £28.4m

Agency expenditure £4.5m (13%) – the majority of agency expenditure relates to medical agency - £3.3m.

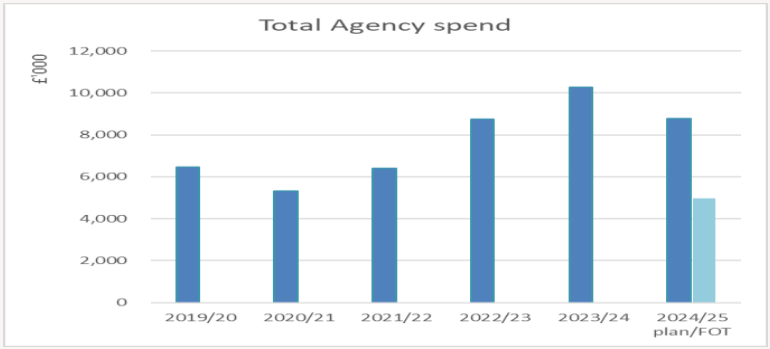
For further analysis on bank and agency expenditure, see pages 7 to 8.



Agency expenditure



KPIs	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Agency spend as % of pay bill (YTD)	3.2%	1.9%	1.8%	1.7%	1.7%	1.7%	1.6%	1.6%
Above price cap bookings - medical	0	11	9	9	9	9	12	12
Above price cap bookings -nursing	0	7	7	5	4	4	4	0
Admin & Estates bookings - Trust	0	0	0	0	0	0	0	0
Admin & Estates bookings - SSL	0	5	4	4	5	5	5	5



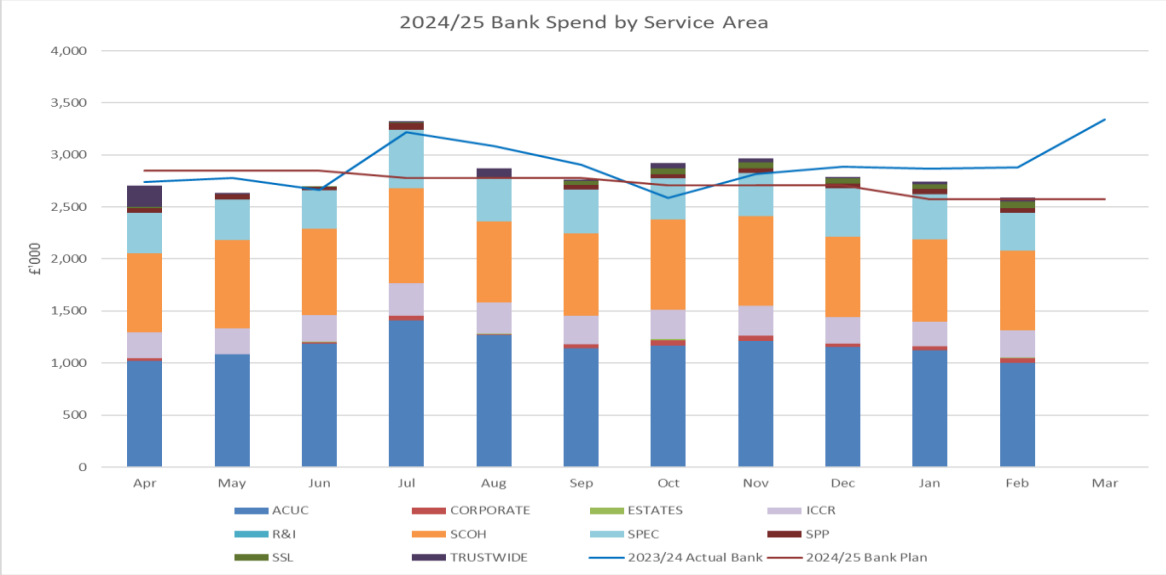
	2024/25 YTD
	£'000
Agency Expenditure	4,470
NHSE Ceiling	8,714
Variance to NHSE ceiling	4,244

		% of total sub category pay
Agency Medical	3,260	7.5%
Agency Nursing (Registered)	775	1.0%
Agency Nursing HCA	6	0.0%
Agency Other Clinical	224	0.5%
Agency Admin & Clerical	206	0.3%
Agency Expenditure	4,470	

Agency expenditure

- The month 11 year to date agency expenditure is £4.5m. This is an underspend of £3.7m.
- Agency expenditure increased in both January and February from the lowest monthly spend in December, predominantly due to ICCR and Specialties medical agency spend. The number of medical above cap agency bookings was 12 during January and February (an increase from 9 during the months of September to December) but has decreased to 10 as at the start of March. Above cap nursing agency books has reduced to nil in February.
- Year to date agency expenditure is 1.6% of the total pay bill which is £4.2m below the NHSE threshold (3.2% of pay bill).
- The full year forecast spend is £5m which is £4m less than plan and £5m less than last year.

Bank expenditure analysis

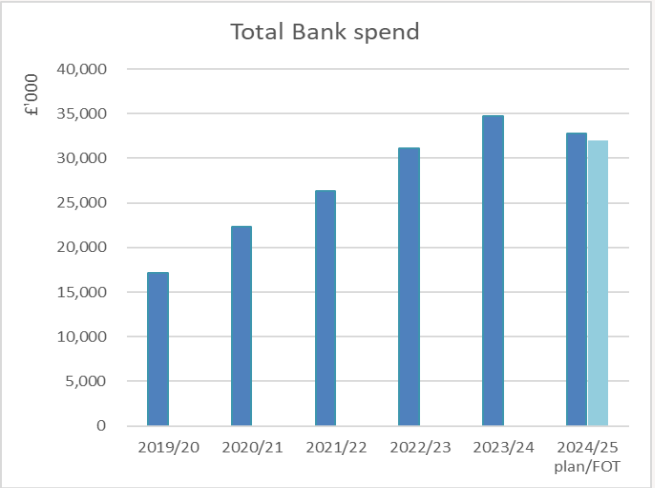


	2024/25 YTD	% of total sub category pay
	£'000	
Bank Nursing (Registered)	11,250	14.5%
Bank Nursing HCA	17,195	39.9%
Bank Other Clinical	402	0.8%
Bank Admin & Clerical	1,899	3.1%
Bank Expenditure	30,745	

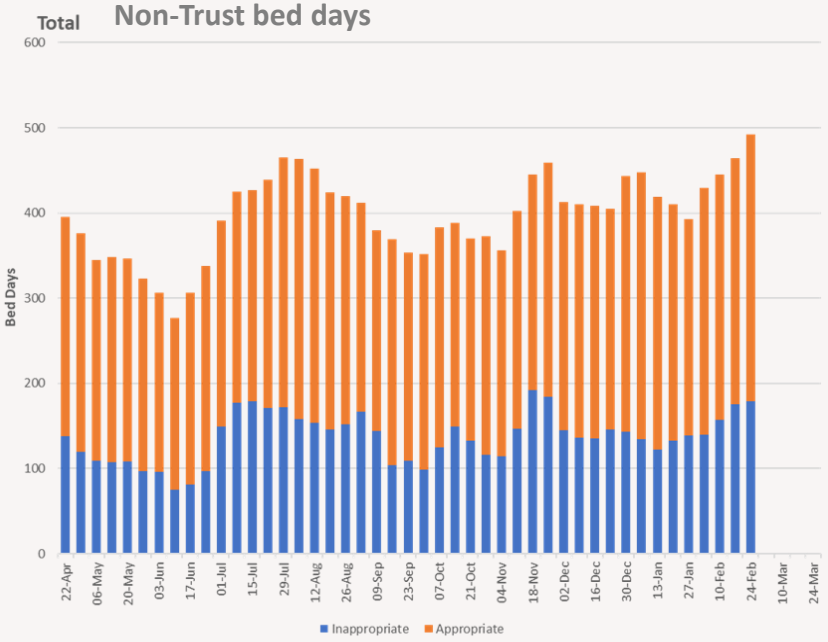
Operational service areas	YTD Bank spend £'000	Bank as % of service area pay
Acute & Urgent Care	12,772	28%
Secure & Offender Health	8,973	20%
Specialties	4,615	38%
ICCR	2,949	6%

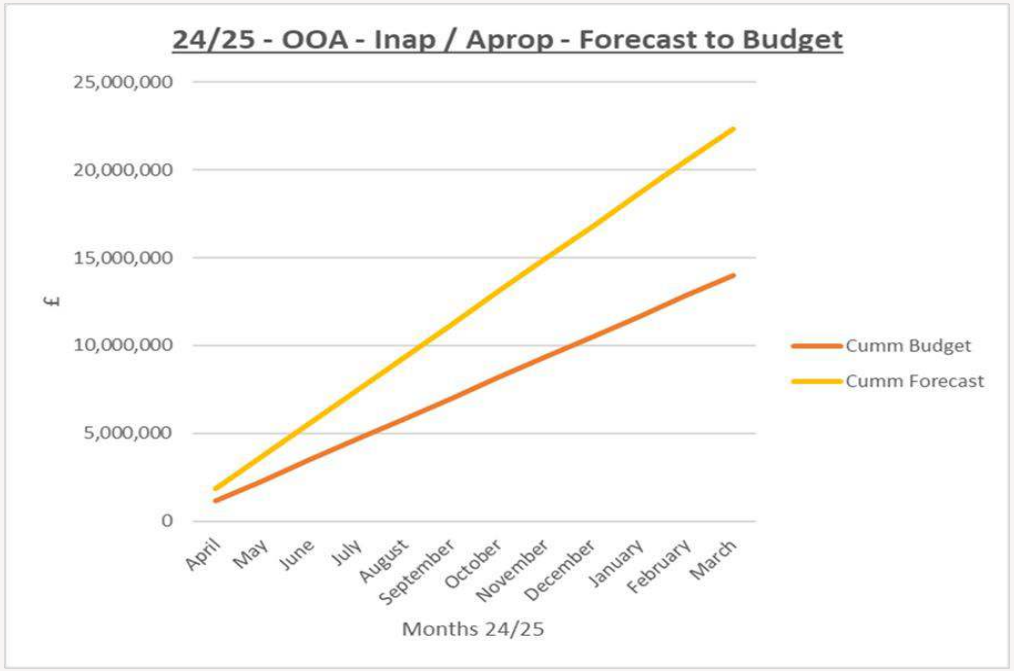
Bank expenditure

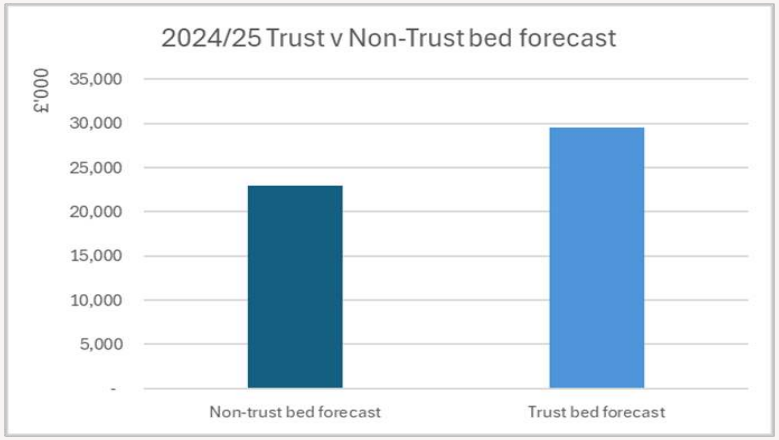
- The month 11 year to date bank expenditure is £30.7m. This is £577k adverse to plan.
- Bank expenditure in February of £2.6m is £151k less than January spend and is £205k less than the monthly year to date average.
- 93% of total year to date bank spend relates to nursing (56% unregistered, 37% registered). The unregistered bank spend of £17m to date equates to 40% of total unregistered nursing pay spend.
- 38% of Specialties pay spend and 28% of Acute and Urgent Care pay relates to bank.
- Year to date bank spend represents 11% of the total pay bill. NHSE are introducing bank expenditure limits for 2025/26, aiming for systems to reduce spend by 15% if current spend is greater than 6.3% of total pay bill.



Non-Trust Beds overspend







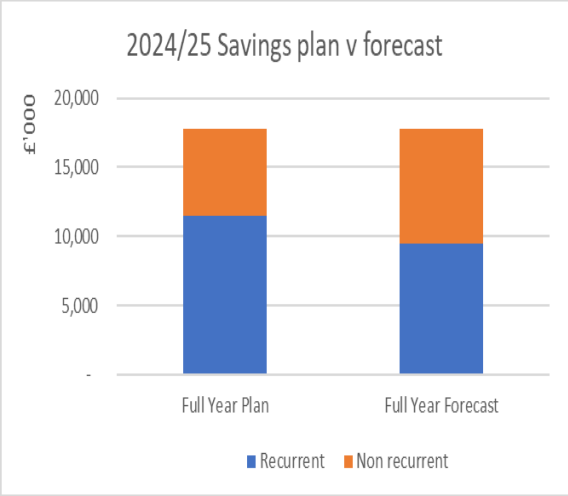
- The total 2024/25 plan for non-Trust bed expenditure is £14m.
- Month 11 year to date expenditure is £20.3m which is £7.5m adverse to plan.
- There has been a significant increase in non-Trust bed days usage during February with bed days increasing to almost 500 which is the highest usage of the year to date.
- The current full year forecast is £22m (£8m overspend).

Efficiencies

	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan FOT £000	Forecast FOT £000	Variance FOT £000
Recurrent						
Pay - Recurrent	2,951	6,777	3,826	3,489	7,132	3,643
Non-pay - Recurrent	7,345	2,173	(5,172)	8,013	2,370	(5,643)
Income - Recurrent	-	-	-	-	-	-
Total recurrent efficiencies	10,296	8,950	(1,346)	11,502	9,502	(2,000)
Non recurrent						
Pay - Non-recurrent	381	381	-	416	416	-
Non-pay - Non-recurrent	1,982	366	(1,616)	2,162	1,117	(1,045)
Income - Non-recurrent	3,424	6,386	2,962	3,735	6,780	3,045
Total non-recurrent efficiencies	5,787	7,133	1,346	6,313	8,313	2,000
Total Efficiencies	**16,083**	**16,083**	**(0)**	**17,815**	**17,815**	-

Savings 2024/25	Plan £'000	Forecast £'000
Recurrent/Non-recurrent		
Recurrent	11.5	9.4
Non-recurrent	6.3	8.4
Total	17.8	17.8
Developed Status		
Fully Developed	8.9	16.5
Plans in Progress	5.0	0.0
Opportunity	2.1	0.0
Unidentified	1.8	1.4
Total	17.8	17.8
Risk Status		
High Risk	8.9	1.4
Medium Risk	0.0	1.5
Low Risk	8.9	15.0
Total	17.8	17.8

- The 2024/25 efficiency target is £17.8m. This comprises £11.5m recurrent and £6.3m non recurrent targets.
- As at month 11, the savings achieved is £16m, this is in line with plan. The slippage against the out of area savings target and the unidentified savings target is mostly offset by agency reduction and non recurrent balance sheet flexibility release.
- It is forecast is that the full savings target will be achieved, with a £2m shortfall against the recurrent target being offset with £2m additional non recurrent savings.



Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - *'Audited'* 31-Mar-24 £m's	NHSI Plan YTD 28-Feb-25 £m's	Actual YTD 28-Feb-25 £m's	NHSI Plan Forecast 31-Mar-25 £m's
Non-Current Assets				
Property, plant and equipment	220.7	218.0	214.8	217.8
Prepayments PFI	1.2	1.2	2.4	1.2
Finance Lease Receivable	0.0	-	0.0	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	221.9	219.2	217.2	219.0
Current assets				
Inventories	0.4	0.4	0.6	0.4
Trade and Other Receivables	21.4	21.4	30.0	21.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	92.2	91.6	87.9	93.1
Total Curent Assets	114.0	113.4	118.4	114.9
Current liabilities				
Trade and other payables	(80.0)	(80.0)	(73.5)	(80.0)
Tax payable	(5.8)	(5.8)	(6.0)	(5.8)
Loan and Borrowings	(2.6)	(2.6)	(2.5)	(2.6)
Finance Lease, current	(1.1)	(1.1)	(1.1)	(1.1)
Provisions	(1.3)	(1.3)	(1.2)	(1.3)
Deferred income	(45.2)	(45.2)	(51.9)	(45.2)
Total Current Liabilities	(136.0)	(136.0)	(136.2)	(136.0)
Non-current liabilities				
Deferred Tax Liability	(0.1)	(0.1)	(0.1)	(0.1)
Loan and Borrowings	(23.0)	(22.2)	(20.8)	(20.8)
PFI lease	(78.3)	(81.9)	(79.1)	(78.8)
Finance Lease, non current	(6.8)	(4.5)	(3.8)	(5.8)
Provisions	(3.0)	(3.0)	(2.5)	(3.0)
Total non-current liabilities	(111.2)	(111.8)	(106.3)	(108.5)
Total assets employed	88.6	84.8	93.1	89.4
Financed by (taxpayers' equity)				
Public Dividend Capital	114.7	115.1	117.9	115.1
Revaluation reserve	48.0	48.0	48.0	48.0
Income and expenditure reserve	(74.1)	(78.3)	(72.9)	(73.7)
Total taxpayers' equity	88.6	84.8	93.1	89.4

SOFP Highlights

The Group cash position at the end of February 2025 is £87.9m.

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

Current Assets & Current Liabilities

Ratios

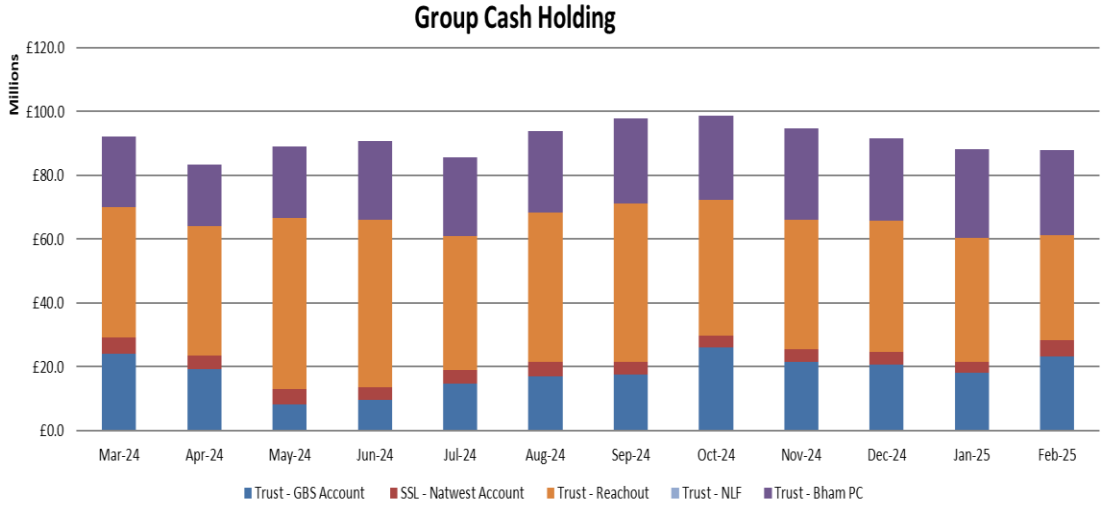
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

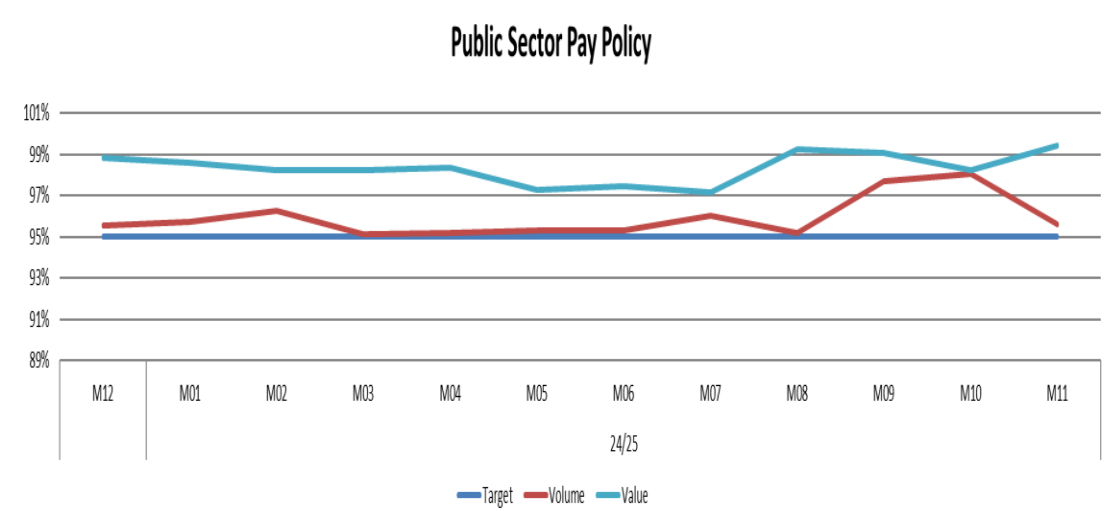
Current Ratio :	**£m's**
Current Assets	118.4
Current Liabilities	-136.2
Ratio	0.9

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

Cash & Public Sector Pay Policy

Birmingham and Solihull Mental Health NHS Foundation Trust





Cash

The Group cash position at the end of February 2025 is £87.9m. This comprises of Trust £23.1m, SSL £5.4m, Reach Out Provider Collaborative £32.7m and Mental Health Provider Collaborative £26.7m.

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

Better Payments

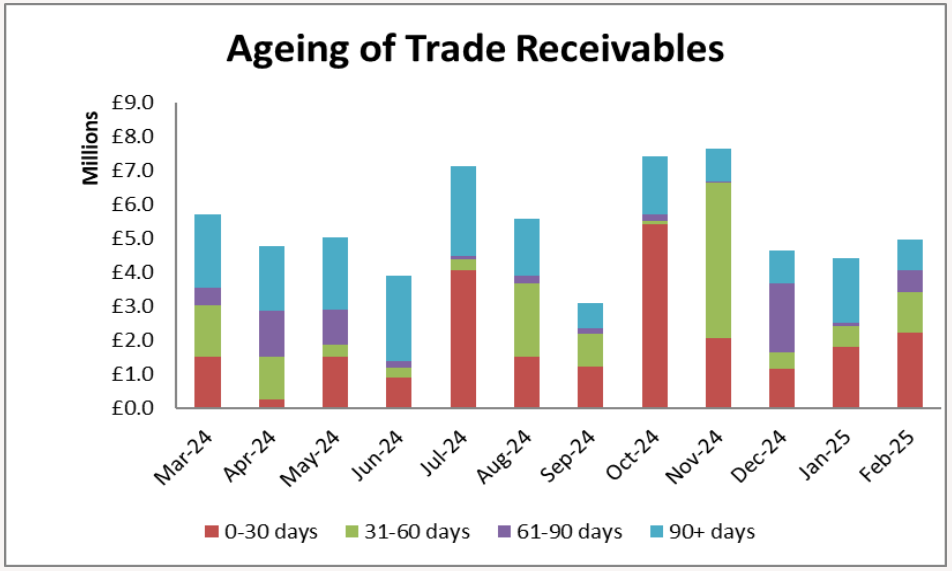
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

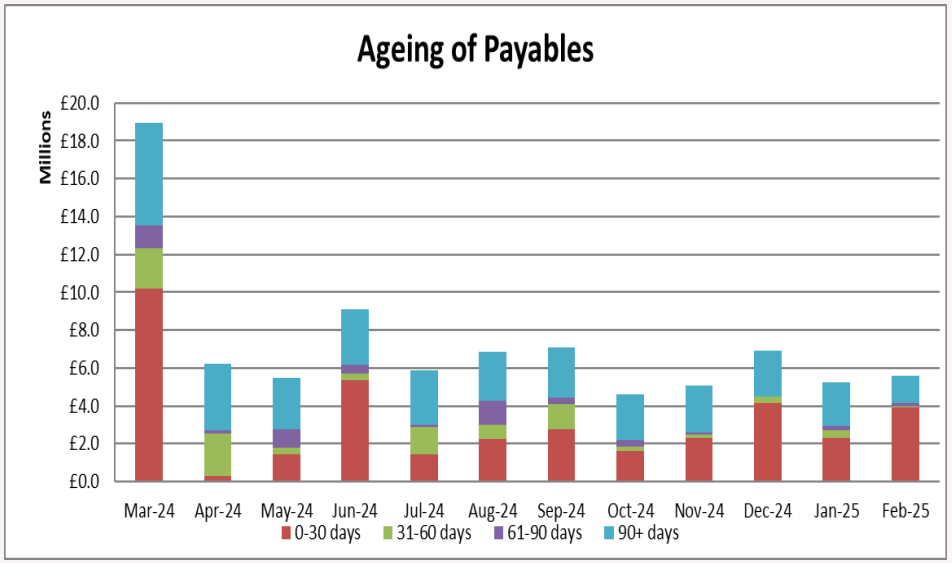
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	98%	✓	100%	✓
Non - NHS Creditors within 30 Days	96%	✓	99%	✓

Trust Receivables and Payables





With a focus in the NHS currently around intra-NHS debts in readiness for the month 12 accounts, BSMHFT have been working with NHS colleagues to ensure as far as possible any issues are rectified.

Trade Receivables :

- **0-30 days-** Overall Balance £2.2m– increase in balance due to £924k invoice to BWC FCAMHS 24/25 Non-Recurrent Investment which has been paid in March 25. *Awaiting authorisation*: a number of individual payments awaiting approval and several debts have been cleared in March 2025.

- **31-60 days-** Overall Balance £1.2m - increase in balance. *Awaiting authorisation:* £1.2m. *In query:* a number of balances that are currently being resolved. Remaining balance mainly staff overpayments (on payment plans).

- **61-90 days-** Overall Balance £638k- increase in balance. *In query*: various balances including Access to Work, Paraxel and Bordesley Green PCN. Remaining balance mainly staff overpayments (on payment plans).

- **Over 90+ days-** Overall Balance £903k –significant decrease in balance due to payment of £975k from BWC. *Awaiting authorisation/paid:* £37k. *In query:* BWC £42k, University of Birmingham £79k, UHB £280k, Ethypharm £87k, Parexel £63k, Access To Work £16k, Bordesley East PCN £18k. Remaining balance mainly staff overpayments (on payment plans).

Trade Payables- Over 90 days:

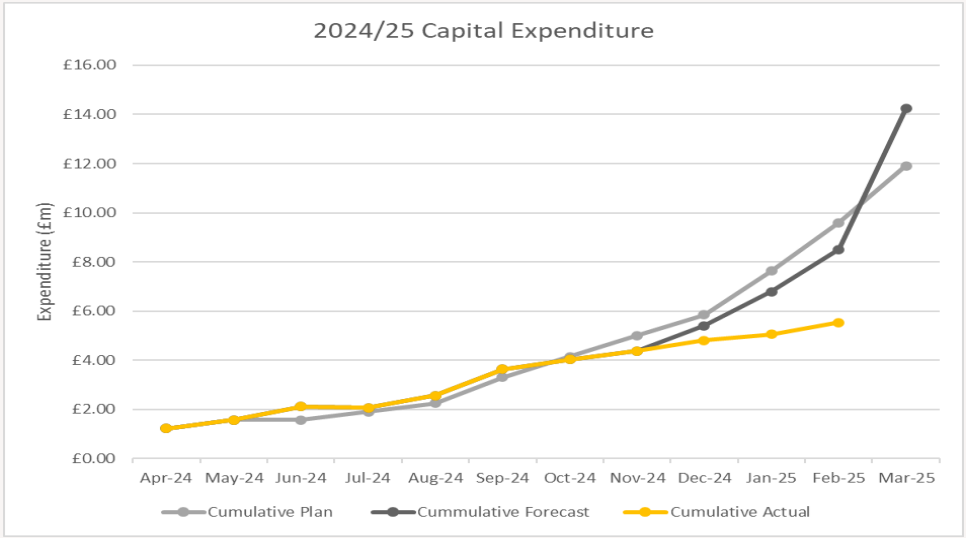
NHS Suppliers £409k: NHS Property £147k-historic invoices with Estates & Facilities, UHB £265k in query (working directly with UHB to resolve before end of March 2025).
Non-NHS Suppliers (47+) £1.0m: mainly bed/out of area fees invoices in query/awaiting approval, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in March 2025.

Month 11 Capital Expenditure

Capital schemes	Annual Plan	Annual Forecast	Adjustments	New annual forecast	YTD Forecast	YTD Actual	Variance to Forecast
	£'m						£'m
Approved Schemes:							
Critical Infrastructure Risks (CIR)	0.0	0.7		0.7	0.4	0.0	0.4
Highcroft Build	0.0	0.6		0.6	0.4	0.2	0.2
Minor Projects (inc Carry-Forward)	2.3	3.3		3.3	2.9	2.9	(0.0)
SSBM Works	2.0	2.0		2.0	1.5	0.9	0.6
Doorsets	0.7	1.5		1.5	0.6	0.4	0.2
Lease Vehicles	1.4	1.4	0.3	1.7	1.2	0.8	0.4
Recognition of IFRS 16 Leases	0.2	0.2		0.2	0.2	0.2	0.0
R&D rTMS Machines	0.7	0.7		0.7	0.4	0.0	0.4
Design Work for Forensics Capital Bid	0.8	0.0		0.0	0.0	0.0	0.0
Medical Device Replacement	0.1	0.1	(0.1)	0.0	0.1	0.0	0.0
ACUC PDC Funded Programme	0.8	0.8	(0.2)	0.6	0.5	0.0	0.5
Other IFRS 16	1.0	0.7	(0.0)	0.7	0.4	0.0	0.4
Pharmacy Robot			0.2	0.2	0.0	0.0	0.0
Northcroft Cladding			0.2	0.2	0.0	0.0	0.0
IT Shared Care			1.4	1.4	0.0	0.0	0.0
Unallocated Core Spend	0.4	0.0		0.0	0.0	0.0	0.0
ICT	0.0	0.5		0.5	0.1	0.1	0.0
System Capital	1.6	0.0		0.0	0.0	0.0	0.0
Total	11.9	12.5	1.8	14.2	8.5	5.5	3.0

Funded by:

PDC Shared care Funding	-1.4
Additional system capital allocation	-0.4
	0.0



Group Capital Expenditure

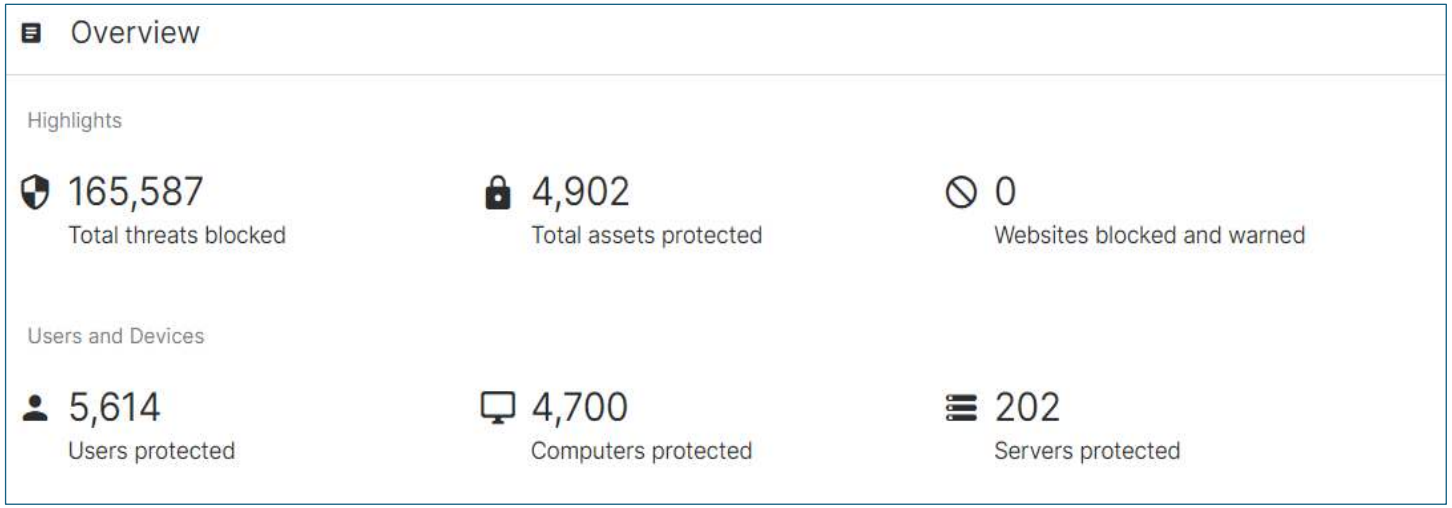
Group capital expenditure is £5.5m year-to-date. This is £3.0m behind the forecast.

Forecast capital expenditure for 24/25 is £14.2m. A breakdown of the movement in available funding since last months forecast has been included in the adjustments column in the table opposite.

Digital Update

April 2025

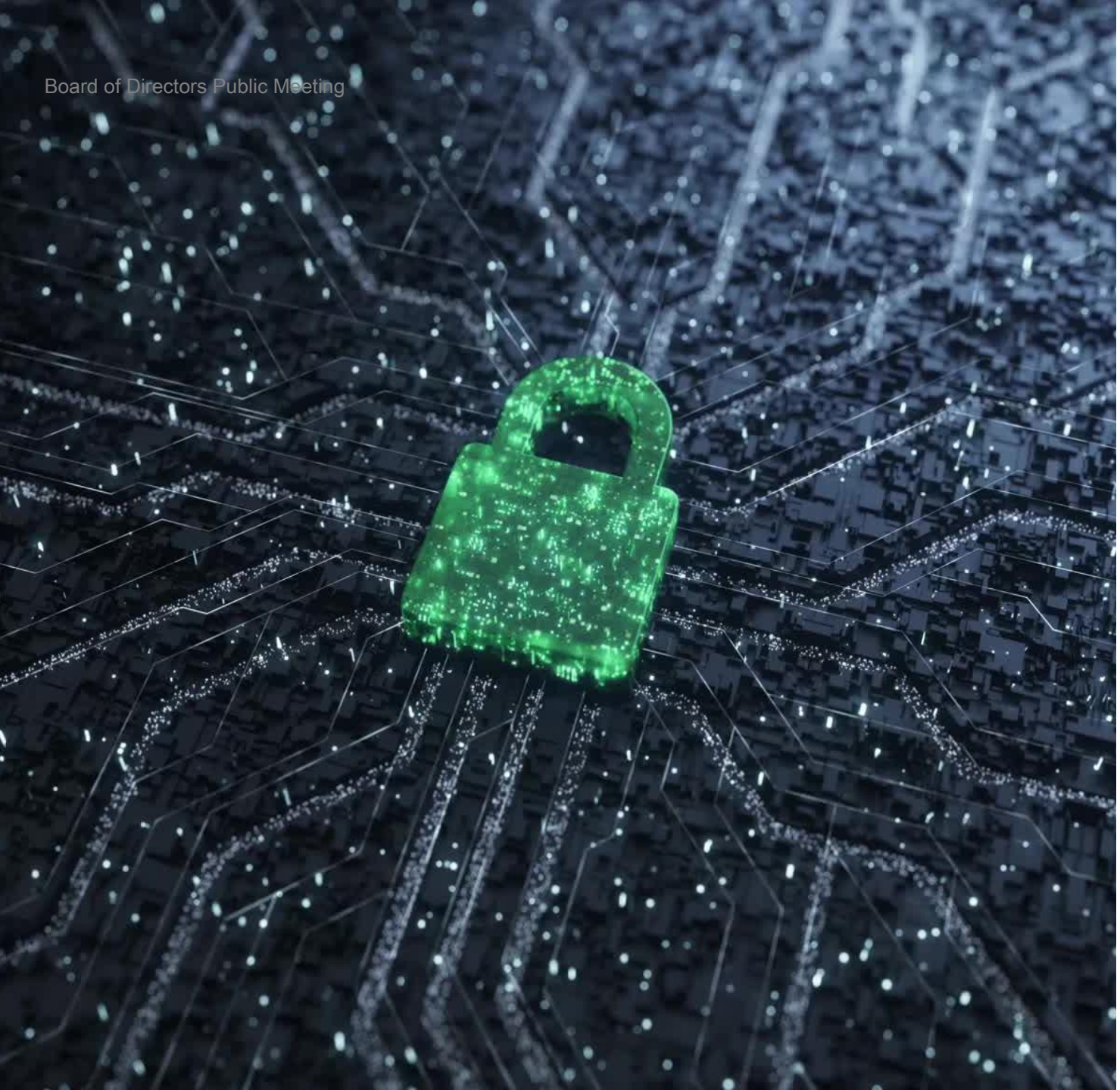
Organisation Name	Windows Exposure Score	Server Exposure Score
NHS SANDWELL AND WEST BIRMINGHAM CCG (CLOSED)		
NHS BIRMINGHAM AND SOLIHULL ICB - 15E	66.9	33.7
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	68.7	65.5
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	56.3	46.4
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST (SUB-GROUP)		
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	72.7	54.9
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST (SUB-GROUP)		
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	25.9	17.9
BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	44.4	27.3
NHS ENGLAND - T1510	68.1	
NHS ENGLAND	52.2	27.7
NHS ENGLAND - X26	76.1	32.9



BSMHFT continue to be in the top 10 Trusts in the country for compliance with respect to the server exposure

2025/26 Priorities and Operational Planning guidance

- **NHS App first** communications to patients (with due regard to digital inclusion), by default through the NHS Notify service
- '**Federated Data Platform (FDP) First**' policy, **85% of all secondary care trusts by March 2026**
- all providers shift to the **national collaboration service NHS.Net**
- all providers deploy the **Electronic Prescription Service**
- all providers integrate systems with the **NHS e-Referral Service**
- implementing the framework for NHS action on **digital inclusion**
- ensure the NHS is fit for the future -making full use of digital tools to drive the **shift from analogue to digital**
- validate patients on a **referral to treatment (RTT)** waiting list after 12 weeks and then every 12 weeks in line with good practice and published guidance, maximising the use of digital tools for both patient contact and data quality



Cyber NCSC brief (31stJan 2025)

- Over the last 12 months, there have been several ransomware incidents against UK healthcare providers and the supply chain
- The cyber threat to the UK health sector almost certainly mirrors the threat we see across all UK Critical National Infrastructure (CNI) sectors
- Beyond ransomware, phishing, data theft and extortion, cyber-enabled fraud and Distributed Denial of Service (DDoS).
- The UK health sector is almost certainly perceived as an attractive target: a vast IT estate with a complex and uncharted supply chain, a quantity of sensitive data, valuable intellectual property, and a time-critical nature of services that can be disrupted
- Industry reporting suggests healthcare companies globally are more likely to pay ransoms than other industries, which in turn makes them more likely to be targeted in the future.

Cybersecurity Tools **(653 orgs)**

- Windows Server Updates – Maintenance Window / Patch Management
- Sophos Managed Detection Response (MDR)
- Sophos Central – threat blocking
- NHS Secure Boundary
- Reporting:
  - ITHealth Lansweeper
  - Microsoft Defender for Endpoints (which provides Organisational Exposure Score)
- User awareness training:
  - Metacompliance

Upgrades

Rio Upgrade

- Rio was successfully upgraded to version 24.05 in September 2024. This upgrade has fixed several bugs that were present in the system.

EPMA Upgrade

- Version 10.23 of EPMA was upgraded on 8th October 2024 following successful testing by both the Application Support team and Reaside, Central, and Summerhill Pharmacies
- AD integration

IAPTUS Upgrade

- Upgraded on 28th September 2024 following successful testing by the Application Support team – zero issues reported

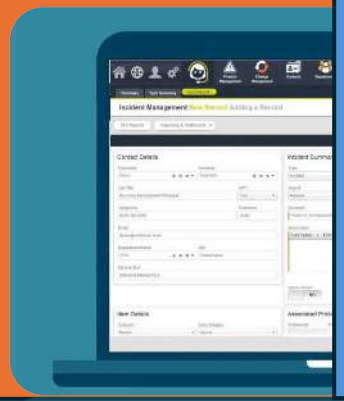
5 Benefits of the new Sunrise ITSM solution

Self-

With a sleek
support and a
and tracking y

Ticke

Not only will I
tickets quicke
provide access
and assets at th
It will also provi
as the tic



Access

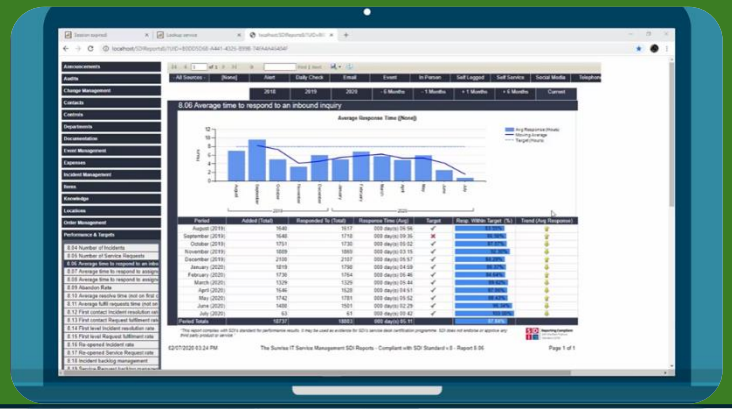
Staff can log
anywhere, ar
engineers, be
assigned work
mean we can

Purchasi

A more familiar
will be delivered
facilities, imag
automat

Knowledge is Power

With more advanced and smart catalogue presenting users and ICT staff as a ticket is filled out and intelligent real-time reporting we'll be able to monitor and manage all incidents and requests as they arrive



Microsoft Intune

Current Position

- Differences in permissions necessitated an impact/options analysis.
- Alternative solutions needed for audit tools and main Trust Intranet.
- Impact analysis close to completion.
- Recommended approaches being finalised

Microsoft NHS N365

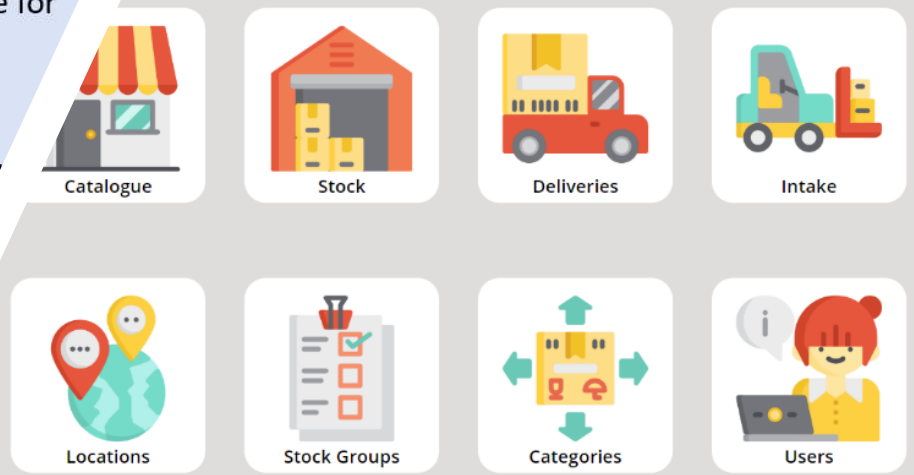
Benefits

- Significant future cost avoidance, circa 500k per annum.
- Opportunities for further annual licence savings.
- Alignment and improved integration with wider NHS.

Next steps

- Submit business case for alternative Intranet solution in May
- Begin engagement a design requirement June.
- Start wider trar planning and
- Increase co highlighti

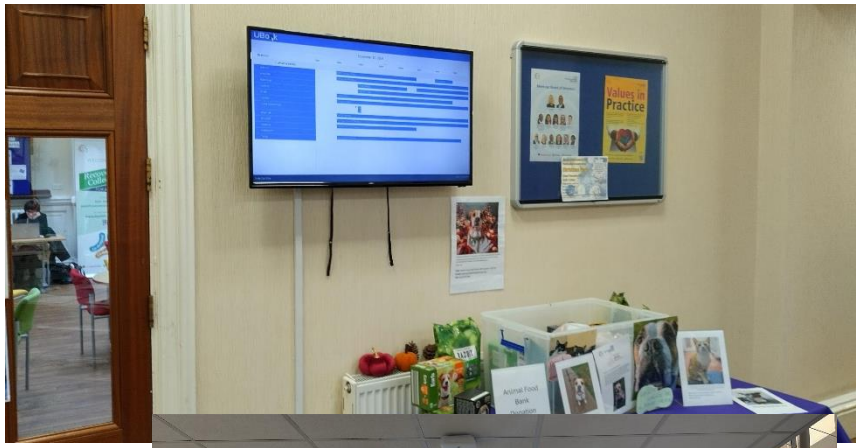
SSL Warehouse Management



Google ChromeOS

Ubook

Successful implementation of a ChromeBox to display Ubook in the Uffculme Reception and 1st Floor Reception at Northcroft.



Digital Display Boards

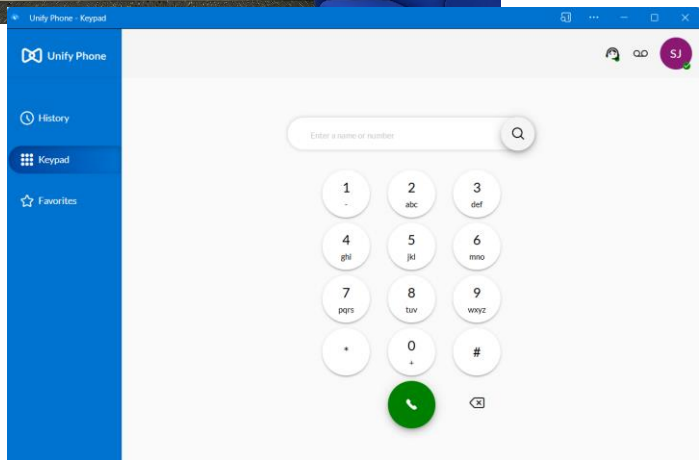
Trials well underway for display boards, this technology can be used to display information to service users and staff around the Trust.

Currently installed on screen in the SSL Hub Reception.

Inpatient Payphone Replacement

Use of Google ChromeOS devices in inpatient areas to replace outdated analogue payphones being investigated.

We are currently working with partners at Unify/Mitel around integrating phone calls into ChromeOS and Teams using the Unify ‘Softphone’ client.



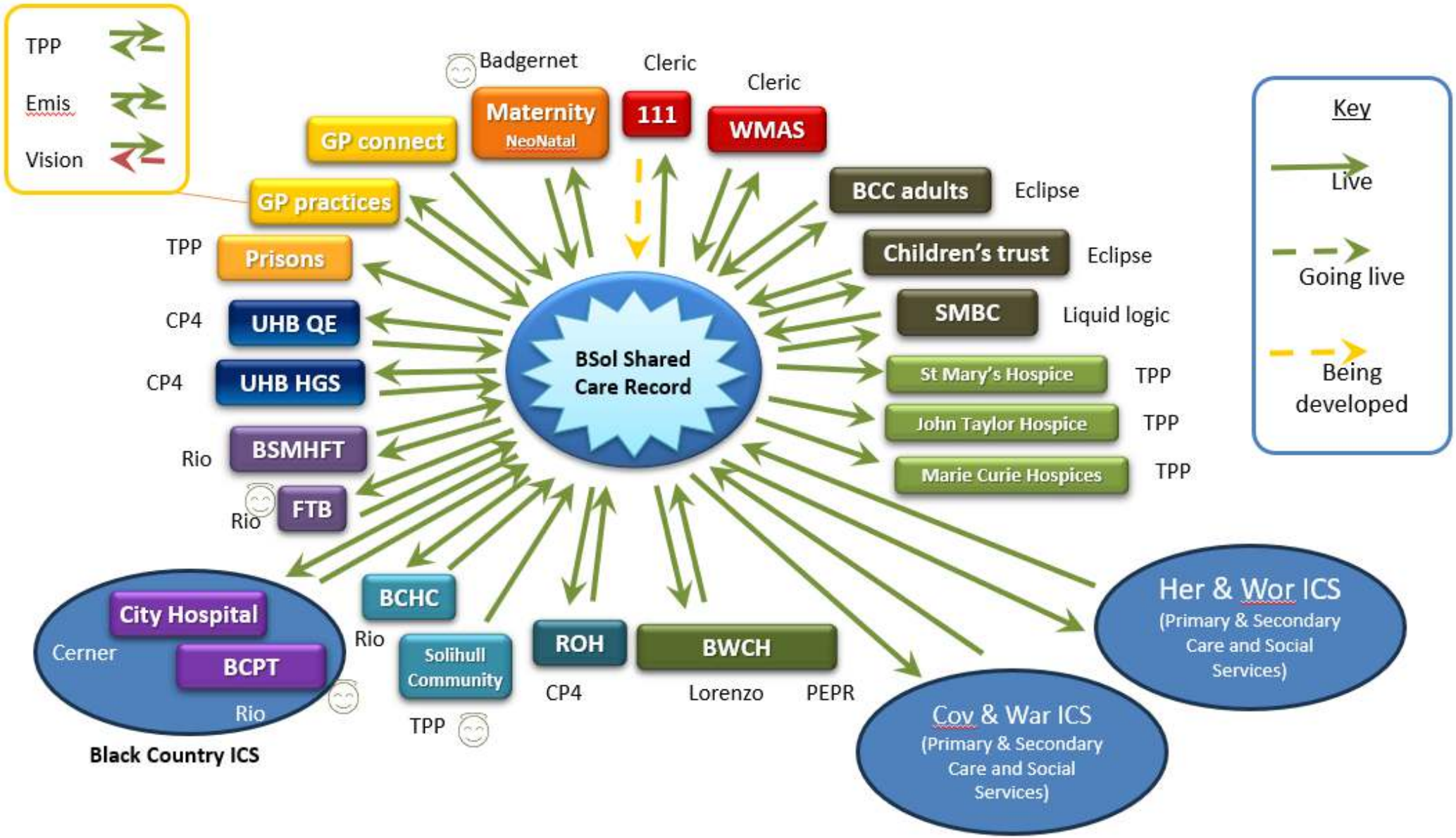
365 Transition Programme

The 365-transition programme is now gathering pace and will manage the transition of Microsoft 365 data and applications during the remainder of 2024 and early 2025.

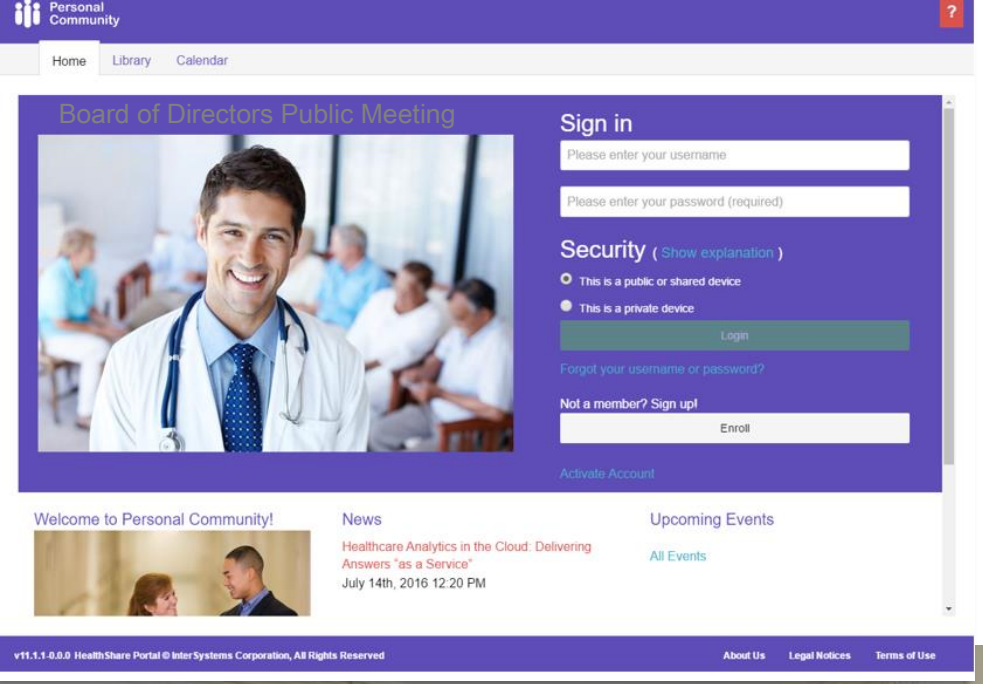
The transition is a strategically important and represents an important opportunity to achieve significant recurrent license savings due to the recent advancement of the NHS England central 365 offering in terms of available functionality.

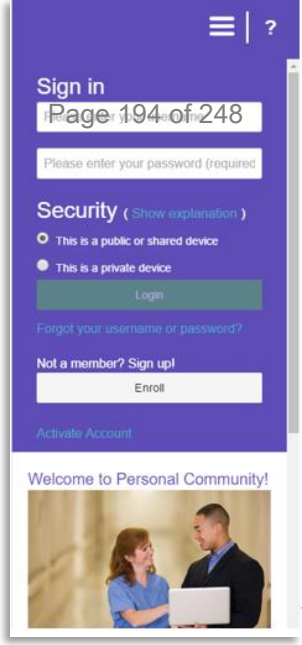
Stage	Description	October 24	November 24	December 24	January 25	February 25	March 25	April 25	May 25
Pre Migration Analysis	Analysis of all 365 data and usage to aid plannng and targeted communications								
Migration Preparation	Detailed planning and extensive testing prior to migration								
Migration	Migration of 365 data to central tenant, including manual input where necessary								
Post Migration Stabilisation	Providing colleagues with support and guidance post migration								

Bsol Shared Care Record



Patient Engagement Portal





NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

I need urgent help

Welcome to the BSMHFT Patient Portal

The BSMHFT Patient Portal provides a single place for you to securely view and manage your health information. You can:

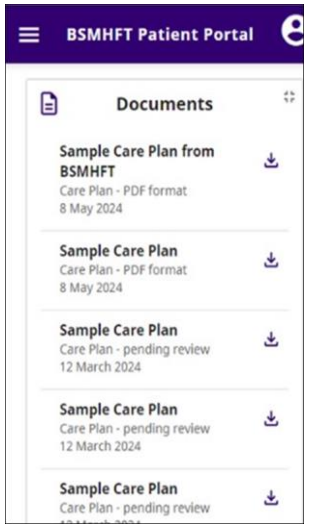
- View your appointments
- View your Care Plans

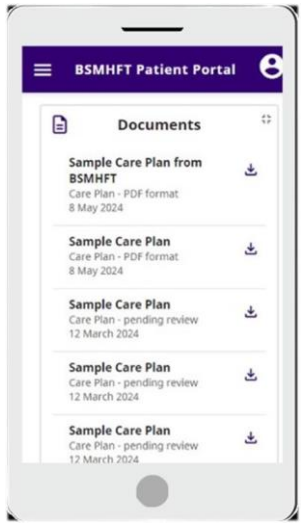
compassionate inclusive committed

Sign In

Continue to NHS login

☐ This is my personal device


BSMHFT Patient Portal
Documents
Sample Care Plan from BSMHFT
Care Plan - PDF format
8 May 2024
Sample Care Plan
Care Plan - PDF format
8 May 2024
Sample Care Plan
Care Plan - pending review
12 March 2024
Sample Care Plan
Care Plan - pending review
12 March 2024
Sample Care Plan
Care Plan - pending review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Documents
Sample Care Plan from BSMHFT
Care Plan - PDF format
8 May 2024
Sample Care Plan
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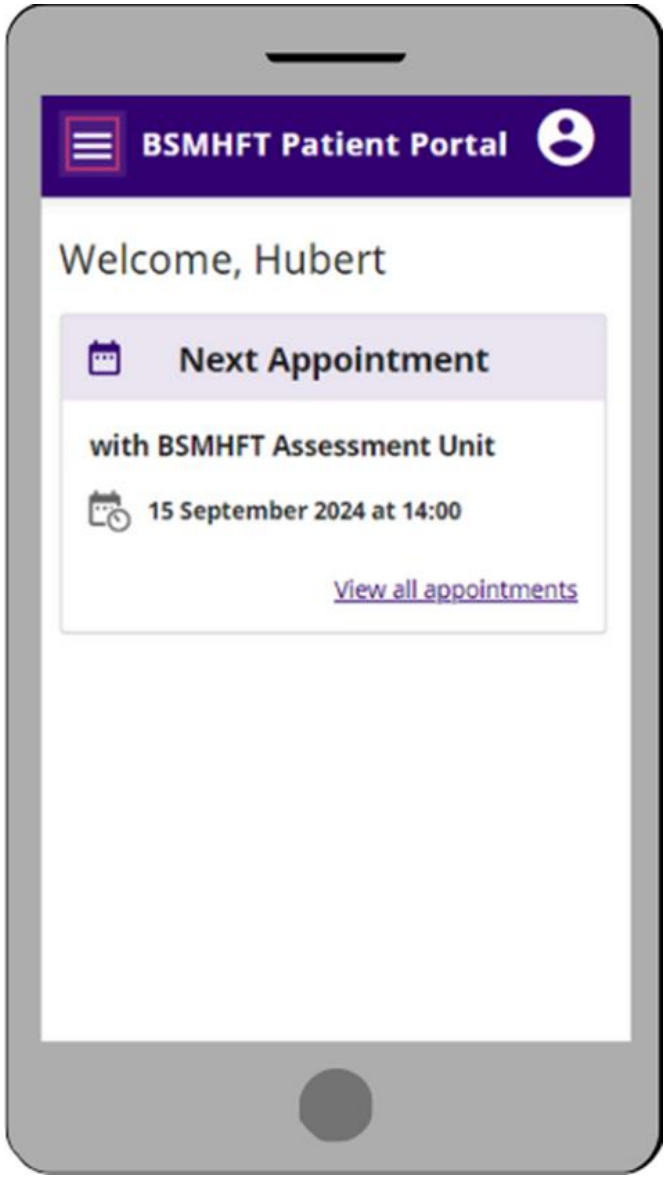
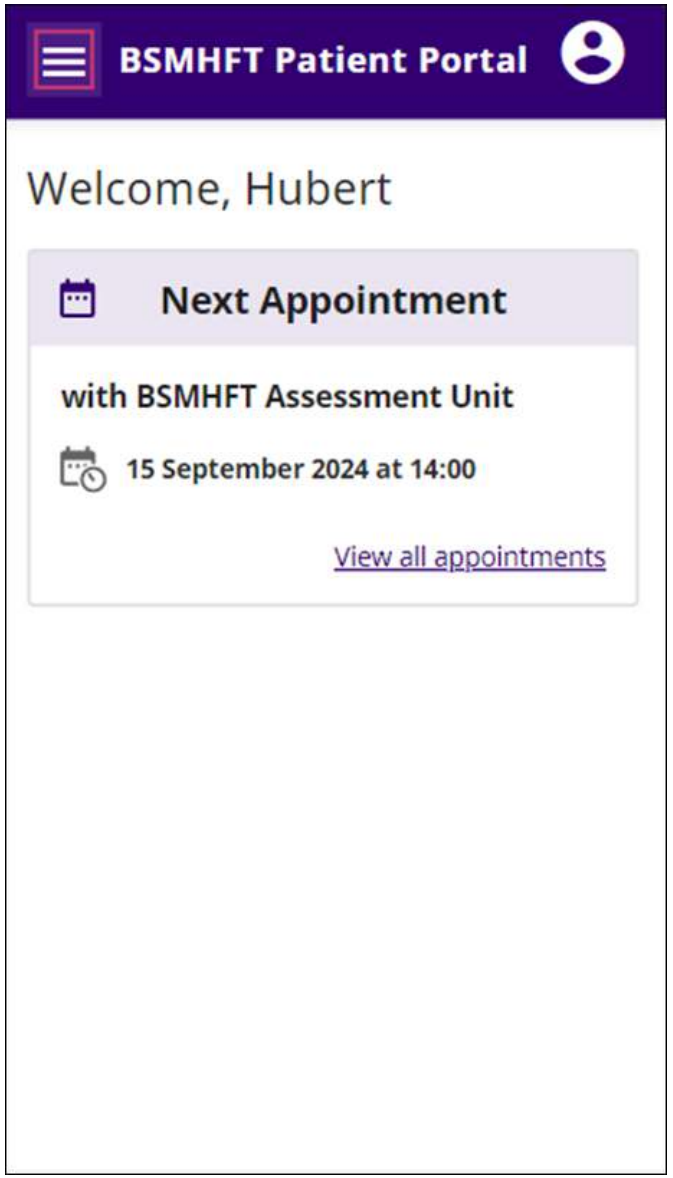
8 May 2024
Sample Care Plan
Care Plan - pending review
12 March 2024
Sample Care Plan
Care Plan - pending review
12 March 2024
Sample Care Plan
Care Plan - pending review
12 March 2024


BSMHFT Patient Portal
Welcome, Hubert
Next Appointment
with BSMHFT Assessment Unit
15 September 2024 at 14:00
View all appointments


BSMHFT Patient Portal
Welcome, Hubert
Next Appointment
with BSMHFT Assessment Unit
15 September 2024 at 14:00
View all appointments

Pharmacy Proof of Concept

- Seven pharmacies are now live on the ShCR
- All BSoL Pharmacies will be on-boarding in the next quarter

End of Life Care

RECENT | RELATIONSHIPS | PATIENT SEARCH | PATIENT RECORD

Kilroy, Drake Date of Birth: 19-May-1958 (64y) Gender: Male *NHS No.* 946 570 1149

- Chartbook
  - Summary
  - Allergies & Alerts
  - GP Summary
  - End of Life Care
  - Warnings

End of Life Care details from GP Connect

GpConnect

Palliative and End of Life Information

	Response	Updated by	Updated on
On Palliative Care Register			
Primary Diagnosis			
Estimated Prognosis / GSF Stage			
Last days of life		MR GPONE TEMPLE SOWERBY	12/01/2023 16:10
Last months of life	Putting this in as a historic entry which should be back dated a month but not back dating	MR GPONE TEMPLE SOWERBY	12/01/2023 16:11
Gold standards framework prognostic indicator stage B (green) - months prognosis		MR GPONE TEMPLE SOWERBY	28/11/2022 14:26
Legal proxy / PoA			
Review of advance care plan		MR GPONE TEMPLE SOWERBY	12/01/2023 16:14
Advance Care Plan			
Has advance statement		MR GPONE TEMPLE SOWERBY	28/11/2022 14:26
ReSPECT			
Has ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)	Note the code is not 1107891000000100	MR GPONE TEMPLE SOWERBY	12/01/2023 16:17
Advance Decision to Refuse Treatment			
Treatment escalation plan		MR GPONE TEMPLE SOWERBY	28/11/2022 14:26
CPR Recommendation			
For cardiopulmonary resuscitation	- may reconsider depending on how condition advances, to be raised at next review	MR GPONE TEMPLE SOWERBY	28/11/2022 14:26
Not for cardiopulmonary resuscitation	- has changed mind to no CPR due to worsening condition	MR GPONE TEMPLE SOWERBY	28/11/2022 14:42
Organ Donation			
Organ donation information leaflet given		MR GPONE TEMPLE SOWERBY	28/11/2022 14:42
Issue of palliative care anticipatory medication box	Note use of synonym	MR GPONE TEMPLE SOWERBY	12/01/2023 16:27

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

Patient: EDITESTPATIENT, NINE - Born:13-Nov-1950 (71 years) - Gender: Female - NHS No: 9999999549 - Published by [redacted] on 02-Aug-2022 10:19

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

The ReSPECT process starts with a conversation between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

1. This plan belongs to:

Full name	EDITESTPATIENT, NINE
Date of birth (dd/mm/yyyy)	13/11/1950
Address	WATERLINKS WARWICK CV344SW
NHS/CHI/Health and care number	9999999549
Preferred name	
Date completed (dd/mm/yyyy)	

2: Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Mr Nine has heart failure and wears hearing aids

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

Advance Statement in top draw of dresser in bedroom

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐Yes / ■**No**

3: What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me ☐ ☐ ☐ ☐ ■ Quality of life and comfort matters most to me

What I most value:	What I most fear / wish to avoid:
comfort	pain

4: Clinical recommendations for emergency care and treatment

Prioritise extending life	or	Balance extending life with comfort and valued outcomes	or	**Prioritise comfort**
				GPname

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

test

CPR attempts recommended Adult or child	or	For modified CPR:Child only, as detailed above	or	**CPR attempts NOT recommended Adult or child**
				GPname

5: Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? Document the full capacity assessment in the clinical record. ■**Yes** / ☐No

If no, in what way does this person lack capacity?

6: Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A, B or C, OR complete section D below):

■	A	This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.
☐	B	This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
☐	C	This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):
☐	1	They have sufficient maturity and understanding to participate in making this plan.
☐	2	They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
☐	3	Those holding parental responsibility have been fully involved in discussing and making this plan.
☐	D	If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7: Clinicians' signatures

Grade / speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Registered Nurse	Caitlyn Adkins	10g0647e	CAdkins	27/07/2022 11:35
GP	Mr Smith	hdhosho	GPname	02/08/2022 10:17

Patient: EDITESTPATIENT, NINE - Born:13-Nov-1950 (71 years) - Gender: Female - NHS No: 9999999549 - Published by [redacted] on 02-Aug-2022 10:19

8: Emergency contacts and those involved in discussing this plan

Involved in Planning	Name	Role and Relationship	Emergency contact no.	Signature (optional)
✔	Mrs Eight	☐Friend ■Family ☐Care Provider	000000000	MEight

* First line is for primary emergency contact

9: Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade / speciality	Clinician name	GMC/NMC/HCPC no	Signature

AI Development

Co-Pilot - Pilot

AI and Automation in Diagnostics: Initial Opportunity Ideas Across The E2E Service

Generative AI
Automate pre-assessment form completion using AI and patient data

Machine Learning
Streamline diagnostic pathway steps using AI

Generative AI
Automate transcription of diagnostic results

Generative AI
Automate the summarisation of complex reports using Gen AI

Referral & Appointment Booking	Pre-Assessment & Preparation	Diagnostic Testing	**Results Analysis**	Reporting & Documentation
Intelligent Automation Automate CT scan scheduling for nodule surveillance using Intelligent Automation	**Machine Learning** Predict optimal diagnostic pathways using AI	**Intelligent Automation** Automate patient cancellations and reschedule appointments based on priority using RPA	**Generative AI / Machine Learning (Classification)** Automate first reading of CT scans using AI for accuracy and reliability	**Generative AI / Machine Learning (Classification)** Automate diagnostic image analysis using AI (e.g., MRI, X-rays)	**Generative AI / Machine Learning (Classification)** Automate diagnostic image post-processing using Generative AI	**Generative AI and RPA** Automate the creation and distribution of patient information leaflets using Gen AI

Rio – Ambient Voice (July 2025)

- **“ambient listening"** or **"ambient intelligence."** In clinical settings, **ambient listening** refers to AI technology that listens to conversations (often between healthcare professionals or between patients and providers) and automatically transcribes and organizes that information into electronic health records or notes.
- This process is often done passively in the background, using microphones or other sensors, which is why it’s sometimes referred to as ambient or passive listening

Report to Board of Directors						
Agenda item:	**19**					
Date	2 April 2025					
Title	Trust Strategic Goals 2025/26					
Author/Presenter	Presenter – Patrick Nyarumbu, Executive Director of Strategy People and Partnerships Author - Abi Broderick, Head of Strategy, Planning and Business Development					
Executive Director	Patrick Nyarumbu	**Approved**	**Y**	✓	**N**	

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

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

Purpose

- The purpose of this report is to share the proposed annual goals for 2025/26 for all four of our strategic priorities: clinical services, quality, people and sustainability and to seek approval from Trust Board.

Introduction

- Our Trust Five Year Strategy was developed during 2019/20 and launched across the organisation April 2021. The Strategy was co-produced with colleagues, service users and carers, and partners. It comprises four strategic priorities, each of which has five-year strategic aims. There are four key themes that are a thread running throughout the Strategy.
- Each year we agree goals for each strategic priority. We are currently in the process of finalising our end of year review of performance against the 2024/25 goals and this will be reported to Board Committees in April 2025.
- The purpose of this report is to share the **goals for our four strategic priorities for 2025/26**, which is the final year of our current strategy. These have been approved by Board Committees in March 2005 prior to being prior to being **submitted to Trust Board in April 2025 for final approval.**
- The report also provides a high level outline of our plans to **refresh the strategy** during 2025/26.

Key Issues and Risks

- The draft goals and deliverables for 2025/26 have been developed through:
    - Review of progress in 2024/25 and identification of any goals that should be carried forward or reframed.
    - Discussion with divisional senior leadership teams and other service leads about priorities, challenges and risks.
    - Review of the 2025/26 planning guidance.

  - Review of benchmarking and productivity opportunities.
  - Identification of system pressures and priorities.
  - Alignment to commissioning intentions.
  - Outputs from the senior leader team planning sessions that are currently taking place.
- Due to the ongoing discussions happening in the planning sessions it is recognised that goals may change over the coming weeks as plans are formulated in more detail. Where this is the case, we will report back to Committee.
- We have not included any specific goals around the services currently provided by Forward Thinking Birmingham. These will be incorporated during the year once services and staff are transferred into BSMHFT.
- Milestone plans are currently being developed by goal owners with a target deadline of the end of April.
- Across our four strategic priorities we have 43 Trust goals. Within these are 6 key priorities for us for the year:
  1. Working with the system to develop a locality model of providing physical and mental health care.
  2. Improving patient flow across our acute and urgent care services.
  3. Rollout and evaluation of the 24/7 neighbourhood mental health centre pilot in East Birmingham.
  4. Improving staff experience, including reducing the number of staff experiencing bullying, harassment, abuse and discrimination.
  5. Implementing the Culture of Care Quality Improvement programme of work, aiming to improve quality, safety, effectiveness and patient experience.
  6. Focusing on productivity and efficiency, including use of digital and artificial intelligence, providing better patient outcomes and more efficient and cost- effective services as a result.
- 2025/26 is the final year of our 5 Year Trust strategy and so during the year we will carry out a comprehensive refresh of the strategy so that we have a new strategy ready for launch in April 2026.
- The report contains a high level outline of the aims of the strategy, our approach to the refresh, and the timeline for the work which includes a summary of how Trust Board will be involved.

Recommendation

The Board is asked to:

1. NOTE this report detailing the planning process for 2025/26 and the plans for the strategy refresh.
2. APPROVE the proposed Trust Goals for 2025/26.

Enclosures

Trust Goals 2025/26 Report

Strategic Priorities

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

Our Trust Five Year Strategy

2025/26 goals

Trust Board
2 April 2025

compassionate inclusive committed

1. Introduction

Our Trust Five Year Strategy was developed during 2019/20 and launched across the organisation April 2021. The Strategy was co-produced with colleagues, service users and carers, and partners **four strategic priorities – Clinical Services, People, Quality and Sustainability**, each of which has a number of five-year strategic aims which describe our particular areas of focus. There are four key themes that are golden threads running throughout the Strategy. A summary of our Trust Strategy can be found on the next page.

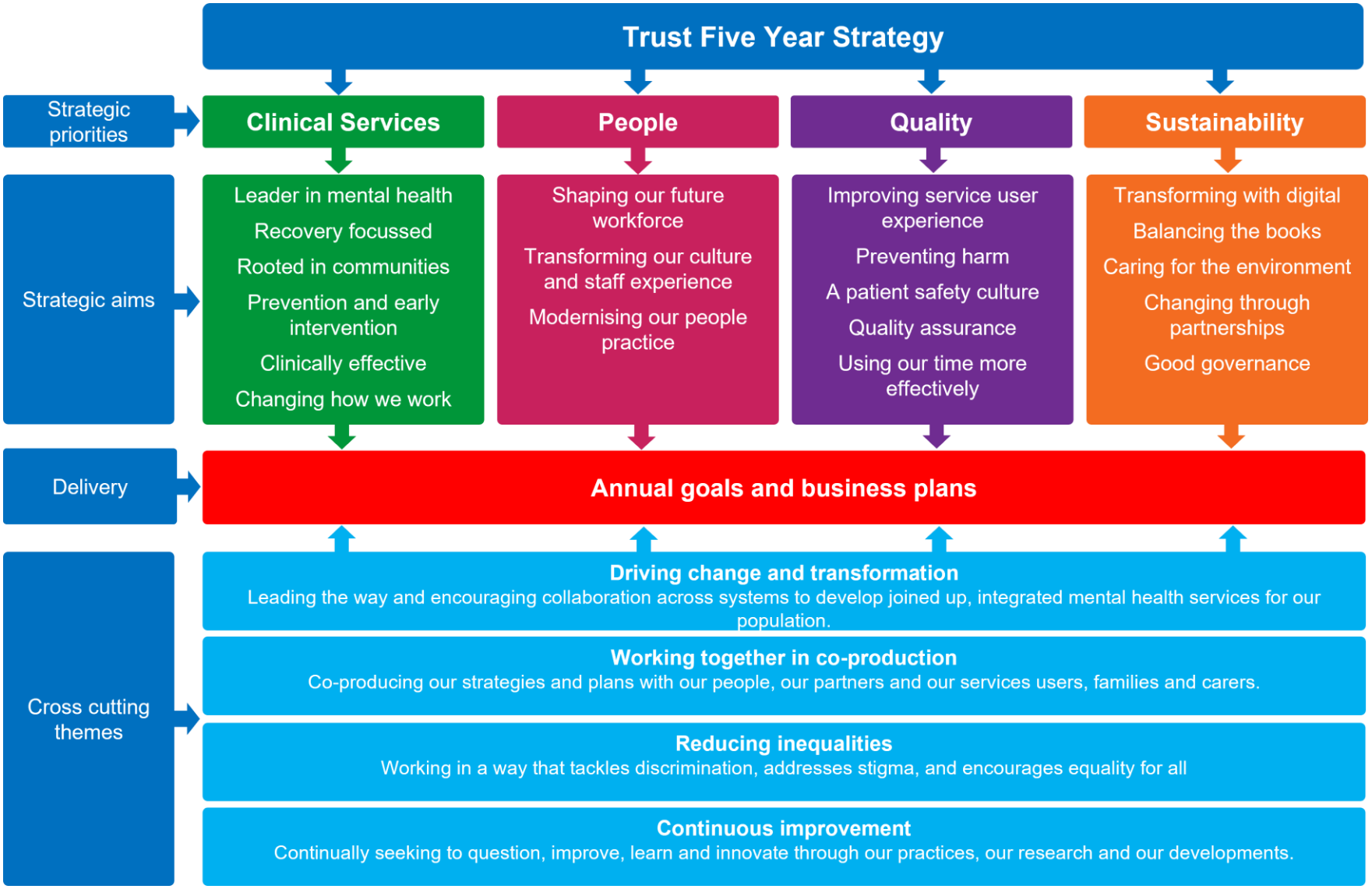
Each year we agree goals for each strategic priority. We are currently in the process of finalising our end of year review of performance against the 2024/25 goals and this will be reported to Board Committee in April 2025.

The purpose of this report is to share the **goals for our four strategic priorities for 2025/26**, which is the final year of our current strategy. These have been approved by Board Committees in March 2005 prior to being prior to being **submitted to Trust Board in April 2025 for final approval.**

The report also provides a high level outline of our plans to **refresh the strategy** during 2025/26.

2. Our Trust Strategy

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust



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3. How we have developed the 2025/26 goals

- The draft goals and deliverables for 2025/26 have been developed through:
    - Review of progress in 2024/25 and identification of any goals that should be carried forward or reframed.
    - Discussion with divisional senior leadership teams and other service leads about local priorities, challenges and risks.
    - Review of the 2025/26 national planning guidance.
    - Review of benchmarking and productivity opportunities.
    - Identification of system pressures and priorities.
    - Alignment to commissioning intentions.
    - Outputs from the senior leader team planning sessions that are currently taking place.
    - Discussion at Operational Management Team meeting in March 2025.
- Due to the ongoing discussions happening in the planning sessions it is recognised that goals may change over the coming weeks as plans are formulated in more detail. Where this is the case, we will report back to Committees.
- We have not included any specific goals around the services currently provided by Forward Thinking Birmingham. These will be incorporated during the year once services and staff are transferred into BSMHFT.
- Milestone plans underpinning the goals are currently being developed by goal owners with a target deadline of the end of April.

4. The national context

The Department of Health and Social Care and NHS England are developing a new 10 Year Health Plan together with the public and health and care staff. This plan will be based around the following 3 shifts and so we are making sure our strategy and our goals for 2025/26 alignswith these. This plan is expected to be published later in 2025.

Moving more care from hospitals to communities	Making better use of technology	Preventing sickness, not just treating it
Moving care from hospitals into homes, closer to the places people live and their community.	Using digital technology promises faster, higher-quality, more connected care.	Preventing rather than simply treating sickness will keep people healthier for longer.

5. The system context

The **BSOL Mental Health Provider Collaborative (MHPC)** is developing a **new mental health strategy**. This will be a life course strategy setting the direction of travel for the next five years. It has shared a blueprint with a wide variety of people and stakeholder groups between January and March 2025, and the final strategy is being developed for launch in the first half of 2025/26. We will need to align our work with the transformation priorities identified by the MHPC.

MHPC transformation priorities

- **Children and young people**
- **Acute and urgent care**
- **Mental health services in the community**
- **Specialist placement pathways**
- **Learning disability and autism**

What's gone well since we launched our strategy in 2021 - examples

- Establishment of the Mental Health Provider Collaborative.
- Closer system working to solve local problems.
- Stronger voice of the VCFSE sector in decision making through the MHPC.
- Increased partnership working between the Trust and the VCFSE delivery of services.
- Joint system work on Learning Disability and Autism (LDA)

Key system drivers for 2025/26

- 2025/26 Planning guidance
- System financial position
- Patient flow and pressures on Emergency Departments and use of mental health beds
- Children and young people's transformation
- Improvement in Talking Therapies
- Need for partnership working to find different solutions to system issues.
- Continued focus on health inequalities and need for co-production and community engagement across

6. The local Trust context

What's gone well since we launched our strategy in 2021 - examples

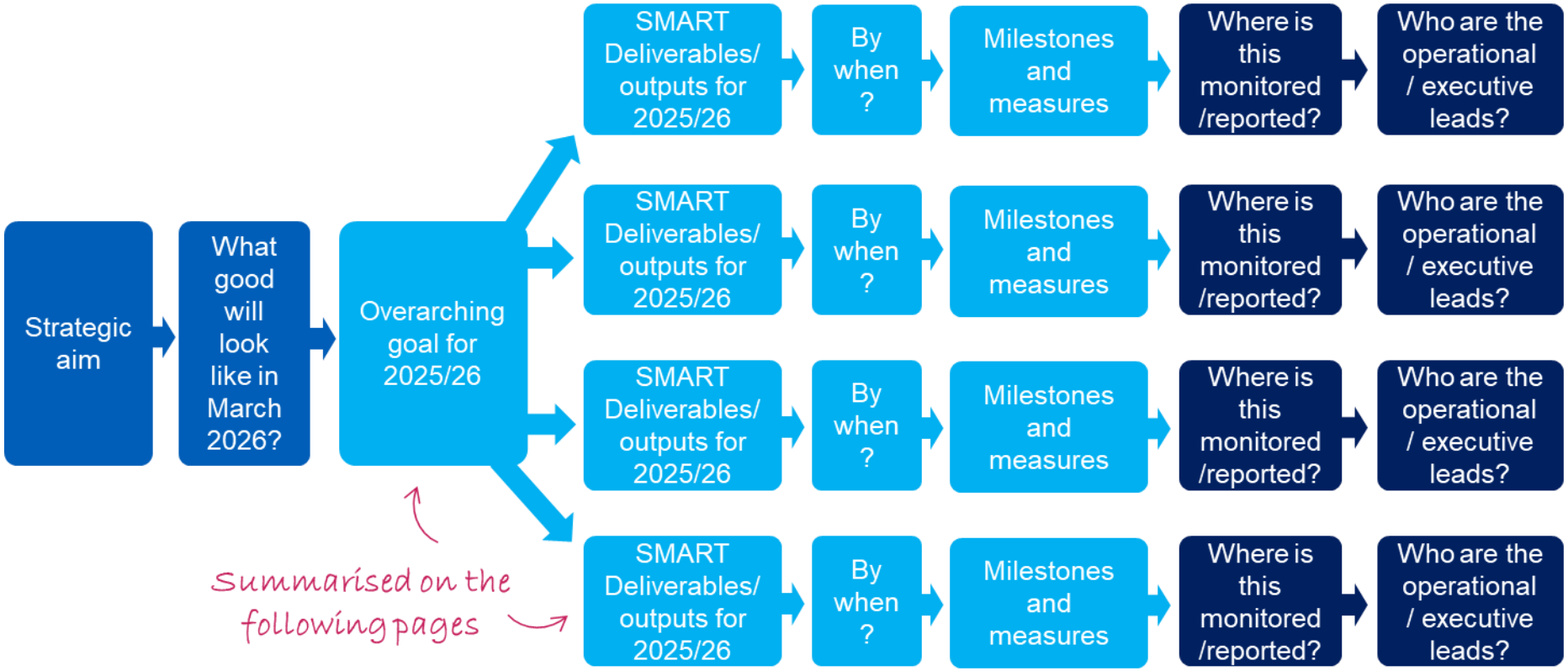
- Retention of services – e.g. prison healthcare, liaison and diversion, veterans
- Development of new services – Community Transformation, 24/7 Neighbourhood Mental Health centre pilot, Enhanced Reconnect.
- Implementation of Integrated Community Rehabilitation Team has had a positive impact on reducing rehabilitation out of area placements, leading to approval of investment for a second team.
- Work to improve health inequalities, e.g PCREF, coproduction work with underserved communities.
- Development of the anti-racist framework.
- Agency reduction has exceeded plan and some improvements in the staff survey around morale.
- Improvements in flexible working.
- Involvement in development of specialist provider collaboratives – Eating Disorders, Perinatal, CAMHS.

Key Trust drivers for 2025/26

- Fragmentation of services impacting on patient experience and outcomes
- Length of stay – 31% of current acute inpatients have a stay duration of 91+ days.
- Out of area/non-contracted bed use – inappropriate out of area bed days increased to 646 in February 2025.
- Talking Therapies – Reliable Improvement Rate at 59.7%, Reliable Recovery Rate 46% - both below national target.
- Transition of Forward Thinking Birmingham services and staff to BSMHFT during 2025/26.
- Workforce – below target for staff sickness and completion of appraisals, bank usage is a significant risk to financial viability and progress on discrimination limited according to the staff survey.
- Financial position for the Trust and getting into recurrent financial balance.

7. Our Planning Framework

We engaged widely on the approach to setting goals for 2024/25 and this approach was agreed by committees and Board. As we enter the last year of our five year strategy, we have continued with this well-received approach for 2025/26, agreeing a number of overarching strategic goals, each with range of specific outputs/deliverables to be achieved during the year.



Summarised on the following pages

Developed with service areas/leads. Outputs/owners could be within one service area/department or across multiple areas depending on the goal

Demonstrating accountability, progress, achievements, impact and outcomes

8. Summary of priorities and goals 2025/26

Summary of goals for 2025/26	Clinical Services	People	Quality	Sustainability	Total
	12	11	14	6	43

We have 43 Trust goals for 2025/26 across our four strategic priorities. A summary of these can be found on the next page, and a detailed summary is in Appendix. Within these goals we have 6 top priority areas for the next 12 months:

1. Locality working: working with system partners in a more joined-up integrated model of mental and physical healthcare tailored to provide easier access and earlier intervention in local communities.

2. Patient flow: providing better access to inpatient settings for our patients by reducing length of stay, facilitating timely and supported discharge and eliminating use of of out of area/non-contracted beds.

3. 24/7 Neighbourhood Mental Health Centres: roll out and evaluation of the 24/7 neighbourhood model to deliver services that reflect the needs of the local community and provide early intervention.

4. Staff experience: improve staff experience including reducing the number of staff experiencing bullying, harassment, abuse and discrimination.

5. Culture of care: Continue to foster a culture with quality, safety, effectiveness and patient experience at its heart so that service users, carers and staff can flourish.

6. Productivity and efficiency: Work together to identify opportunities to do things differently with our resources, including use of digital and AI and use of temporary staffing, providing better patient outcomes and more efficient and cost- effective services as a result.

9. 2025/26 goals at a glance

***** Addressing inequalities is woven throughout our strategic goals for 2025/26*****

Clinical Services (12 overarching goals)

Rooted in communities

- Joined up services and locality working
- Continue to progress transformation of community services
- 24/7 neighbourhood mental health pilot
- Improve patient flow (forensic)
- Improve patient flow (older adults)
- Improve patient flow (acute and rehabilitation services)

Prevention and early intervention

- Transform urgent care pathways
- Transforming and improving children and young people's services
- Specialist pathways to better meet needs of specific groups
- Improving access, experience and outcomes in Talking Therapies

Clinically effective

- Dialog+ and care planning implementation
- Better support for service users LDA

Quality (14 overarching goals)

Improving service user experience

- Improve patient experience and participation

Preventing harm

- Embed standards, skills and competencies, and learning
- Continue to deliver the AHP strategy
- Harm reduction and long term support for physical health
- Reducing restrictive practice
- Improve safeguarding awareness
- Implement positive risk management approaches
- Suicide prevention

Patient safety culture

- Foster a culture where service users, carers and staff can flourish

Quality assurance

- Robust audit and assurance of policies
- Improve quality data and monitoring

Using our time more effectively

- Effective use of resources and rostering
- Fit for the future clinical governance
- Quality improvement/Quality Management System methodology

People (11 overarching goals)

Shaping our future workforce

- Reduce vacancy and turnover rates
- Ensure workforce does not exceed funded establishment
- Increase fundamental training compliance
- Reduce average time to recruit

Transforming our culture and staff experience

- Reduce sickness levels
- Increase number of staff who would recommend the Trust
- Reduce harassment, bullying or abuse
- Improve staff engagement scores in staff survey
- Reduce disproportionality of racialised groups in people processes

Modernising our people practice

- Ensure workforce systems are fit for purpose
- Reduce response times to common casework

Sustainability (6 overarching goals)

Transforming with digital

- Use of technology to improve productivity

Caring for the environment

- Implement refreshed estates and facilities strategy
- Work towards new sustainability targets

Changing through partnerships

- Maximising opportunities through provider collaborative

Balancing the books

- Improve the underlying financial position

Good governance

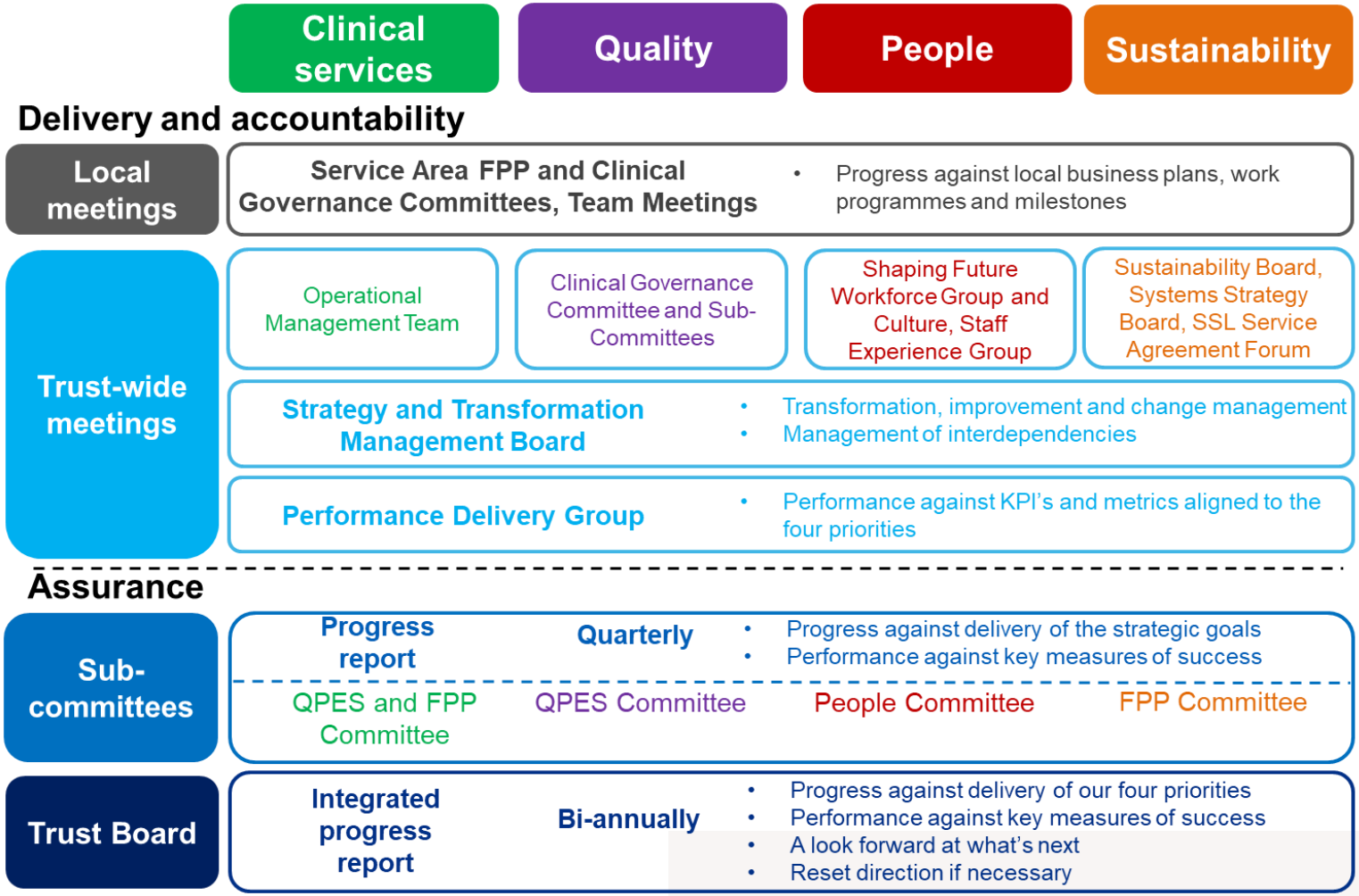
- Ensure the safe transfer of services and staff from Forward Thinking Birmingham

.

10. Strategy Governance Framework

Birmingham and Solihull Mental Health NHS Foundation Trust

The diagram below sets out our framework for monitoring delivery of our strategy and providing assurance through the organisation by describing the role of different groups and forums and the role they play.



11. Refreshing our strategy for 2026-31

Context

- We are entering into the final year of our 5 Year Trust strategy.
- During 2025/26 we will carry out a comprehensive refresh of the strategy so that we have a new strategy ready for launch in April 2026.
- When we developed our current strategy in 2019/20, we wanted to make the strategy real and meaningful and so we carried out a widespread engagement campaign with our staff, service users, families and carers, and our partners. This meant our strategy reflected their views, needs and what they felt was important for us to focus on.

What do we want our refreshed strategy to do:

- **Celebrate the successes** we have achieved during the last strategy.
- Set out our **aspirations** and the **direction of travel** for our Trust, being clear about where we want to be at the end of the next five years.
- Describe our **roadmap** of what we need to focus on, helping us to prioritise our work and ensure we are doing the right things to achieve our priorities.
- Be clear about how we will **measure success** and impact of our actions, and how we define what 'good' looks like.

12. Aims of our strategy refresh

- We want to have the same level, if not more, **engagement** than we did in developing the current strategy. We aim to replicate and build on the success of the **'help us brew up our Trust Strategy'** campaign, which engaged people in a fun and creative way making the strategy meaningful for colleagues across the Trust, and is still remembered and referenced to this day.
- We will take **multi-channel approach** to engagement, including face to face conversations with teams at Trust sites, service and profession-based focus groups, online surveys, comment cards, online and offline materials and use of existing Trustwide communications channels.
- We will be encouraging and equipping **local leadership** to support engagement with frontline teams so that when asked staff say they feel connected to the strategy.
- We will maintain and grow the involvement of **Experts by Experience**, ensuring that we retain the Recovery for All Quality Mark for the Trust Strategy, demonstrating the principles of recovery and co-production throughout the strategy development.
- Last time we started with a blank page, this time we will **celebrate our successes** from the past 5 years and identify what more we need to do.
- We will take the **learning** from the development of the current strategy and take more time, using the whole of the 2025/26 financial year to refresh our strategy.
- Our strategy will **align** with the national direction of travel, the ICS 10 Year Strategy, and the local strategies of the Provider Collaboratives we are the lead provider or a partner of.

13. Our approach to the refresh

1. National drivers

- NHS 10 Year Plan
- NHS People Plan
- Specific national mental health strategies
- Advancing MH Inequalities Strategy
- PESTLE analysis (political, economic, social, technological, legal, environmental)

2. Local drivers, data and intelligence

- BSOL ICS Strategy
- MHPC 5 Year Strategy
- Provider Collaborative strategies/plans
- Mental Health Needs Assessment
- Progress in achieving current strategic goals
- Financial position
- Performance data
- Quality data including themes from serious incidents, complaints, compliments
- Staff survey results
- CQC reports/ action plans
- Key risks and challenges

3. Co-production and engagement

- Engagement with staff
- Engagement with experts by experience
- Engagement with unions
- Engagement with Council of Governors
- Review of other sources of coproduction and community engagement e.g. Experience of Care Campaign, CYP model of care coproduction, Community Connexions, Community Transformation
- Engagement with partners

- **Where do we want to be at the end of the next five years**
- **What do we need to focus on to get there**
- **How do we measure our success and impact**

14. Proposed approach to internal engagement

Birmingham and Solihull Mental Health NHS Foundation Trust

Its time for another brew up….”

How we will engage with people

- Commit to visit every Trust site (including Execs and NEDs)
- Discussions with:
  - Staff networks
  - Unions
  - Professional advisory groups
  - Senior leadership team
  - Governors
  - Trust Board
- Focus groups and workshops:
  - With teams in local areas
  - With different staff groups
  - With experts by experience
- Listen Up sessions
- Connect page and regular communications about how to get involved and what is happening

How people can give their views

- Online survey
- Comment cards and letterboxes
- Planned focus groups, workshops and sessions about the strategy
- Discussion with the strategy team
- Dedicated connect page

What we will ask

- What positive changes have you seen over the past 4 years?
- What do we need to focus on in the future?
- What do you want he Trust be like in 5 years time?

Note - indicative activities – to be further developed and refined

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15. Strategy Timeline

Jan – Mar 2025
Agree refresh approach and establish governance and plan

Jan – May 2025
Desktop review of national and local drivers and development of baseline assessment of current position

April – Aug 2025
'Its time for another brew' engagement

Oct – Nov 2025
'Taste our brew' to test the strategy blueprint

Aug – Oct 2025
Collate feedback, identify themes and produce a strategy blueprint

Nov 2025– Jan 2026
Produce and design strategy for approval

Feb – Mar 2026
Approval through Trust governance

April 2026+
Launch of refreshed strategy

Involvement of Trust Board in the Strategy Refresh

- May 2025 - strategy session with Trust Board focussing on our direction of travel and ambitions for the next five years
- Engagement – execs and NEDs will join some of the engagement activities, including site visits
- Throughout the year – regular assurance updates about progress and key themes from the strategy refresh work
- Oct/Nov 2025 – strategy session to look at strategy blueprint
- March 2026 - Approval of the strategy

Appendix

A full list of our 2025/26 goals and deliverables

Our five-year strategic aims for clinical services

	What are we trying to achieve?	What will good look like at the end of March 2026?
Rooted in Communities	Services provided close to home in the least restrictive setting, reducing inequalities, and linking closely with and drawing on the strengths of our diverse local communities. .	• Our services will be anti-racist, anti-discriminatory and trauma-informed. • Services will be co-designed and co-delivered with local communities and organisations so that they are centred around local needs • No one will be admitted to an inpatient bed outside of our area unless this is deemed appropriate.
Prevention and Early Intervention	Help available at the earliest opportunity before mental health problems escalate or become more complex, through access to a range of treatment options whether with us or one of our partners.	• Everyone who becomes unwell, or whose illness worsens, will be able to access support quickly and easily. • People will access care in the most appropriate setting, whether that's primary, community or inpatient care, and at a time and place that works for them. • There will be specialist pathways in place to address the specific needs of a range of vulnerable groups in our population.
Clinically Effective	Service users consistently receiving high quality multi-disciplinary care based on models and pathways that consider their holistic needs and meet national standards and guidelines. A focus on measuring and improving outcomes will provide evidence that we are being clinically effective.	• Everyone who becomes unwell, or whose illness worsens, will be able to access support quickly and easily. • People will access care in the most appropriate setting, whether that's primary, community or inpatient care, and at a time and place that works for them. • There will be specialist pathways in place to address the specific needs of a range of vulnerable groups in our population.

Leader in mental health → Recovery focussed → Changing how we work

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Strategic aim: Rooted in communities (1)

Our overarching strategic goals for 2025/26

Outputs/deliverables that will achieve this goal

Joined up services

Reduce fragmentation, handovers and transitions across teams, making it easier for service users to access joined up health and care services in their local communities

1. Streamline interfaces and improve joined up working between acute, urgent care and community teams – across all divisions and all age.
2. Develop and implement a model of locality working, collaborating with system partners to join up mental and physical health care in local communities tailored to population needs and aiming to reduce health inequalities.

Community transformation

Continue to progress the transformation of community services across all geographical areas within the BSOL footprint

1) Continue co-production work with the 8 underserved communities, identifying and addressing gaps in access, experience and outcomes.
2) Improve support for family and carers of service users with bipolar and psychosis through awareness campaign and resource/support pack.
3) Pilot Mood on Track in primary care.
4) Finalise a single Community Mental Health Wellbeing Service pathway – e.g. joint referrals and step down, operational framework, MDT working.
5) Caseload stratification.
6) Joint working around transition points to support people where needs change (link to intensive review).
7) Enhance partnerships and pathways with VCFSE organisations, e.g. enhance The Waiting Room, discharge, employment, CGL, Gambling Harms Clinic
8) Develop no referral required in-reach offer.
9) Embed a sustainable approach to Trauma Informed Care training.
10) Peer worker review across BSOL, including fidelity to the model.

Strategic aim: Rooted in communities (2)

Our overarching strategic goals for 2025/26	Outputs/deliverables that will achieve this goal
24/7 neighbourhood mental health pilot Improve access, experience and outcomes for local people through delivering a 24/7 neighbourhood mental health service pilot in East Birmingham	1) Continue to roll out the implementation of the 24/7 neighbourhood mental health pilot including: • Community partners engagement and delivery, to build trust in communities and develop a delivery model that reflects their cultural needs. • Workforce model and training for staff. • Estates implications 2) Evaluate impact of the pilot, and work with the Mental Health Provider Collaborative to develop options for future scale up and sustainability.
Improve patient flow (forensic services)	1) Work with Reach Out to develop non secure pathways and services out of secure inpatient care, meeting the specific needs of our diverse population. 2) Implement Dawn House step down service for women's forensic service users. 3) High level equitable psychological therapies in forensic services re offending, substance misuse and relapse prevention to support Clinically Ready for Discharge and reduce length of stay. 4) Prison referrals to hospital: assessments within 14 days and transfer within 28 days
Improve patient flow (older adults services)	1) Dedicated social worker in older adult services to support step down and discharge in a culturally competent way 2) Ensure full complement of therapeutic interventions 3) Review older adults MDT process review

Strategic aim: Rooted in communities (3)

NHS Foundation Trust

Our overarching strategic goals for 2025/26

Improve inpatient flow (acute and rehabilitation services)

Reduce length of stay and total inpatient bed usage and by ensuring:

- Purposeful admission
- Therapeutic inpatient stay
- Post discharge support

Outputs/deliverables that will achieve this goal

1) Ensure all acute inpatient admissions are purposeful and unavoidable by:

- Robust purposeful admission guidelines
- Escalation for potential out of area placements
- Review of the model of care during an inpatient stay (e.g. learning from the secure care SCALE model)
- Clear roles and responsibilities across acute and home treatment teams from pre-admission through to discharge
- Proactive case management of inpatients, in and out of area
- Implementing daily reviews e.g. Red 2 Green approach.
- Incorporation of Trauma Informed Care principles and training.
- Understanding demographic access, experience and outcomes.

2) More effective and joined up working with providers of respite beds to maximise use of capacity.

3) Review the day hospital model and offer.

4) Implement Patient Informed Follow Up to reduce avoidable admissions.

5) Implement Integrated Community Recovery Team business case to develop a second team to reduce rehabilitation out of area placements and facilitate earlier discharge.

6) Develop the CART model to bridge the gap between CMHT and AOT teams.

7) Progress delivery of procurement, planning and build of the 30-bed hospital at Highcroft

Strategic aim: Prevention and early intervention

Our overarching strategic goals for 2025/26	Outputs/deliverables that will achieve this goal
Urgent care Transform our urgent care pathways and services to eliminate inappropriate attendances and waits in A&E and acute care settings, with a focus on reducing demographic disproportionality	1) Develop Psychiatric Assessment Centre at the Urgent Care Centre as an alternative to people attending emergency departments. 2) Transform the urgent crisis response offer, streamlining current provision and access points, making sure there is an effective and resilient service in and out of hours. 3) Review of Home Treatment, including how they support inpatient flow, fidelity to the model, skill mix and out of hours cover. 4) Develop the role of CMHT interface workers, working with known service users presenting at A&E.
Children and young people services Transforming and improving services for children and young people to improve access, experience and outcomes and reduce health inequalities	1) Scope implications and impact of the CYP transformation new model of care on Solar and deliver Year 1 implementation plans. 2) Sustainable and safe provision of CAMHS secure services.
Specialist pathways Make sure we have specialist pathways to better meet the specific needs of a range of groups in our population	1) Develop EUPD pathway to prevent A&E attendances/ avoidable admissions to inpatient care 2) Review ADHD provision 3) Improve dementia diagnosis pathways
Talking therapies Improve access, experience and outcomes for those who use our Birmingham Healthy Minds service.	1) Introduce initiatives to reduce the number of Do Not Attends (DNA's) and measure the impact. 2) Improve Recovery Rates in line with targets and trajectories. 3) Improve access, experience and outcomes for racialised groups.

Strategic aim: Clinically effective

NHS Foundation Trust

Our overarching strategic goals for 2025/26	Outputs/deliverables that will achieve this goal
Dialog+ and care planning Ensure that our service users' care plans are co-produced and personalised to improve outcomes and quality of life	1) Continue implementation of Dialog+, including: • Embedding use in all relevant teams and focussing on continuous improvement • Moving towards personalised culturally appropriate approaches to risk to include Safety Planning approach. • Capturing the views of families and carers and involving them in care planning.
Learning Disability and Autism Better support for service users with learning disability or autism	1) Reduce unnecessary admissions and improve discharge experience in acute inpatients for patients with LDA 2) Enhance care for patients with LDA in forensic services: • Recruit lead for LDA in forensic community services • Training across forensic inpatients in assessment and working with service users with LDA 3) Aim for Autism Accreditation through the National Autistic Society for all inpatient areas. 4) Implement and improve use of the Dynamic Support Register 5) Implement new Intensive Support Team 6) Enhance co-production with Experts by Experience

Strategic aim: Shaping our future workforce (1)

Our Trust Five Year Strategy		2025/26 strategic goals	
What are we trying to achieve?	***What will good look like by March 2026?***	***Our overarching goals for 2025/26***	***Outputs/deliverables that will achieve this goal***
A diverse, innovative, and agile workforce with the right skills and experience to meet our changing demands and where differences are valued to enhance service user experience and recovery	All colleagues will have appropriate training to support them to be effective in their role. Flexible working arrangements available to all colleagues We will recruit and retain the right workforce to meet the needs of our local population. No colleagues will experience discrimination or its effects in recruitment and career progression	Aim to reduce the vacancy rate from 11% to 9% with a target of 9% turnover current baseline is 9.8%	Effective recruitment strategies, Strengthen links with local universities, recruitment events, school engagement, apprenticeship offer People Promise initiatives - stay conversations, flexible working programme Workforce planning - affordable plan, workforce planning training, looking at specific roles e.g TNAs, NDAs etc Promoting BSOL ICB new offer Targeted approaches on hotspot areas Representative workforce - attracting a diverse workforce to meet the needs of the organisation and service users.

Strategic aim: Shaping our future workforce (2)

Our Trust Five Year Strategy

What are we trying to achieve?

A diverse, innovative, and agile workforce with the right skills and experience to meet our changing demands and where differences are valued to enhance service user experience and recovery

What will good look like by March 2026?

All colleagues will have appropriate training to support them to be effective in their role.

Flexible working arrangements available to all colleagues

We will recruit and retain the right workforce to meet the needs of our local population.

No colleagues will experience discrimination or its effects in recruitment and career progression

2025/26 strategic goals

Our overarching goals for 2025/26

To ensure that substantive and temporary workforce (total workforce) does not exceed the workforce plan funded establishment.

Aim to achieve overall FT compliance of 95% by March 2026.

Reduce average time to recruit from 12 to 16 weeks

Outputs/deliverables that will achieve this goal

Enhance controls and monitoring around temporary staffing and substantive recruitment. Ensure that bank reduces in line with substantive growth.

Ensure maximum effectiveness of both substantive and contingent workforce.

Reduce bank by a further 15% and agency by 30% (from 1.7% of total paybill to 1.5%)

Targeted support for Teams below 75% compliance. Baseline data will be taken from Insight reports 31st March 2025.

Map the process and identify opportunities for streamlining/ digitalisation

Ongoing monitoring and reporting

Work with recruiting managers to reduce time spent on activities

Training

Strategic aim: Transforming our culture and staff experience (1)

Our Trust Five Year Strategy

What are we trying to achieve?

A culture of inclusivity, compassion and shared learning that fosters a psychologically safe climate to support us to demonstrate our Trust values and behaviours in everything we do.

What will good look like by March 2026?

We will have a strong culture of engagement where we all feel involved, listened to and valued

We will have a comprehensive wellbeing offer that supports the individual requirements of our diverse workforce

All colleagues will be supported to be the best version of themselves irrespective of background

All colleagues have the confidence and feel safe to speak up

Our culture will be of kindness where we are supported to challenge behaviours that are not in line with our values

All people processes will be developed and implemented free from bias

2025/26 strategic goals

Our overarching goals for 2025/26

Achieve a reduction in Trust sickness absence to the national average of 5.0% (2024, NHS Digital)

67.5% of staff would recommend BSMHFT as a place to work for staff survey 25/26

Outputs/deliverables that will achieve this goal

Average reduction in sickness absence rates across the Trust by 1%.

Increased manager completion rates for Managing Health and Wellbeing Masterclasses for teams with a sickness rate above Trust average

Develop and implement a HWB strategy for teams above 5% sickness rate

Support for managers to fulfil their potential through building an effective leadership development framework

Compliance with Trust policies in responding to colleagues in a formal employee relations process.

Create safe reporting cultures through roll out of just culture and PSIRF

Improvements to workforce inequalities across access, experience and outcomes of an employee lifecycle

Strategic aim: Transforming our culture and staff experience (2)

Our Trust Five Year Strategy

What are we trying to achieve?

A culture of inclusivity, compassion and shared learning that fosters a psychologically safe climate to support us to demonstrate our Trust values and behaviours in everything we do.

What will good look like by March 2026?

We will have a strong culture of engagement where we all feel involved, listened to and valued

We will have a comprehensive wellbeing offer that supports the individual requirements of our diverse workforce

All colleagues will be supported to be the best version of themselves irrespective of background

All colleagues have the confidence and feel safe to speak up

Our culture will be of kindness where we are supported to challenge behaviours that are not in line with our values

All people processes will be developed and implemented free from bias

2025/26 strategic goals

Our overarching goals for 2025/26

To reduce the number of employees experiencing harassment, bullying or abuse from colleagues and managers by 1%.

Outputs/deliverables that will achieve this goal

Restorative Just and Learning Culture (RJLC) implementation, promote a culture of learning, accountability, and repair rather than blame

Active bystander training - Equip staff to intervene safely and effectively when they witness inappropriate behaviour

Management essentials skills training - Train managers in conflict resolution, inclusive leadership, and people management

Divisional workforce inequalities plan - Identify and address disparities in employee experiences based on protected characteristics

Anti racist supervision - Educate leaders on addressing racial inequalities, unconscious bias, and intersectional discrimination

Strategic aim: Transforming our culture and staff experience (3)

Our Trust Five Year Strategy

What are we trying to achieve?

A culture of inclusivity, compassion and shared learning that fosters a psychologically safe climate to support us to demonstrate our Trust values and behaviours in everything we do.

What will good look like by March 2026?

We will have a strong culture of engagement where we all feel involved, listened to and valued

We will have a comprehensive wellbeing offer that supports the individual requirements of our diverse workforce

All colleagues will be supported to be the best version of themselves irrespective of background

All colleagues have the confidence and feel safe to speak up

Our culture will be of kindness where we are supported to challenge behaviours that are not in line with our values

All people processes will be developed and implemented free from bias

2025/26 strategic goals

Our overarching goals for 2025/26

Improve staff engagement scores to 57.5% for staff survey 25/26

To reduce the disproportionality of racialised groups involved in people processes by 10% with a focused approach in Secure Care and Offender Health

Outputs/deliverables that will achieve this goal

Implement and operationalise an employee engagement strategy

Assessment and enhancement of the Trust Employer Value Proposition (EVP)

Effective implementation of the corporate support offer

Increase appraisal compliance by 3% with positive experience

Divisional workforce plan to identify People processes as a priority focus.

RJLC roll out across all people managers.

Create clear links with Culture of Care Programme & PSIRF

Embed and support uptake of Management Essentials training workshops

Strategic aim: Modernising our people practice

Our Trust Five Year Strategy		2025/26 strategic goals	
What are we trying to achieve?	***What will good look like by March 2026?***	***Our overarching goals for 2025/26***	***Outputs/deliverables that will achieve this goal***
People practices that meet the evolving needs of our workforce, supported by integrated working	We will have a range of digital solutions that will streamline our people processes Our workforce information systems will be improved and more reflective to support patient care effectively We will effectively analyse data to gain insight and truly understand the needs of our workforce and improve staff experience	Work collaboratively with others to ensure our workforce systems are fit for purpose and we are in a state of readiness for the new workforce solution.	Establish a group to oversea, data quality, data governance and ESR functionality. Ensure our ESR platform holds accurate and credible workforce data. Reduce pay errors that are occurring due to incorrect ESR data. Work alongside NHSBA on new solution readiness.
		Reduce response times to common employee relation casework by 30 days	Embed and encourage uptake of the HR advice line chatbot
			Introduction of Managing Employee Performance Policy, Masterclass and Manager Resources
			Continued development of casework and sickness Power BI dashboards
			Embed and support uptake of Management Essentials training workshops

Strategic aim: Improving service user experience

Our Trust Five Year Strategy

What are we trying to achieve?

Shared decision-making with service users and families about their treatment and care to aid their recovery.
Service users empowered to be active participants and partners in their own care, enabling self-care.
Co-production is business as usual

What will good look like by March 2026?

- Experts by Experience will be core members of all service user, family and carer facing quality improvement projects
- Service users will be supported to participate in care plan co-production and families and carers will support and participate in care plan production (where appropriate)

2025/26 strategic goals

Our overarching goals for 2025/26

Work together with service users to improve experience and participation in line with the principles of the HOPE strategy

CCS **
1, 3, 9.

Outputs/deliverables that will achieve this goal

Implement a range of opportunities and mechanisms for service users and carers to feedback on our service, including Friends & Family Test, 15 Steps Challenge , service user projects, participation team

Demonstrate the impact Recovery College has for learners and implement actions to increase accessibility

Ensure a range of coproduction and codelivery opportunities available for our experts by experience through our participation programme

**** Quality goals have been mapped to the Culture of Care standards**

Strategic aim: Preventing harm (1)

Our Trust Five Year Strategy

What are we trying to achieve?

Reduction in:
- unwarranted variations and harm across our services.
- level of harm and suicide rate amongst our service users.
- harm that sometimes comes to our staff during the delivery of care.

What will good look like by March 2026?

- We will have compassionate engagement with those affected by patient safety incidents
- We will have a suite of learning from safety methods, to include learning from everyday work.

2025/26 strategic goals

Our overarching goals for 2025/26	*Outputs/deliverables that will achieve this goal*
Ensure safe care and staffing by embedding standards, skills and competencies and learning. **CCS** 2, 6	Set out practice standards, training needs and assurance around skills and competencies for professionals and bank staff.
	Develop a framework for clinical education across nursing
	An effective and efficient training offer in general physical health care for clinical staff
	Ensure continuous learning and improvement from recent national reports and inquiries.
Continue to deliver the AHP strategy **CCS** 2, 11	Implement new system for safe and effective AHP staffing linked to national strategy

Strategic aim: Preventing harm (2)

Our Trust Five Year Strategy

What are we trying to achieve?

Reduction in:
- unwarranted variations and harm across our services.
- level of harm and suicide rate amongst our service users.
- harm that sometimes comes to our staff during the delivery of care.

What will good look like by March 2026?

- We will have compassionate engagement with those affected by patient safety incidents
- We will have a suite of learning from safety methods, to include learning from everyday work.

2025/26 strategic goals

Our overarching goals for 2025/26

Ensure harm reduction and long-term support for physical health support)

CCS
6, 11

Reducing restrictive practice

CCS
2, 6

Outputs/deliverables that will achieve this goal

Implement rigorous infection control procedures

Collaborating with our partners to have the right physical health care, at the right time and in the right place for our service users.

A range of physical health programmes of work and resources. Including tobacco dependency, long term condition care, weight management and end of life care.

Clear goals to deliver the 2024/27 physical health strategy

Enhanced de-escalation for staff for more proactive management of escalating situations.

Strategic aim: Preventing harm (3)

Our Trust Five Year Strategy

What are we trying to achieve?

Reduction in:
- unwarranted variations and harm across our services.
- level of harm and suicide rate amongst our service users.
- harm that sometimes comes to our staff during the delivery of care.

What will good look like by March 2026?

- We will have compassionate engagement with those affected by patient safety incidents
- We will have a suite of learning from safety methods, to include learning from everyday work.

2025/26 strategic goals

Our overarching goals for 2025/26	*Outputs/deliverables that will achieve this goal*
Improve safeguarding awareness and practice relating to service users who experience domestic abuse CCS 6	Work with CYP and women's services and link with community transformation to pilot a domestic abuse survivors suicide prevention and screening tool (DASST) in Neighbourhood Mental Health Teams
Implement positive risk management approaches that involve the service user in identifying and managing their risk CCS 2, 6	Implement evidence-based models for positive risk-taking vs risk assessment
Suicide prevention CCS 2, 6	Embedding directorates' plans; linking to Learning from Deaths Themes.

Strategic aim: A patient safety culture

Our Trust Five Year Strategy

2025/26 strategic goals

What are we trying to achieve?	*What will good look like by March 2026?*	*Our overarching goals for 2025/26*	*Outputs/deliverables that will achieve this goal*
A culture where we are: - treated fairly if things go wrong and feel confident to speak up about something we think is wrong. - inclusive, recognising and respecting all of the different experiences, diversity, views and contributions that each other can bring. - recognised and celebrated when we achieve something really good. - kind to each other and always treat service users and each other with kindness and respect. - always learning and using new ways to do things more safely including learning from things that work well as well as what goes wrong.	• All clinical staff will be accessing high quality and meaningful clinical supervision • Services will have access to intelligence systems and data to help them understand where teams are facing challenges in real time and where they have great success • There will be an embedded approach to post incident support • Our work to create a Just Culture will continue and Civility Saves Lives methodology will be in use across the Trust	**Continue to foster a culture across all services where service users, carers and staff can flourish** **CCS** All	Roll out the Culture of Care programme across all inpatient areas Expand Think Family principles to embed the family and carer voice in patient care. Improve training and understanding around clinical supervision. Promote models of visible leadership and civility. Further develop leadership and support for staff to speak up. Develop professional infrastructure for social workers. Develop a nursing strategy Embedding Learning from Incidents e.g. roll out of more regular Learning events, using themes to inform Improvement work

Strategic aim: Quality assurance

Our Trust Five Year Strategy

What are we trying to achieve?

A quality assurance framework to underpin and assure us of the quality of our services and care on a continual basis, developed with staff, service users, families and carers, that helps us to act quickly to recognise good care and practice, and equally act quickly where improvement is needed.

What will good look like by March 2026?

- We will be using a range of data to understand our outcomes, recognise success and identify opportunities for improvement
- We will be able to evidence sustainability of good practice and improvement through local audits and a quality assurance framework
- Our quality assurance peer review processes will be in place across teams and will include a role for service users, families and carers

2025/26 strategic goals

Our overarching goals for 2025/26	*Outputs/deliverables that will achieve this goal?*
Ensure robust audit and assurance of policies to ensure they are effective reflect the reality of practice	• Develop the audit framework • Improvements in PSIRF process • Audit demonstrating learning
Improve quality data and monitoring from a Trust and divisional perspective	Review oversight and reporting of quality metrics including review of divisional deep dives and integrated performance reporting

Strategic aim: Using our time more effectively

Our Trust Five Year Strategy

What are we trying to achieve?

Use of technology and quality improvement approaches to manage resources well without impacting on the quality of care we deliver. This includes improvements in the way that service users are able to easily move through and access our services and increasing clinical time to care.

What will good look like by March 2026?

- Staff will be supported with quality improvement and continuous improvement methodologies
- We will be using evidence-based practice and research as a routine way to inform transformation of care and services
- We will have a triple aim approach to our quality improvement programmes

2025/26 strategic goals

Our overarching goals for 2025/26	*Outputs/deliverables that will achieve this goal?*
Develop leaders to make effective use of resources and rostering to support quality care CCS 2	Ensure e-rostering compliance
	Provide support for leaders to build effective substantive teams
Ensure fit for the future clinical governance and foster effective and supportive relationships between the nursing and quality division and clinical services	Implement changes following internal audit of clinical governance in 2024/25 and re-audit
	Develop our clinical governance offer to colleagues to ensure it is fit for purpose and effective.
Quality Improvement and Quality Management System Methodology	Embedding QI and QMS Methodology in all improvement work which will be guided by quality and safety priorities

Strategic aim: Transforming with digital

Our Trust Five Year Strategy

What are we trying to achieve?

Being a leader in digital innovation in health care, transforming the way that services are delivered and care is experienced and maximising the benefits of cutting-edge technology as an organisation and a system to improve efficiency, quality, health outcomes and decision-making

What will good look like by March 2026?

We will be clear and specific about the value that technology can offer in health care

Digital leaders will work regularly and openly with clinicians and others in developing and implementing joined up plans for the exploitation of technology

We will have established a track record of delivering meaningful improvement in efficiency, quality and health outcomes by use of technology

Managers and staff will be satisfied that Trust systems are intuitive, efficient and provide value to them

2025/26 strategic goals

Our overarching goals for 2025/26	*Outputs/deliverables that will achieve this goal*
Use of technology to improve productivity .	Increase use of Artificial Intelligence to streamline/ improve efficiency of tasks
	Better use of Office 365 applications
	Develop robotic process automation e.g. for password resets
Develop our business intelligence capability to improve the information and performance insights available for Trust service areas	Demonstration of delivery of redesigned data capture processes aligned to key Trust change projects.
	Range of new reporting developed aligned with achieving the Trust's corporate, clinical and operational objectives.

Strategic aim: Caring for the environment

Our Trust Five Year Strategy

What are we trying to achieve?

Caring for the environment by managing our buildings and the way we operate to reduce negative impacts on the world around us, including travel, waste, pollution and energy usage, while improving the experience of service users and staff and partners.

What will good look like by March 2026?

We will make best use of the buildings in which we work and deliver high standards of accommodation for staff and service users.

We will be routinely doing strategic estates forward planning, working with the system and local communities so that we have flexible and adaptable estate.

We will build on our track record of delivering on and leading the Green agenda in BSOL

Clinicians and staff will understand the Green agenda and the part they play in it and recognise the value delivered by SSL

2025/26 strategic goals

Our overarching goals for 2025/26

Implement a refreshed Estates and Facilities Strategy to ensure our estates and facilities are fit for the future

Work towards the achievement of the new sustainability targets

Outputs/deliverables that will achieve this goal

Finalise strategy, take through the approval process, launch across the organisation and develop implementation plans

Improve space utilisation:

1. Expand Ubook
2. Develop Main House
3. Review of unused Trust estate

Deliverables include:

- Messaging and communications to staff
- Establishing financial implications
- Working in a joined-up way across the BSOL ICS

Strategic aim: Changing through partnerships

Our Trust Five Year Strategy

What are we trying to achieve?

Effective and efficient formal partnerships, strategic alliances and provider collaboratives with local and regional organisations from within and outside the NHS where this transforms services and improves pathways and service user outcomes, sharing of expertise and spread of best practice between partners.

What will good look like by March 2026?

The BSol Mental Health Provider Collaborative will be regarded as an exemplar in the area of provider collaboratives

We will be seen as a proactive and constructive business partner by a wide range of bodies

Reach Out will have continued to develop positively and will work well with its LDA partners

The relationship with the voluntary sector will be seen as strong and mutually beneficial and delivering meaningful outcomes for service users

Summerhill Services Ltd (SSL) will be seen as a key component in the delivery of BSol ambitions and plans and cited as good business partner

2025/26 strategic goals

Our overarching goals for 2025/26

Maximising opportunities through provider collaboratives to improve access, experience and outcomes and address inequalities for our diverse population and staff

Outputs/deliverables that will achieve this goal

BSOL MHPC

1) Finalise and launch five-year strategy, and ensure robust implementation plans and governance over delivery and measuring success.
2) Coproduce a mental health Coproduction Framework
3) Embed Community Voice into commissioning

Reach Out

1) Refreshing the clinical strategy
2) Embedding new commissioning and contracting arrangements with the ICB
3) Developing non forensic community interfaces with secondary care

Strategic aim: Balancing the books

Our Trust Five Year Strategy

What are we trying to achieve?

Spending less than we earn on an ongoing basis and generate sufficient cash to invest in the transformational development of facilities, technology and clinical services for the benefit of our staff, service users and carers, and the local system.

What will good look like by March 2026?

We will provide assurance that public resources are used effectively for the benefit of service users, carers and families

We will be seen as a low-risk organisation by CQC, NHS England and BSol ICB, giving us more freedom to develop and deliver high quality and innovative health care.

We will have an effective and efficient corporate infrastructure.

2025/26 strategic goals

Our overarching goals for 2025/26

Improve underlying financial position, ambition and timescale for achieving recurrent balance, with identified proposals for generating cash releasing cost savings

Outputs/deliverables that will achieve this goal

Use productivity and benchmarking information as a driver for identifying opportunities, for example:

- Corporate benchmarking
- NHSE productivity analysis

Develop mechanisms for reviewing services and fitness for the future

Review financial reporting for the all elements of the Group to ensure visibility of financial position, decisions and priorities.

Strategic aim: Good governance

Our Trust Five Year Strategy

What are we trying to achieve?

Robust and transparent governance arrangements to provide assurance that public money is being used well and deliver positive improvements, while guarding against adverse incidents, outcomes and failures, ensuring a safe and supportive environment in which high quality and innovative health care can be provided and our ambitions achieved.

What will good look like by March 2026?

We will provide assurance that public resources are used effectively for the benefit of service users, carers and families

We will be seen as a low-risk organisation by CQC, NHSE and BSol ICB, giving us more freedom to develop and deliver high quality and innovative health care.

We will have an effective and efficient corporate infrastructure.

2025/26 strategic goals

Our overarching goals for 2025/26

Ensure the safe transfer of services, staff and infrastructure from Forward Thinking Birmingham

Outputs/deliverables that will achieve this goal

Deliver the transition plan by 1 July 2025 adhering to the minimum viable product

Progress business case approvals through BSMHFT, BWC and NHS England governance

Develop a clear development plan for post transition date

Committee Escalation and Assurance Report

Name of Committee	**Report of the Caring Minds Committee**
Report presented at	**Board of Directors**
Date of meeting	**2 April 2025**
Date(s) of Committee Meeting(s) reported	**24 February 2025**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Forward planner • Charity Update • Consideration of bid, to utilise Equitix donation • Approval of Current Criteria and Due Diligence policy • Development proposal 2025/26 • Bid Criteria Draft • Caring Minds Acceptance of Gifts and Donations policy • Approval of the Annual Report & Accounts for 2023-24 • Caring Minds Financial update • Cazenove update • Terms of Reference
Alert:	The Committee wished to alert the Board of Directors to the following: • The Committee reviewed the development proposal for 2025/26 and noted the benefits associated with the revised SLA and collaboration with Birmingham Community Health Care Trust whereby additional capacity would be bought into to support the development and ambitions for Caring Minds. The Committee noted the financial commitment required for the resource and approved the proposal in line with the budget allocation previously approved. The Committee approved the proposal in principle on the basis the Committee will receive the revised job description, SLA and KPIs to support the proposal.
Assure:	The Committee were assured the Cazenove portfolio remains positive with a total balance of £657k with dividends of £20k for the financial year. The Committee were assured the charity remains active across the Trust with positive engagement supporting ongoing fundraising. The Committee received the bid for HMP Birmingham wellbeing spaces noting the total allocation will be shared with Birmingham Community Health Care Trust. The Committee approved the bid.

Advise:	The Committee approved the Caring Minds Acceptance of Gifts and Donations policy. The Committee approved Current Criteria and Due Diligence policy in principle with minor changes agreed to the restrictions on bids within three years of funding already allocated. The Committee approved the forward planner for 2025/26. The Committee approved the terms of reference with the addition of climate change statement and a revised scheme of delegation statement. The Committee agreed further amendments to the Criteria and Due Diligence policy including clarification on timescales for bids.	
Board Assurance Framework	The Committee noted the development of the Board Assurance Framework continues to be developed and requires alignment to the Charity Strategy.	
	New risks identified: No new risks were identified.	
Report compiled by:	Monica Shafaq Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	21					
Date	2 April 2025					
Title	Trust Seal Report					
Author/Presenter	Safia Khan, Head of Legal					
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**	

The Trust and Healthcare Support are party to the Project Agreement (PFI) and Healthcare Support and Amey are party to a Service Management Contract. The Parties have concluded commercial discussions regarding the consequences of delays in the issuing and agreement of certain Performance Management Reports in connection with the Project and have agreed to a settlement agreement making payment in recompense to the Trust and Amey.

Trust Seal Number 2/2425

The Trust Seal was used on 24 February 2025 and affixed to a Settlement Agreement between the Trust, Healthcare Support and Amey.

Recommendation

The Board is asked to acknowledge and endorse the use of the Trust Seal.

Enclosures

N/A