NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Quality Account Report 2023/24

compassionate

inclusive

committed

Quality Account Report

Contents

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

How to provide feedback on this Quality Account

If you would like to provide feedback on this quality account, or would like to make suggestions for content for future accounts, please email gill.mordain1@nhs.net
Or write to
Company Secretary
Birmingham and Solihull Mental Health NHS Foundation Trust
Uffculme Centre
52 Queensbridge Road
Birmingham B13 8 QY

PART 1 – STATEMENT ON QUALITY

CHIEF EXECUTIVES'S STATEMENT ON QUALITY

I am delighted to present our Quality Account for 2023/24. It looks back at our performance over the last year and gives details of our priorities for improvement in 2024/25.

I want to begin by stating how immensely proud we are of all our colleagues who have continued to demonstrate their extraordinary resilience, compassion, and flexibility to providing high quality care throughout such ongoing challenging times.

We continue to learn from our achievements and recognise areas where we can improve. We are striving to build a community with our service users, staff and carers that inform the actions that we take to drive improvement in relation to patient safety and quality. Following a few CQC inspections across our services we have responded swiftly to identify actions to address issues raised. Many were already in our plans while for others we recognised there was more we could do to improve the care we provide for those who rely on us.

2023/24 has been a busy year but one in which we have made great progress in strengthening our journey in relation to patient safety, improvement, and transformation and improve health equalities for our populations.

We have made considerable strides to implement the new Patient Safety Incident Response Framework (PSIRF) implementing safety panels and safety summits where we can share learning to drive quality improvements and support families and carers within the process.

Central to the way that we will improve this is our strategic plan. Our plan identifies four workstreams: clinical quality, people, quality, and sustainability. As an organisation we are working together to improve the quality of care provided across all areas of the Trust within each of the workstreams.

Through our reconfiguration and transformation programme we are investing in our wards to reshape our environments to make them safe and therapeutic spaces. Colleagues across the Trust have put in an enormous amount of work in to constantly improve our services, keep patients safe and provide the best possible environment for care and recovery.

To enhance the services that we provide we are working closely with partners to put in place Locality Delivery Partnerships.

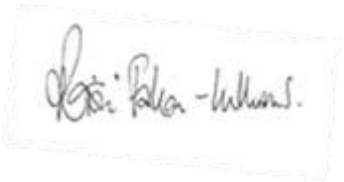
This will incorporate five in Birmingham and one for Solihull providing a collaborative infrastructure that will drive the delivery of integrated care in neighbourhoods and localities supporting people to stay healthy in their communities. They are designed to deliver inclusivity and equality across all neighbourhoods.

This Quality Account sets out what we have achieved during 2023/24 including progress against our five quality priorities and sets out our ambitions for 2024/25.

As I close this introduction, I reiterate my thanks and that of my fellow Board members, to our compassionate and committed staff, our service users, families and carers, our stakeholders, our partners in the Integrated Care System and our Council of Governors and look forward to continuing to tackle our challenges, build on our successes and make progress in 2024/245.

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

Roísìn Fallon-Williams
Chief Executive Officer



Phil Gayle
Chair

BACKGROUND

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

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

What the Quality Report includes:

- What we plan to do next year (2024/25), what our priorities are, and how we intend to address them.
- How we performed last year (2023/24), including where our services improved.
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS Trusts
- Stakeholder and external assurance statements.

Purpose and Activities of our Trust

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

With more than 40 sites, we serve a culturally diverse population of 1.3 million, spread out over 172 square miles. We have a dedicated workforce of around 4,000 staff and a range of local and regional partnerships, making us one of the most complex and specialist mental health foundation trusts in the country. Our catchment population is ethnically diverse and characterised in places by high levels of deprivation, low earnings, and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas.

One Vision

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

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

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

We continue to hold an ambition around the quality of care that we provide, that we have developed in partnership with our Experts by Experience and our colleagues.

Our Ambition

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

Our Aims

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

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD.

2023/24 QUALITY IMPROVEMENT PRIORITIES
PROGRESS AGAINST THE PRIORITIES AGREED

Continuous quality improvement is of paramount importance to BSMHFT, and we have strived over the last year to deliver on the Quality Priorities we set in our Quality Account 2023/24. This section of the report describes the progress we have made in these areas.

In creating our quality priorities and goals, we have considered the aspirations in the NHS Long Term Plan, NHS England's Five Year Forward View for Mental Health and NHS Improvement Planning and reviewed feedback from our service users, workforce, and partners.

2.1 Quality Priority 1: Improving Service User Experience

Improving service user experience	
Empower patients through inclusion of Patient Safety Engagement Partners in the Patient Safety Framework.	Measures of success: • 8 Patient Safety Partners (PSPs) recruited (2 per division). • Number of PSPs who have completed training. • Attendance at local clinical governance meetings, trust-wide clinical governance committee, quality, experience and safety committee, experts by experience meetings and supervision meetings. • PSPs involved in serious incident investigations and oversight meetings. • Feedback in relation to compassionate engagement and involvement of individuals affected by patient safety incidents.

Why was this a priority?

NHS England and Improvement published a Framework for Involving Patients in Patient Safety in June 2021. The framework is in two parts: the involvement of patients on an individual level in their own safety, and the involvement of patients strategically via the role of patient safety partners (PSPs).

This is a key part of the new Patient Safety Incident Response Framework (PSIRF) which will ensure that patients, families and carers have a powerful and equal voice in their own care, as well as helping to shape and influence future developments at the Trust to improve patient experience and reduce health inequalities within our populations.

The role of a Patient Safety Partner is to enable the Trust to value, listen and provide meaningful involvement opportunities for patients, families and carers in the ongoing patient safety work of the organisation. They will support a culture which is patient-centered through:

- Joining key conversations and meetings within the Trust that address patient safety.
- Challenging the way that we work and being our critical friend.
- Bringing the insight of patients, carers, and families as users of our services into these meetings and conversations.
- Co-designing the developments of patient safety initiatives.
- Ensuring we consider the diversity of our populations.

How did we do?

We have welcomed new 5 Patient Safety Partners into the Trust.
We have supported our safety partners with bespoke training and continuous mentoring to ensure that they are able to fully contribute to the further developments of our PSIRF learning responses, safety improvement work, and codesigning our future processes with the patient voice at the forefront of what we do.

Our partners have started a number of workstreams which include our Sexual Safety Working Group, Emerging Risk Group and Patient Safety Advisory Group. Our partners are from a diverse background that enables us to support our drive as an organisation for inclusivity and diversity.

Quality Priority 2 : Preventing Harm

Preventing harm	
Implement the Patient Safety Incident Reporting Framework (PSIRF) to pursue excellence in learning and understanding incidents and ensure cross-organisational learning.	Measures of success: • Systemwide response and review of incidents. Reduction in complaints. • Feedback identifying compassionate engagement and involvement of those affected by patient safety incidents. • Response to incidents and complaints in agreed timescales • Systemwide response to incident themes.

Why was this a priority?

The new Patient Safety Incident Response Framework (PSIRF) responds to calls for a new approach to incident management, one which facilitates inquisitive examination of a wider range of patient safety incidents in the spirit of reflection and learning rather than as part of a framework of accountability. Informed by feedback and drawing on good practice from healthcare and other sectors, it supports a systematic, compassionate, and proficient response to patient safety incidents, anchored in the principles of openness, fair accountability, learning from excellence and continuous improvement.

How did we do?

We have successfully implemented PSIRF and transitioned to a new way of working. Through Safety Summits and the Patient Safety Advisory Group we have adopted a strong learning capacity that is being used to transform the way in which we work. The appointment of our Patient Safety Partners is enhancing our approach to the provision of compassionate engagement and involvement of those affected by patient safety incidents.

As part of implementation of PSIRF the Trust are required to put together a Patient Safety Incident Response Plan. This plan sets out how the Trust will manage and learn from incidents under the new framework. Part of this plan considers how we will investigate those incidents that require deeper analysis. Investigating incidents in this way is called a Patient Safety Incident Investigation (PSII).

There are nationally mandated incidents that require this approach and in addition the Trust can identify its own safety priorities for this type of investigation. The table below indicates the safety priorities identified by the Trust.

Priority	Approach	Local and system improvement route
Co morbidity with drug/alcohol – people in active treatment at BSMHFT.	Patient Safety Incident Investigation (PSII) where agreed.	Create local organisational actions in quality improvement strategy plus a system wide response to improving services for this cohort.
Incidents resulting in harm or deaths by suspected suicide where care is fragmented/multiple contacts across the pathway.		
Incidents of evidence of disengagement, with 3 or more consecutive failed contacts prior to death by suspected suicide.		
Harm or death of a service user with an emerging risk (increased calls crisis line, duty contacts, street triage contacts) and no evidence of risk management plan.		
Lack of family involvement, not hearing/taking on board warnings of concerns from family, resulting in harm.		

Quality Priority 3: Patient Safety Culture

Patient Safety Culture	
Review the organisation's safety culture to understand how safe our staff feel at work and engage with them to provide a safe working environment where they can flourish.	Measures of success: • Improvement in relation to recruitment and retention. • Reduction in incidents of bullying and harassment. • Number of individuals undertaking just culture and human factors training. • Reduction in grievances. • Staff Survey responses. • Stronger understanding of diversity factors and the impact that may create.

Why was this a priority?

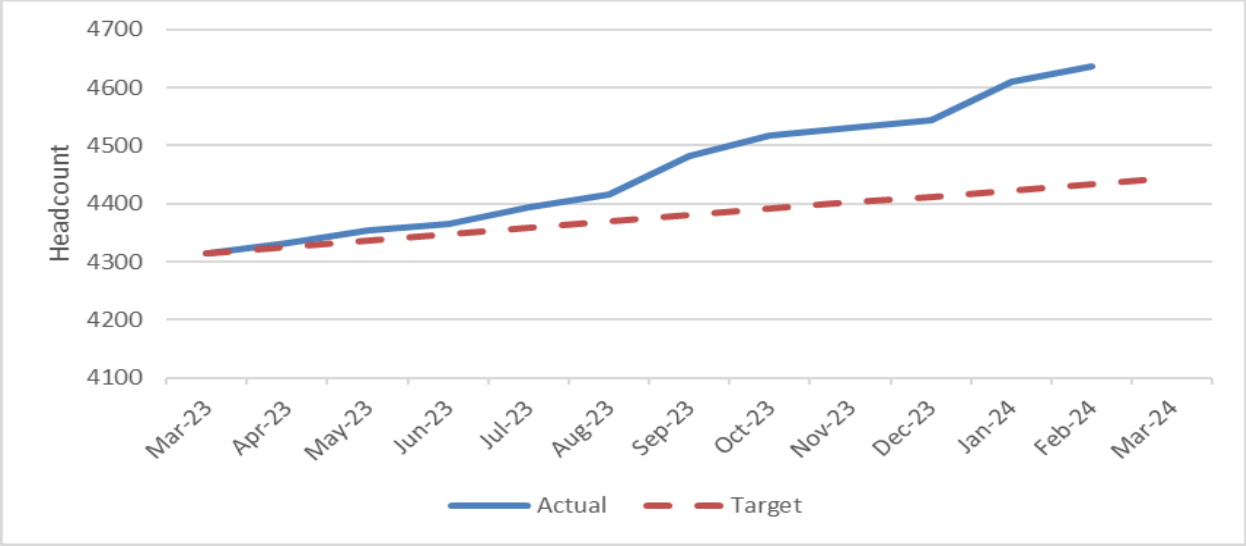
Our staff survey results for 2022 tell us that we have some way to go to truly embed a compassionate culture in which our staff feel safe, able to raise concerns and that their concerns will be addressed. They also show that team working is not as strong as we would like it to be. This in turn impacts morale, the pressure staff feel they are under and ultimately staff retention.

We aimed to implement a culture of fairness, openness and learning across our organisation by making staff feel confident to speak up when things go wrong, rather than fearing blame. By listening to our staff and service users this will enable valuable lessons to be learnt so errors can be prevented from being repeated,

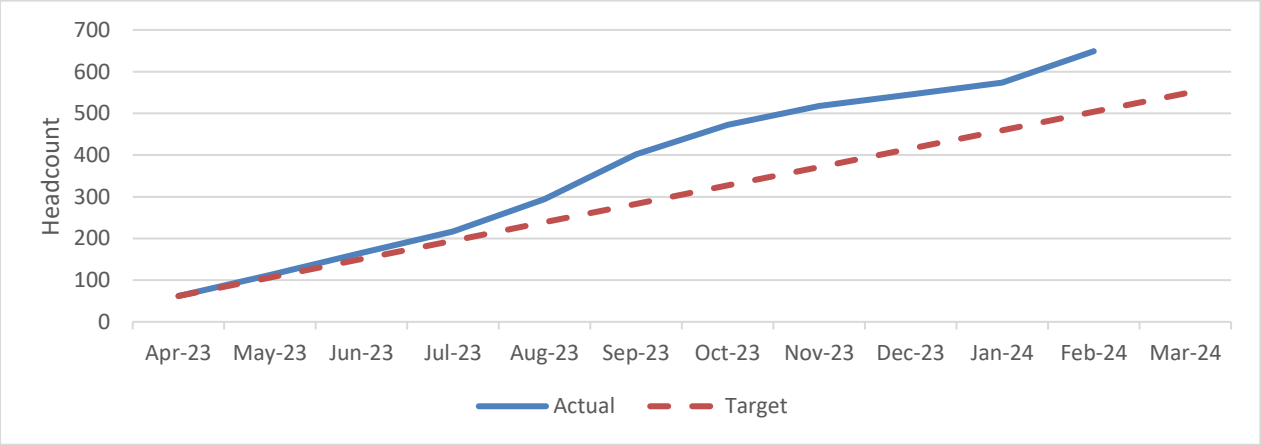
How have we done?

The Trust continues to address concerns related to Workforce Planning KPIs aligned to the Shaping our Future Workforce Strategic Aims under the Trust's People Strategic Priority. While it is recognised that ongoing improvements are required, there have been some positive improvements.

We have seen a 3% increase in the total number of substantively employed staff in post compared against 01.03.23 baseline total.



New starters joining the Trust shows an upward trend and we have seen a 3% increase in the total number of 'new starter' staff joining BSMHT during the year (against the 01.04.23 baseline).



- Turnover has reduced to 7.3% in February. This is a 0.4% reduction from January.
- In the rolling 12-month period 2023/2024, 338 staff left the Trust.
- All service areas are below the Key Performance Indicator (KPI) level of 11%, however, when looking at staff groups, Pharmacy (14%) and Psychology Improving Access to Psychological Therapies (IAPT) (13.%) are all above the KPI. Recruitment of Psychological wellbeing practitioners within our IAPT service and nationally remains a challenge.
- We are continuing to work on initiatives to support turnover such as flexible working. For flexible working, we are looking at the culture of teams around flexible working and enabling managers to support requests.
- Although we are behind on numbers of staff undertaking Just culture and Human Factors training, the Trust remains committed to this training and will continue to promote and enhance numbers of staff completing the training during 2024/25.

Staff Survey Results

We are really pleased to see that we have seen significant improvement across a number of indicators within the staff survey. These are detailed later in the document (Page 81).

Quality Priority 4: Quality Assurance

Quality assurance	
Develop and embed the principles of 'Think Family'. Embed a system wide open door approach increasing coordination between children and adult services.	Measures of success: • Consultation regarding measures with Experts By Experience (EBE) and carers is planned in the coming weeks. • Building a profile of EBE's that represents our population. • Number of staff trained in this approach as part of safeguarding training.

Why was this a priority?

A Think Family approach means that we identify wider family needs which extend beyond the individual we are supporting. It means that, in relation to safeguarding, while we work primarily with adults, we will still consider the safeguarding needs of children and other family members, and where we work with children in Solihull, we will still consider the needs of vulnerable adults in the family. This aligns with our Trust's approach to safeguarding – that it is everyone's responsibility and for us all to consider in our day-to-day practice.

Think family means securing better outcomes for adults, children and families by coordinating the support and delivery of services from all organisations, underpinned by the following principles:

- No wrong door – contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children's services.
- Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities.
- Providing support tailored to need – working with families to agree a package of support best suited to their particular situation.
- Building on family strengths – working in partnerships with families recognising and promoting resilience and helping them to build their capabilities.

How have we done?

- The Trust Safeguarding Team have developed a simple Think Family Standard which breaks down what clinical teams need to do so that Think Family is embedded in their everyday good clinical practice. The Think Family Standard has been printed into coloured leaflet format and is shared with participants on each of the Level 3 training courses.

- The Think Family Standard was introduced by our Team Lead by way of Listen Up Live.

- Think Family Standard (pdf version) was uploaded onto the home page of our Safeguarding Hub on Connect. It's prominence on our homepage underlines the fact that it is a central requirement of good safeguarding practice.

- The Think Family approach is integrated into both the statutory/mandatory Level 3 Safeguarding Children and Young People training and the Level 3 Safeguarding Adults Level 3 training. The emphasis of both courses is on the need to meet the holistic needs of a service user and working collaboratively with other services ***(both adult and children facing where relevant***) to meet the needs of the family.

- The Think Family approach was introduced through a Trust wide broadcast of Listen Up Live by our Team Lead with support from the Trust Communications Team.

- The Trust Communications Team have supported the dissemination of the Think Family Standard by designing The Think Family leaflet itself and providing a platform for a month of 'Think Family' news items in Colleague Briefing during December of 2023.

- The Think Family Standard includes a simple outcome statement that our service users should be able to say as follows**: 'I am a partner in meeting the needs of my family and keeping them and myself safe along with Trust staff and other professionals'**. In making the outcome for service users explicit, we have enabled clinicians to consider how best to tailor their approach to this end.

- The Trust Safeguarding Team commissioned a film maker to produce a short film to be played at Trust induction for all staff. This film delivers the message that a Think Family approach is central to requirements of clinical good practice. This film is also shared in Safeguarding Adults Level 3 training.

- The Safeguarding Hub has a six-minute explainer webinar on the home page to support access to the Think Family Standard.

- The Safeguarding Team worked with support from the Trust Project Management Team who coordinated a Project Board to inform and steer our approach. This work increased accessibility for Trust staff to Safeguarding Team Think Family messaging.

- The Trust Safeguarding Team commissioned safeguarding supervision training and opened this as a resource to clinicians across the Trust. Colleagues attended this training from both adult

and children facing services. The principles of the training package were underpinned by the principles of a Think Family approach.

- Two audits were completed focusing on our operational team's participation in the child protection process.

Expert By Experience Involvement

- Our Project Board recommended that EBE's be involved in the dissemination of messages relating to our Think Family Standard and Approach through training. The idea of making a film of EBE's delivering their views was suggested.

- EBE engagement event was held at Uffculme with support from the Recovery, Participation and Experience Team. This was in advance of the launch of our Think Family Standard. EBE's shared the key messages relating to keeping them and their families safe that they felt needed to be understood by mental health clinicians.

The key messages from this engagement were used to refine our Think Family Standard and Approach.

- Expert by Experience consultation took place, and their input supported the refining of Think Family messages delivered to clinical teams.

Think Family Standard statements that relate directly to Quality Assurance statement.

Embed a system wide open door approach increasing coordination between children and adult services.

See yourself as a part of a wider team around a child. You may not have access to them that allows you to explore their feelings, but key information should be shared with others (e.g. Social Worker, teacher, health visitor) that do to support their ability to respond to children's needs.
Respond to the 'Voice' or 'Lived Experience' of the child by sharing your insight with other relevant professionals and making referrals to children's services as appropriate.
Where needs are identified, share information with relevant avenues of support and work to engage them on behalf of the family.
Where necessary, apply appropriate challenge to other professionals when needs remain unmet, or risks are not controlled following a referral.
Consider young (child) carers – signpost to avenues of support and share information in the best interests of the child with other services who may offer support.
Work in partnership with other professionals to help family members understand the mental health needs of their loved ones and how they can best support them.
Work with other professionals and families to control and respond to risks.

Safeguarding training Figures

Safeguarding training has shown that there has been a significant increase in compliance with the current data shown in the tables below:

Competencies	Percentage Completion
Safeguarding Adults – Level 1	97.1%
Safeguarding Adults – Level 2	97.7%
Safeguarding Adults – Level 3	89.2%
Safeguarding Children - Level 1	96%
Safeguarding Children - Level 2	96%

Quality Priority 5: Using Our Time More Effectively

Using our time more effectively	
Engage colleagues and scope how we can use quality improvement methodologies to release time to care.	Measures of success: • Number of individuals trained in QI approaches. • Key areas for improvement identified through a process mapping programme. • Reduction in time spent on non- clinical tasks, such as administration.

Why is this a priority?

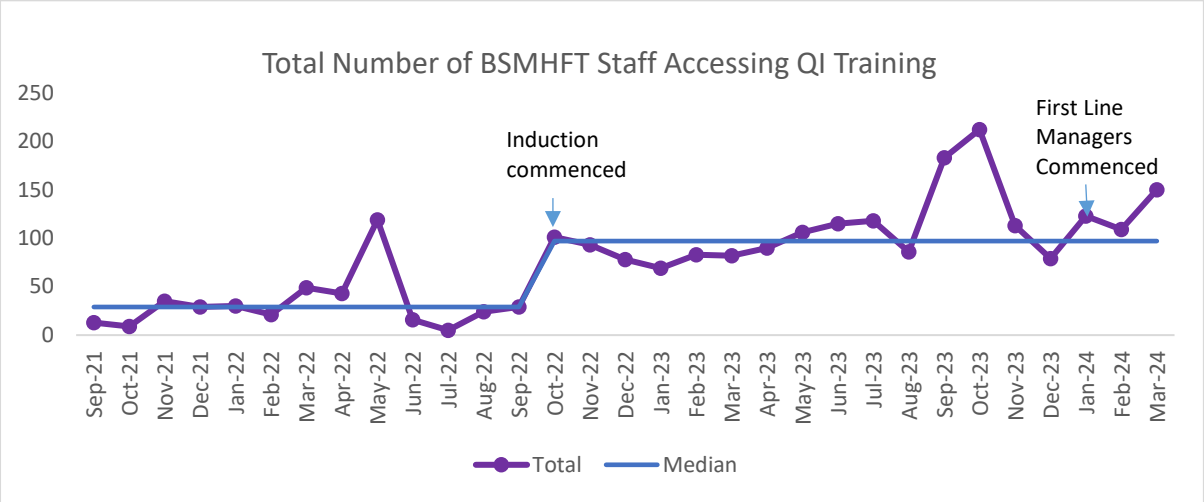
We want to ensure that patients know that their health is central to everything we do. One of the frustrations that our clinicians regularly feedback is that they spend too much time on non-clinical tasks that reduce the time they are able to spend on patient-facing care. Some of the contributing factors to this are a large amount of paperwork, unnecessary duplication, inconsistent expectations, and use of our administration functions and systems that do not have effective interfaces.

How did we do?

The QI training academy focuses on two aims. The first is to offer QI at an introductory level, to ensure staff are aware of the methodology, how it can support them and how to access further training and assistance. Further training is then available on how to utilise the QI methodology through bronze and silver training. The training offer continues to evolve and in 2022 a session on the trust induction was introduced, and in 2023 training to first line mangers was developed which commenced in January 2024.

From April 2023 to March 2024, 1374, staff have accessed introductory training through induction, Intro to QI, the new 1st line managers programme and various ad hoc training. There have been 110

staff who have undertaken more in-depth training on the methodology via half day Bronze training and 3-day Silver training. This is an increase of 742 on the year 2022 /23.



The training evaluations show a high level of satisfaction with the training. The overall training score averages 4.76 and the average rating for the course fulfilling expectations and training needs is 4.7.

Example of Feedback Received

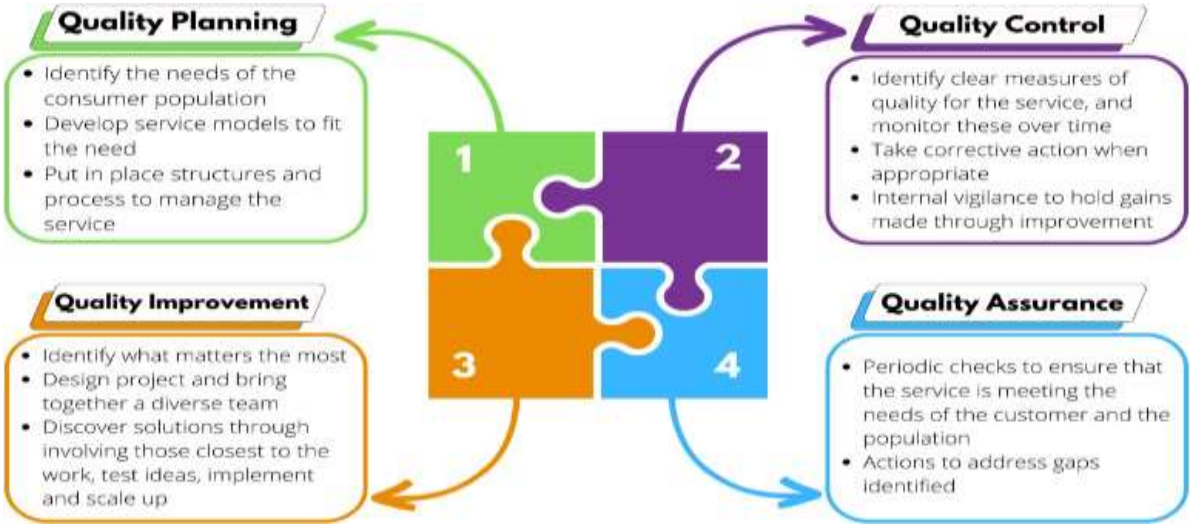
“I have used it to think differently about how we should be setting and measuring the impact of our Trust strategic goals, making them more outcome focused and ensuring we will know that they have or haven't made a difference. I have been involved in QI before, but it reminded me of how useful it is and to be honest was a bit of a eureka moment for some work I've been struggling with around demonstrating the impact of our Trust Strategy. I've already used some of your slide content around the model for improvement and QI principles particularly as we start when talking to teams about linking their work to the Trust Strategy and/or setting goals. I think moving this forward by linking the strategy work with the QMS and QI work is a really exciting opportunity, particularly as we start thinking about how we are going to refresh the strategy ready for 2026. I personally think QI training should be Mandatory.”

As a Trust we have invested in our approach to quality improvement and want to ensure we are using that methodology and associated tools to identify where we can improve our processes and systems to release more time for direct patient care, to improve their experience and the experience of our clinicians. The views and needs of our population are of significant importance and as a result we are driving an inclusive approach to ensure the voices of all who use our services are heard.

We have developed a program of work using the quality management framework set out below to underpin and assure us of the quality of our services and care on a continual basis, to identify opportunities for quality improvement and to embed quality planning. Working together across services we have developed and agreed a work plan to enhance delivery of patient care. This will

help us to act quickly to recognise good care and practice, and equally act quickly where improvement is needed.

Quality Improvement Priorities for 2024/25



Information from a number of sources and consideration of national improvement plans and priorities has helped inform the Trust's priorities for 2024/25.

BSMHFT has been on a journey of improvement, and we remain committed to driving forward quality change, to learn, listen and to innovate, so that we can deliver the highest quality and safest are possible. As a Trust we are wholly committed to delivering the vision of making BSMHFT the safest possible organisation.

This is the agenda that drives everything we do, and the evidence shows that it is having a real, visible and measurable effect in the organisation. During 2024/25 we will embed a quality improvement strategy to support the Trust's five-year Strategic Plan.

Quality Goal Priority 1: Service User Experience

Why is this a priority?

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

Empowerment and autonomy are key aspects of SDM, as it involves service users directly in their healthcare decisions, respecting their right to make informed choices about their health. When service users are actively engaged, they are more likely to feel in control of their health journey, leading to increased satisfaction and engagement with treatment plans.

When service users and carers feel heard and involved in the decision-making process, their satisfaction increases. They are more likely to feel respected and valued, which enhances their overall experience and

fosters a positive relationship with our teams providing care. Involving service users and carers in decision making aligns with ethical and legal standards of informed consent and patient rights, supporting the principles of dignity and respect.

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

Service User Experience

Why is this important?	**Measures of success:**
Shared decision making with service users and families about their treatment and care to aid their recovery.	• Develop a strategic plan and deliver identified outcomes for working with people, families, and communities in line with national guidance. • Co-produce with Experts by Experience the implementation of a plan including goals and outcomes against national frameworks to identify and address health inequalities, such as Patient and Carer Race Equality Framework (PCREF), Equality Diversity System 2022, the Accessible Information Standard and Patient Led Assessments of Care Environments. • Co-produce with service user networks plans and goals to strengthen involvement for people who identify as a minority or with a protected characteristic as per the Equality Act 2020 • Identify and measure quality improvement projects with service users/carers and co-produce measurable outcomes to deliver against plans.

How have we done this?

The Participation, Experience and Recovery (PEAR) group is a sub-group of the Clinical Governance Committee and oversees the governance and development of the experts by experience (EBE) programme,

experience projects and experience data collection and reporting. It is a dynamic collective of experts by experience and colleagues and is co-chaired by an external academic health had wellbeing expert with an EBE and BSMHFT service user governor as deputy chair.

The EBE programme has continued to grow and flourish, with over 3,000 hours contributed by EBEs in co-production. This includes recruitment and selection interview panels, recovery college delivery, EBE educators delivering staff training and a Trust Induction session, EBE quality advisers, EBE safety partners and specific project work. Service users and carers can access our EBE induction programme to become involved, and we have introduced a quarterly EBE Sharing Space for EBEs to network, celebrate good practice and share challenges.

One particular highlight was the Lived Experience Action Research (LEAR) group taking a lead at BSMHFT's Research and Development, this places lived experience in research at the heart of the Trusts' research programme. LEAR is a group of committed service users and carers and is chaired by an EBE. The group is integral to the research approvals process at BSMHFT, as well as providing advice and support to anyone interested in undertaking research. The group has established partnerships with Aston University and Birmingham University, contributing to a number of separate projects.

The group comprises of approximately 15 members, who have a specific interest in research and who have been under the care of BSMHFT. Members have a range of experience and knowledge of both mental health conditions and services.

The group currently meets monthly and we have seen a steady increase in the amount of interest in the group including approaches from researchers in the early stages of their research – this is very positive and as outlined has very much been a priority for the group to have researcher engagement with LEAR early, rather than as a rushed after thought – it really feels like the message is getting out there.

Our policy regarding the "Approval of BSMHFT Research Projects" has recently been approved, a major update for this was to ensure all Trust sponsored studies include involvement from the LEAR group.

Three recovery college terms were delivered, providing a range of opportunities for service users, carers, and colleagues to learn equally in a safe and inclusive environment. Sessions were delivered face-to-face and online, and all were co-designed and co-delivered with an EBE.

The Health through Opportunity, Participation and Experience (HOPE) Strategy was co-produced with experts by experience and was launched at the Trust AGM with a video by EBE's.

The video can be seen here:

https://www.youtube.com/watch?v=KmVtIHkWsBg

The HOPE strategy sets out principles and ambitions for recovery via the domains of Health through Opportunity, Participation and Experience. The strategy is aligned with the Trust Strategy and sets out the structure for co-production to be central to strategy delivery and development through HOPE action groups. The HOPE strategy sets out the rights-based, collective direction being taken by BSMHFT where any service user, family member or carer can utilise a range of co-production activities to exercise their participation rights.

The participation and experience team have co-delivered with carers an awareness training to hundreds of colleagues across BSMHFT.

The co-delivered service user and carer experience Trust Induction session includes a participatory activity on best practice in supporting a family member of someone with dementia. Also, this session includes key messages on the importance of identifying, involving, and supporting carers, and makes important points about appropriate information sharing with carers.

The family and carer pathway and engagement tool is still available for colleagues to shape their conversations with families and carers: a review of the pathway is planned to ensure that it aligns with and compliments dialog+ and community transformation.

Quality Goal Priority 2: Preventing Harm

Why is this a priority?

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

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

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

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

Quality Goal priority 3: Patient Safety Culture

Why is this a priority?

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

Patient Safety Culture	
Why is this important? A patient safety culture will strengthen the confidence to speak up and promote learning and will enhance the values, beliefs and behaviours that support patient safety.	**Measures of success:** • Measurement of delivery and outcomes related to compassionate engagement with those affected by patient safety incidents. • Identify outcomes related to the delivery of safety summits across all services to promote learning. • Implement a suite of new learning from safety methods. • Provide evidence regarding the Strengthening of the relationship between safeguarding and service areas. • Provide evidence of Increasing numbers of staff undertaking just culture/human factors training. • Reduction in grievances and disciplinary cases. • Positive recording of incidents leading to no harm to expose learning.

Quality Goal priority 4: Quality Assurance

Why is this a priority?

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

Quality Assurance	
Why is this important? It will give clarity in relation to how we monitor and evaluate service delivery.	**Measures of success:** • Implementation of dashboard to measure data and understand outcomes to improve care. • Evidence that pathways have been created to drive improvement. • Implementation of AMaT (Audit Management and Tracking Tool) and evidence it is embedded across services. • Provide evidence of our Peer review processes demonstrating improvement across services. • Evidence based practice ensuring a reduction in CQC activity and delivery against outstanding actions.

Quality Goal Priority 5: Using Our Time More Effectively

Why is this a priority?

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

planning and the ability to respond swiftly to emerging challenges. Ultimately, effective time management in our organisation is fundamental to delivering high-quality, patient-centred care in a timely and resource-efficient manner, contributing to the overall sustainability and effectiveness of the healthcare system.

Managing our Time Effectively	
Why is this important? To enhance patient care and staff satisfaction.	**Measures of success:** • Demonstrate outcomes against Quality Improvement Programs that demonstrate improvement in care. • Outcomes that demonstrate that evidence-based practice and research are a routine way to inform transformation of care and services. • Evidence related to the reduction in waiting lists and length of stay.

2.2 Statements of Assurance from the Board

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

	Prescribed information	**Form of Statement**
1.0	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	During 2023/24 BSMHFT provided the following mental health services: A&E Liaison Adult Acute Ward Adult CMHT Adult Day Care AOT Child and Adolescent Mental Health Services (CAMHS) Deaf Inpatient Eating Disorders Community Eating Disorders Inpatient Early Intervention Forensic CAMHS Community Forensic CAMHS LOW SECURE Forensic CAMHS MEDIUM SECURE High Dependency Wards Home Treatment IAPT Justice Liaison Low Secure Perinatal Community Perinatal Inpatient Medium Secure Wards Neuropsychiatry Older Adult Acute Ward Older Adult Community Memory Services OPIP (Older Adult Day Care) Psychiatric Intensive Care Unit (PICU) Primary Care Prison Mental Health Care Rehabilitation Ward Substance Misuse Services
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	BSMHFT has reviewed all the data available to them on the quality of care in these services.

1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2022/23 represents 90 % of the total income generated from the provision of relevant health services by BSMHFT for 2022/23.

Participation in National Clinical Audits and National Confidential Enquiries

	Prescribed information	**Form of statement**
2.0	The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period, and which covered the relevant health services that the provider provides or subcontracts.	During 2023/2024, 6 national clinical audits covered relevant health services that Birmingham and Solihull Mental Health NHS Foundation Trust provides.
2.1	The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period Birmingham and Solihull Mental Health NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in.	The national clinical audits and national confidential enquiries that the Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in during 2023/24 are as follows: . National Audit of Dementia (NAD) - Spotlight on Memory Assessment Services • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP)

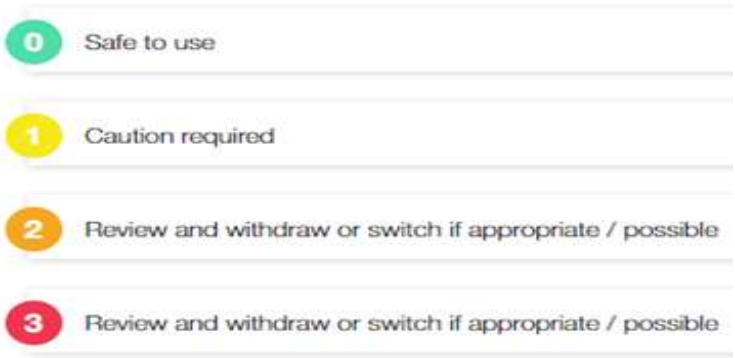
		• POMH 7g: Monitoring of Patients Prescribed Lithium • POMH 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services • POMH 22a: The Use of Medicines with Anticholinergic (Antimuscarinic) Properties in Older People's Mental Health Services • POMH 23a: Sharing Best Practice Initiatives
2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in.	• National Audit of Dementia (NAD) - Spotlight on Memory Assessment Services • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • POMH 7g: Monitoring of Patients Prescribed Lithium • POMH 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services • POMH 22a: The Use of Medicines with Anticholinergic (Antimuscarinic) Properties in Older People's Mental Health Services • POMH 23a: Sharing Best Practice Initiatives
2.4	A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during April 2023 to March 2024 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Title of National Clinical Audit	Eligible	Participated	%*
National Audit of Dementia (NAD) - Spotlight on Memory Assessment Services	Yes	Yes	100% (50)
National Clinical Audit of Psychosis (Early Intervention Services) (NCAP)	Yes	Yes	100% (60)
POMH 7g: Monitoring of Patients Prescribed Lithium	Yes	Yes	100% (68)
POMH 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services	Yes	Yes	100% (100)
POMH 22a: The Use of Medicines with Anticholinergic (Antimuscarinic) Properties in Older People's Mental Health Services	Yes	Yes	100% (79)
POMH 23a: Sharing Best Practice Initiatives	Yes	Yes	N/A

2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of 5 national clinical audits were reviewed by the provider in 2023/24 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	

POMH 22a: The Use of Medicines with Anticholinergic (Antimuscarinic) Properties in Older People's Mental Health Services

Aims: This audit was conducted to address the quality of prescribing of medicines with anticholinergic properties specifically in older adults. Comparisons against the National Sample were also reviewed to assess the Trust's position against other providers. This audit looked at whether Trusts are using an Anticholinergic Effect on Cognition (AEC) scale when prescribing for older adults. The infographic below explains the scale system:



Key Success(es):

• 22 out of the 69 patients in the Trust sample were prescribed antipsychotic medication. Of those 22, **64%** (**n=14**) were prescribed medication that had an AEC score of 1 or less. The national sample saw **57%** (**n=1784**) of patients being prescribed medication with an AEC score of 1 or less.
• The Trust's total anticholinergic burden of patient's prescribed medication regimens saw **81%** (**n=64**) with an AEC score of 1 or less. The national sample saw **64%** (**n=5047**) in the same category. In the same measurement, the Trust also demonstrated a lower number of patients with an AEC score of 3 or more (**7.6%** (**n=6**)) when compared with the national standard of (**23.1%** (**n=1835**)).

Key Area(s) for Improvement:
• **0%** (**n=0**) of patients in the Trust sample had a documented review of the total anticholinergic burden of patients' medication regimens where medications with anticholinergic properties are prescribed for older people, compared to **14%** (**n=748**) of patients in the national sample. It should be noted that this percentage includes **9%** (**n=465**) of patients who were assessed clinically but with no use of an anticholinergic burden scale being used.

Key Action(s):
• As illustrated in the areas for improvement, there are few Trusts using an ACE scale scoring system and documenting this in the patient records. A widely used scoring system (Medichec) is currently being reviewed for approval for use by the Trust. This tool is completely free and allows clinicians to tally the score of medicines being given to older adults. This action has been assigned to the Pharmacological Therapies Committee (PTC) for progress monitoring

POMH 7g: Monitoring of Patients Prescribed Lithium

Aims: This audit was conducted to address the quality of prescribing of lithium. Comparisons against the National Sample were also reviewed to assess the Trust's position against other providers.

Key Area(s) for Improvement:
• Realistically speaking, there were no key successes in this audit. In comparison with the 2019 POMH audit, the Trust appeared to perform worse in the majority of standards. However, there were issues with data collection as the process was reliant on non-medical facilitators with sometimes limited access to clinical records. This produced inaccurate results as certain tests couldn't be seen as recorded when in fact, they had been recorded but couldn't be accessed by the data collectors.
• The main issue from this audit was the lack of clarity on the process for data collection. Rather than there be certain aspects of the audit that need actions, the audit itself needed a reaudit using clinical staff as the collectors.

Key Action(s):
• The first action is for a reaudit to take place. This was agreed in the Pharmacological Therapies Committee and will be completed on a slightly smaller scale. Once the results are compared with 2019, any progressions / regressions can then be measured. Any actions required at this point can then be agreed and monitored for progress.

POMH 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services

Aims: This audit was conducted to address the quality of prescribing of valproate. Comparisons against the National Sample were also reviewed to assess the Trust's position against other providers.

Key Area(s) for Improvement:
• There were several issues with the data collection process for this POMH audit. The first issue was that there were no clinical staff involved in the data collection process. This meant that data collection was reliant on facilitators who had severely limited access to clinical records at the time.
• Another issue identified during collection was the lack of clarity on where certain documentation related to women of a child-bearing age should be located within the online clinical records.
• In similarity with POMH Lithium, this was identified as an issue and added as a risk in order to resolve the lack of clinical input on the POMH process as a whole. There was also an agreement for a reaudit to take place. This is currently in progress and being completed by junior doctors with experience in valproate prescription.

Key Action(s):
• Reaudit on a smaller scale was agreed in the Pharmacological Therapies Committee. This is in progress and being completed by junior doctors who have experience in valproate prescription. Once this reaudit has been completed, the Trust can then compare the results with the previous round of POMH for prescription of Valproate and look for any progressions / regressions in performance. Any actions required at this point can then be agreed and monitored for progress.

POMH 23a: Sharing Best Practice Initiatives

Aims: This audit was conducted to look at previous POMH audits submitted by the Trust, the actions that came from them, and the progress on those actions.

Key Takeaways:
• 35 Trusts took part in this program, with 123 submissions of previous audits. 3 out of 5 submissions related to either Clozapine, Valproate or Antipsychotic Prescribing.
• Activities undertaken as actions following these audits included changes made to forms embedded in Trust IT systems, developing new/updating existing policies/protocols, further local audit, delivering educations initiatives for staff, developing/providing educations material for patients etc.
• 65% of submissions said that these audits were discussed at their relevant committees. The Trust also does this through PTC, CEAG and any relevant CGCs.
• The majority of actions mentioned above fell under the 'worthwhile improvement achieved but further work needed.' This is similar to the Trust's submissions. Lots of actions were undertaken with significant progress made, but with more work still to do.
• Barriers to these actions included lack of time and resources, limitations of the Trust ePR, service interface issues, limited clinical support, cost, time taken to make changes on systems such as ePMA, and unclear policies/procedures.

Recommendations:
• There are no current specific recommendations to be made from this piece of work. This was an informative project that looked at the ongoing follow-up work from previous clinical audits with POMH.

National Clinical Audit of Psychosis - NCAP (Early Intervention Services)

Background:
Each year the Early Intervention services undergo a National Clinical Audit of Psychosis (NCAP) lead by the Royal College of Psychiatry. The audit looks at a number of aspects which align with NICE guidelines for

psychosis to ensure that the care delivered is holistic, evidence based, and effective. The audit gives an overall rating between 1-4 with 4 being a top performing team.

Key Success(es):
• Over the years the team has worked with the informatics team to develop reporting that aligns with the NCAP standards to enable the team to monitor the interventions delivered and standard of work. These monthly reports have enabled the team to look at areas of improvement that were required and have aided with the service achieving '**TOP PERFORMING'** Level 4. The categories that the service scored top performing in and how they achieved this are as follows:

• 14-day Referral to treatment (RTT) - Internal process for screening and booking in assessments. The result within the audit is a BSol (Birmingham and Solihull) result however Solihull EIS has been consistent over the years with a RTT of between 95% - 100%.
• Number of service users accessing CBT-p (Cognitive Behavioral Therapy for Psychosis) – Up-skilling of the current work force and access to HEE training and supervision.
• Family Interventions and carer-focused interventions - Recruitment of a Family Intervention lead who over see's the family work and supervises the staff that are on the relevant training course.
All staff are trained in either the Behavioural family therapy (BFT) or have completed the new HEE funded Family interventions (FI) training for Psychosis.
• Individual placement support (IPS) - There is a partnership with the Shaw trust who specialise in employment and there is a staff member embedded within the team.
• Physical health screens and interventions - The service recruited a health instructor who works alongside the physical health lead in the team to address and help prevent any physical health issues.
• Outcome measures (Paired outcomes) - The use of outcome measures is incorporated into all reviews.
• Clozapine usage (in line with recommendations of the unsuccessful usage of two antipsychotics) - Internal processes around medication management etc.

Key Action(s): from the Audit:
• No key actions required. The EIS for BSMHFT scored top performing and so their current work is showing they are achieving the level of care expected from Trusts.

2.7	The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.	The reports of 11 local clinical audits were reviewed by the provider in 2023/24 and Birmingham and Solihull Mental Health Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	

Safewards Audit

Background:
Safewards is an evidence-based violence reduction model that seeks to challenge two facets of aggression management dynamics: containment and conflict. The Safewards model was introduced to all inpatient units in Y1 of the Trust 5-year violence reduction strategy. In Y2/Y3 the PPCEP Safewards work stream will focus on the process of imbedding the model, and this audit is the first phase of this process. The aims were:

- To establish the current status of Safewards implementation in BSMHFT inpatient services

- To benchmark unit compliance with Safewards modules
- To identify successful methods of implementing the model in order to support those areas where there are issues
- To use results to identify areas of deficit and supportive strategies to improve compliance

Key Findings:
• Majority of all service areas had good level of Safewards compliance
• Acute care and Secure care were 100% compliant in responses to Safewards modules
• Safewards posters had good overall compliance amongst all directorates where responses for data collection were received.
• A cause for concern is with in Acute care Endeavour House had no compliance with Safewards posters on wards.
• Within all directorates Acute care was the most compliant with 81.2% of discharge messages.
• Specialities at Barberry have been least compliant with discharge messages being given by service user/patient. There is clear recognition that specialties services such as D&F may require support in adapting this Safewards module to meet the needs of their service user population.
• With all directorates combined 71% knew of each other's profiles with Acute care having the most compliance from responses received for this audit.
• All inpatient wards had (78.6%) evidence of calm down methods available. An issue for concern Dementia and Frailty (DF) Directorate Reservoir Court and Rosemary had non calm down methods. This being the only directorate amongst all in patient units with non-compliance to calm down methods.
• Acute care was the lowest in compliance for this compared to other in-patient units for all other directorates. DF Reservoir court and Rosemary Ward were none compliant with Mutual help meetings.
• With all directorates combined 71% knew of each other's profiles with Acute care having the most compliance from responses received for this audit.
• Dementia and Frailty where (n=2) had no evidence in information in relation to knowing profiles.
• From within all directorates 71% were compliant in conducting mutual help meetings. Un expectedly Acute care was the lowest in compliance for this compared to other in-patient units for all other directorates.
• Within DF Reservoir court and Rosemary Ward were none compliant with Mutual help meetings.
• Acute care and secure care are 100% compliant in embedding principles of Safewards except for Endeavour House
• Dementia and Frailty and Specialties require a lot of work on Safewards compliance.

Key Action(s):
• Although some directorates are 100% compliant, work is still needed to be done to embed Safewards terminology into reporting and recording. This provides invaluable evidence that Safewards is becoming 'business as usual' in care delivery.
• Not all units within every directorate responded to this audit, which needs to be addressed with Ward Managers.
• In the Dementia and Frailty Directorate, including Specialties work needs to be done to embed Safewards terminology into reporting and recording, as this was reported as non-compliant for 2 inpatient units including Bergamot and Sage. A climate of collaborative working and sharing experiences will be a primary vehicle to improve compliance in such areas.

Clozapine Assays Audit

Background:

• BSMHFT non-secure services have a total of 892 patients registered with the Denzapine Monitoring Service (DMS) for the prescribing of clozapine as of 25th July 2023. In the six months from 1st January 2023 to 30th June 2023, there were 242 Clozapine plasma levels that were reported as being above 600ug/l within non-secure inpatient and community teams, for a total of 120 different patients. There were 199 reports of Clozapine plasma levels between 600ug/l and 1000ug/l and 43 reports of Clozapine plasma levels above 1000ug/l.
• Within Non-Secure services, the deputy chief pharmacist reviews the trust Insight report on raised Clozapine plasma levels (levels over 600mcg/l) each Monday and sends an email to the consultant listed as being responsible for managing that patient's Clozapine prescriptions. An entry is also made on Rio progress notes and the Clozapine review form on Rio completed.

Key Findings:
• Of the 70 raised Clozapine plasma levels in the sample, 69 (86%) are documented as being escalated by the Clozapine pharmacist. Of the 11 raised Clozapine plasma levels that were not escalated by the pharmacy team, 3 had already been escalated by the nurse who had taken the call from Pathology. The other 8 were reported during leave for the Clozapine pharmacist and though followed up after the leave, they were not escalated at the time. All of the 69 raised clozapine plasma levels that were escalated by the pharmacy team had an entry made in Rio, an email to the consultant, as well as a Clozapine review form being completed on Rio. This highlights the benefit of pharmacy involvement in clinical teams and escalation of raised Clozapine plasma levels. In the full sample there were also some reports that were escalated by admin and clerical staff following phone calls from Pathology relating to those levels above 1000mcg/L.

Key Action(s):
• New e-learning package purchased for clozapine training. A short 3hr course intended for all staff managing clozapine patients and a 10-hour one for prescribers and pharmacists. Plan will be to ensure all relevant staff are informed of this and trained before next re-audit (likely October/November 2024).
• All staff ordering clozapine assays are aware of the criteria for ordering these. No unnecessary assays done without instruction from consultant.
• All assay results added to the clozapine review section on Rio.
• All assay results above 600mcg/L reviewed by the consultant or the team.
• All levels above 800mcg/l reviewed within seven days of consultant being informed.
• All levels over 1000mcg/l or with signs of toxicity reviewed within 24hrs of consultant being informed, and dose adjustment made to correct these.
• Clear documentation of "clinic questions" on each visit and appropriate escalation by team.

Initial Child Protection Conference (ICPC) Audit

Background:
The focus of this audit was to review practitioners' involvement within child protection processes, primarily focusing on the Initial child protection conference (ICPC) procedure. ICPC conferences are initiated following a section 47 investigation, which have been completed and were concerns of significant harm have been substantiated.
The objective of ICPC's is to bring together all professionals who are involved with the family and review and analyse all relevant information and plan how best to safeguard and promote the welfare of the child(ren). It is imperative that all professionals involved should work together to safeguard the child(ren) from harm by taking timely, effective action to the plan agreed. It is important to note that only a small sample of cases were reviewed, due to the ICPC process only recently being embedded within the trust.

Key Findings:

• Out of the 20 cases we audited, only 3 agency reports were submitted.
• 0 reports were shared with the family prior to the conference.
• Despite 11 practitioners attending the ICPC conference, only 5 official reports were uploaded on the service user's records. It is unknown whether all 11 ICPC minutes were received by practitioners or whether practitioners have failed to upload them.
• 11 practitioners attended the ICPC conference, of these cases 3 service users were managed under Care support and 6 under Care Programme Approach.
• Within the 19 cases where clinicians had liaised with the allocated social worker for the family, only 9 practitioners had liaised with the social worker prior to the conference. It is evident on the clinical records that the remaining 10 had liaised with the social worker due to being informed of the ICPC taking place.
• 11 children and sibling's forms were completed on service user's records, however 5 of these cases were completed by our Adult mental health family liaison worker.
• It is evident within the audit that 'think family and the voice of child has been considered in more than half of the cases audited. Some examples of this:

- Practitioners thinking about the safety of children due to concerns regarding the service user's lifestyle. i.e. Substance misuse, financial concerns, childhood adverse experiences.
- Young people being seen alone for the voice of the child to be captured.
- Service users noted to potentially taking on caring responsibilities.
- Suitability of home environment explored by practitioners.

It is important to note that within 20 of the causes audited, only 2 cases were service users who were children.
• Of the 11 practitioners that attended the ICPC, 8 clinicians documented some elements of the discussion and concerns. 3 cases had no ICPC documentation from the practitioner that attended. 9 cases where teams did not attend the conference.
• Out of the 8 cases where clinicians had documented some information regarding the discussions of the ICPC meeting, only 3 had made a reference to the sliding scale scoring by professionals.

Key Action(s):

• To liaise with teams who were audited and to ascertain why they were not able to attend the conference or submit a report.
• Following liaison with clinical teams, to implement additional support around the ICPC process focusing on their concerns identified.
• Mandatory support sessions to be held to go through the ICPC process to strengthen clinicians understanding and explain what is required of them.
• Clear guidance to be formulated regarding ICPC documentation.
• To review whether Child protection cases are being brought to safeguarding or clinical Supervision.

Multi-Agency Neglect Case Audit for Solihull Safeguarding Children

Background:

In line with our commitment to multi-agency practice and learning in 2023/24, a multi-agency audit around the theme of neglect was undertaken and involved key partner agencies from across the partnership. The audit group consider 7 children and young people as part of this themed deep dive audit. Graded Care Profile 2 (GCP2) was utilised at some point in the child's journey for 6 out of the 7 children. The use of this tool is planned for the remaining child pending the allocated worker being trained to use GCP2.

Key Findings:

• For the most part, referrals were of a good quality.

• Strategy meetings have been undertaken where necessary.
• The voice of the child was captured for a number of the children we looked at.
• Good multi-agency input in assessments.
• All reviews took place within timescales.
• Good multi-agency contribution to review the plan.
• Other agencies were not always aware of neglect concerns due to a lack of information sharing (GPs and Education).
• Timelines of involvement and chronologies are imperative to safeguarding and understanding cumulative impact, this is something that could be improved to ensure they are up to date and useful.
• More consideration needs to be given to understanding the short- and long-term impact of neglect in relation to a child's needs for example, self-esteem and forming relationships.

Key Action(s):
• Devise a clear continuum of tools to support all practitioners to be able to use an appropriate method of identifying and recording neglect concerns to enable robust information sharing.
The continuum of tools includes single agency chronologies/timelines of involvement, multi-agency chronologies, neglect screening tool and GCP2.
• Develop a tiered capability framework, supported by partner agencies, to ensure that everyone who is in contact with children, young people and families can recognise their roles and responsibilities concerning the prevention and identification of neglect.

Routine Enquiry Audit

Background:
The focus of this audit was to review whether practitioners were asking questions about domestic abuse through "Routine Enquiry" The audit will measure against the requirements of the Domestic Abuse Policy and measure how BSMHFT's team members have identified, recognised, and responded to domestic abuse. Since 2003 it has been a DH Policy that all adult service users should be asked about violence and abuse in mental health settings. Routine Enquiry is supported by Royal College of Nursing, Royal College of Psychiatrists and National Institute for Health and Care Excellence (NICE). A frequent theme which is identified in all Domestic Homicide Reviews (DHR's) is a lack of Routine Enquiry. A report conducted by Visible Project noted that in their evaluation of routine enquiry with professionals, whilst most practitioners were supportive of this approach there was some opposition, mainly based around a fear of making things worse, lack of confidence, a lack of knowledge of specific services to signpost to and a lack of understanding as to why this is a requirement.

Key Findings:
• The audit although a small sample; does continue to demonstrate that women are predominantly the victims and that men are predominantly the perpetrators of Domestic violence and abuse. The ages collected in this audit range from 26 to 52 years, and it is noted that no over 55 years were represented. Due to the size of the audit, it does not give a clear picture if there are specific age groups that are more at risk although there is data collated by Office of National Statistics (ONS) that show more 16 – 25year olds are recorded as experiencing domestic abuse.
• In the 16 cases sampled,15 was intermate partners and one case was child (an adult) to parent abuse (CPA). CPA is a particular difficult type of domestic abuse that can be hard to identify as parents may not see this as domestic abuse, and rarely seek support when it is their child who is abusing them. Parents may feel that it is ultimately their responsibility and may have failed their adult child in some way, the child parent bond runs very deep and in most cases the parent tends to neglect their own needs, this type of domestic abuse is prevalent within BSMHFT.

• The audit does suggest that practitioners are thinking about domestic abuse in their contacts with service users, out of the 16 cases targeted, 37.5% of the cases evidenced some discussion about domestic abuse. RIO is not currently set up to collect specific data on a wider level about Routine Enquiry as there is no specific place to record this and most practitioners use the progress notes to record conversations or disclosures. The Assessment Summary does have a section that asks about abuse, although this is useful it's too broad so again cannot be used to collect this information. The Risk Assessment asks about harm from other and harm towards other (it prompts consideration of domestic abuse) but again is broad and anything specific about domestic abuse in the free text box cannot used to collect the data. It is also impacted on by the staff members recording skills and knowledge of clinical applications.

Key Action(s):
• To create a Survey Monkey to be disseminated to the identified clinical teams, this will focus on practitioners' awareness of routine enquiry, confidence in exploring domestic abuse and any barriers.
• Develop a be-spoke animation on Think Family and domestic abuse for Trust Induction.
• Routine Enquiry/Think Family sessions for identified teams, commencing with Primary Care mental health Teams.
• Liaise with ROAD re evidence of routine Enquiry on RIO.
• Raise awareness of Routine Enquiry through Safeguarding Supervision.

NEWS2 (Q3 23/24)

Background:
Taking physical observations is a fundamental part of the assessment process. The interpretation of the information from this assessment is vital in determining the level of care a service user requires for us to provide an intervention or treatment and stop/preventing a service user's deterioration from an otherwise preventable cause. (NICE, 2018)

The term physical observation refers to the physical assessments of the service users' vital signs. Vital signs are traditionally used in the context of the collection of a cluster of physical measures, such as pulse, respiration, temperature, blood pressure, pulse oximetry and more recently if the service user is prescribed oxygen therapy and chance to consciousness.

Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) uses the NEWS2 tracing and trigger system which is based on a simple scoring system in which a score is allocated to our routine observation of the six physiological measurements– respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.

The score is placed on the digital ward platform and is used by clinical staff to record vital signs, assign each a score, and monitor people's physical condition where necessary. The total score lets the practitioner know if a patient is deteriorating, prompting them to take urgent action, to review the care of the patient and call for specialist help if necessary.

The NEWS2 has been shown to be a highly effective system for detecting service users at risk of clinical deterioration or death, prompting a timelier clinical response, with the aim of improving service user's outcomes in the trust. (NICE, 2007) (Royal College of Physicians, 2017). This scoring system is fundamental in the identifying and managing the deteriorating patient.

Key Findings:
• The 151 raised NEWS2 scores in this quarter have been scrutinised. These results were from 88 individual service users. Some service users had multiple raised scores. Due to the increase in monitoring

to review their deterioration, we have service users having repeated observations with at higher risk scores. We had one service users who had instances of NEWS over 4, on 26 occasions, one service users 7 times, one service user 5 times, one service users 4 times, and seven service users 3 times; however, most were on 1 or 2 occasions. Service users that deteriorated they were managed on the wards and/or transferred to acute care. This highlights the system we have in place have improved our prompt responses to the individual needs of the service user.
• We have good evidence the reviews and the appropriate response has improving significantly, especially post pandemic. The staff are now acutely aware of the risk of deterioration of physical health. We also have a good system in place, so we have a real time understanding of any deterioration. The trust has provided multidisciplinary face to face training for all at the start of the pandemic and periodically during subsequent waves to improve physical health awareness and help with how to deal with acute deterioration. We have also increased inhouse training via our Physical Health Clinical Education Team providing face to face training and direction to appropriate eLearning packages.

Ongoing Work:
• We are making sure the clinical guidelines are widely read and understood.
• We also have developments The Management of the Deteriorating Patient policy which now links to the NEWS and SBARD guidelines.
• We now have a generic insight report so the Heads of Nursing/AHP and matrons will have quicker/easier access to this information so they can look to made improvements locally.
• The trust has now seen the introduction of the new role of 'Deteriorating Patient, Resuscitation and End of Life Lead' that will further support improvements in care.

Pharmacy - Inpatient Controlled Drugs Audit

Background:
The Duthie Report and the RPSGB /DH report "Safe and Secure Handling of Medicines: A Team Approach" indicates that controlled drug audits should be carried out at least every 6 months. This also forms part of the assurance framework registration with the care quality commission.
This audit follows the amended version from the West Midlands Medicines Safety Officer Network published in the summer of 2020. Standards are derived from the DH report "safer management of controlled drugs – a guide to good practice in secondary care" published in October 2007 and also NICE guidance on the management of controlled drugs published in 2016. Audits form part of the basis for identifying concerns that may need to be reported to the local intelligence network for controlled drugs. For BSMHFT, this is currently the Birmingham and Solihull CD LIN.
This revised audit is the fourteenth and carried out during November 2023. It follows previous audits conducted between 2009 and March 2023. Standards were equivalent to those for the September 2020 and subsequent audits. Where applicable, comparisons are made with the March 2023 audit.

Key Findings:
• This audit covers 47 wards. Across the 47 wards, there was 87% Page 2 Adapted from original produced by the West Midlands Chief Pharmacists Network – Medicines Safety Network subgroup (November 2019) for use within BSMHFT compliance which is slightly above that for March 2023 but comparable with the results from audits carried out in 2020 and 2021.
• Three wards achieved 100% compliance which is one less than the previous audit in March 2023.
• Ardenleigh has shown a large improvement since the last audit with small improvements seen within Acute Inpatient South, Demetia and Frailty wards, Steps to Recovery and Reaside. There has been a drop in Acute Inpatients North.

Key Action(s):
• All wards should review their action plans and implement the actions agreed.
• Where needed, pharmacy staff will provide additional controlled drugs training for staff to enable them to comply with all standards.
• Where the same nurse receives a controlled drug as has ordered a controlled drug, this should be annotated within the CD order book.
• Ward staff should make use of the medicines code flash cards as well as the full medicines code in order to fully understand procedures around management of controlled drugs including ordering, receiving, administering, and recording use of controlled drugs.
• This audit will be repeated in spring 2024.

Pharmacy - Prescribing Compliance with Mental Health Act (MHA) Consent to Treatment (CTT) Forms

Background:
Trust wide inpatient MHA CTT audit have been completed annually since 2011 (excluding 2022) to monitor the extent and nature of service user's treatment adherence to CTT as per requirements of the MHA and Care Quality Commission (CQC) guidelines. Non-adherence to MHA CTT certificate has been identified as a risk of unlawful administration to service users.

Previous audit recommendations have been implemented, including:
- presentation and dissemination of audit finding to relevant trust committees.
- encouraging medical, nursing and pharmacy professionals to regularly check CTT certificates for each service user detained under the Act.
- action any discrepancies and Eclipse report where necessary.
- ensure access to the most up to date copies of a service user's CTT certificate is available during prescribing (especially in MDTs) and administration of medication.

Results from this year's audit will be used to highlight areas requiring improvements in standards and to target further training and education needs to improve practice. The results may also highlight a need to review the BSMHFT systems and policies regarding the implementation of the MHA, especially if non-adherence is found to be widespread.

Key Findings:
• 93% of service users had MHA CTT certificate in place to authorise their prescribed treatment for mental health disorders, representing a 2% improvement in practice compliance from 2021.
• Across the Trust, within inpatient services, 7% of service users had one or more medication prescribed breaching MHA CTT requirements at the time of audit.
• Secure Care continues to record high levels of prescribing adherence to MHA CTT, this year achieving 98% compliance in comparison with 99% in 2021.
• Non-secure service areas have also shown an improvement in prescribing adherence to MHA CTT by 6% (85%) in comparison to results found in 2021 (79%). The clinical pharmacy service provided in non-secure care has continued to improve over the years, with more wards receiving clinical pharmacy input/support and each ward increasingly receiving more extensive support when all clinical pharmacist positions are filled.
• A total of 18 wards were found to have non-compliance in prescribing adherence to MHA CTT certificates, a decline from 2021 (15 wards). There were no obvious outliers in this standard with all wards having either one or two breaches amongst their service users.

• The service area with the highest percentage of prescriptions without MHA CTT certificates was North Acute, accounting for almost half of the overall total for the Trust (49% n=14). Steps to recovery has shown a large improvement in overall compliance since the previous audit, growing from 80% in 2021 to 95% in 2023.
• The majority, per class of medication, of MHA CTT prescribing breaches were due to prescriptions for regular and PRN anxiolytics (combined total of 57% n= 17) which is consistent with the findings of the 2021 audit. The next largest percentage was attributable to regular antipsychotics (13% n =4).

• In contrast to 2021, Foundation Year (FY) Trainee Doctors were one of the lowest prescribers responsible for prescriptions breaching MHA CTT certificates with Consultants, Specialty Doctors and Core Trainees recording similar numbers of non-compliant prescriptions.
• Fewer pharmacy interventions were recorded for this audit than in previous years with 37% of service users having had documented involvement from pharmacists over CTT discrepancies. A total of 214 pharmacist CTT interventions were recorded, and the overall rate of pharmacist Interventions made per service user was 0.7. As in previous audits, Secure Care had the highest total number of pharmacist interventions; this service area also had the largest contributing sample size in addition to the pharmacists-service user ratio being higher compared to non-secure care service areas.
• Steps to Recovery have made huge improvements in reducing the number of unauthorised prescriptions and improving general compliance with CTT requirements (from 80% in 2021 to 95% in 2023). This is thought to be because of increased pharmacist intervention and collaboration with nursing staff. As the largest non-secure cohort of service users, Steps to Recovery have made positive changes and have consequently achieved significant progress.
• The number of hard copies of CTT certificates available on the ward fell from 83% in 2021 to 65% in 2023. This may be due to more staff relying on the more commonly used electronic forms when conducting their own ward-based audits. Results indicated 100% of all CTT paperwork was available via electronic (RiO) records.
• For 96% of service users there was some evidence of wards preforming MHA CTT certificate checks as part of the wider MHA monitoring completed monthly. This has improved since 2021 (89%) and 2020 (78%). Continued assessment of the process wards uses to scrutinise CTT certificates may highlight areas of further improvement which may contribute to better overall compliance.
• As a result of this audit 13 eclipse reports were completed, with a reporting rate of 65%, a reduction from 2021 (84%).
• 13% of T2 forms audited authorised short acting IM medication, a reduction from 2021 (17%) with no recorded administrations of these medicines via this administration route.

Key Action(s):
• Nursing, medical and pharmacy staff should continue to complete Eclipse reports on finding unauthorised medicines prescribed or administered for the service user. The ward manager and Responsible Clinician should be informed promptly of breaches found; administration of such medicines should be withheld until appropriate CTT certificate is in place. With the view that this is done within a time frame that would not lead to missed doses and hence compromise the service users mental state and continuity of treatment.
• Pharmacists should prioritise checking prescribing adherence to MHA CTT paperwork on ward visits and in MDT meetings. In non-secure care the pharmacy team need to develop new ways of working to incorporate MHA CTT certificate authorisation for all clinical checks they complete. Secure Care pharmacists to continue reviewing CTT prior to completing a clinical check on all psychotropic medication. Pharmacy technicians should also undergo training on the MHA and statutory CTT certificate requirements in preparation for their increasingly ward based roles, in which they can also aid in identifying and preventing breaches at both ward and dispensary level. This may be particularly helpful for those wards who have experienced reduced pharmacist input due to staffing pressures.

• The Mental Health Legislation Team and Pharmacy should jointly develop an eLearning package to disseminate consistent, easy to access training for all relevant staff including bank nursing staff. Consider whether this should be mandatory for medical, nursing and pharmacy staff.
• Nursing staff must be vigilant when administering medication to service users, ensuring that they are legally entitled to do so and that all the legal requirements have been met. Administration of a medicine for the treatment of mental disorders to a service user without authorisation on CTT certificate may constitute an assault and therefore be a criminal offence.
• Medical/nursing staff to ensure MHA CTT certificate is referred to at the point of prescribing especially when prescribing PRN medications, out of hours and rapid tranquilisation.
• The practice of authorising short acting IM medication on T2s needs reviewing to ensure legality of administration. Pharmacists to discourage this practice when delivering the rapid tranquilisation presentation as part of the ILS training day. Though the number of actual administrations of short acting IM medication authorised by a T2 in this year's audit was zero, the risk of administration remains high if these prescriptions remain on the T2 certificate. There has been a general improvement in this area however continued progress needs to be made going forward rather than regressing to levels of previous audits.
• This audit should be repeated in 2024 to assess whether improvement in practice has continued and if the risk of unlawful administrations to service users has been reduced. This can then inform the review of this risk on the pharmacy and medicines risk register.

Pharmacy - Antimicrobial Guidelines

Background:
Trusts and primary care. It is important to ensure that prescribing guidance is adhered to where prescribers are unfamiliar with the medicines used to treat infectious disease. Mental health units can also have outbreaks of severe infections leading to ward closures. Use of antimicrobials and infectious diseases are therefore an issue taken very seriously within Birmingham & Solihull Mental Health Foundation Trust.

This is the antimicrobial audit report for the year 2022/23. The audit is designed to look at the overall use of antibiotics in comparison to good prescribing practice and antimicrobial prescribing guidelines. Clinical pharmacists performed a snap-shot audit of all antimicrobial prescriptions they reviewed during the week of 6th November 2023.

Key Findings:

• 39 prescriptions for antimicrobial treatment have been reviewed across Inpatient areas within BSMHFT during November 2023. This audit suggests that there has been a maintenance of compliance with standards for use of antimicrobials since the last audit in March 2023.
• Compliance with the antimicrobial guidance remains close to the commissioner's target and this has been sustained in this quarter.
• The number of prescriptions where treatments were not started promptly remains roughly high. However, the majority of delayed treatments were topical treatments which would not be kept by wards or in out of hours services. Very few systemic treatments had delays in starting treatments as the majority of these were already stock on wards. Whilst any delays would always want to be minimised, it is unlikely that a short delay for starting topical treatment for an infection would lead to a significant risk to patient's safety or risk problems with treatment outcomes.
• Similarly, there were a number of missed doses throughout the course of treatment. The majority of these reasons were due to patients declining treatment. These tended to be sporadic doses and unlikely to affect the outcome of treatment. The majority of systemic antimicrobial treatments had outcomes

documented which is similar to the previous audit. The majority of treatments where there were no outcomes were either ongoing or were topical treatment.
• Clinical pharmacists continue to follow up antimicrobial treatments where outcomes have not been documented. This was sustained in this audit, although there were relatively few systemic (oral) antimicrobial treatments requiring additional follow up. Pharmacists will continue to work with medical staff where necessary to maintain this.

Key Action(s):

• This audit has shown that antimicrobial prescribing in November 2023 was similar to previous autumn audits. Compliance with antimicrobial guidance in this audit was within the commissioner's target.
• No significant concerns were identified in the analysis of either delays in starting treatment or the number of missed doses.
• Medical documentation of outcomes from antimicrobial treatment continues to be good though this needs to be maintained and supported by Clinical pharmacists who will continue to sweep up where medical reviews are not conducted in a timely fashion ensuring that outcomes are documented.

Pharmacy - Safe and Secure Handling – Inpatient Units

Background:
For the safe and secure handling, organisations should broadly comply with the DH/RPSGB report "The Safe and Secure Handling of Medicines: A Team Approach" published in March 2005. In BSMHFT, the Medicines Code defines the standards and procedures that wards should observe in the storage and handling of medicines.
This audit report covers the audit carried out in June/July 2023 and follows on from previous audits carried out between 2009 and 2022. Comparisons of previous audits are given for wards with significant non-compliance with standards in this audit.

Key Findings:
• This audit illustrates that compliance with minimum standards on the safe and secure handling of medicines within each ward has improved from a good position to an even position. The number of wards continues to illustrate difficulties in meeting minimum standards has fallen and there have been improvements in most areas of the trust but especially Acute Inpatients North, Ardenleigh and Reaside.
• Some standards, which are not being met, are relatively easy to comply with for example ensuring that clinic room temperature monitoring is being carried out appropriately and with thermometers that are appropriately calibrated. Not all medicines cupboards appear to comply with BS2881. Where medicines cupboards are being replaced, estates and the wards should liaise with pharmacy to identify suitable storage cabinets for medicines. The chief pharmacist shared the most recent Health Service Building Notes on medicines storage with the deputy director of estates in 2022.
• All wards have been left with an action plan through which they can improve their compliance with standards for the safe and secure handling of medicines.

Key Action(s):
• Pharmacy Services will continue to work with staff on Inpatient wards to provide training on key safe and secure handling of medicines issues.
• Pharmacy staff will work intensely with those wards showing the greatest non-compliance with standards.

• In line with the recent Health Services building note, pharmacy will work with wards and estates to ensure that where medicines cabinets are non-compliant with BS2881 and are due to be replaced then suitable alternative cabinets that comply with the standard are procured.

Pharmacy - Safe and Secure Handling – Community Teams

Background:
The distribution, storage and use of medicines pose significant clinical and financial risks within any healthcare organisation. As part of the risk management for medicines, the Trust has a Medicines Code that focuses on managing the key risks associated with medicines. All medicines are procured by, and distributed, across the Trust by the Pharmacy Department. In the course of the Trust's business, significant quantities of medicines are kept on individual Wards and Teams throughout the Trust. The Trust should handle medicines within the legal framework for medicines, and also within the Trust policy, i.e. the Medicines Code.

One of the key assurance mechanisms for ensuring the Medicines Code is followed is audit against the standards of the Medicines Code. This assurance forms part of the assurance framework for Standards for Better Health. Within Standards for Better Health, medicines management standards are included in standard C.4d. medicines management. This report summarises the audit of the Safe and Secure Handling of Medicines within community teams across the Trust.

Key Findings:
• This audit report of safe and secure handling of medicines within community teams has found a fall in compliance with standards for those teams visited to date from 90% to 82%. Following the pandemic and workforce issues within the pharmacy team, there has been little pharmacy input into community teams since 2019 other than responses to prescription queries, requests for advice, particularly around the ordering of prescription medicines from Summerhill pharmacy.
• Previously, there had been year on year improvements in medicines management within community teams which highlights the impact that even an occasional pharmacy presence can have within community teams.
• A review of requirements for refrigerators should be undertaken within community teams which may include a review of the need to use long-acting risperidone injection. It may be possible that most community teams can remove the need for a medical refrigerator thus removing the requirement to comply with temperature monitoring.
• The chief pharmacist will work with the community team matron to review and implement improved audit trails for the receipts and delivery of patient's medicines. There is a solution within the EPMA system that may be appropriate to use in all teams and was originally developed with this intention.
• There is a clear need to review medicines stock lists and agree these with community team managers. This will be undertaken alongside the implementation of generic paliperidone long-acting injection which will be added to team stock lists during autumn 2023.
• There is a need to review the arrangements for management of FP10 forms in many teams including a review of the Appendix in the Medicines Code for management of FP10 forms.
• The need for a list of trained nurses and their signatures/initials will be reviewed. With the need for ongoing depot administration cards, this is considered to be necessary and will be discussed with community team managers through the clinical governance committee and the community team matron during October 2023.
• Finally, there appears to be a lack of standard procedures covering activities concerned with medicines use. This will be discussed with the community team matron and a suitable list of procedures to

complement the medicines code developed. These will be drawn up alongside a review of the Medicines Code scheduled for autumn 2023.

Key Action(s):
• Results for individual teams have been will have been shared with the lead or team manager and action plans agreed. For a number of community team wide actions, the above actions will support and complement these action plans. The chief pharmacist will continue to work with the community team matron, Head of Nursing and AHPs for ICCR and the Associate Director for ICCR in improving medicines standards across community teams within the Trust.

Weight Gain in Inpatient Mental Health Settings Audit

Background:
Obesity is an important cardiovascular risk factor contributing to the premature death of people with mental illness. On average, the life expectancy of those with a Serious Mental Illness is 15-20 years less than the rest of the population and this is mainly due to preventable physical illnesses.
Both nationally and globally, the incidence of Obesity is increasing. The impact of this means an obese personal will be three times more at risk of colon cancer, two and half times more at risk of high blood pressure and five times more likely to have Type 2 Diabetes.
This re-audit is part of the implementation plan laid out in the BSMHFT Weight management strategy (My weight, My Recovery 2019). Our trust is committed to improving the physical health of our service users to correct the health inequalities that exist for this population.

Key Findings:
• On the whole, there is some evidence of whole Trust improvement in supporting service users to maintain body weight during admission – during which there are a myriad of complex contributory effects including sedentary activity, medication side effects, reduced free food choices and eating as a pastime. The impact of the Covid 19 Pandemic is also to be factored in as this significantly impacted leave and ability to access exercise sessions.
• The Body Mass Index profiles of the service users demonstrates higher level of obese service users (38% vs 26% in the general population) and highlights the increased risk of heart disease, diabetes, and some cancers. Supporting physical health for mental health service users is a key public health priority and better joined up working between health and social care providers is essential. This work to date has focussed on service users during hospital admissions however understanding the impact of SMI on the service users in the community setting is just as vital, given that this is where most people with SMI reside.
• In nearly all settings there is evidence of positive clinical outcomes for undernutrition for service users who are admitted with a BMI at less than BMI 20. The exception is noted in the Secure Women's service which requires further investigation. Higher levels of malnutrition are also expected in older adults (and hence why excluded) will be the subject of a separate audit and service evaluation.

Key Action(s):
• Food services are nutritionally balanced and offer clearly identified opportunities to choose healthier meal choices.
• Staff feel confident and skilled at having supportive, non- judgemental conversations about weight gain – and have access to local good quality training for this.
• BMI > 30 is documented as medical problem and regularly reviewed in the MDT meeting and care planned accordingly.
• Service users have parity of access to physical activity opportunities and active lifestyle support which are embedded into the therapeutic programmes.
• There is a co-produced weight management pathway incorporating the available resources and latest evidence base.

• Using appreciative inquiry, we should look at the areas with positive outcomes and learn/share any lessons of good practice. • Much of the above recommendations are to be looked at through a Quality Improvement approach.

Research

	Prescribed Information	Form of Statement
3.0	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	The number of patients receiving relevant health services provided or subcontracted by **Birmingham and Solihull Mental Health NHS Foundation Trust** in **2023-2024** that were recruited during that period to participate in research approved by a research ethics committee is 276.

In addition, BSMHFT remains committed to the development of quality services and innovation through research. The Trusts' research and development department currently have 26 open studies, 11 National Institute for Health and Care Research (NIHR) in set up and 9 NIHR studies in the feasibility stage. The table below provides a sample of open studies.

	Project Full title	Total recruitment to date	Site TARGET	% of total target reached	End date	
1	A stratified randomised controlled trial to evaluate the clinical and cost-effectiveness of Stimulant compared with non-stimulant medication for adults with Attention-deficit/hyperactivity disorder and a history of Psychosis or Bipolar disorder (SNAPPER)	18	24	75%	31/10/2024	
2	A Randomised, Placebo-Controlled, Double-Blind Study to Evaluate the Effect of SAGE-718 on Cognitive Function in Participants with Huntington's Disease	3	5	60%	30/04/24	
3	Enroll-HD: A Prospective Registry Study in a Global Huntington's Disease Cohort	225	120	188%	14/01/2063	
4	National Centre for Mental Health (NCMH)	49	150	31%		
5	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	350	n/a	n/a	04/01/2022	
6	HDClarity: a multi-site cerebrospinal fluid collection initiative to facilitate therapeutic	37	20	185%	30/04/2025	

	development for Huntington's disease					
7	ESMI-II: The effectiveness and cost effectiveness of community perinatal Mental health services	79	16	493%	31/03/2024	

CQUIN

Prescribed Information	**Form of Statement**
Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement, or arrangement with for the provision of relevant health services.	BSMHFT income in 2023/24 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. Agreement was reached across BSOL providers for this to be removed and the existing contractual mechanism for reviews to be utilised to maintain oversight
If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	
If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	

Care Quality Commission

Registration with the Care Quality Commission (CQC)

Prescribed Information	**Form of Statement**
Whether or not the provider is required to register with CQC under Section 10 of the Health and Social Care Act 2008.	Birmingham and Solihull Mental Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional. BSMHFT has the following conditions on registration – none. Birmingham and Solihull Mental Health NHS Foundation Trust had the following conditions on registration, but they were removed by the Care Quality Commission in December 2023. 1. The registered provider must take steps to address the ligature risks across all wards by 18 June 2021
If the provider is required to register with CQC: (a) whether at end of the reporting period, the provider is: (i) registered with CQC with no conditions attached to registration. (ii) registered with CQC with conditions attached to registration.	

(b) if the provider's registration with CQC is subject to conditions, what those conditions are and (c) whether CQC has taken enforcement action against the provider during the reporting period.	2. By 29 January 2021 the Registered provider must implement an effective system to improve risk assessments and care planning. The Registered Provider must report to the Commission on the steps it has taken in connection with this by 5 February 2021. 3. By 4 January 2021, the registered provider must inform the Commission of the order of priority in terms of addressing the ligature risks and timescales for addressing the ligature risks across each ward. 4. Commencing from 5 February 2021 the registered provider must report to the Commission on a monthly basis setting out progress being made in respect of including mitigating measures being put in place until all ligature risks are addressed. 5. Commencing from 1 March 2021, the Registered Provider must report to the Commission on a monthly basis the results of any monitoring data and audits undertaken that provide assurance that the system implemented is effective. The Care Quality Commission has taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2023 to 31 March 2024. Two Section 29 notices were issued to Community Mental Health teams and the Trust provided action plans to the Care Quality Commission to address the points raised.
Prescribed Information	**Form of Statement**
Whether or not the provider has taken part in any special reviews or investigations by CQC under Section 48 of the Health and Social Care Act 2008 during the reporting period.	Birmingham and Solihull Mental Health NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 1 April 2023 to 31 March 2024.
If the provider has participated in a special review or investigation by CQC: (a) the subject matter of any review or investigation (b) the conclusions or requirements reported by CQC following any review or investigation (c) the action the provider intends to take to address the conclusions or requirements reported by CQC and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period.	Focused Inspection of: • Community Mental Health Teams Focused Inspection (To determine the removal of the conditions imposed by Section 31 and Section 29) of: • Acute wards for adults of working age and psychiatric intensive care units. • Long stay/rehabilitation mental health wards for working age adults. • Mental health crisis services and health-

	based places of safety. • Forensic inpatient or secure wards.

Data Submission

Prescribed Information	Form of Statement
Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider.	Birmingham and Solihull Mental Health NHS Foundation Trust did not submit records during 2023/24 the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's: (i) valid NHS number (ii) General Medical Practice Code (b) the percentage of records relating to outpatient care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code (c) the percentage of records relating to accident and emergency care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code.	

Information Governance

Prescribed Information	Form of Statement
The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.5	Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Assessment Report for 2023 / 2024 is not due to be submitted until the 30th June 2024 in line with national submission timescales relating to the Data Security and Protection Toolkit. The 2022/23 Data Security and Protection Toolkit attainment level for the Trust was "standards met"

Payment Results

Prescribed Information	Form of Statement
Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.	Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the Payment by

If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider	Results clinical coding audit during 2023/24.

11. Data Quality

Prescribed Information	Form of Statement
The action taken by the provider to improve data quality.	Birmingham and Solihull Mental Health NHS Foundation Trust will be taking the following actions to improve data quality: • Maintaining regular assessment of the quality of data underlying all key performance measures so that any issues can be addressed. • Continuing detailed audit and review of the accuracy of clinical case classification, activity monitoring and clinical outcome measurement information. • On-going comparison of service user contact and GP registration details with the national NHS Summary Care Record database to ensure information in our clinical systems stays up to date. • Close monitoring and continuous quality improvement work on a range of data quality performance indicators, with clinical and administrative staff using monitoring reports to identify and correct data errors. • Maintaining work on completeness and validity of Mental Health Services Data Set (MHSDS) submissions guided by the nationally defined Data Quality Maturity Index • Undertaking preparatory work to assure data quality in relation to the new experimental data items to be included in the Data Quality Maturity Index from July 2024 • Actively using the NHS Digital Data Quality summary to improve the data submitted to the MHSDS. • Improving the completeness of Restrictive Interventions data submitted to the MHSDS • Maintaining work on completeness and validity of NHS Talking Therapies data submissions and assessing the related new experimental data set items added to the Data Quality Maturity Index

	• Active data quality support to operational services by service-aligned data analysts bringing any data issues forward for attention and supporting and monitoring improvement actions.

Learning from Deaths

Prescribed Information	Form of Statement
1. The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2023/24, BSMHFT recorded 1,696 patient deaths. This comprised the following number of deaths which occurred in each quarter of that reporting period: 433 in the first quarter 448 in the second quarter 514 in the third quarter 301 in the fourth quarter
The number of deaths included in item 1 above which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	During this year we have transitioned from the Serious Incident Framework to the Patient Safety Incident Framework. As part of this transition, we have expanded our learning from deaths criteria. At the date of submission 60 Mortality Case Note Reviews, 33 Structured Judgement Reviews and 26 Serious Incident investigations have been carried out in relation to the 1,696 deaths. Of those deaths discussed at the learning from deaths group and the local safety panels 0 were felt to be more likely than not due to problems in care. The number of deaths in each quarter for which a case record review or an investigation was discussed were as follows: 16 in the first quarter 11 in the second quarter 13 in the third quarter 17 in the fourth quarter
An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	No patient deaths were judged to be more likely than not to have been due to problems in the care provided to the patient, in this sample.

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	The overall learning themes identified as follows: • Risk assessment and formulation. A group has been established to review the processes that support Clinical Risk Assessment and formulation this work will be rolled out over 2024/25. • Training and Education The Trust will be implementing Structured Judgment review training in June 2024 which will be rolled out to all clinicians who undertaking a review. This will drive improvement in the quality and safety of patient care. • Multi-agency working We are working with NHS Birmingham & Solihull and from May 2024 will be meeting on a monthly basis to discuss information relating to LFD and developing learning plans from this.
A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	The following actions have been undertaken and are ongoing: • Substance misuse- we have set up a subgroup looking at various aspects of improving care for service users with drug and alcohol needs, which reports quarterly to our Clinical Effectiveness Advisory Committee. This oversees changes in training for detoxification, raising awareness of related patient safety issues and improving multi-agency working. • Specific work has been completed. in the prisons setting in relation to ligature risk assessments • Autism and learning disability - we have started a workstream relating to supporting service users with autism, including training, improving the environment for inpatients, and raising awareness of patient safety related issues. • The clinical risk assessment and management policy is due for review and will make reference to how staff can improve their risk assessment and risk management for key groups of service suers, including where there is a risk of drug or alcohol use, service users with autism.

An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Due to the scale of work involved in the actions listed above it would be premature to evaluate the outcome.
The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	14 case record reviews and 32 investigations completed after 31-03-2023 which related to deaths which took place before the start of the reporting period.
An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	5 representing 0.33% of the patient deaths before the reporting period (2022-23), are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Root Cause Analysis investigations and Mortality Case Note Reviews.
A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths. referred to in item	Of the deaths reviewed in 2023-24, 5 representing 0.33% of the patient deaths in 2023-24 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Reporting Against Core Indicators

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

- The percentage of patients on Care Programme Approach who were followed up within 7 days of discharge from psychiatric inpatient care during the reporting period.
- The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.
- Readmission to hospital within 28 days of discharge.
- Patient experience of community mental health services.
- Patient safety incidents.
- The Staff Friends and Family Test.

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

The percentage of service users being treated under the Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care was 90.7%.

This indicator identifies whether people with a mental illness discharged from our inpatient wards have a direct face-to-face or telephone follow-up contact with a member of clinical staff on at least one of the seven days following discharge. The measure aims to ensure that service users are protected at a time of significant vulnerability and appropriately supported through their transition back into day-to-day life outside hospital. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health NHS Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2023-24	90.7%	*	*	*
2022-23	92.0%	*	*	*
2021-22	92.5%	*	*	*
2020-21	91.8%	*	*	*

Data Source: Rio - our internal clinical information system

***** *No national comparator figures were collected or published for 2020-21 or 2021-22.*

No national comparator figures have been collected or published since 2019-20.
Please note performance dipped in March 2020 due to the impact of Covid-19

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

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

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

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

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

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

Whilst the Trust has taken these actions to improve the percentage completion, 2023/24 compliance has remained impacted by changes in practice introduced during Covid -19 to ease the burden on operational, front-line staff regarding administrative tasks. Where patients were discharged to the care of another mental health trust, we stopped the practice of staff having to contact the receiving trust to check if follow up has taken place. This practice has recently been reintroduced during the latter few months of 2023/24.

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

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

	Birmingham and Solihull Mental Health Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2023-24	**95.9%**	*	*	*
2022-23	96.7%	*	*	*
2021-22	95.4%	*	*	*
2020-21	97.5%	*	*	*

Data Source: Rio - our internal clinical information system

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

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

Birmingham and Solihull Mental Health NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by ensuring oversight of this process is maintained through regular review.

2.3.3 Readmissions to hospital within 28 days of discharge

The percentage of admissions to Trust hospitals of patients aged:
(i) 0 to 15 and
(ii) 16 or over
which were readmissions within 28 days of discharge from a hospital which forms part of the Trust. There is no national indicator meeting exactly this definition. Trust data is based on all readmissions happening on the same day as a discharge from Trust inpatient services or any of the following 27 days.

This indicator measures quality of inpatient care, discharge arrangements and ongoing community support by identifying the extent to which service users discharged from hospital need to be readmitted within 4 weeks, our Trust's aim being to keep early readmissions to a minimum. National comparison figures are not available.

There is no national data available for comparison for this indicator.

	Age 0-15	Age 16+
2023-24	0.0%	3.78%
2022-23	0.0%	3.9%
2021-22	0.0%	5.3%
2020-21	0.0%	6.2%

Data source: Rio – our internal clinical information system

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

- Admission and discharge dates, and service user dates of birth, are audited regularly as part of the Trust's routine data quality audit programme.
- Service user dates of birth are also subject to regular validation against information held on the NHS national Summary Care Record.

Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following action to improve these percentages and so the quality of its services, by ensuring oversight of this process is maintained by monthly reporting and review at regular divisional performance meetings.

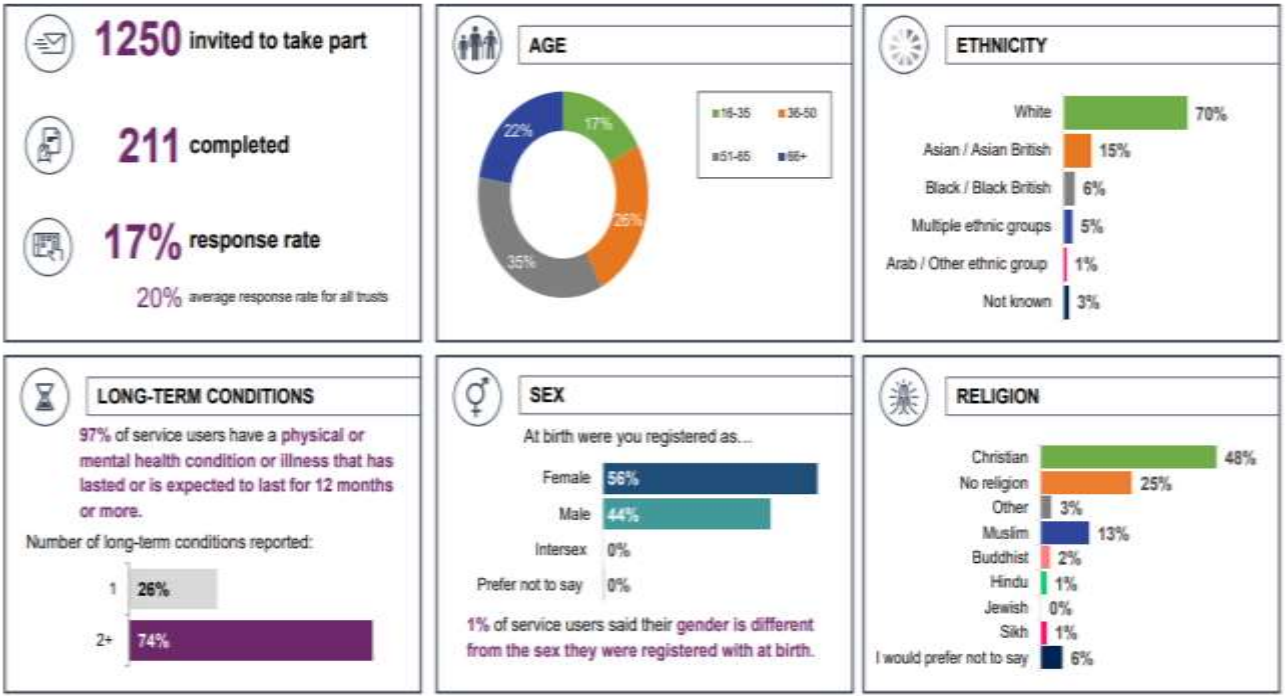
2.3.4 Patient Experience of Community Mental Health Services

The Department of health set out a rolling programme of service user surveys, for 2023. The survey response rate for BSMHFT was 17%.

The National Service User Survey was undertaken for Birmingham and Solihull Mental Health NHS Foundation Trust between August and November 2023. The sample for the survey was generated at random

on the agreed national protocol. It was highlighted that within this sample there was a small number of people included who said that had not been in contact with mental health services for several years and were unable to provide feedback. No respondents said that they had never seen anyone from NHS mental health services.

Service user demographics



Summary of areas where service user experience is best, and areas identified for improvement.

Top & Bottom Five Questions

The management report highlights the highest and lowest results for the current year across the entire survey. The Trust has identified actions to address areas for improvement which are outlined in the key management report recommendations.

Highest scoring questions

Question	Score
Q25. Thinking about the last time you received NHS talking therapies, did you have enough privacy to talk comfortably?	79.5%
Q12. Did your NHS mental health team treat you with care and compassion?	74.1%
Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental Health services?	73.7%
Q22. In the last 12 months, has your NHS Mental Health team asked how you are getting on with your medication?	73.4%
Q21a. Have you had a discussion about the purpose of your medication?	70.3%

Lowest scoring questions

Question	Score
Q32d. In the last 12 months, did your NHS mental health team give you any help with finding support for cost of living?	10.6%
Q32b. In the last 12 months, did your NHS mental health team give you any help or advice with finding support for finding or keeping work?	12.7%
Q32c. In the last 12 months, did your NHS mental health team give you any help or advice with finding support for financial advice or benefits?	17.7%
Q40. Aside from this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of care?	19.7%
Q32a. In the last 12 months, did your NHS mental health team give you any advice with finding support in joining a group or taking part in an activity?	29.0%

Key Management Report Recommendations

Report Recommendation	Action Required
• Ensure that all services users are offered resources to support their mental health during the time between their assessment and first appointment for treatment. Ensure that these are easy to find and provide both paper based and digital resources where possible.	Patient Experience/ EBE team to work with divisional teams and divisional QI leads to develop relevant QI projects address this.
• Direct mental health teams to provide service users with advice and support on how they may join groups and activities. Review the breadth of groups and activities available regularly as well as the materials which signpost these to service users.	Patient Experience/ EBE team to work with divisional teams to support relevant and contemporary signposting to trust, community, and system opportunities for service users.
• Review current support offered to assist service users with accessing their care and treatment (e.g. physical support such as ramps, language support, format of materials such as braille, accessing online appointments).	Patient Experience/ EBE team to work with divisional teams to review requirements for care adjustments.
• Examine the data to identify which groups of service users do not feel the support meets their needs.	Patient Experience/ EBE team to work with divisional teams to review data and extrapolate.
• Review arrangements for ensuring service users know who to contact within the NHS if they have a crisis outside of office hours. Consider ways to make this information more accessible and understandable.	Patient Experience/ EBE team to work with divisional teams to support ongoing work regarding discharge and crisis support. Best practice to be shared from QI project for Acute and Urgent care discharge pack.
• Inspect the data to identify any areas where service users report that they do not have a care plan.	This will be addressed by the implementation of Dialog+ care planning.
• Ensure service users are involved in the development of their care plan and are given a written document that explains the support provided by each member of their care team, outlining who is responsible for what and when, and that it is evaluated at least once per year.	This will be addressed by the implementation of Dialog+ care planning.

Patient Safety Incidents

The number and rate of patient safety incidents reported within the Trust, and the number and percentage that resulted in severe harm or death.

Figures released by the National Reporting and Learning System (NRLS) are reported on an annual basis and are a reflection of harm levels caused by incidents reported during that data period. The quoted national figures are for all mental health trusts.

	Reported patient Safety Incidents per 1000 bed days				Percentage of Patient Safety Incidents resulting in Severe Harm or Death			
	Trust	**National Median**	**Highest National**	**Lowest National**	**Trust**	**National**	**Highest National**	**Lowest National**
Apr 21 - Mar 22	55	666	222	7	0.4%	1.0%	57%	0.0%
Apr 20 – Mar 21*	58	64	236	21	0.3%	1.0%	58.5%	0.0%
Oct 19 – Mar 20	49	53	146	18	0.4%	1.0%	4.2%	0.0%
Apr 19 – Sep 19	51	56	131	17	0.5%	0.9%	3.3%	0.0%
Oct 19 – Mar 19	44	53	119	15	0.6%	1.0%	4.3%	0.0%

**Note: NRLS reporting is annual for 2021-22 figures.*

	Patient Safety Incidents – Total Reported	**Patient Safety Incidents per 1000 Bed days**	**Patient Safety Incidents resulting in Severe Harm or Death**	**% Patient Safety Incidents resulting in Severe Harm or Death**
Apr-21-Mar 22	12356	55	48	0.4%
Oct 20 – Mar 21	6427	58	24	0.4%
Apr 20 – Sept 20	6588	58	23	0.3%
Oct 19 – Mar 20	5823	49	22	0.4%
Apr 19 – Sep 19	6188	51	31	0.5%
Oct 18 – Mar 19	5330	44	31	0.6%

**Note: NRLS reporting is annual for 2020-21 figures.*
Data source: National Reporting and Learning System (NRLS)

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

Data is submitted weekly to the National Reporting and Learning System (NRLS) from the Trust's incident reporting system (Eclipse). Any re- classification of incidents in relation to cause or harm flags up the incident locally and it is resubmitted to the NRLS; the new record overwrites the original to avoid duplication. The coding of incidents in relation to harm is based on guidance provided by NHS Improvement.

- Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve this data, and so the quality of its services, by:

- Transferring to Learning From Patient Safety Events (LFPSE)
- Continuing to deliver incident reporting training via incidents awareness sessions and Incident Manager training. Continue our approach to governance and incident reporting at the junior doctor's marketplace, preceptorship training and at Student Experiential Learning Pathway sessions.
- Constantly evolve incident types to be reflective of incidents occurring in the Trust.
- Continuing to develop and promote the utilisation of the Eclipse, our innovative governance intelligence analytics portal, providing in-depth automated analysis of incidents data from ward to board.
- Improving the learning lessons framework and promote adoption through new practice guidance.
- Thematic reviews of incidents and reporting trends.

Part three – Other Information

In this section of the report, we share other information relevant to the quality of the services we have provided during 2022/23 which together with sections 1 and 2 of this report, provide an overview of the quality of care offered by our Trust during this period.

Safety

The two indicators selected for patient safety are:

- Serious Incidents
- Never Events

Serious Incidents

During 2023/24 we completed the groundwork to move the investigation of our serious incidents in line with the NHS Patient Safety Incident Response Framework in preparation for the national roll out of this programme. We continue to work closely with partners across various agencies which support health and social care in Birmingham and Solihull to complete multi-agency reviews where it was evident that a patient involved in a serious incident was receiving care, support, or advice from more than one agency. This enables us to take a system wide view on opportunities to improve how agencies can work together for the benefit of patients. We will be developing and embedding a number of processes to aid learning, including safety summits within wards, and teams and also for key safety topics.

	2019/20	2020/21	2021/2022	2022/23
Number of Serious Incident Reported	78	87	82	91

** Serious incidents recorded prior to the transfer to PSIRF*

Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. We are pleased to report that the Trust has not reported any Never Events during 2023/24.

	2020/2021	2021/2022	2022/23	2023/24
Number of Never Events Reported	0	0	0	0

Patient Experience

The Trust identified the following key indicators for monitoring the quality-of-service user and carer experience. These were identified in the previous Quality Account and following review; they were still deemed to be a priority.

With ongoing system pressures as well as significant staffing shortages within the team it has been a challenging year for the Customer Service Team. We have received a total of

	2019/20	2020/21	2021/22	2022/23	2023/24
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	68%	59%	67%	Data not available	Data not available
Number of complaints	85	81	109	115	95
Timeliness of complaints	100%	100%	99.1%	95.8%	97.9%
% of dissatisfied complainants	18 returned (20%)	9 returned (11%)	9 returned (8%)	12 returned (10%)	21 returned (22%)
Number of referrals to the Ombudsman	2 0 accepted for re-investigation	2 0 accepted for re-investigation	2 0 accepted for re-Investigation	*See Below	*See Below
FFT Score	91%	94%	79%	83%	84%

95 formal complaints which is a decrease of 17% since the previous year, and unfortunately 21 complainants have returned asking for a reinvestigation; this is 22% of the total complaints responded to and a 75% increase from the previous year.

We failed to meet the agreed timescale for 2 complaints, which is an improvement from 4 in the previous year.

We received notification that 9 complaints were raised with the parliamentary and health service ombudsman (PHSO), with 5 still undergoing further enquiries and 4 being closed with no further investigation required. We also received a final decision from 1 PHSO complaint that had been raised in the previous year, which was upheld with actions for the Trust.

In the coming year, the focus will remain on reducing response timeframes, whilst finalising an updated complaints policy as well as designing a standard operating procedure. There is plan for a thematic review of complaints raised by BAME service users, with learning feeding into the PCREF workstream. The team will also be developing a strategy highlighting further plans for development, as well as a rebranding of the PALS service in order to improve early resolution outcomes. Further information can be seen under complaints.

Complaints

Timeliness of complaints – of the closed complaints how many breached:

2022/23 5 out of 118 (4.2%)
2023/24 2 out of 97 (2.1%)

% of dissatisfied complainants – sourced from the CIT Reopened Complaints Tab using the date final response was sent.
2022/23 – 12/115 = 10%
2023/24 – 21/95 = 22%

***Number of referrals to the ombudsman**

All of the final response letters inform complainants that they can go to the Parliamentary and Health Service Ombudsman (PHSO) should they not be happy with the outcome of an investigation.

We capture contact information with the PHSO

*2022/23 – 9 contacts from PHSO. 1 complaint upheld.
*2023/24 – 9 contacts from PHSO. At time of reporting there are: 4 reviewing to investigate or requests for information, 4 closed with no further actions and 1 proposal for investigation.

Complaints

Data source for analysis:

Safeguard.

Date of analysis and selection criteria:

Cases opened and cases closed between 01/04/2023 to 31/03/2024.

In 2023/24 (April 2023 – March 2024) BSMHT received 95 formal complaints regarding services across the Trust, 6 formal complaints were subsequently withdrawn and 7 were closed as consent wasn't received. At the end of March 2024, the number of active formal complaints was 41.

Formal complaints closed.

97 formal complaints were closed, with the following outcomes:

Outcome	Count	%
Actions Identified	53	55%
Actions Not Identified	29	30%
Complaint Withdrawn	6	6%
Consent Not Received In Time	7	7%
Early Resolution	2	2%
Grand Total	**97**	**100%**

Patient Advice and Liaison Service (PALS) queries and locally resolved concerns.
In addition to formal complaints received, the Trust received 28,245 Patient Advice and Liaison Service queries (made up of 5,614 phone calls and 22,631 emails). We opened 720 PALS cases and closed 703 during the financial year of 2023/24.

Complaint Themes – Category Type

Category Type for Formals Opened	Count	%
Communications	28	29%
Patient Care	18	19%
Clinical Treatment	14	15%
Access to Treatment or Drugs	14	15%
Values and Behaviours (Staff)	8	8%
Admissions and Discharges (Excluding Delayed Disch	6	6%
Appointments	3	3%
Other	2	2%
Prescribing	2	2%
Grand Total	**95**	**100%**

For a large proportion of the year the team have been operating on under half capacity, which has unfortunately had a considerably negative impact on complaint response timeframes. At worst, our average response time was 169 working days, meaning that a portion of our formal complaints were being responded beyond 6 months. The team acknowledge that this is not an acceptable standard and over recent months the have taken numerous steps to reduce response times including successfully recruiting to vacancies, undertaking internal and external training, commencing a quality improvement project, setting clear team objectives and KPIs to enable better team performance monitoring. At present the average response is 153 working days, however this is projected to significantly improve in the coming months.

Over the past year there has also been a focus on reducing outstanding actions to ensure that meaningful learning is taking place following complaints being responded to. The number of outstanding actions has been reduced from a peak of 59, to 9 at the present day.

Performance against the relevant indicators and performance thresholds

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

National Mental Health Indicators

	NHSE/I Oversight Framework updated in November 2017: National Indicators – 2022/23	National Threshold	2023/24
1	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	60%	97.6%
2	Improving access to psychological therapies (IAPT): ** a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. within 18 weeks of referral	50% 75% 95%	48.1 51% 80%
3	Inappropriate out-of-area placements for adult mental health services (average bed days per month) *	n/a *	768
4	Admissions to adult facilities of patients under 16 years old	n/a	0.0%

*The waiting times for IAPT have fallen behind the national targets primarily due to factors outside the Trust's immediate control. 2023-24 has focused on recovery of services from Covid 19 which commenced with the reopening of primary care facilities, allowing face to face appointments to be reintroduced. Use of digital appointments also continues to be made where appropriate. A system wide forum has been established within Birmingham and Solihull including third sector partners to jointly develop plans to improve the position going forwards.

Nationally there is a recognised shortage in the availability of appropriately qualified staff which impacts on the activity levels that can be carried out. A recruitment plan is currently being taken forward working with partners to support training, recruiting these staff, and retaining staff. As part of the recruitment strategy, a social media campaign is in place to support rolling adverts for both qualified and future trainee posts. Recovery action plans are also in place and the 6 week waiting times have recovered and at the end of March are 74.8%, just below the 75% national target.
**Due to the impact of COVID-19 on the need for acute and urgent mental health services, it was recognised by NHSE/I that the national target to achieve 0 out of area placements by end March 2022 would not be possible. It currently remains a national aspiration but without a set timescale for delivery.

In addition, please note that the quoted figures for average bed days per month for 2023/24 take into account a Standard Operating Protocol agreed with NHS England whereby admissions to agreed local independent sector beds have been classified as 'appropriate placements' as arrangements are in place to

ensure that the standard and continuity of care provided are equivalent to when people are cared for in beds managed directly by the Trust.

NHS England recognise that this protocol of reclassification of beds is not reflected in national MHSDS reporting figures, which will continue to show admissions to these beds as being 'inappropriate' placements due to MHSDS data constructs. A trajectory was in place in 2023-24 agreed with commissioners to reduce inappropriate out of area bed days to 328 bed days by March 2024. This has remained challenging for the Trust and a project group is in place to identify and implement a range of actions, which include a dedicated bed manager whose focus is to manage the needs of out of area patients with a view to supporting transfers back to their home localities where possible and exploring the use of additional beds locally. Three workstreams have been established to look at internal practices to maximise capacity, reducing delayed discharges working with partner organisations to facilitate service user discharge in a timely manner and development of a locality bed model. Further actions are being planned in partnership with Forward Thinking Birmingham which address patient flow challenges and will include reviewing delayed transfers of care on a system wide basis across Birmingham and Solihull.

Other Information

In April two hundred colleagues united for a very special annual awards ceremony to shine a light on and celebrate the success, hard work and achievements delivered by our people. It provided an opportunity to stop and reflect on the incredible work that has been achieved over the last 12 months. The Awards saw colleagues and teams recognised for their inclusive, committed, and compassionate work.
We celebrated colleagues in nine award categories:

- Compassionate Award
- Inclusive Award
- Committed Award
- Team of the Year in Clinical Services Award
- Team of the Year in Professional Support Services Award
- Service User and Carer Choice Award (sponsored by Caring Minds)
- Rising Star Award
- Quality Improvement, Research and Innovation Award
- Lifetime Achievement Award

Infection Prevention and Control (IPC)

From an infection control perspective, we have aimed to provide and maintain high standards throughout the year by ensuring systems are in place to manage and monitor the prevention and control of infection using the following:

- Surveillance of alert organisms and conditions.
- New centralised audit process put into place including compliance dashboard.
- IPC, decontamination and mattress compliance audits.
- Annual mattress/ Sharps/ Food safety audits.
- Regular IPC compliance visits.
- Monthly hand hygiene audits/ training.
- IPC Champions study days/ training (3 per year)
- Monthly cleaning scores / PLACE scores.

We ensure standards of environmental cleanliness are maintained with the recent role out of the National Standards of Cleaning which was implemented within the trust.

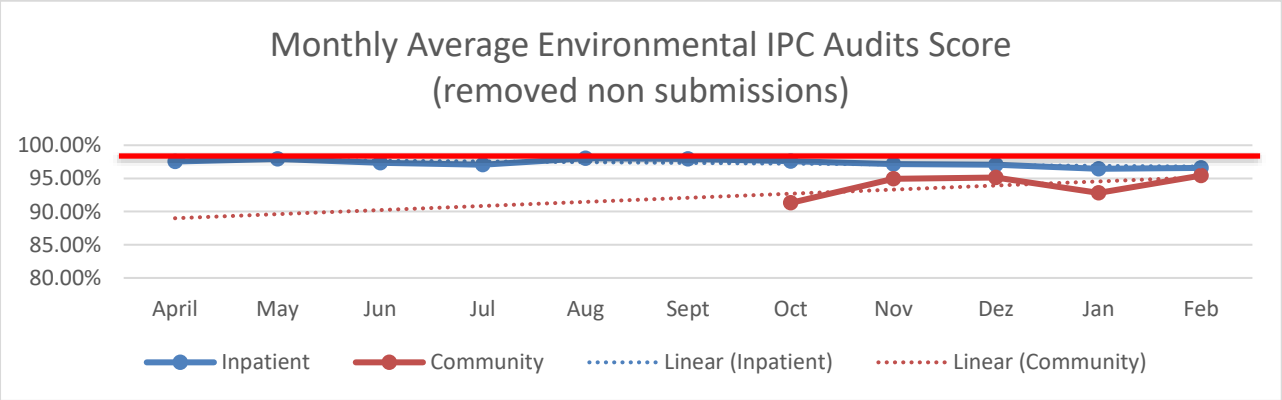
We have in place systems for infection control practices and procedures in line with national guidance, i.e. Health & Social Care Act 2008, NICE Guidance.

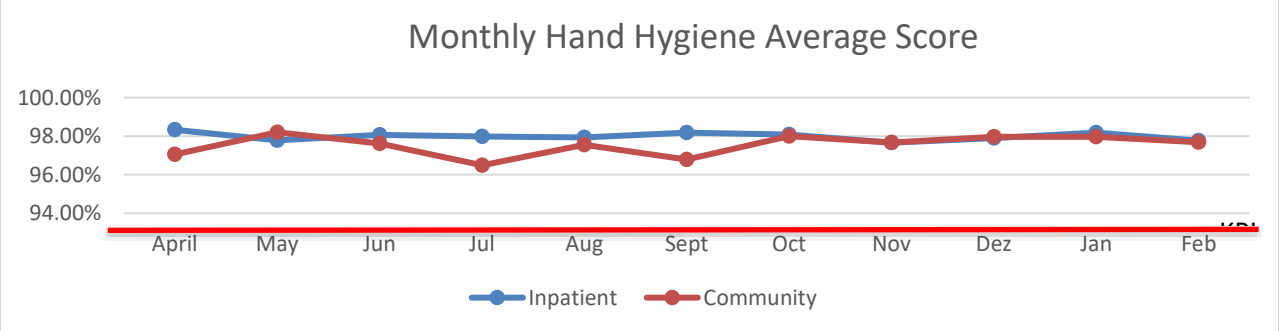
The IPC team works proactively in collaborations with other local health and social care providers to reduce risk from infection, such as BSOL, Consultant Microbiology/ Laboratory Assistance, UK Health Security Agency, the Integrated Care Board (ICB) and National Health Service England (NHSE) Infection Control specialists. Throughout the year we have engaged in shared decision making regarding COVID-19 procedures ensuring our procedures were aligned nationally to the living with COVID-19 government strategy.

Outbreaks: - All outbreaks were investigated, monitored, and reviewed. The IPC team carried out meetings with Internal/external stakeholders.

Water Safety: The IPC team have supported the water safety group in addressing ongoing issues in water outlets, attending frequently held meetings to discuss plans, risk and monitor the situation.

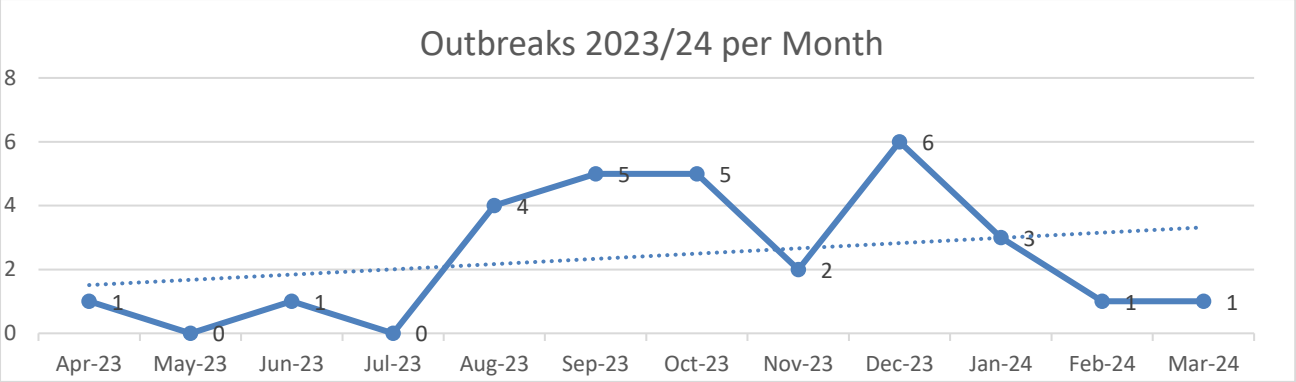
- IPC Environmental audits and hand hygiene average scores consistent with uncertainty margin that puts the Trust in red to amber scores due to low compliance, in some areas within the Trust, in particular community teams.





There is focused work in the small number of areas of non-compliance to support engagement and improved results. This is being supported by the Heads of Nursing and senior nursing teams.

- COVID-19 outbreaks shorter in duration and affecting less staff and SU. There was a break in outbreaks during December 2023.



All outbreaks were investigated, monitored, and reviewed. The IPC team carried out meetings with Internal/external stakeholders.

Challenges

- Air Safety Group not yet commissioned in the Trust.
- Low FFP3 face fitting coverage (program now being put in place and will be rolled out in 2024/2025)
- Lack of immediate IT solutions to support some aspects of IPC work – AMaT system acquired that will cover the auditing program, but no IT solution currently for the IPC records and surveillance in place.
- Legionella counts have been elevated in some Trust sites – Dosing plants implemented on most high-risk sites and new water safety plan due for approval. The IPC team have supported the water safety group in addressing ongoing issues in water outlets, attending frequently held meetings to discuss plans, risk and monitor the situation.

Based on the identified Key issues in infection prevention and control (IPC) within the Trust, the following recommendations are proposed to enhance IPC practices and mitigate risks during 2024/25

- Hand Hygiene and Environmental Audits: Support the development of accountability for IPC by the clinical areas with the recommendation of the Heads of Nursing to include on their reporting IPC aspects such compliance on environmental audits and Hand Hygiene
- Prevalent Conditions and Microorganisms: Support recommendation for the Trust to acquire IPC systems such as ICNet to ensure IPC can monitor microbiology results and follow up on support given as well as being able to audit IPC work.
- Confirmed Cases of Measles and TB: Ensure dissemination of lessons learned.
- Air Safety Group: Support the creation of an Air Safety Group in the Trust
- BAF – Ensure the IPF BAF is incorporated into the Trust BAF to ensure there is IPC visibility at Trust board.

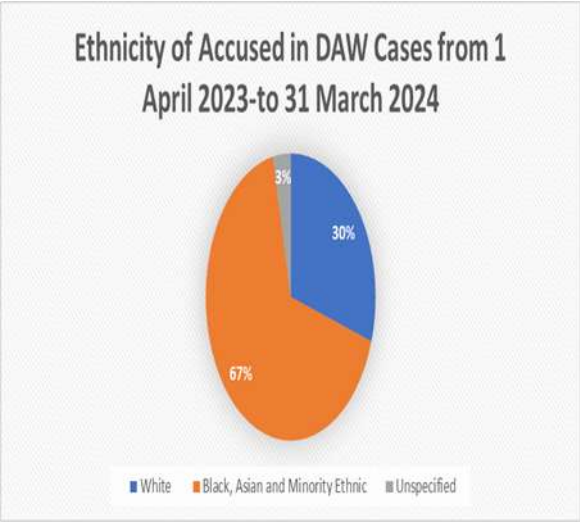
By implementing these recommendations, the Trust can strengthen its infection prevention and control measures, enhance patient safety, and minimize the risk of healthcare-associated infections. These actions should be undertaken collaboratively and with a commitment to continuous improvement in IPC practices.

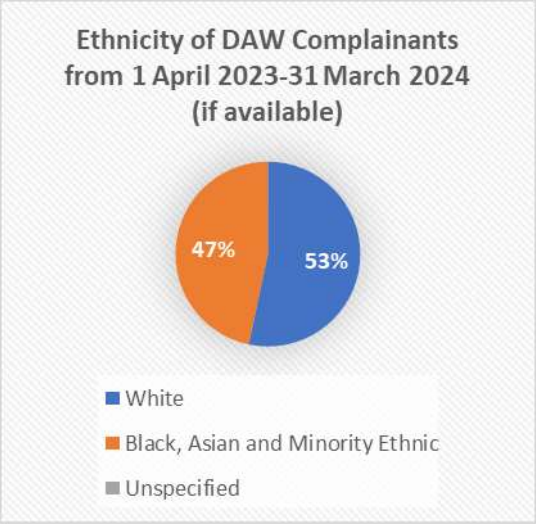
Workforce

This information reflects the number of employee relations cases that have been managed across the Trust. Employee relation cases refers to Dignity at Work (DAW), Grievance and Disciplinary cases.

The reporting period is 1 April 2023 to 31 March 2024.

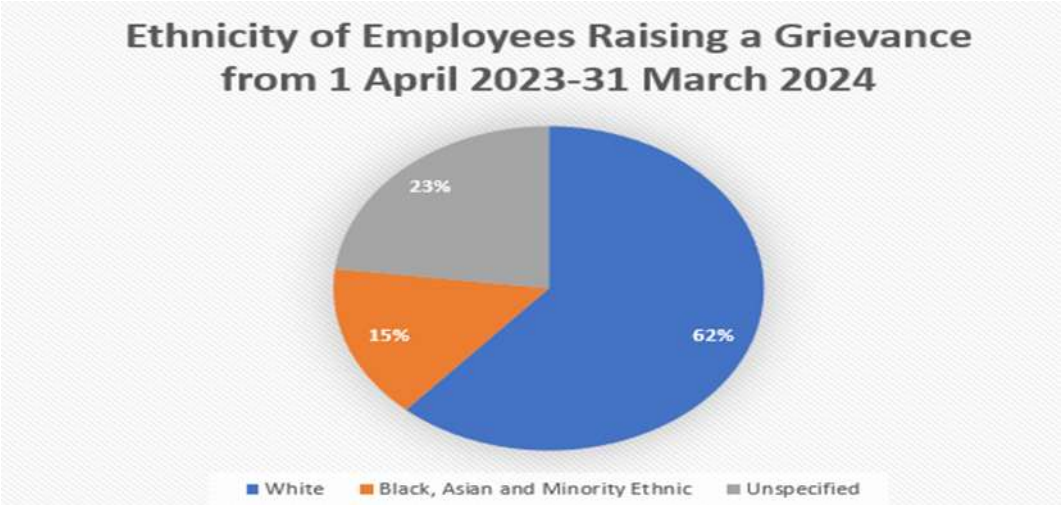
1. Number of staff entering a DAW process reported by ethnicity.





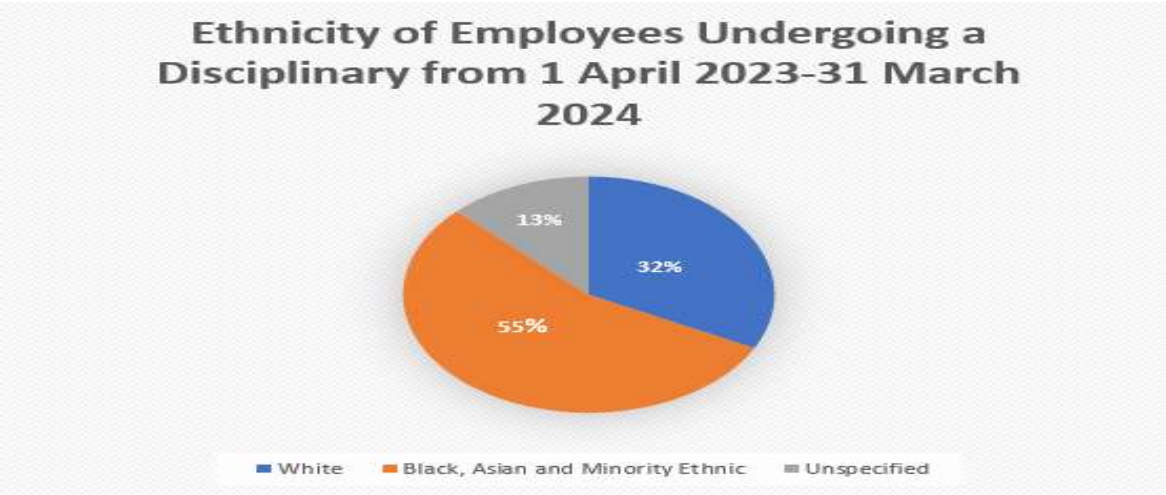
DAW Demographics 1 April 2023-31 March 2024	White	Black, Asian and Minority Ethnic	Unspecified
DAW Ethnicity of Accused	9	20	1
DAW Ethnicity of Complainant (if available)	8	7	0

2. Ethnicity of employees going through a grievance process.



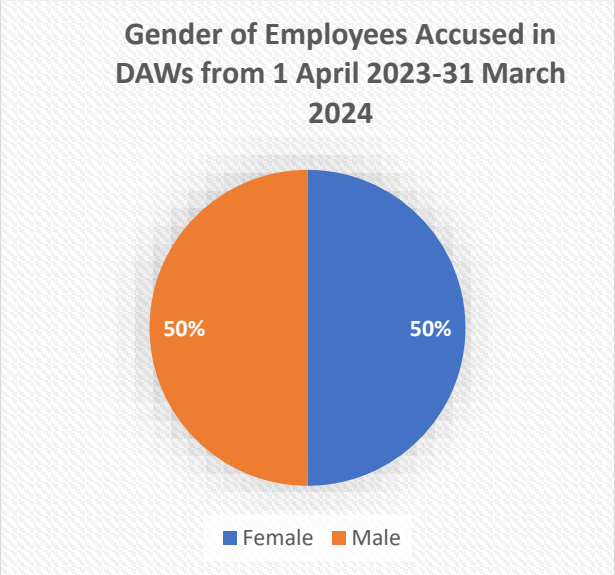
Grievance Demographics 1 April 2023-31 March 2024	White	Black, Asian and Minority Ethnic	Unspecified
Ethnicity of Employees Raising a Grievance	8	2	3

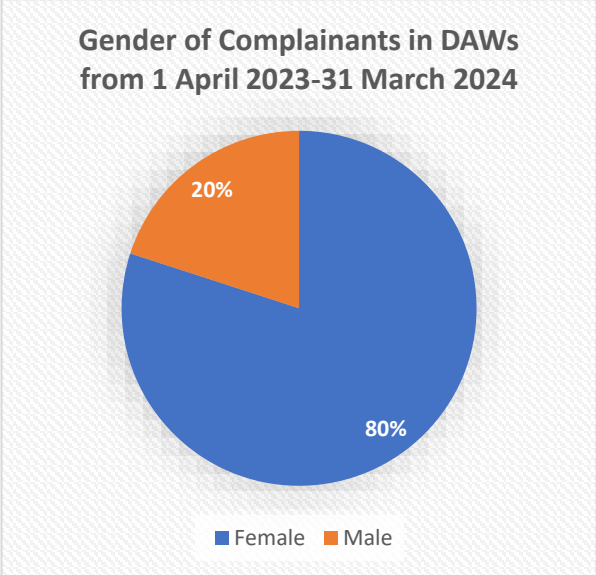
3. Number of people entering disciplinaries by ethnicity

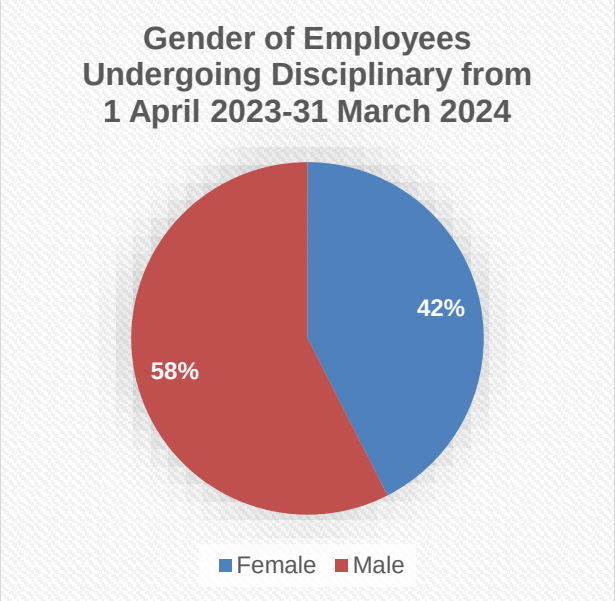


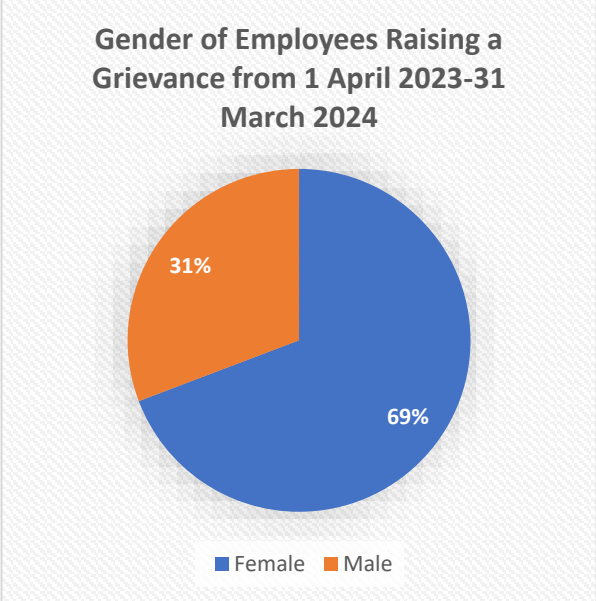
Disciplinary Demographics 1 April 2023-31 March 2024	White	Black, Asian and Minority Ethnic	Unspecified
Ethnicity of Employees Undergoing a Disciplinary	13	22	5

4. The gender of staff in employee relation cases.









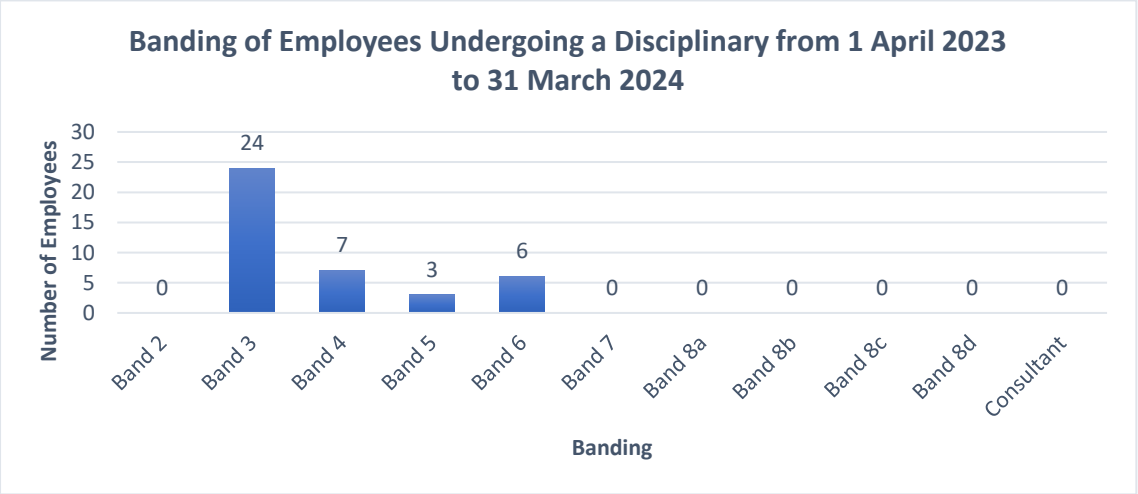
DAW Demographics 1 April 2023-31 March 2024	Female	Male
DAW Gender of Accused	15	15
DAW Gender of Complainant (if available)	12	3

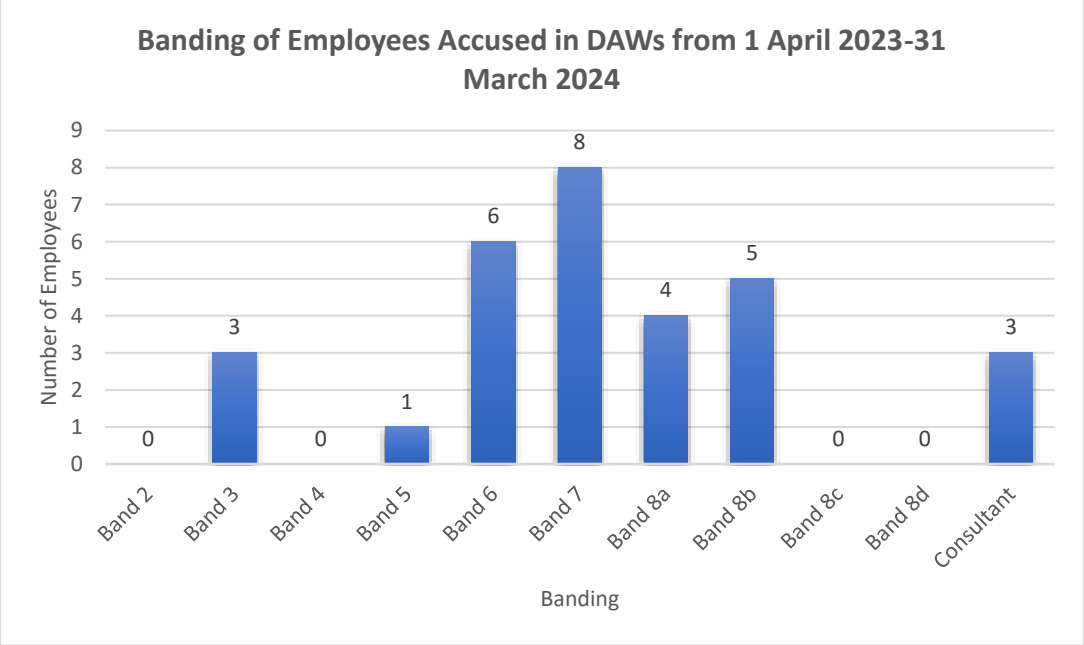
Disciplinary Demographics 1 April 2023-31 March 2024	Female	Male
Gender of Employees Undergoing Disciplinary	17	23

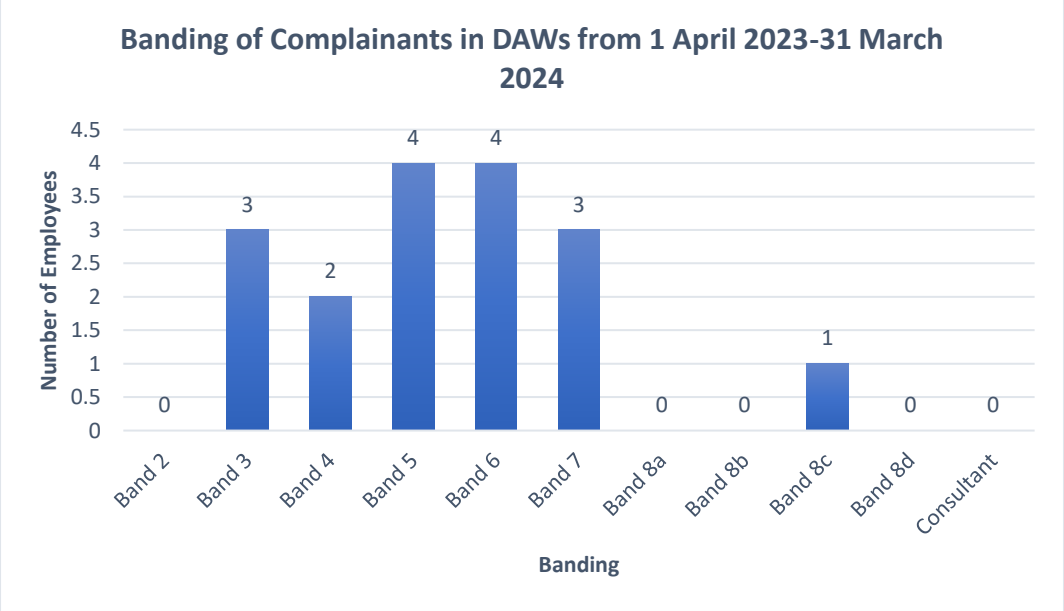
Grievance Demographics 1 April 2023-31 March 2024	Female	Male
Gender of Employees Raising a Grievance	9	4

DAW Demographics 1 April 2023-31 March 2024	Female	Male
DAW Gender of Complainant (if available)	12	3

5. Banding of employees entering the various employee relation processes.







Data Analysis and Actions Proposed

In *diagram 1* there is evidence that more staff from a Black Asian and Minority ethic background are accused of and are investigated for DAW cases and more employees from white background are the complainants in DAW cases. More white employees raise grievances than others, but more Black, Asian and Minority ethnic employees go into disciplinary process.

More male employees enter a disciplinary process than female staff. More complaints are received from female employees in DAW cases, similarly more female employees raise grievances.

Regarding bandings there is a higher proportion of employees in bands 3, 4, 5, 6 who enter the disciplinary process.

This information demonstrates that the Trust needs to look at reasons why more people from an ethnic minority are more likely to enter a disciplinary process than white people.

One of the key actions the People team is looking to do is to roll out the disciplinary training for line managers, this will also include the review of our Decision-Making Group Process (DMG). There is also work being done to look at the Restorative Just Culture Framework. These actions although not a panacea to address all the questions this information has posed but it is the beginning of challenging the data and to improve staff experiences from all background and banding.

Guardian of Safe Working Hours

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

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

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

To fulfil this role, The GSWH:

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

3.4.2 Freedom to Speak Up Guardian

The Trust refreshed its speaking up arrangements in November 2020 and currently employs one full time Lead Guardian and another full time Guardian reporting to the Lead Guardian. Both are registered on the National Guardians Directory. There is also an expanding network of 13 Freedom to Speak Up Champions based in local teams, from different professional backgrounds and bandings. All Champions undertake national training. Unlike the Guardians, Champions do not hold cases but are based across the Trust in their local areas providing advice and support to their colleagues. They signpost and role model a positive speaking up culture.

Freedom to Speak up Guardians are responsible for 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.

Staff are encouraged to raise concerns and suggestions for improvement through existing channels such as line managers and supervisors, via incident reporting mechanisms, through informal/formal HR processes such as the Dignity at Work and Grievance and Disputes policy. Other avenues are the four staff networks, Staff side representatives and the Spiritual Care Team. This year the Trust has also launched the Values in Practice Initiative which supports individuals to raise concerns about acts of bullying, harassment and/or discrimination as well as those accused of unacceptable behaviours.

Periodically, colleagues are invited to report their health and wellbeing at work through the NHS People Pulse Survey alongside the annual NHS Staff Survey. Staff can also raise concerns which may meet the threshold of the Public Interest Disclosure Act (PIDA, 1998) with senior managers, the Freedom to Speak Up Guardians or externally, to the CQC or other prescribed bodies.

Freedom to Speak Up Guardians operate independently and impartially providing an alternative route if any of these routes are blocked or if barriers exist. Reporting directly to the Board they can escalate concerns to anyone internally or external to the organisation. They are also responsible for monitoring and reporting detriment as a result of speaking up, with allegations reported to the Lead Executive for FTSU with oversight from the FTSU Non-Executive Director.

Guardians ensure that staff who speak up are thanked, that action is taken by the Trust to address concerns and that feedback is received. They seek to identify learning and development which ultimately leads to improvements in patient safety/quality and staff experience. Three months after initial contact and when a case is closed, colleagues are asked to provide anonymous feedback of their contact with the FTSU service:

Guardians are required to collect, and report anonymised data on the cases raised with them by workers reporting this quarterly to the National Guardians Office. This data is categorised as follows: cases raised including an element of patient safety and quality; worker safety and wellbeing; bullying and harassment; detriment for speaking up and cases raised anonymously. The Lead Guardian reports to the Board in person twice yearly and in the interim to the People Committee (a sub-committee of the Board) reflecting trends and themes and recommendations for improving the organisations' speaking up arrangements.

In the 2023/24 period, there were a total of 361 enquiries to the Guardians. Copies of previous FTSU Board reports which provide further detail and activity over the last financial year can be viewed here: Trust board papers - Birmingham and Solihull Mental Health NHS Foundation Trust (bsmhft.nhs.uk)

By the end of January NHSEI asked all trust Boards to update their local FTSU policy to reflect the new national policy template and to have assessed their FTSU arrangements against the revised guidance, providing assurance that they are on track in their implementation of the latest FTSU improvement plan. This plan, setting out the high-level actions to be taken over the next 6-24 months was approved by the Board in February 2024.

Staff Survey

Employee Experience and Engagement Surveys

We continue to monitor and respond to staff concerns through both the NHS People Pulse survey and the NHS National Staff Survey. We use the People Pulse Survey on a quarterly basis to understand any changes to staff experience and engagement with a particular emphasis on wellbeing. The Annual Survey is used extensively in the Trust as an annual assessment of progress towards our People Goals. The total number of responses in 2023/2024 for the staff survey was 2393 compared to 2230 in 2023. The Trust recognises the need for ongoing improvement related to the staff survey, However, we are pleased to see some clear improvements in the staff survey in 2023 compared to 2022.

- 112 teams received localised reports compared to 92 in 2022.
- No questions are “significantly worse” in comparison to 2022 and 63 are “significantly better”.
- Employee experience has improved for both White colleagues and Black and Asian colleagues.
- Increase in all 9 People Promise elements and themes scores largest increase in ‘we are compassionate and inclusive’ and ‘we work flexibly’.
- We are above the average on learning and morale and seven of the nine themes are below average. The only theme which remains significantly below the average is We are compassionate and inclusive.

The Trust recognises the need to learn from the results of the staff survey and ensure ongoing improvement. Over the course of 2023 improvements based on 2022 results included:

- Initiatives to ensure career development and interview practices are more inclusive has proven effective, as 54% of colleagues believe the ‘Organisation acts fairly in relation to career progression’ with an increase of almost 5%.
- Another 5% of colleagues feel satisfied with the recognition they get for their work, 54% of colleagues feel career progression is fair (was 46% in 2019).
- 56% (7% increase) of colleagues think the Trust is committed to helping people balance work and home life - that equates to 350 colleagues having a different experience
- 39% (4% increase) of colleagues say their appraisal has helped them improve how they do their job.
- 99% of colleagues know our trust values. More people are demonstrating our values more than ever before with the percentage of managers (69%) (7% increase) and colleagues 65% (6% increase) demonstrating our values.
- All nine measures of managers significantly improved year on year with all at or within one percent of the average either way. Return of manager training – more focus.
- Teamwork – improvement across the Board
- Employee experience has improved overall for Gay, Lesbian, Bisexual or ‘other’ colleagues, including a consistent pattern of improvement in questions that relate to the likelihood of raising concerns.

Our approach to the staff survey includes a substantial engagement exercise with teams across the trust. Teams are assisted to understand and examine their local team or directorate results and to make changes in response to enhance employee experience. In addition, we use anonymous surveys regularly as part of policy development and problem solving in our wider approach to Organisational Development.

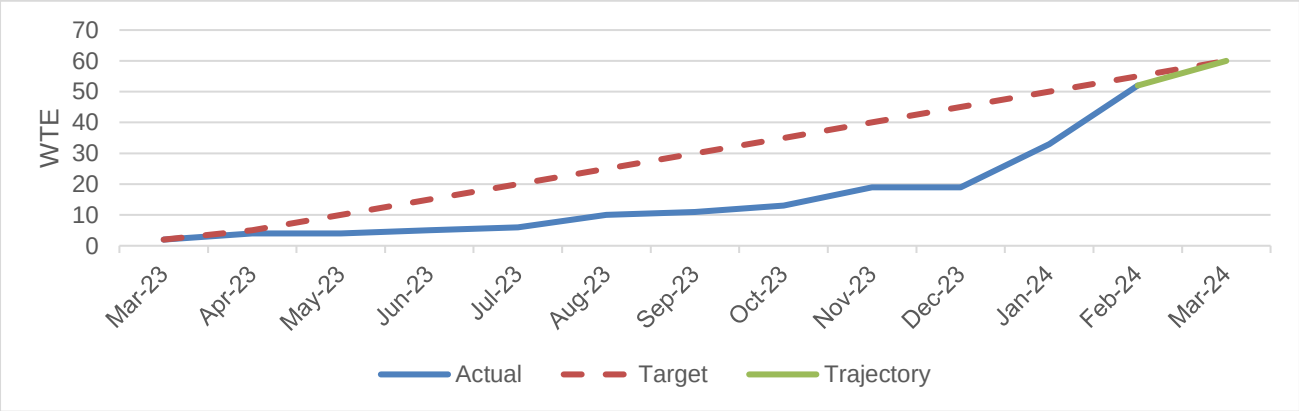
International Nursing Recruitment

International Recruitment

We are continuing our International Recruitment programme with ongoing success. We continue to recruit nurses from diverse backgrounds to enhance our overall nursing workforce, our current position is:

- In February 19 internationally recruited nurses joined the Trust. This pushes our total arrivals up to 52. Although slightly below the current target, the pipeline of nurses looking to join us in March is very good and it is expected that these cohorts will be large enough to reach the target of 60 arrivals.
- We are still actively interviewing international nurses; we appointed 7 in February and are anticipating arrivals until December 2024.
- Objective Structured Clinical Examination (OSCE) bootcamp,19 internationally educated nurses (IEN's) at OSCE bootcamp 5 IEN's arriving on March 28th 2 IENs arriving in April 11 IEN's arriving in May 10 arriving in June.

International Recruitment target

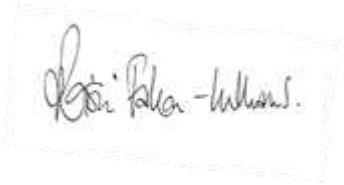


STATEMENT OF DIRECTORS' RESPONSIBILITIES

The Board of Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011). In preparing the Quality Account, the Board of Directors are required to take steps to satisfy themselves that:

- The Quality Account presents an open and balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review, and;
- The Quality Account has been prepared in accordance with Department of Health guidance. The Board of Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account. By Order of the Board of Directors:

Roísìn Fallon-Williams
Chief Executive Officer 20 June 2024



Phil Gayle
Chair 20 June 2024

Annex 1: Stakeholder Statements

BSMHFT Council of Governors Statement on the Quality Account 2023/24

As a Council of Governors, we were invited to review the goals set out in the Quality Account with delivery against 2023/24 goals and those identified for 2024/25 in line with the Trusts five-year strategy. The workshop that took place provided Governors with an opportunity to assure members of our Trust, that quality and patient safety are at the heart of what we do and will not be compromised. We will ensure that the priorities set for 2024/25 will be met and be taken forward.

Whilst it has been a challenging year it has also been one where we have been able to build on the achievements of the last couple of years which saw investment in our services and delivery against our five-year plan. We recognise that there is a clear drive to improve quality and meet the needs of our populations.

We continue to support this organisation to provide a leading health and wellbeing service supporting and enabling our communities to thrive and be supported within environments that meets needs on an individual basis.

Solihull Health and Adult Social Care Scrutiny Board – Chair's Response

Thank you for sharing the Birmingham and Solihull Mental Health Foundation Trust Quality Account Report 2023/24. I'm grateful to provide the following response as Chair.

I recognise, as set out in the Quality Account, the work of all staff in providing services throughout such ongoing challenging times.

One area of notable concern related to Mental Health services – regularly raised by fellow Scrutiny Board Members and residents – is the waiting times children and young people experience when attempting to access support. I agree that service user experience must continue to be a critical area of focus for the Foundation Trust.

I welcome that the Quality Priorities for 2023-24 has included focus upon the following:

- Priority 4 – Quality Assurance – develop and embed the principles of 'Think Family. Identifying the wider family needs and providing support that takes account of each family situation must continue to be of crucial importance.
- Priority 5 – Using Our Time More Effectively – engage colleague and scope how we can use quality improvement methodologies to release time to care. The use of quality improvement approaches to reduce time on non-clinical tasks and maximise the time spent on patient-facing care is greatly welcomed.

I support the following priorities identified by the Trust for 2024/25 and agree they are essential to ensure improved outcomes for service users and families:

- Priority 1: Service User Experience
- Priority 2: Preventing Harm
- Priority 3: Patient Safety Culture
- Priority 4: Quality Assurance
- Priority 5: Using Our Time More Effectively

I note, with concern that the Care Quality Commission has taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2023 to 31 March 2024. Two Section 29 notices were issued to Community Mental Health teams and the Trust provided action plans to the Care Quality Commission to address the points raised. It is requested that reporting on the delivery of CQC improvement actions is provided, as part of the local Scrutiny Board's future work programme.
I welcome how, as part of the results for the NHS Community Mental Health Survey, the Foundation Trust's highest scoring questions included service users stating they were treated with care and compassion, as well as with respect and dignity. I note, with concern, the lowest scoring questions related to service users receiving help with finding support for cost of living, for finding or keeping work, as well as for finding support for financial advice or benefits. I request that the Foundation Trust looks to work with local partners on this – including, where appropriate, signposting service users to Here 2 Help, which provides residents support on accessing food, help with money and essentials, as well as finding work.

Thank you again for the opportunity to submit this statement. I note the future reporting scheduled for the local Scrutiny Board on progress against the Mental Health Delivery Plan.

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