A YEAR IN QUALITY IMPROVEMENT AT BSMHFT 2023/24

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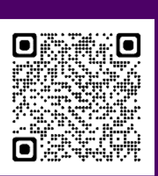

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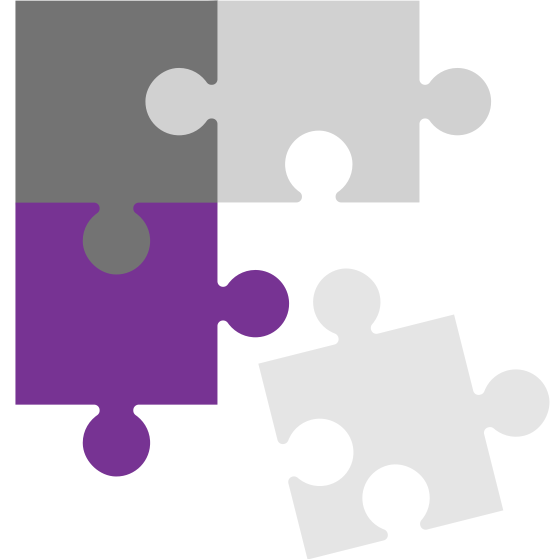
Foreword

Over the last 12 months we have been focused on supporting teams with utilising QI methodology to support the wonderful work they do with our service users and staff teams. Looking to foster knowledge and support for continuous improvement whether that is in using QI tools in leadership (driver diagrams, process mapping, collating data etc) or the formation of QI projects or QI light approach.

At the same time aligning projects to the Trust Strategy quadrants and collaborating with peer improvement teams to enable us to work differently in the future. We have also fostered and worked in tandem with our Patient Safety Colleagues to ensure that continuous improvement and a learning culture is being encouraged through PSIRFs introduction in autumn 2023.

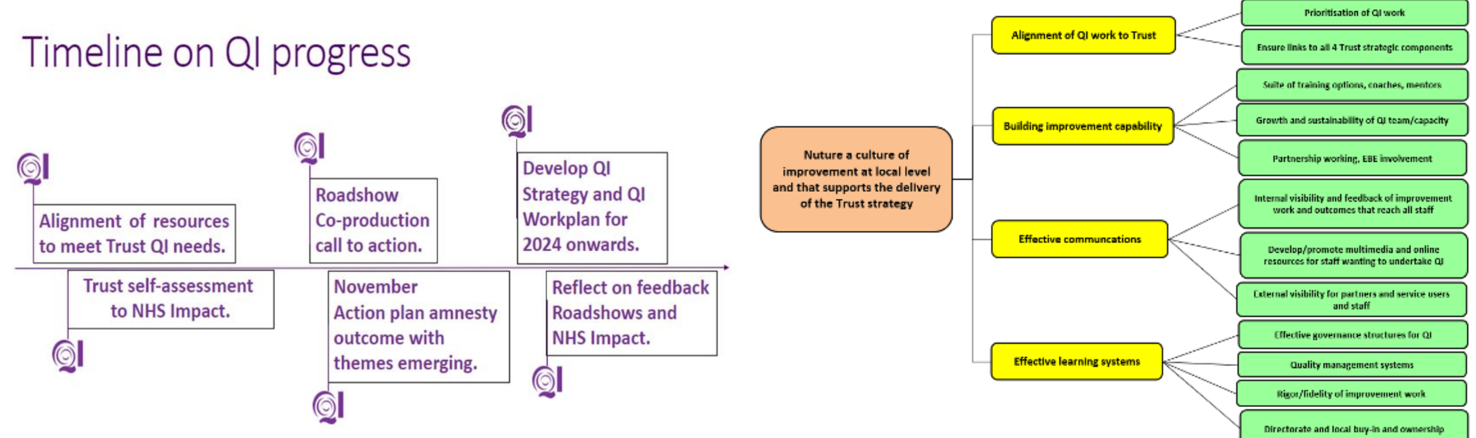
Teams involved in QI are rightly proud of some of the projects they have been involved in and seen positive engagement results. They have entered themselves in poster presentations at various respected events and been shortlisted in 4 to date. Projects are vitally important to be inclusive of our service users, staff and carers and where possible there is a focus on ensuring we have an Expert by Experience or 3 in most projects and we have plans to develop this further in the next year.

Julie Romano
Head of QICE (Quality Improvement and Clinical Effectiveness)

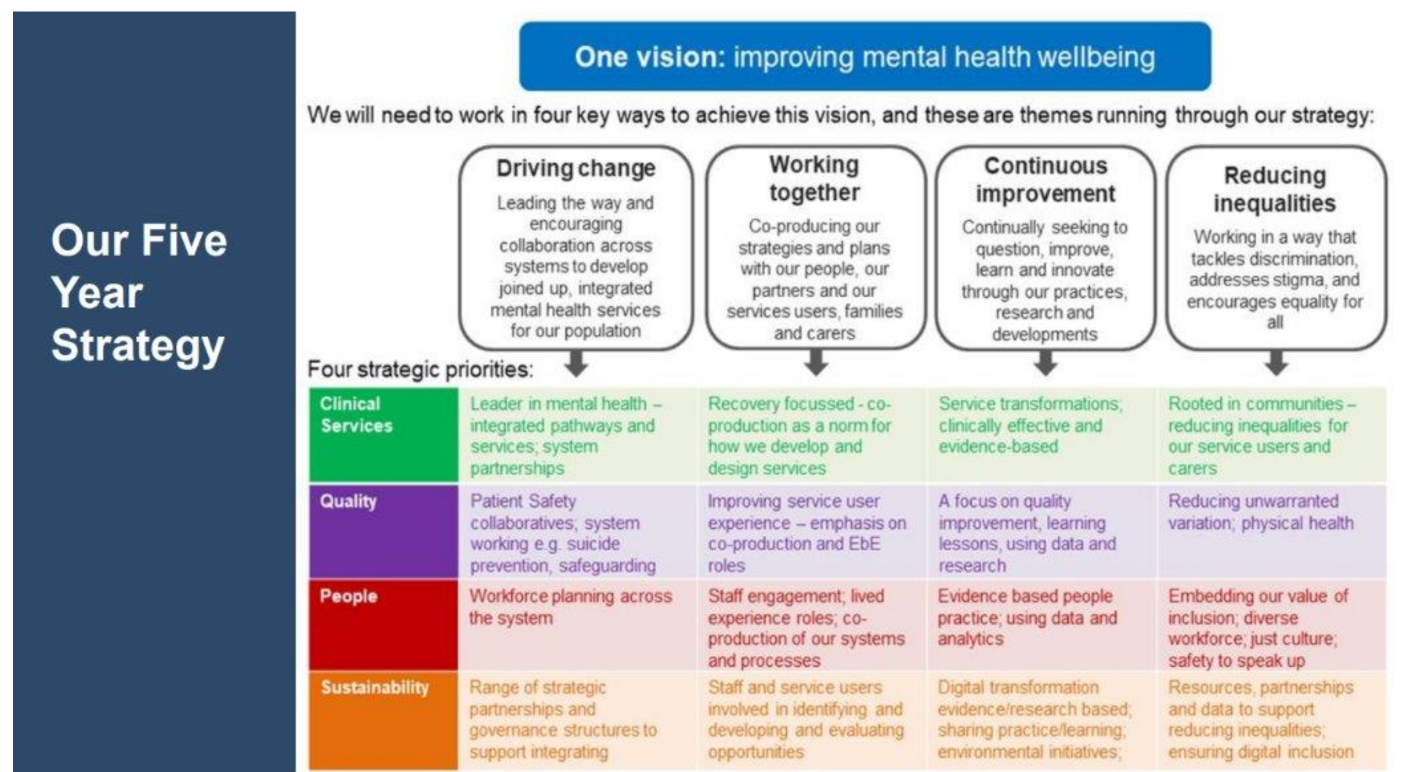


In last 12 months we have supported 35 completed projects. We have also supported many PDSA's and simple change management ideas that fall outside of project work.

Timeline of QI



QI Strategy aligned with the Trust Strategy.



Key Events

April 2023: *QI at AHP Conference*

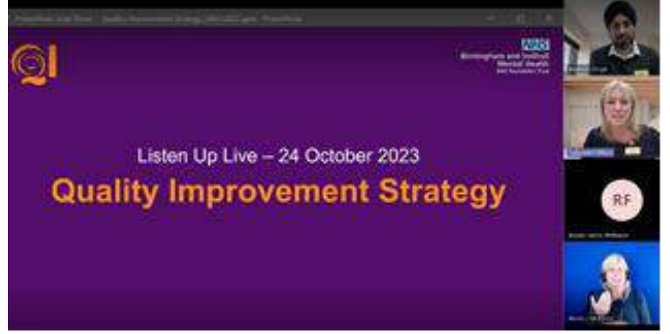
As part of our Comm's Officer's QI project to improve staff engagement with QI Communications, the team were invited to carry out a QI workshop with AHP colleagues at the AHP conference on Tuesday 21 March, taking place at Birmingham City Football Club.

June 2023: *Solar project at Specialties away day*

At the Specialties away day, Harvey Tagger and Kuldeep Singh presented the Joy in Work QI project that took place in Solar. The session was a success with good engagement from the colleagues who attended.

October 2023: *Listen Up Live*

The Quality Improvement (QI) Team has had the privilege of featuring and presenting on two Listen Up Live Sessions within the last 6 months. In October 2023, the QI Team presented the Quality Improvement Strategy on the Listen Up Live. QI was at Listen Up Live, not in the audience but as the presenter. Listen Up Live host Roisin Fallon-Williams (Chief Executive) introduced the QI Team to present the QI strategy in the session. Julie Romano (Head of QICE), Tabassum Mirza (QI Improvement Advisor) and Kuldeep Singh (QI Improvement Advisor) presented the Quality Improvement Strategy to 91 members in the session. The team reflected on the improvements made in past and current projects followed by a short video 'Why QI' showcasing project leads and members who have given a positive response on how QI has helped their service. The second portion of the Quality Improvement strategy looked at what is next for QI as Julie Romano went through the timeline for the year ahead. This was followed by another short video on what is next for QI and the services it has helped.



We were given a lovely opportunity to reach out and engage with staff across the Trust on LUL. We discussed how as a QI Team we were looking to the future and next steps to support the Trusts Continuous Improvement Journey whilst reflecting and look back at the overall Trust Strategy. This was to ensure we are mapping through the capability and potential to support our staff Trust wide to be able to make positive changes to making working life a positive experience for them and service users alike. This has included QI being on induction training so new staff can know how to contact us as often our newest staff arrive with a fresh eyes approach and when able can help us all look at how we can utilise QI methodology in day-to-day work.

-Julie Romano Head of QICE

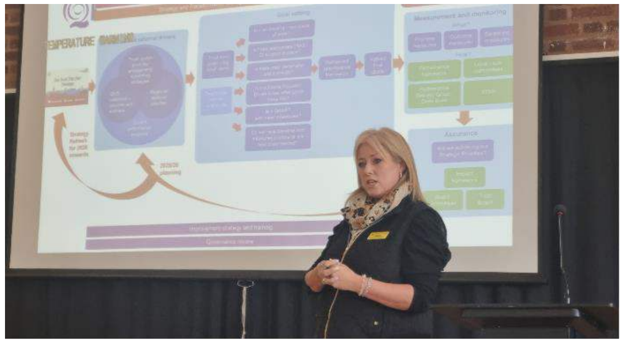
Quality Improvement Advisors Heather Hurst, Shelley Wreford and Dr Nat Rowe, Consultant Forensic Psychiatrist and Deputy Medical Director for Quality and Safety. Shelley Wreford (Quality Improvement Advisor in Specialties) started the session on Quality Improvement Strategy to 106 members: providing insight into QI engagement capability and activity across the organisation at both trust and local level. This was followed by an informative QI video featuring current projects and partnerships from Project Leads and Project Members who have given a positive response on the progress made through the help of QI with their service. Heather Hurst (Quality Improvement Advisor in Acute care) highlighted after the video the clinical QI activity across the Trust; providing further examples of where this work maps onto strategic workstreams. This led onto how the Quality Management System (QMS) framework helps to support continuous improvement within the organisation, which Dr Nat Rowe provided an in-depth presentation into the importance of QMS linking in with the QI projects, but also using the Trust strategy and the other different work streams that are going on.

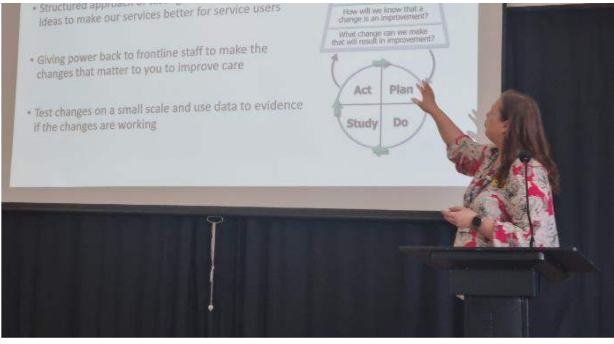
March 2024: *Senior Leaders Session*

Quality Improvement (QI) at the Senior Leaders session at the Midlands Art Centre (MAC). Stepping up to the podium, the QI Team shared QI top tools, drawing inspiration from QI projects. Senior Leaders put QI into action through developing driver diagrams in the session.

Deputy Chief Executive, Patrick Nyarumbu started the session with an insightful introduction into utilising transformation and sustainability to promote changes to the system. It's all about thinking and doing things "differently" and making great improvements that can be sustained over time in the Trust.

QI Ambassadors and QI colleagues took to the stage to highlight the latest updates within Quality Improvement. Dr Nat Rowe, Consultant Forensic Psychiatrist and Deputy Medical Director for Quality and Safety and Julie Romano, Head of Quality Improvement and Clinical Effectiveness led an engaging talk to shed a spotlight on the incredible impact of Quality Management System (QMS) with Quality Improvement strategy on the many services and departments within the Trust. QI Lead Heather Hurst opened with a superb introductory into the Model for Improvement, which then QI Leads Tabassum Mirza and Kuldeep Singh delved into depth on how driver diagrams can be utilised within QI projects. Members of the session were inspired by the examples of QI projects that utilised the driver diagram process; The International Medical Graduate project was one of the example projects showcased to highlight the impact of change ideas on staff wellbeing since starting the QI project.





March 2024: *QI Attends The Dynamic Space Event*

Many departments including the Quality Improvement, PMO, ODP, Digital and Transformation, Communications and many more attended the collaborative space to engage in transformation talks last week. Looking at the bigger picture of "how can we better commission and manage transformation and improvement to support delivery of our Trust strategic priorities?" The aim of the workshop is to give attendees an equal opportunity to join the dynamic discussion and share ideas. Follow link for full article: QI Attends The Dynamic Space Event

QI Project Shortlisted and Awards

Many Quality Improvement projects were nominated into several Awards and conferences within the year.

April 2024: Values Awards 2024

The Trust Values Awards returned for another year. 343 nominees over 10 award categories. **Quality Improvement, Research and Innovation Award.** This award is for an individual who uses research and innovation in every element of their role to bring about service improvement for our service users and colleagues. 3 QI nominations are shortlisted:

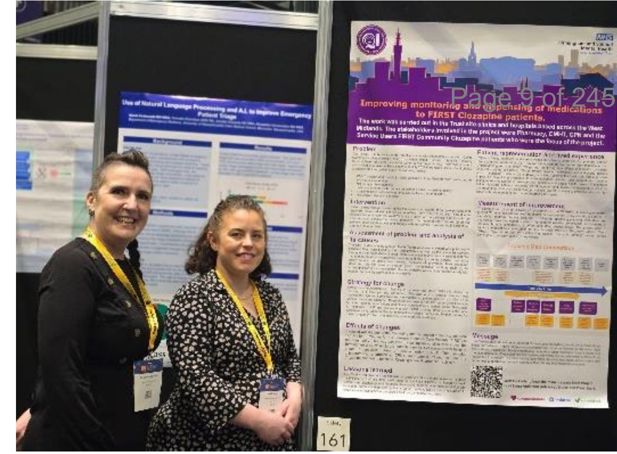
- Steps 2 Recovery Service
- North Hub CMHTs-Reducing Emergency FP10s issued by North Hub CMHT (ESCA)
- Dr Katarina Lietavova-DNA HTT Medical Review at Sutton Home Treatment Team (Project Lead and Associate Specialist, Sutton Home Treatment

November 2023: RCPsych Awards 2023

In November 2023, two incredible QI Project Teams from BSMHFT were shortlisted for the RCPsych (Royal College of Psychiatrists) Psychiatric Team of the Year: Quality Improvement category. One team represented the QI Collaborative that has done phenomenal work across the organisation to reduce restrictive practice, which resulted in a 37% reduction in non-prone restraint, 60% reduction in prone restraint, 51% reduction in rapid tranquilisation. The other team represented some remarkable work as part of the community transformation process. This involved looking at improving the physical health care of service users. Experts by Experience have been involved in both projects to co-produce and collaborate on the amazing work that has been done.

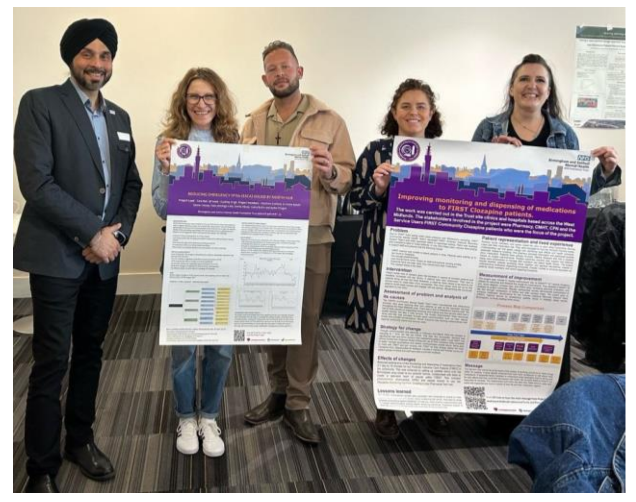
April 2024: MHImprove Event 2024

Two fantastic QI projects presented at the MHImprove 9th Edition 2024 Event. On the day, both QI projects *'Reducing Emergency FP10s (ESCA) issued by North Hub CMHT'* and *'FIRST Clozapine Clinic'* presented their work at the World Café. This great platform was an opportunity to share and learn from the national and international QI community (please see Appendix 4 and 5).



April 2024: International Forum on Quality and Safety in Healthcare 2024

The FIRST (Forensic Intensive Recovery Support Team) Clozapine Clinic QI project entered the BMJ/IHI International Forum on Quality and Safety in Healthcare 2024 conference to showcase the incredible impact made throughout the QI project. Project Lead Laura Anderson (Advanced Nurse Practitioner and Prescriber) showcased the QI project poster at the Event along with Project member and Pharmacy Technician Sarah Hodges-Smith. Improving monitoring and dispensing of medications to FIRST Clozapine patients. The work was carried out in the Trust site clinics and hospitals based across the West Midlands. The stakeholders involved in the project were Pharmacy, CMHT, CPN and the Service Users FIRST Community Clozapine patients who were the focus of the project. Watch the video now about the QI project: https://youtu.be/VOCmITQp2ns. (Please See Appendix 4).

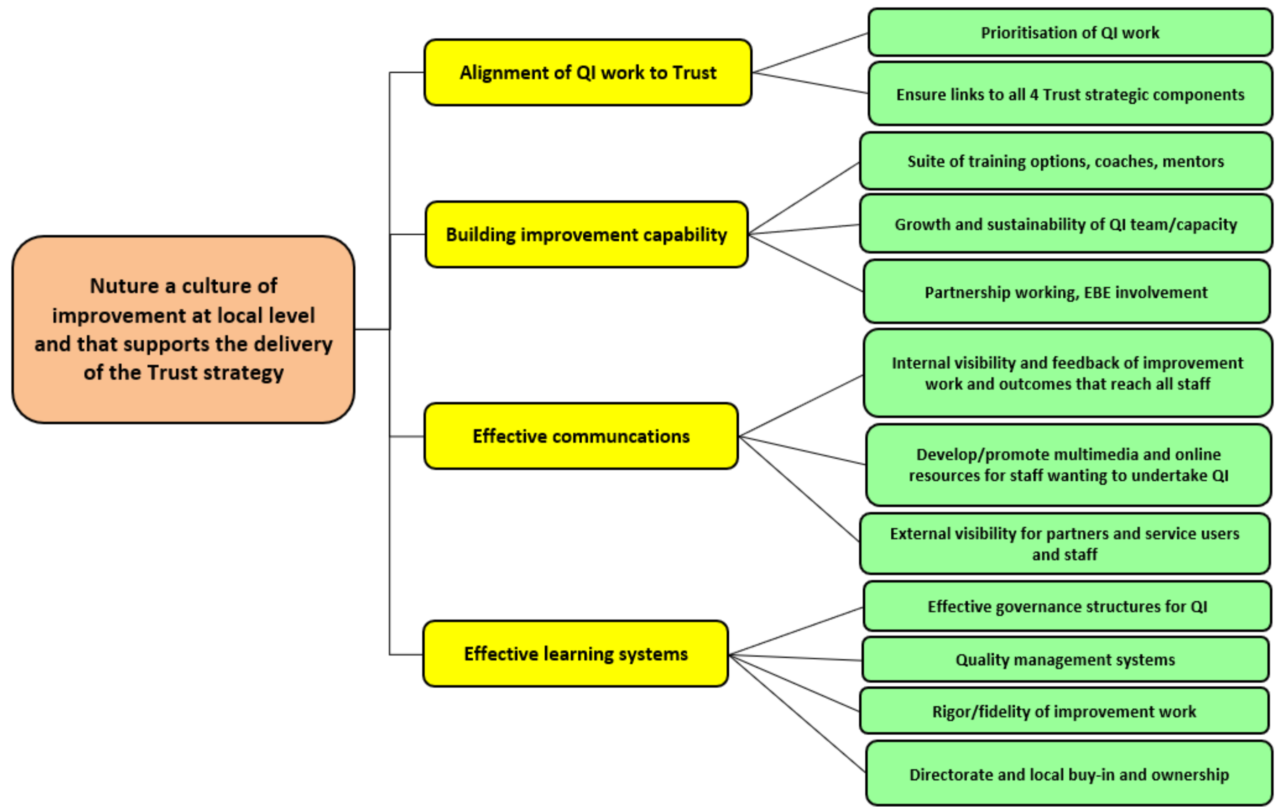


QI Strategy

Delivering a 5-year strategy: Vision

- Leadership for improvement from the Trust Board, senior leaders and Experts by Experience
- QI embedded into clinical roles, inc. doctors, heads of nursing/AHP, matrons, service leads.
- Centralised QI capability/capacity maintained within the organisation
- Each directorate has local QI capability including trained and experienced QI coaches/mentors to support local level 3 and level 4 projects.
- Innovation for improvement is encouraged and supported at all levels of the organisation.
- QMS (Quality Management System)
- Finance support to deliver triple aim (improved population health, quality of care and cost-control)
- Data analytics support available for local and large-scale improvement collaboratives.

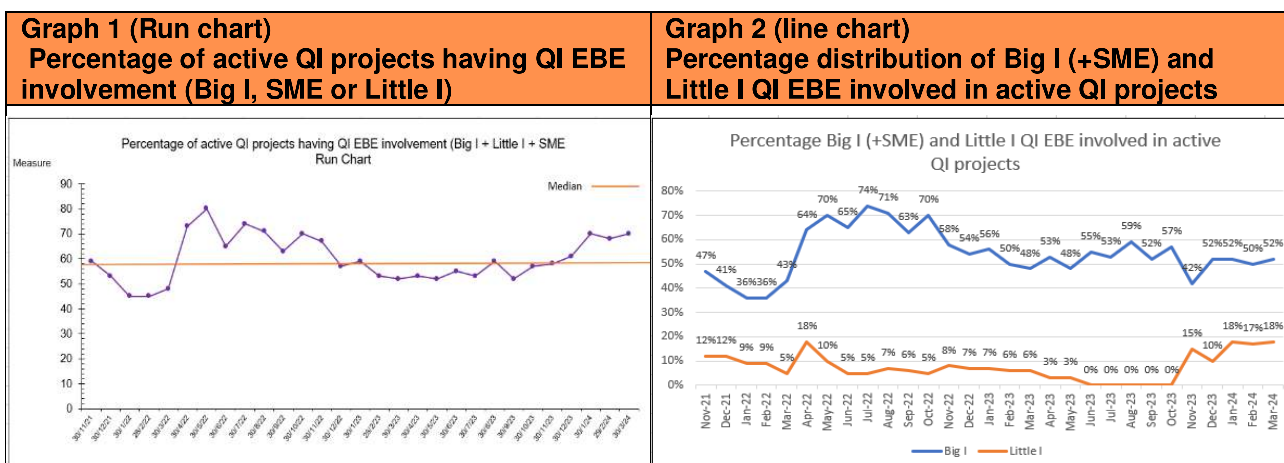
Five-year strategy for Continuous Improvement culture Driver diagram



Service User and Carer Involvement

Within our team we recognise the need to include the people who receive our services, or care for those that do, is a fundamental part of Quality Improvement. Furthermore, we believe that this will greatly enhance the success of our QI projects as we can then measure improvements for staff, service users and carers. We are using the terms Little I and Big I to differentiate the level of participation.

- Little I – Means involving service users and carers at various points throughout the life of a project, the team may ask for ideas of what should be changed or about the impact changes have had to the services they receive.
- Big I – Means involving service users and carers directly and continuously throughout the whole life of the QI project.



The first chart shows the total (%) of open QI projects having active QI EBEs involvement (includes Big I, SME and Little I) = 70%. Paused projects have been excluded from the total number of projects. Total projects: 33 (incl QI Lite), Projects with Big I, SME or Little I QI EBEs: 23

The second chart shows the percentage distribution of Big I (+SME) and Little I QI EBEs in all active QI projects excluding paused projects. (Numbers 17 & 6 respectively)

Note: The EBE involvement % goes up to 72% if staff focused projects are excluded from the count. Scope exists for exploring and increasing EBE/SME involvement in other projects.

The QI Team continue to involve Experts by Experience (EBE) and Subject Matter Experts' (SME) in QI projects. 72% of all projects are co-produced and co-design with either Big I, SME or Little I involvement. Here are some highlights from EBE involvement in QI:

- Some upcoming cross-directorate and Trust provider collaborative projects have requested multiple QI EBEs to be involved.
- QI at Recovery College - Co-designing and co-delivered session set for July 2024.
- Due to recent surge for QI EBE demand, additional QI bronze-level training being scoped.
- Children and Young people (CYP) EBE and parents to be involved in a Solar QI project starting soon.

Highlights of completed projects.

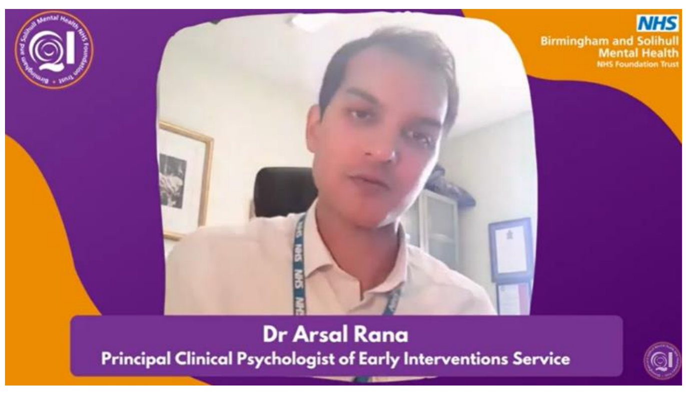
Quality Improvement Video Case Studies

QI Case Study: Improving Diversity in the Psychological Workforce

In this Quality Improvement Case Study Dr Susan Adams, Consultant Clinical Psychologist at Birmingham and Solihull Mental Health Foundation Trust, talks us through her QI project around increasing diversity within the psychological workforce. Watch QI Case Study: QI Case Study: Improving Diversity in the Psychological Workforce (youtube.com)

QI Case Study: Naloxone

In a BSMHFT QI case study interview, Dual Diagnosis Practitioner, Verity Ford, shares with us the outcomes of her project looking at the provision of Naloxone on discharge from Mary Seacole 1. The project aimed to address two key issues - the screening of admissions for substance use in the first instance, followed by the process for issuing Naloxone, including the education/training of ward staff and patients. Follow link to view QI interview: QI Case Study: Naloxone (youtube.com)



QI Case Study: Improving early warning sign materials for those with autism experiencing Psychosis

Dr Arsal Rana, Principal Clinical Psychologist of the Early Interventions Service, discusses his QI project seeking to improve early warning sign materials and staying well plans for individuals experiencing psychosis on the autistic spectrum. Follow link to view QI interview: QI Case Study: Improving early warning sign materials for those with autism experiencing Psychosis (youtube.com)

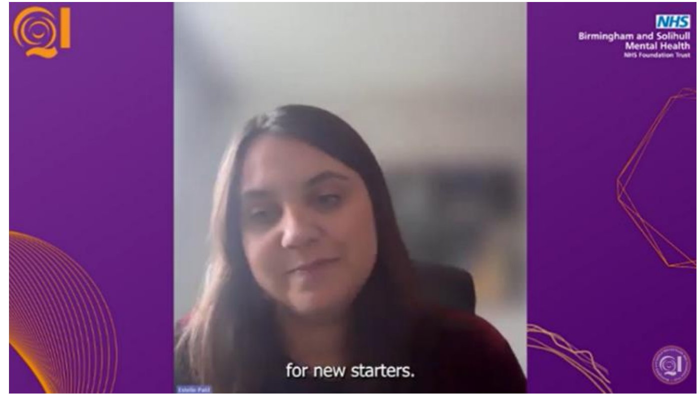
Visit Quality Improvement on Connect

How can we improve happiness and wellbeing at work?

In this QI case study, Dr Harvey Tagger, spoke about the Joy at Work project at Birmingham and Solihull Mental Health Foundation Trust. Follow link to view QI interview: How can we improve happiness and wellbeing at work? (youtube.com)

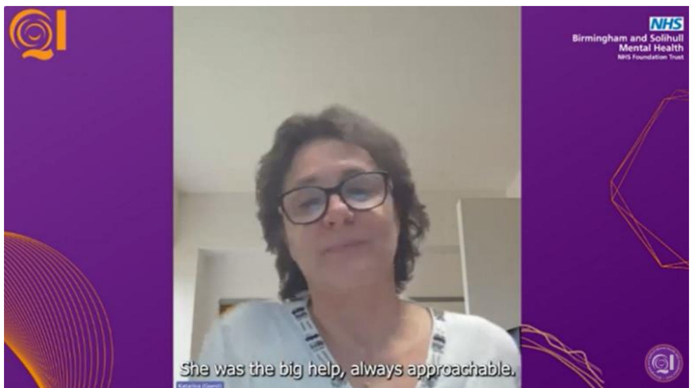
QI Project FIRST Clozapine Clinic

In this QI case study, Project Lead Laura Anderson (Advanced Nurse Practitioner and Prescriber), gave insight into the FIRST Clozapine Clinic QI project. This Quality Improvement project involved improving the monitoring and dispensing of medications to FIRST Clozapine patients. QI project Clozapine Clinic (youtube.com)



QI Project Induction for new starters: face to face Induction workstream

Project Lead Estelle Patil (Induction and Fundamental Training Lead) highlighted the importance of feedback from new starters as the team received feedback in person from new starters saying that “they were happy to be there.” The aim of the QI project is “Induction will provide a values driven content that supports new starters to feel welcomed and to be work ready.” The pandemic had a major impact on Inductions, but with coproduction at the heart of the project enabled continuous improvement to happen. Watch QI Case Study:
QI Project Induction for new starters : face to face Induction workstream (youtube.com)



QI Project DNA HTT Medical Review with Dr Katarina Lietavova

Project Lead Dr Katarina Lietavova is an Associate Specialist for the Sutton Home Treatment Team and gave an insightful interview on the Quality Improvement project. The project aimed to improve attendance of medical reviews within Sutton Home Treatment team using quality improvement techniques by offering Service Users to be an active part in arranging their medical reviews. This was achieved by offering options to have medical review at home or at base. Follow link to view QI interview: QI Project interview with Dr Katarina Lietavova (youtube.com)

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QI Highlights

New Team Members

September 2023

Priya Roadh joined the Trust in the Quality Improvement department as the new Quality Improvement Communications Officer in September.

"I am passionate about working within the mental health trust and utilising my media and transferrable skills/experience to provide the best service within my role."

November 2023

Samsuma Bibi's journey with BSMHFT started in 2013 working within the admin field with different teams. In 2021 Samsuma rejoined the Trust on the bank under TSS. Since then, Samsuma worked with the QI Team and Compassionate Team and joined the QI Team as a Quality Improvement Programme Administrator in November 2023.

April 2024

4 new members joined the Quality Improvement Team in April 2024, the Quality Improvement Facilitators. Amy Jowicz, Donna Thomas, Hannah Stanyard and Lisa Farmer have started their QI journey to promote the Trust's Quality Improvement vision and in turn, the Trust strategy by supporting individuals and teams to use Quality Improvement Methodology the 'Model for Improvement' to bring about measurable improvement in our services.

S2R QI Partnership

In November 2023, Steps to Recovery, invited 20 colleagues from S2R's (Steps to Recovery) 7 teams presented their QI projects at the 1st quarterly Share & Learn event. There was a common theme during the event, which was 'co-produced tweaks go a long way!'

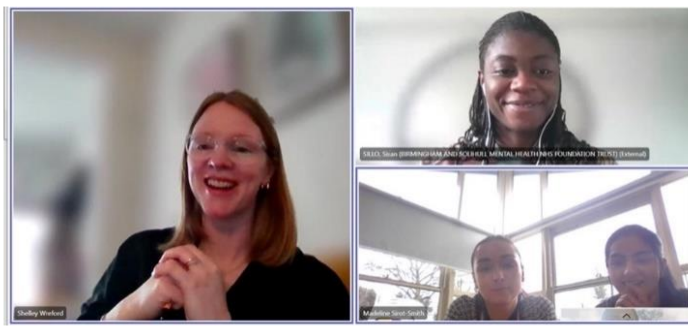
QI Lead Kuldeep Singh led the event with Project Sponsors Tom Bell (Matron) and Sarah Jones (Matron). The S2R'S 7 QI Project Teams included Dan Mooney House, David Bromley House, Endeavour Court, Forward House, Grove Avenue, Hertford House and Rookery Gardens. All shared their QI project updates through colourful and informative presentations of the change ideas implemented, which showcased the improvements that has helped.

Digital Champions

A digital scheme started across the Trust. The QI Team announced their official Digital Champions in March 2024. Alongside their role, QI Communications Officer Priya Roadh and Quality Improvement Programme Administrator Samsuma Bibi are the official Digital Champions for the QICE (Quality Improvement and Clinical Effectiveness) Team. The incredible initiative aims to bring colleagues together across the Trust who are interested or passionate about digital technologies to enable a smoother digital transformation within BSMHFT. This role encourages to become a digital leader and voice for the department when it comes to adapting new technology and solutions. Digital champions will bridge the gap between the non-clinical IT staff who builds, develops, procures these technologies and the wider staffs who uses the technology for patient care. This digital development will explore current and new applications to utilise and cater these technological tools within the different departments.

Spotlight on Directorate QI Projects

Here are some Quality Improvement (QI) projects from each directorate detailed below and their impact of improvements.



Specialties QI112 Empowering Women of a childbearing age who are on psychotropic medication.

A phenomenal Quality Improvement (QI) Project to empower women of childbearing age within the Perinatal Service. QI Lead Shelley Wreford is supporting the project team to develop a clear aim statement, measures and change ideas to not only improve preconception counselling provision now, but ensure improvements are sustained going forward too. Solihull Early Intervention service is collaborating with our perinatal service on an ambitious Quality Improvement project aiming to empower women aged 16-50 years who are on psychotropic medications to make informed decisions around family planning. The hope is that by strengthening processes within Solihull Early Intervention (EI) service, access to preconception counselling will be consistent and equitable.

Follow link for full article: Let's Empower With QI Power!

QI71 Reducing emergency FP10s (ESCA) issued by Northcroft.

The project team was multidisciplinary with Project Lead Zora Bell (Clinical Hub Manager), Dr Alisha Bakshi (ST4 in Psychiatry), Matthew Stafford (Clinical Lead), Sanna Ceesay (Advanced Nurse Practitioner), Kate Jennings-Cole (Clinical Lead), Emma Allsop (Support Services Manager), David Somers (Staff Nurse) & Aysha Chughtai (Clinic Nurse). The overall aim of the Quality Improvement project was to reduce the number of FP10's requiring ESCA (Electronic Shared Care Agreement) by 10% by end of the project. This aim was met and exceeded by achieving a 14% reduction. The team continued to sustain some of their change ideas and their overall aim sustainability data measure, checked after a gap of 3 months over December 2023. A reduction in numbers continued to fall and was at a remarkable 64% when compared to project baseline.

Follow link for full article: Lights, Camera and QI with the Community Mental Health Team at Northcroft

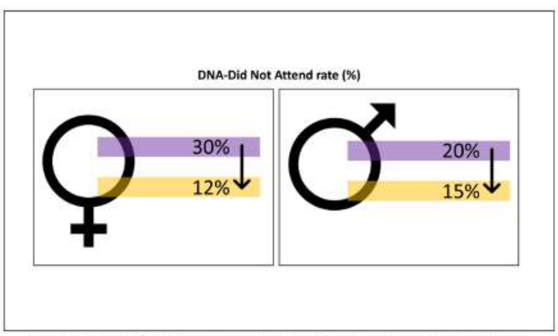
QI68 Improving International Medical Graduate Doctors' experience within BSMHFT. The NHS has long relied on professionals from abroad. In 2022, a third of the 136 322 doctors working in NHS hospital and community services in England reported a non-British nationality—representing 168 other counties, including Egypt, India, Ireland, Nigeria, and Pakistan. (Source: Baker C. NHS staff from overseas: statistics. 21 Nov 2022).

Although employers, colleagues, and patients are mostly welcoming, insufficient initial and ongoing support, social isolation, arduous visa, exam requirements, and racism can lead to demoralisation, anxiety, and burnout. Attention to these challenges could help improve recruitment and retention of the International Medical Graduates (IMGs), crucial to tackling chronic NHS understaffing to the tune of 12 000 hospital doctors (Source: House of Commons Health and Social Care Committee)

The International Medical Graduate (IMG) QI project has a committed group of IMG's from across the Trust who are emotionally invested in testing out change ideas to help coproduce a clear road map with a wealth of resources and support and build a BSMHFT IMG community. In the last year the group has grown, several new resources have been tested and finalised and discussions have been had with the project sponsor and Dr Fabida Aria, Medical Director in order to see how the project can be further supported.

Follow links for full articles:
International Medical Graduates (IMG) Forum QI Project
An inspiring QI workshop with International Medical Graduates
Watch video: https://youtu.be/iqC4L50fF64

QI101 To raise awareness and improve experience of colleagues with Perimenopause and Menopause at BSMHFT.
As part of the Quality Improvement project on raising awareness and improving workplace experience of colleagues with Perimenopause and Menopause at BSMHFT, Project Lead Sophie Pierro and the Project Team have been following a PDSA cycle for the Menopause project to ensure that colleagues including new starters have the option to choose the new breathable uniform. Project sponsor Dr Fabida Aria is really supportive of the project. Follow links for full articles:
'Breathable' uniform for BSMHFT colleagues
Let's eLearn about Menopause.



For males the DNA rate before any changes was 20% which reduced to 15% after (represented by the right-hand side of the graphic). However, for females the DNA dropped from 30% to only 12% after (represented by the left-hand side of the graphic).

QI95 To improve attendance and reduce DNAs (Did Not Attend) of Medical Review within the Home Treatment Team
Missed appointments is a universal problem across healthcare, and within psychiatry is estimated to be about 20%, which is twice that of other medical specialities. Missed appointments can interrupt care reviews and treatment, which can impact recovery, and when service users DNA without notice, that appointment can't be offered to someone else.
The Sutton Home Treatment team undertook a QI project to tackle this issue, and by the end of the project had reduced DNA's (did not attend) by 50%. This remarkable achievement was reached with a very simple idea, which had a huge impact. Follow link for full article:
Reducing DNA's to the Home Treatment teams medical review

QI Training Academy

The training strategy continues to build a strong foundation of QI capability to put improvement at the heart of what we do. The strategy aims to provide a breadth of training which enables staff to develop awareness of QI, and those participating in QI projects will have sufficient skills, knowledge and expertise to participate or lead QI projects. The QI academy offers a range of short courses which outline the model for improvement (please see Appendix 1), it's value and when it can be applied. For those who plan to participate in QI or develop additional skills there is more in-depth training through the bronze or silver offer. Attendees who have completed the QI courses receive a follow up thank you email with QI resources slides to look back on the information provided in the course. They also receive a certificate for completion of the course (please see Appendix 3i, 3ii, 3iii).

Throughout this journey, the team collects evaluations of the training in the interests of making the training effective and enjoyable for those attending. The feedback we have received from the training we provide has been overwhelmingly positive (please also see Appendix 2), with delegates sharing that the training built their knowledge and understanding. Comments include;

"Have booked on to the bronze training, it was interactive and interesting."

"I very much enjoyed the succinct explanations and the funny video/trucks in the harbour."

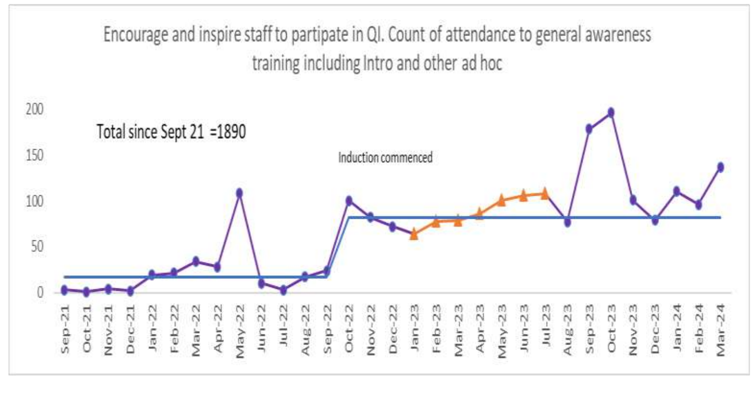
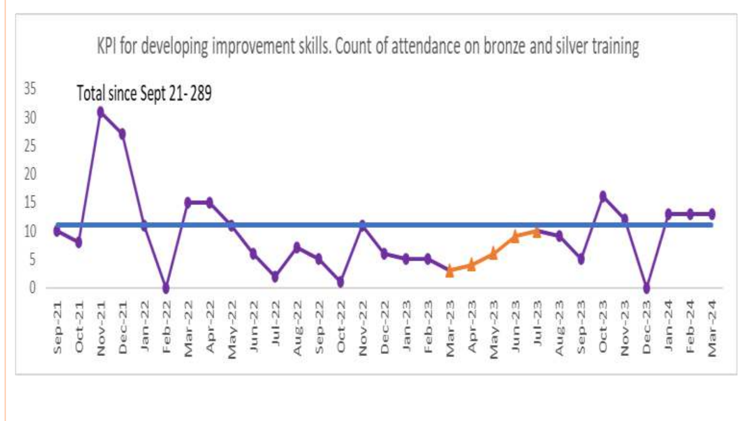
"Really informative, looking forward to sharing ideas with QI team to see how they can help."

"I thought it was brilliant, the trainer was so knowledgeable. Thank you so much for this training its invaluable."
- Bronze training, December 2023

"Good for an intro - right amount of info and length of training. have booked on to the bronze training."
- Intro March 2024

"Really useful, informative and straightforward training session. Thank you."

""Very good course to cover a large amount of material in a short period of time".
Bronze training, June 2023

Encourage and inspire staff to participate in QI through the Intro to QI course and other ad hoc training opportunities.	For those staff who are leading / participating in QI projects, to have the skills and knowledge to apply the model for improvement.
	

The increases in recent months are due to a gradual sustained increase in numbers, as well as some ad hoc training which took place. In total 1,890 staff have now accessed some form of QI training since this version of the QI academy was commenced in September 2021.The first line Managers course is a new addition to the QI Training Academy and commenced in January 24. Whilst it does include an introduction to the QI model, it also includes a section around the management of change. Whilst groups are currently small, it is evaluating well.

Where are we now?

At present we have successfully trained 2412 delegates from across BSMHFT in Quality Improvement since the current training academy format was launched in September 2021. There has been an increase in both the training offer and uptake year on year. Most recently a module has been launched as part of the First Line Managers programme called "Quality Improvement: Inspiring change leadership."

Intro to QI Training
Mon, 10 Jun, 14:00

See all

First Line Managers Program

We offer Quality Improvement: Inspiring change leadership as part of the First Line Managers program.

The training course looks at the basics of what a QI project is: when, how and why to use QI: Leadership role in change and QI: and getting started with your QI project. This is just a brief introduction to QI principles and how they can be incorporated into your leadership role. It is not intended to be a full introduction to how to run a QI project, and at the end we'll tell you about how to access the rest of our training which will take you through this is you are interested. Training takes place over Microsoft Teams.

Please click on the link below and follow the instructions. The link will take you directly to ESR, if you are not already logged in, you'll be asked to log in and then it will take you to the page where you can select the course date that suits you and you can click the enrol button. You will get an automated email from Production Workflow confirming your booking. Click here to book

First Line Managers course 2024 dates:

Thursday 25th January 10am to 11.30am on Teams

Thursday 22nd February 10am to 11.30am on Teams

Thursday 7th March 10am to 11.30am on Teams

Thursday 21st March 10am to 11.30am on Teams

Thursday 4th April 10am to 11.30am on Teams

If you have any queries or would like to know more information about the course, please email bsmhft.qualityimprovementteam@nhs.net

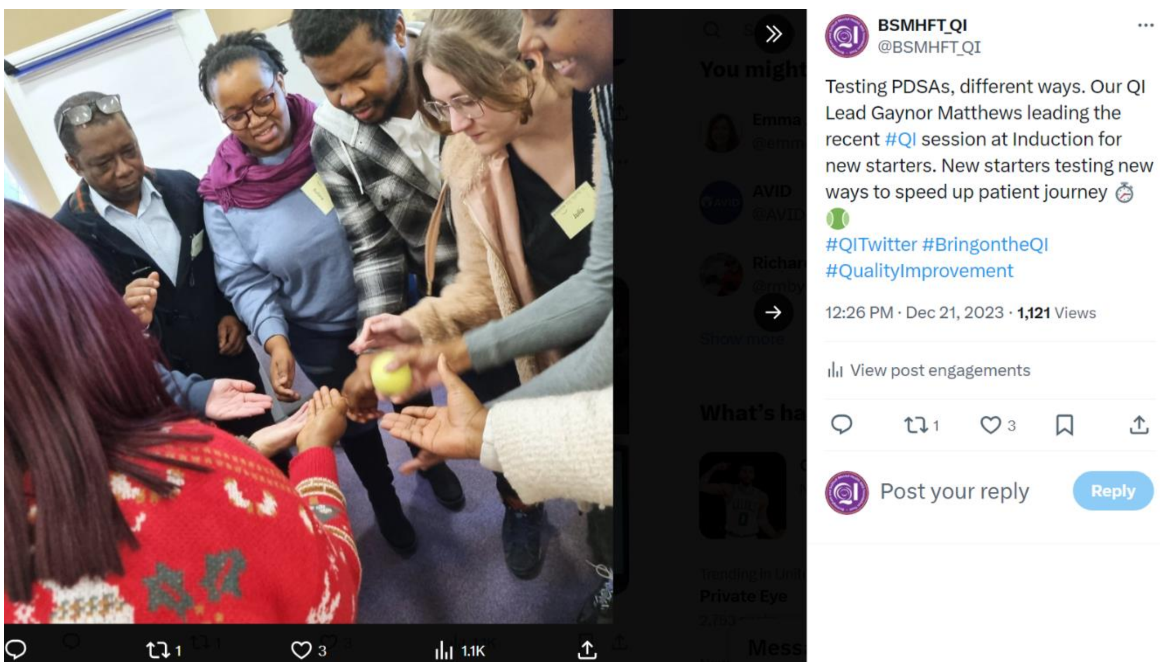
Visit Quality Improvement on Connect

Intro to QI	Quality Improvement projects are a way for teams to address some of our more complex areas for improvement work. Although many people will have heard about QI, this course is a short introduction aimed at all staff who are curious to find out what it is. Over the course of 1-hour participants will learn why we use QI, when it can be used and what a QI project is.
Bronze	This is a half day workshop which outlines the model for improvement within QI. Participants will learn how to understand and apply the model to a quality improvement project and how to use the PDSA cycle. This is aimed at people participating in a project. You will come away with enough knowledge to actively participate in project meetings as you will recognise the language being used, and what needs to happen for each part of the model.
Silver	Silver training aims to support participants to translate the QI methodology into practice. Participants should come with a QI project, which they then develop during the training and implement in-between the training days. The course covers QI methodology, introduces tools and guides participants to translate this into the real world. Exercises are fun and engaging with support on hand. This is ideal for project leads and project members looking to develop their skills. As project work is undertaken during the course it works particularly well when project members can all attend together.
First Line Managers	The training course looks at the basics of what a QI project is; when, how and why to use QI; Leadership role in change and QI; and getting started with your QI project. This is just a brief introduction to QI principles and how they can be incorporated into your leadership role. It is not intended to be a full introduction to how to run a QI project, and at the end we'll tell you about how to access the rest of our training which will take you through this is you are interested. Training takes place over Microsoft Teams.

Visit Quality Improvement on Connect

Induction

Quality Improvement has a regular session at the Trust's 'Welcome Induction.' New starters are introduced to the Model for Improvement (See Appendix 1) and are encouraged to participate in an interactive PDSA (Plan Do Study Act) cycle exercise. The QI methodology was used to gain insights and shape this session.



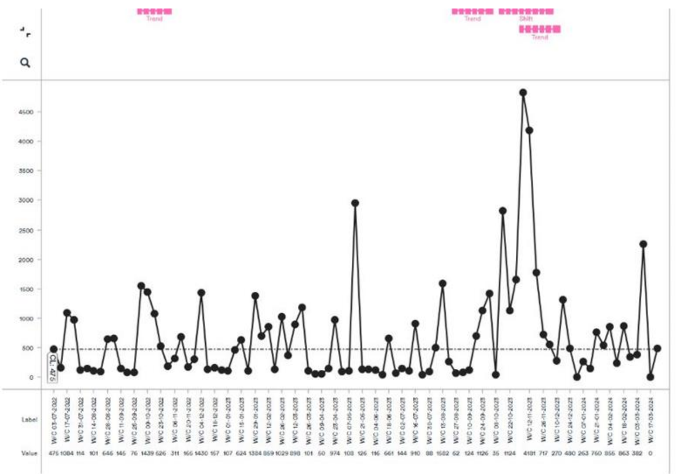
QI43 Review of the Corporate Induction

A Quality Improvement project was recently completed within the last year, focusing on improving the experience of the Trust's induction for new starters. The aim of the project was to create a value driven induction that supports new starters to feel welcome and work ready.
High levels of co-production at QI Induction

QI Communications

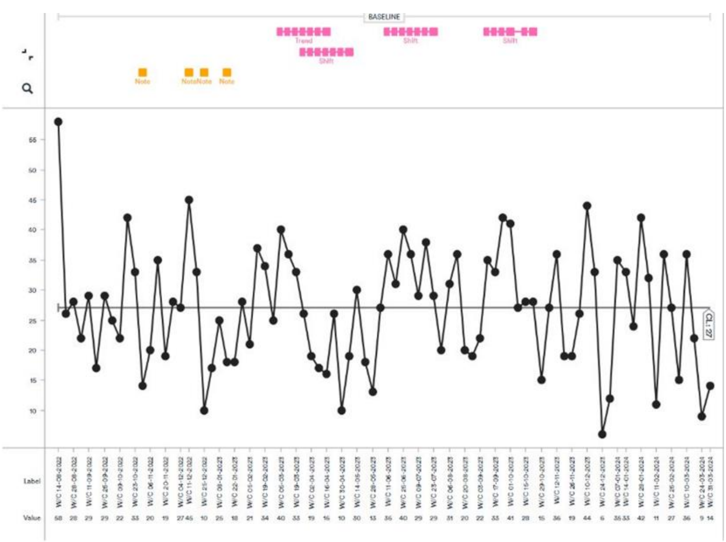
Twitter

The Quality Improvement X page formerly known as Twitter has been successful in growing an online presence. This is evident through the analytics monitored by the QI Communications Officer. Current followers to date are at 790, which has grown through consistent social media posts each week, QI Training, Induction, and conferences. (Please see Appendix 6)



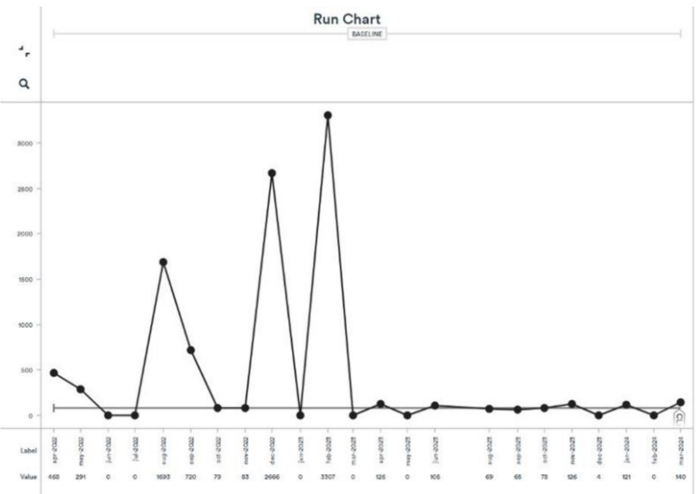
QI Connect

The Quality Improvement Connect page (please see Appendix 7) is updated regularly with the latest QI project updates through weekly articles and a newsletter that is published every 6-8weeks. The QI Training Academy page is updated with a new set of training dates and promoted via Newsletter.



Newsletter

The Quality Improvement newsletter is published every 6-8weeks and shared to over 250 colleagues within the Trust (please see Appendix 8). The newsletter features the latest QI news, QI project updates and announces QI training dates for staff to sign up. Scan the QR codes below to view the latest QI newsletters.



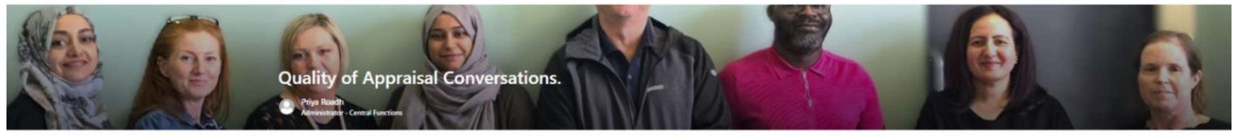
November 2023

January 2024

March 2024

Colleague Briefing Articles

Quality Improvement is involved in the Colleague Briefing, which is published each week. Colleague briefing articles are published each week, giving staff within the Trust a view of the latest Quality Improvement project updates and news. The articles spread awareness about the QI projects, starts conversations on QI and in turn encouraging staff to get involved in QI.



This week's Values Based Appraisal QI Project meeting explored potential change ideas utilising QI methodology. The Quality Improvement project aims to empower staff in having effective Appraisal conversations for their professional development.

Project members attended the Quality Improvement project meeting to discuss improvements that can help the Values Based Appraisal process to work effectively for staff when completing their Appraisal, which is also known as Annual Development Review. This included reviewing resources that are available on Connect website, such as a step-by-step guide on how to complete the Annual Development Review. Quality Improvement Leads Gaynor Matthews and Tabassum started the QI (Quality Improvement) project meeting with a walk-through of the Model for Improvement, focusing on 'What are we trying to accomplish?' Project Lead Sunny Basra and project members discussed the current process to identify areas that could be improved drawing from experiences and knowledge by the Subject Matter Experts. A positive point was raised on how the appraisal process helps to inform opportunities for professional development such as training courses and opportunities to shadow/observe. The project team produced a flow chart to review resources and generate potential change ideas.

These potential change ideas will be reviewed in the next project meeting.

Project Team meeting.
Nicky Emes (Senior Internal Communications Officer), Nicholas Wareing (HCA Inpat Acute), Olalekan Gabriel (Community Psychiatric Nurse), Sunny Basra (Project

Project Team Photo
(Left to right)
Tabassum Mirza (Quality Improvement Lead), Lisa Farmer (Quality Improvement Facilitator), Gaynor Matthews (Quality Improvement Lead), Sam Bibi (Quality Improvement Programme Administrator), Nicholas Wareing (HCA Inpat Acute), Olalekan Gabriel (Community Psychiatric Nurse), Sunny Basra (Project Lead/Learning and Development Manager) &Nicky Emes (Senior Internal Communications Officer).

Lisa Farmer (Quality Improvement Facilitator), Gaynor Matthews (Quality Improvement Lead) & Nicky Emes (Senior Internal Communications Officer).
Flow chart notes.

QI Projects

QI Project Progress	
Acute & Urgent Care **Currently 6 projects open across Acute and Urgent Care** **13 closed projects from April 2023 – March 2024**	Within Acute Care projects have been undertaken which focus on taking bloods and ECG following admission to Meadowcroft PICU, supporting clinician triage conversations when referring to Home Treatment Teams, supporting clinicians when making decisions about admission to acute or PICU wards and reducing DNA's to medical reviews within the Home Treatment Teams. There have been some notable successes, for example the reducing **DNA project in HTT** reduced **DNA rates** from **26%** of medical reviews being missed to **13%**. Within Urgent Care projects have been undertaken which focus on improving induction for trainees, improving the quality of information given to patients in A&E and introducing **Mortality and Morbidity meetings**. The **Mortality and Morbidity meeting project** has been selected for a poster presentation to the Faculty of Liaison Psychiatry Annual Conference 2024.
Corporate **Currently 9 projects open across Corporate Services** **3 closed projects in 2023/2024**	Within the Corporate services projects are taking place that focus on staff wellbeing and experience, including; Improving **International Medical Graduate doctors'** experience, this project has been a great success so far. **3 change ideas** have concluded, with more PDSA's cycles planned in the next few weeks. A poster abstract will be on display at **RCPsych Annual Conference**. Improving the experience of **staff with Peri-Menopause or Menopause symptoms** has also been a success so far with more change ideas in the pipe line. Following a PDSA cycle, Breathable uniforms are now available to order for women experiencing symptoms. The QI project **'Raising the confidence of trainees to raise concerns'** has almost come to an end with a number of ideas successfully tested and implemented to help support trainees

	to speak up in relation to raising training concerns or patient safety concerns. The QI team have been also working on how to improve the experience of receiving or conducting Values Based Appraisals. This project is ongoing with lot of ideas to test.
Integrated Community and Recovery Services **ICCR currently has 7 open active projects.** **6 closed projects from April 2023 – March 2024**	ICCR projects spanned over joy at work, early warning signs and staying well plans for individuals experiencing psychosis and autistic spectrum conditions, improving internal QI communications channels, addressing cultural competencies to enhance person centred care, reducing FP10s related to ESCA, improving referral of delays from Solihull EIS, and several local themes within S2R QI Partnership. There are currently **19 projects** in the directorate of which **seven** are active projects, **12** potential projects. The reducing F10s (ESCA) at North Hub CMHT had the following achievements in additional to improvement in outcomes measures: • **Trust Values Awards** - Shortlisted in the Quality Improvement, Research and Innovation Award category • **RCPsych International Congress 2024** – Poster accepted • **MHImprove 2024** - Mental Health Improvement Network – London, presented in world café • One of its change ideas adopted for all CMHTs through the Medicines management committee. • Project outcomes' scale up and spread requested by Strategy and Transformation Management Board. Steps 2 Recovery Service QI Partnership – **Trust Values Awards** - Shortlisted in the Quality Improvement, Research and Innovation Award category
Secure Care and Offender Health **Currently 6 QI projects open**	There are currently **6 QI projects open** and active in SC&OH with 14 prospective projects of which 2 projects are likely to be registered as open soon they are: **Wellbeing Wednesday and Improving the experience of young people with the Criminal Justice Recovery Service.**

7 closed projects from April 2023 – March 2024	The **continuous quality improvement project** in SC&OH has had a positive impact over the last 12 months in the directorate with early indications of a change in culture demonstrated by an increase in activity measured by the total number of open and prospective projects in Q1 2023-24 (see run chart to the right). The key difference is seen in the number of prospective projects indicating more conversations taking place around potential project ideas and that staff are increasingly thinking about QI projects as the first port of call for improvement ideas. Similarly, there has been an increase in the number of bespoke QI training sessions requested from SC&OH and there are now more QI meetings at a local level each month in place of one monthly over-arching meeting giving rise to the increase in QI conversations. Projects coming through in the past 12 months have varied in scope and topic including: ·A local **QI project in FIRST looking to improve the time taken to dispense Clozapine** which successfully improved from 2-7 day to just 10 minutes and was presented at the MH Improve event in London in April 2024. ·A much bigger piece of work is with **Reach out**, a collaborative working with several partner organisations including prisons and providers. Timescales for referral, assessment and transfer incorporate the time between first and second psychiatric assessments and the time to transfer and the recommended timeframe is within **28 days**. This was not being achieved and the purpose of this QI project was to look at the wide range of issues including the pathway for transfer from prison to hospital and look at the range of issues, challenges, and barriers in achieving the target timeframe. There were five virtual workshops to map out the pathway as imagined and as done, mapping out actions, quick wins and change ideas. The project is at its final stages of working through actions and change ideas. Other projects include working with young people in the **Forensic Child and Adolescent Mental Health Service in Ardenleigh** to improve experience during family visits by coproducing more meaningful activities to participate in, improving the environment and access to rooms. All in all, a very successful year for SC&OH on its journey to embed a QI culture with a positive trajectory going forward.

Specialities	
Specialities **There are 7 projects currently open in the Specialties directorate.** **7 closed projects from April 2023 – March 2024**	Within the Speciality services, there a number of QI projects are underway, including: projects focusing on reducing waiting times from referral to assessment in the **Eating Disorders Service; reducing wait times for accessing the HI CBT pathway in BHM (Birmingham Healthy Minds)**; and **the Empowering women project** – a collaboration between our **Perinatal Service** and the **Solihull Early Intervention team**, which is looking to improve the timeliness of preconception counselling to women of a childbearing age. In our **Older Services**, QI projects range from an overhaul of the **Dementia Pathway** in our **Older adult CMHT's**, focusing specifically on the service user experience following a dementia diagnosis, to a project in **CERTS (Community Enablement and Recovery Service)** directly linked to the Trust-wide roll out of **Dialog+**. **The Eating Disorders QI project** which is currently wrapping up has demonstrated a sustained improvement, with a reduction in the median wait time from referral to assessment of **68 days** (from an average of **104 days** down to an average of **36 days**). The data for the **BHM project** (which is still on-going) is showing a positive shift in the in the right direction for the ambitious aim of reducing to zero the number of patients waiting for over **40 weeks** for HI CBT.

For more details of the Quality Improvement projects and the directorates follow the link for the Transformation and Improvement Hub (TIH) below.

[Quality Improvement (sharepoint.com)]

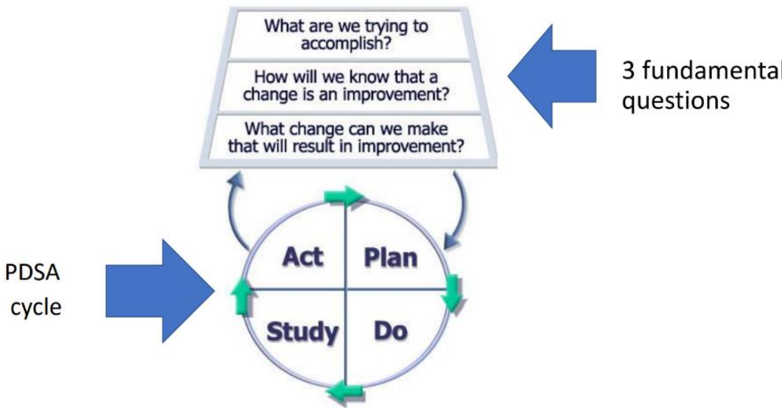
The Next 12 Months for Quality Improvement at BSMHFT

National and Regional	Local/Trust level
• NHS Impact • West Midlands Regional NHS Impact Group (Co-designing Midlands improvement priorities) • BSOL ICS Improvement group • PSIRF (Patient Safety Incident Response Framework) • CQC (Emphasis on assessing the presence and maturity of a quality improvement approach)	• Alignment with Trust goals/objectives • Supporting directorate priorities • QI support - QI advisors and QI facilitators • QI Academy training courses • Dedicated data support • Support for transformation. • QI Co-production with EBE, carers and families • Recognition and celebrating improvement work

Appendices

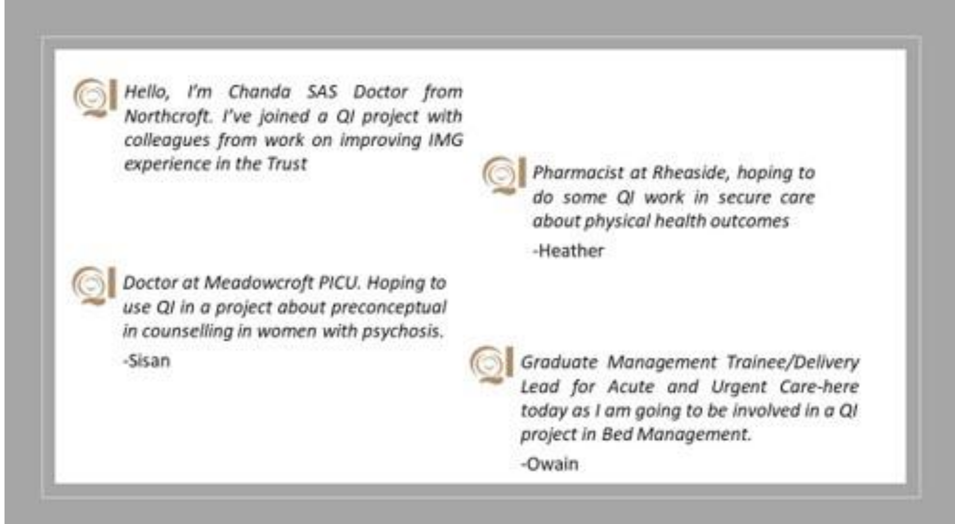
QI Methodology

Appendix 1: Model for Improvement



Training

Appendix 2: Feedback from colleagues, QI Bronze Training



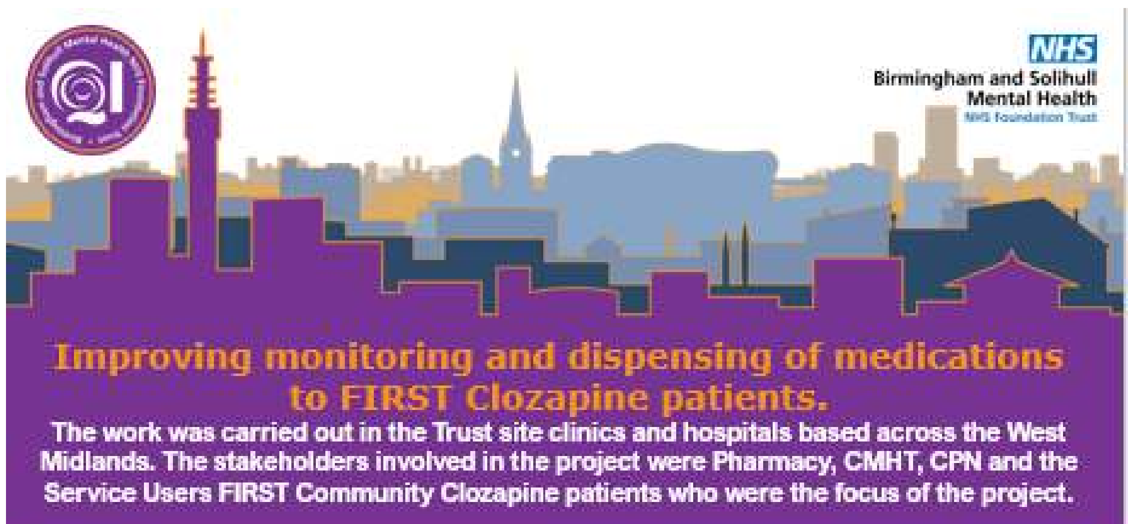
Appendix 3i: Intro to QI Training certificate

Appendix 3ii: Bronze QI Training certificate

Appendix 3iii: Silver QI Training certificate

QI Project Posters for Conferences

Appendix 4: QI Project FIRST Clozapine Clinic Poster for the MHImprove Event 2024 and BMJ/IHI International Forum on Quality and Safety in Healthcare Conference 2024.



Problem

Intervention

Assessment of problem and analysis of its causes

Strategy for change

Effects of changes

Reduced waiting time of the monitoring and dispensing of medications from 2-7 day to 10 minutes for our Forensic Intensive Care Patients (FIRST) in the community. This was achieved by setting up satellite clinics over the Birmingham area closer to our patients' homes. Collaborated with fields to create a specialist team of people within FIRST. This included phlebotomists, pharmacists, CPN's and people trained to use the Clozapine monitoring machine. Creating a new Pharmacist Tech role.

Lessons learned

Patient representation and lived experience

Measurement of improvement

Process Map Comparison

Message

Scan QR Code to hear the main message from Project Lead Laura Anderson (Advanced Nurse and Prescriber).

committed

Appendix 5: QI Project Reducing Emergency FP10s (ESCA) issued by North Hub CMHT Poster for the MHImprove Event 2024.

BACKGROUND

North HUB Community Mental Health Services use FP10 forms to ensure that patients in need of urgent medication supply can be issued with a prescription. Essential Shared Care Agreements (ESCAs) are then created between North HUB and GPs to allow the seamless transfer of this prescribing responsibility from the specialist services to general practice. However, this arrangement wasn't working well and resulted in the following:

- Culture of ESCAs not being done in a timely manner
- Last minute phone calls for repeat prescriptions impacted on staff and patients causing anxiety.
- Communication gaps led to duplicate prescribing sometimes
- GP reluctance to take over mental health prescribing
- EPMA system not updated and electronic prescriptions not used consistently.

INITIAL ASSESSMENT

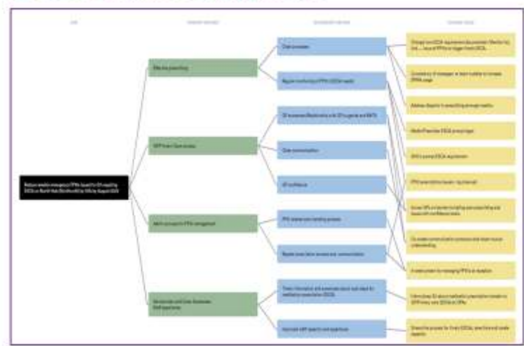
Using QI approach, data insights and feedback from different stakeholders identified a few key reasons for the issue:

- Low GP confidence regarding mental illness repeat prescriptions (FP10)
- FP10 issued by the Hub for months as no ESCA established
- Service User anxiety over requesting repeat prescriptions from GPs
- Medication changes not updated on EPMA by North Hub prescribers
- No effective system at admin desk for managing FP10 requests

AIM

Reduce weekly emergency FP10s issued to service users requiring ESCA on North Hub (Northcroft) by 10% by August 2023

STRATEGY FOR CHANGE – DRIVER DIAGRAM



KEY CHANGE IDEAS TESTED USING PDSA (PLAN, DO, STUDY, ACT):

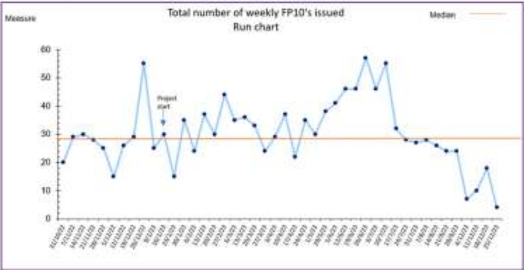
- Innovative clinician prompt reminders
- Documenting FP10s instances at OPA and keeping patients informed
- Admin Desk System for managing FP10 requests
- Increase Consistent use of EPMA system
- Collaboration and communication with Neighbourhood MHT and GPs

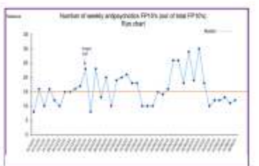
INVOLVEMENT AND IMPACT

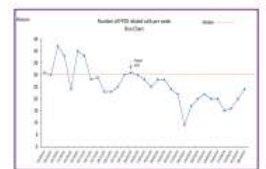
The multidisciplinary project team and wider team involved the clinical hub manager, ST4 clinician, pharmacist, local clinical leads, GPs, advanced nurse practitioners, admin services manager, staff nurses and service users. Co-production with multidisciplinary staff groups and service users resulted in a holistic approach and addressed what mattered most to people closest to the issue.

OUTCOMES

- Reduction in FP10 Issuance: Achieved a 14% reduction initially in total weekly FP10s, with sustained improvements over months post project completion showing a remarkable 64% reduction compared to baseline.
- Decrease in Antipsychotic FP10s: Successfully reduced weekly antipsychotic FP10s by 20%, demonstrating improved prescribing practices.
- Decline in FP10-related Calls: Implemented interventions led to a consistent positive shift, resulting in a 27% reduction in FP10-related calls, alleviating workload pressure.







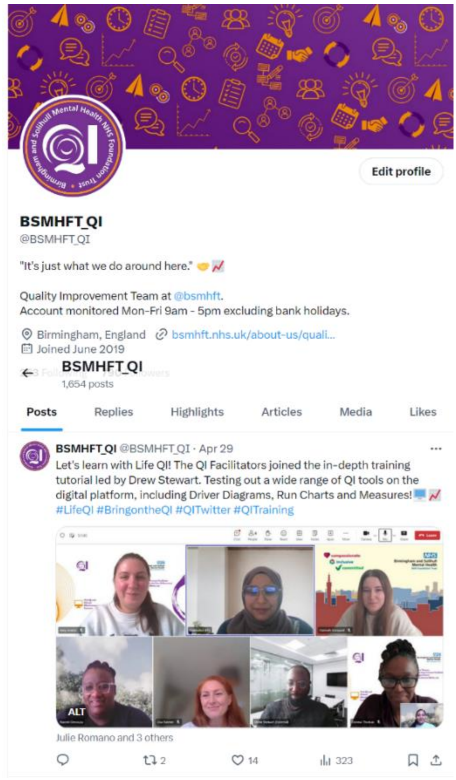
LEARNING AND WHAT NEXT....

The project team acknowledge there were significant barriers and challenges faced by them during their first QI project, noticeably the staffing situation, entrenched ways of working culture, capacity for improvement work and limited sphere of influence on various system issues. As FP10s and ESCAs continue to be an issue for the directorate, there is a recommendation to use learning from this project to widen the scope of this work and involve wider system stakeholders including more service users for a

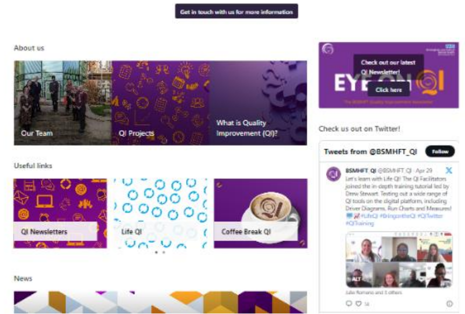
Scan QR Code for a short video from the Project team

QI Resources

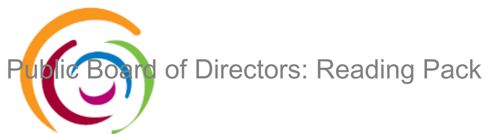
Appendix 6: QI X (formerly Twitter) Page.



Appendix 7: QI Connect Page.



Appendix 8: QI Newsletter Page (QI March 2024 Newsletter) https://sway.cloud.microsoft/ZxO8wtApxwE4Byz0?ref=Link.



Research and Development

ANNUAL REPORT

2023/24

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1.0 Introduction:
This report serves to provide an update of the work undertaken by the Research and Development Department on behalf of Birmingham and Solihull Mental Health NHS Foundation Trust in 2023/2024.

2.0 Executive Summary:
2023/4 has been an exceptionally successful year for the R&D team. We have grown our Research Capabilities exponentially through new partnerships and collaborations and by attracting more income to invest in the Trusts research infrastructure.

We brought in £0.9m income within the financial year from grants, bids and trial activity and this is set to increase to a minimum of £1.1m in the new financial year. We have invested in new staff appointments and have developed and planned new posts meaning that by the end of the next financial year, we will have a clear career development pathway within R&D in either delivery or governance roles from Band 4 through to Band 7. We regularly attract high calibre staff and it's hoped that with more opportunities for development, we will retain them.

Our researchers have successfully been awarded grant funding in excess of £5m and infrastructure funding of £11.5m. Of this, £1.9m (inc. £0.6m capital) will come directly to the Trust. Of the remaining awards, approximately £3m will be subcontracted to the department to cover the costs of collaboration and/or to provide the infrastructure required to deliver the research. When we are not in direct receipt of the income, R&D include a charge to host and manage the delivery of the grant to make sure that this remains sustainable. We will be discussing, reviewing and firming this up with our academic partners and collaborators to ensure that the ongoing management of grants and trials remains sustainable now and in the future.

To date we have recruited 276 participants to a number of complex National Institute for Health Research portfolio trials. Trusts that are research active have better outcomes for all patients, reduced mortality and improved overall quality of care not just those who are participating in clinical trials. Delivering these complex trials cannot be done in isolation and we have worked with a large number of our clinical colleagues and teams to get the studies out and make the studies available to our service users. We have highlighted the need to expand our reach within the organisation beyond that of the research delivery team within this report so that we can reach more service users. Service users want to be treated by clinicians in a research active Trust; they feel heard and valued and know that their care team want to provide them with the best evidence based available care. It improves Trust. In addition, it reduces burnout amongst staff and benefits the wider care system, transforming care by improving clinical practice and ultimately reducing the cost of healthcare.

Our governance team have supported over 100 different research teams during the financial year, across all stages of the research pathway from protocol development support, costing advice, through to regulatory approvals and delivery set up. Studies are approved and set up in an average of 53 days with amendments to projects being arranged in 24 days. Whilst we perform better than the national average in terms of amendments (n35 calendar days) we are below the average for project approval (n40 calendar days) and will look to improve on this within the next year.

We have clinical academics (i) representatives on International Groups who are advising on guidelines for the use of Valporate in Epilepsy and NICE technology assessments for new antiseizure medicines and novel applications; (ii) leading on the development of national policy and guidelines for the improvement of access to mental health services for people with Huntington's Disease; (iii) developing Occupational Therapy guidelines in collaboration with the European Huntington's Disease Network (iv) we have research leaders who have developed

guidance for NHS talking therapies to support family members affected by relatives with alcohol problems. Our leadership and knowledge in these areas bring significant local improvements in clinical care in line with developing evidence.

We are participating in addictions research that is impacting the UK national drug treatment programme for opioid addiction and lastly, by recruiting to a study to review the effectiveness of take-home/lay delivered naloxone, we have as a minimum provided service users across the midlands who have an opioid addiction access to potentially lifesaving medicines. Through research, we are actively improving our patient outcomes.

We are developing neuromodulation research services to support people with Treatment Resistant/Difficult to Treat depression and once established, we will be the only NHS site in the West Midlands with the ability to offer these novel treatments. Through research, we are leading the way with our clinical care.

Our Art Psychotherapist researcher won the NHS Improvement Award and Markel 3rd Sector Development and Innovation award for his work, “No barriers here!” and the’ Mood on Track’ tool was a finalist in the 2023 HSJ awards in the category of improving mental health through digital.

We have become official partners of the Mental Health Mission, Oxford Biomedical Research Centre and Birmingham Health Partners and continue to work closely with the Institute for Mental Health at the University of Birmingham. As a result of these new partnerships, we have access to substantial funding to develop new clinical research services for Difficult to Treat Depression, to enhance our capacity to deliver commercially funded income generating research and to explore the opportunities for developing research careers. We are in a position to be central to the improvement of the health of the communities we serve.

Educating researchers of the future, our clinical academics and clinical researchers are supporting six Post Doctoral students and almost twenty master’s students. We will look to enhance this through the exploration of attaining Teaching Trust/University Hospital status. Such status will allow us to attract high quality, passionate students and clinicians of the future, to attract highly trained academic and research leaders allowing us to increase both our reputation as a leading provider of research and teaching and our capacity to generate more income. In summary, through research and teaching, we will deliver improved care and outcomes making us reputationally, the leading place to work and to be cared for.

Finally, our Lived Experience Action Research Group (LEAR) continue to be a critical friend to R&D, ensuring that research priorities are focussed, that research is designed with the needs of the service user in mind, and by allowing the group to develop research based on their priorities. In addition, we want to build on this fantastic infrastructure by identifying sustainable and supportive pathways for our service users to be involved in research delivery and in paid employment.

Throughout the annual report we have identified actions and future work which are later summarised in section 10.0.

3.0 Finance and Resources

The Research and Development department is mainly funded from external sources, contracted to deliver research trials for commercial, charitable and non-commercial funding bodies, the largest of which is the National Institute for Health and Care Research (NIHR) and it's adopted partners. The core management and infrastructure team are funded centrally by the Trust. This section will explore our income and expenditure, our workforce and future plans/forecasts.

3.1 Financial Position 2023-2024

R&D received circa £0.9m income in the financial year; the majority of which is from grant and trial activity, and approximately a third from the NIHR. The core admin and management function are funded centrally. A breakdown of income is shown below:

Income	£m
NIHR	0.4
Grant & Trial activity (commercial and non-commercial)	0.5
Total	0.9
Central core funding	0.5
Expenditure	
Pay and non-pay	1.4
Balance	
	-0.1

Financial management has been a challenge in year with a shortage of junior corporate finance support and therefore we are unable to provide a clear breakdown between commercial and non-commercial activity. In addition, £0.1m has been deferred into the new 2024/25 financial year which effectively shows an overspend in year.

Despite the challenges, R&D have worked hard with senior finance partners to get our accounts into a healthy position for the new financial year, and to ensure that we can more effectively monitor our income and expenditure. We have now implemented a robust system using EDGE (the national research management system) to manage ongoing trial activity. This means that for any studies that have a per patient or trial activity payment, we can manage these through the EDGE system, ensuring that invoices are raised in a timely manner enabling us to reconcile income with forecast income, something we have been unable to do to date. In 2024/5, we will support our colleagues in Pharmacy to utilise the EDGE system to manage trial set up and ongoing invoicing, again, to ensure that all income owed is received.

Two new management accountants have been appointed to join the finance team in the new financial year who will provide much needed support to the corporate team, one of whom will have full responsibility for R&D and will continue to ensure clear and robust process are in place. A joint R&D and Finance Standard Operating Procedure is currently in development to ensure that processes are cemented. Finally, we will look to implement a model of distribution of income for commercial studies between the local research team and the R&D team, ensuring equity and ensuring any capacity building income is available to the R&D team. Further details on the NIHR's distribution of income model can be found at https://www.nihr.ac.uk/documents/income-distribution-from-nihr-crn-industry-portfolio-studies/11441.

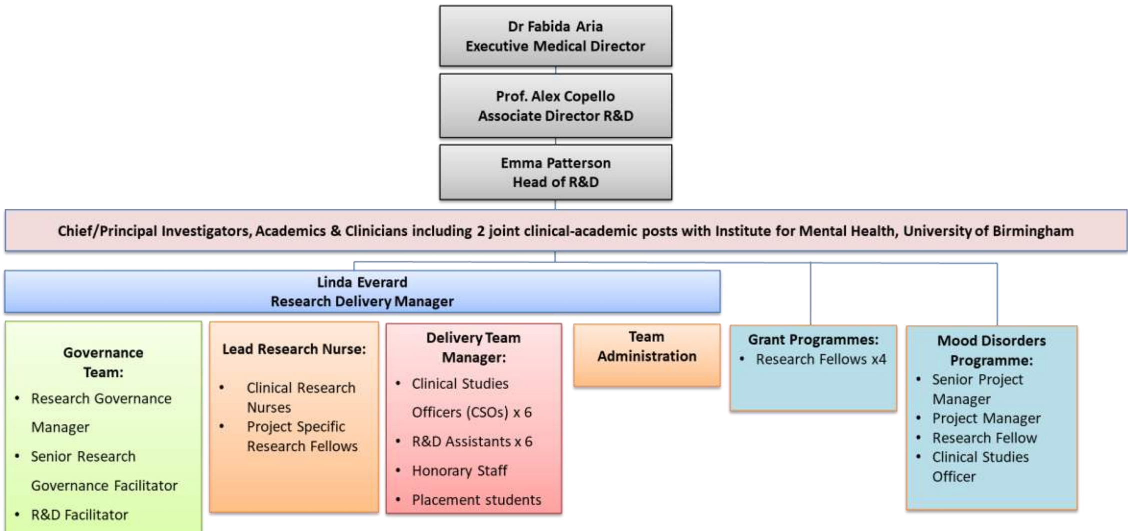
3.2 Forecast for 2024-2025
In the new financial year, we have an increased income target of £1.1 million, with £0.6m funded centrally. The expenditure budget is currently set at £1.7m. A breakdown of the target is outlined below:

Income	£m
NIHR	0.4
Grant & Trial activity (commercial and non-commercial)	0.7
Total	
Central core funding	0.6

With tighter management and controls now in place, we will be able to accurately monitor our performance against our income target.

3.3 Departmental structure, in year changes and developments:
The R&D Department currently employ 26 members of staff, comprising mainly research delivery staff (Research Nurses, Clinical Studies Officers, R&D Assistants and Research Fellows) and a core management and governance team. We have seen lots of changes in 2023/24 with lots of new starters joining the department to help deliver some of the exciting projects we have taken on. This includes a Lead Research Nurse (new role), four additional Band 5 R&D Assistants and a Senior Project Manager, the latter of whom oversees delivery of the Mental Health Mission's objectives. We have also replaced existing roles with several staff going on to achieve promotion, to move into clinical roles of or to begin clinical training. We continue to promote internally with one of our R&D Assistants being promoted to CSO, and a previous placement student joining us as an R&D Assistant. The R&D Assistant and Clinical Studies Officer Roles are quite often transient roles, offering experience and/or a stepping stone into either research specific roles, clinical roles and as a result, we attract high calibre staff.

3.2 HR Plans for 2024-25:
The structure below provides snapshot of the department as of May 2024:



With a host of new collaborative NIHR portfolio projects due to be opened (see list of pending projects, Appendix 1), we are advertising for two further R&D Assistants (taking the total to 6), have appointed to two additional Clinical Studies Officers, we remain out to advert for a Clinical Research Nurse, and we have filled a vacancy for a Project Manager in the Mood Disorders programme. New Delivery Team Manager and Project Support Officer posts are under development, for which we are seeking funding from the West Midlands Clinical Research Network. We hope that this additional resource will allow us to meet our contractual requirements, in addition, it creates a clear development pathway in the delivery team from Bands 4 to 7.

We have several large grants starting in year that will require the employment and ongoing management of staff by the R&D department. We will be working with our academic partners and collaborators to put clear processes in place to ensure that these management costs are planned for and covered.

Finally, we will work with our expert by experience research group (LEAR – see section 8.6) to identify sustainable and supportive pathways for our service users to be involved in research delivery and in paid employment.

4.0 Research Governance and Study Support Service

Our Research Governance Manager, returned from maternity leave in September 2023. A Senior Research Governance Facilitator, employed to part cover the vacancy, remains in post to provide a single point of contact for the set-up of National Institute for Health Research (NIHR) Clinical Research Network (CRN) portfolio studies. Our Business Administration Manager remains the single point of contact for the set-up of academic studies, in addition to the processing of Honorary Contracts, Letters of Access and research study amendments. The small team provide an efficient service, involved in the set up and governance of all research studies within the Trust, as well as ensuring suitable HR arrangements are in place (Honorary Contracts/ Letters of Access), we ensure that all research undertaken adheres to the UK Policy for Health and Social Care, which replaces the previous Research Governance Framework, and sets out good practice in the management and conduct of health and social care research in the UK.

4.1 Number of research studies approved:

In year, they have approved 31 research studies, 18 of which were NIHR CRN portfolio studies, with the remaining 11 being academic studies. None of these studies were sponsored by the Trust. Of the 31 research studies approved, these were approved in an average of 48 calendar days from receipt of the local document pack; for NIHR CRN portfolio studies only, this was achieved in an average of 58 days. Although study set up is no longer a High-Level Objective of the CRN would be to approve NIHR projects within 40 days on average. We have not met this for the last financial year, predominantly due to the complexity of an increase in more complex interventional trials, requiring greater time to set up, and a temporarily decrease in delivery staff ready to take on the study, impacting on set-up times.

There are 28 research studies currently in set up with the Assess, Arrange and Confirm team. Eight of these are academic studies; the remaining 20 are either confirmed or are planning to be adopted onto the CRN-portfolio. All research activity is listed in Appendix 1. Information regarding performance of NIHR Portfolio Research is covered in section 5.0.

R&D have rapidly processed 66 amendments to previously approved research studies, within 24 calendar days meaning that this research studies can continue to recruit in improved ways moving

forward. Nationally, R&D departments are given 35 calendar days by which to review and implement an amendment, so we are processing amendments well below this target.

4.2 Number of research teams supported, and clinical areas represented:
R&D have supported just over 100 different research teams during financial year 23/24, across all stages of the research pathway from protocol support, costing advice, through to regulatory approvals and delivery set up.

Perinatal services opened the largest number of studies this financial year (6), closely followed by neuropsychiatry (4), and there were 5 studies that were able to recruit Trust wide. Other represented services include Art Psychotherapy, our Bipolar service, Birmingham Healthy Minds, Eating Disorders, Forensic CAMHS, Secure Care, Recovery College, Solihull Early Intervention and Spiritual Care.

4.3 Honorary Contracts and Letters of Access:
We continue to provide a quality service to our research colleagues from out of area, issuing 38 HR arrangements this year. Of those, two were Honorary Research Contracts and the remaining 36 were Letters of Access. Undertaking these HR arrangements on behalf of the Trust has ensured that our staff and service users are only ever in contact with researchers who have undergone the appropriate checks and who have legitimate access to their data. There is no national timeframe by which to issue Honorary Contracts or Letters of Access, however the governance team act upon receipt of the full documentation (which can include a Research Passport, DBS, Occupational Health Clearances and a CV) and have a dedicated member of the team primarily responsible for HR arrangements. We regularly receive positive feedback from study teams on the efficiency of our Research HR service.

4.4 Governance Policy and Procedure: Policies
Three local policies were reviewed and re-approved this financial year; they were:
- The Approval of Research Projects within BSMHFT
- The Management of Intellectual Property within BSMHFT
- Screening for Potential Participants

All involved minor administration changes only.

4.5 Governance Policy and Procedure: Local Standard Operating Procedures (SOPs):
In 2023/4 we reviewed and amended the National Data Opt-Out SOP to ensure that it met the requirements of the audit team, in addition to Research and Service Evaluation.

This SOP remains pending due to a technical change to the 'R' required in Rio. The R on Rio is used to indicate if a service user is involved in a research trial, if they have opted out of research and/or if they have opted out of their data being used for research without their consent. At present, we cannot distinguish between a red R for data opt out or for all research which causes problems when screening for research participants. *NB. opt out is for projects that do not require consent; service users can still be contacted to consent to participate.*

Work in 2024/25 will focus on amending the Research Form on Rio to ensure that each Electronic Health Record contains comprehensive and accurate information regarding a service user participating in a clinical trial. In addition, we will continue to work with our information team to accurately identify applicable National Data Opt-Out notification given the current difficulties with the 'R' flag. The SOP will be amended and finalised accordingly.

Finally, the Standard Operating Procedure for the issuing of Research Passports for non-NHS employed researchers is due to be reviewed.

4.6 Governance Policy and Procedure: National changes:

A number of national procedural changes have been implemented by the Health Research Authority (HRA) this year:

- *A* new *Investigator Initiated Study Agreement* making it easier for us to contract with a commercial organisation who are only providing financial or other support such as free products to a research study. We can use this agreement when one of our staff have an idea, and R&D support in the design and management of the research.
- An updated *Organisational Information Document (OID)* aligning the clauses with those in the model non-commercial agreement (mNCA) for interventional studies. This means that there is clarity on topics such as personal data and the handling of confidential information, and clearer detail to facilitate payments for non-interventional studies.
- Updated *Commercial and Non-commercial Model Agreements* with the biggest benefit being a new clause to the financial appendix to ensure that we can defer the use of funds into future financial years to built research capacity.
- A new *Master Confidentiality Disclosure Agreement* so that we can have a single contract in place with a commercial company, adding individual studies to the agreement through an amendment process.
- *Participant Information Quality Standards* and *Design and Review Principles* both of which are mandatory requirements that need to be included by researchers making application to the Research Ethics Committee (REC). They ensure that research participants are provided with better information.
- Full roll out of the *National Contract Value Review (NCVR),* an initiative to improve the set-up of commercial studies, ensuring that there is a consistent approach to study resource review, pricing and contracting. From October 2024, all commercial research studies undertaken in the UK undergo a single resource review, through the submission of the Interactive Costing Tool. NHS organisations are no longer able to apply their own local prices for commercial research, and instead accept the Lead NHS organisations review outcome and iCT generated prices, thus significantly speeding up the set-up process.

5.0 National Institute for Health Research Portfolio and High-Level objectives (NIHR – HLOs)

This section demonstrates our annual performance against the National Institute for Health Research (NIHR) targets as set (and monitored) by the West Midlands Clinical Research Network (WM: CRN).

This year the NIHR have set out some new HLO's which has taken a turn away from numbers of participants recruited into portfolio research to focus more on ensuring studies are delivering to time and target in both commercial and non-commercial contracts and, to assess the level to which participants in NIHR supported research feel that their contribution is valued. Specifically, they are as follows:

a) Percentage of open to recruitment commercial contract studies which are predicted to achieve their recruitment target (target 80%)
b) Percentage of open to recruitment non-commercial studies which are predicted to achieve their recruitment target (target 80%)
c) Number of NIHR CRN Portfolio study participants responding to the Participant Research Experience Survey

NB. As of October 2024, the Clinical research Network is transitioning to become known as the Research Delivery Network. This transitional period will take approximately 6 months and will build upon the success of the CRNs work and research eco system therefore, as yet no targets for 2024/25 have been set.

5.1 NIHR Portfolio Project Performance: Participant Recruitment:

Our total recruitment to Portfolio studies for the last financial year (April 2023- March 2024) is **276** participants over **23** portfolio studies. Our performance against HLOs a) and b) is highlighted below in a RAG (red, amber, green) report. The RAG ratings are measured against targets a) and b) as set out in section 5.0. We currently have a range of portfolio studies open in several different research areas including psychosis, HD, inequalities, mood disorders, and addictions.

Table 1. Recruitment RAG report – May 2024

	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 Randomized, Placebo-Controlled, Double-Blind Study to Evaluate the Effect of SAGE-718 on Cognitive Function in Participants with Huntington's Disease	3	5	60%	30/04/2024	
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%	31/03/2024	
5	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	350	N/a	N/a	04/01/2027	
6	HDClarity: a multi-site cerebrospinal fluid collection initiative to facilitate therapeutic development for Huntington's disease	37	20	185%	30/04/2025	
7	ESMI-II: The effectiveness and cost effectiveness of community perinatal Mental health services	79	16	493%	31/03/2024	
8	The effect on relapse of Culturally-adapted Family Intervention (CaFI) compared to usual care among African & Caribbean people diagnosed with psychosis in the UK: a Randomised Controlled Trial	6	96	6%	30/09/2023 (Closed Early by Sponsor)	

9	A multi-national, prospective mixed methods study of the effectiveness of naloxone (including intranasal Nyxoid) administration by lay people in reversing opioid overdose	228	500	46%	30/09/2023	
10	Development and validation of multilingual, multinational HD specific need-based quality of life assessment tools: HD value assessment study	3	0	-	01/09/2024	
11	Antidepressant for the prevention of DEPression following first episode Psychosis trial	0	12	0	30/06/2025	
12	Experience based investigation and Co-design of approaches to Prevent and reduce Mental Health Act Use: (CO-PACT)	22	20	110%	31/08/2023	
13	Pregnancy and birth with two or more long term health conditions: a qualitative study of experiences and care	3	20	15%	01/02/2023	
14	Randomised controlled trial of the Community Navigator programme to reduce loneliness and depression for adults with treatment resistant depression in secondary mental health services	36	77	47%	31/07/2024	
15	Pharmacy Homeless Outreach Engagement Non-medical Independent prescribing Rx (PHOENIx) community pharmacy based pilot randomised controlled trial	50	50	100%	31/12/2023	
16	Cognitive Remediation in Bipolar (CRiB2): a randomised trial assessing efficacy and mechanisms of cognitive remediation therapy compared to treatment as usual.	30	60	25%	01/07/2024	
17	Access Assessments for Admission to Adult Medium & Low Secure Services	7	7	100%	31/12/2023	
18	Secure Care Hospital Evaluation of Manualised (interpersonal) Art-psychotherapy: A Randomised Controlled Trial	1	10	0	30/06/2024	
19	What people think about doing physical activity: a questionnaire study	0	20	0	01/04/2024	
20	Understanding anger and aggression: A questionnaire study	5	15	0	20/05/2024 (Closed Early by Sponsor)	

21	New Roles, New Challenges: Understanding boundary work to support the implementation of new roles in mental health Trusts	0	1	0	31/05/2025	
22	Healthcare professional's prioritisation of barriers to accessing psychological support for perinatal obsessive-compulsive disorder and generation of recommendations to improve access to support. (The open door project)	4	10	40%	12/05/2023	
23	STARS: An Open-Label, Multicenter, Outpatient Extension Study to Evaluate the Safety and Tolerability of Staccato Alprazolam in Study Participants 12 Years of Age and Older with Stereotypical Prolon	0	2	0	01/12/2024	
24	DIAMONDS Randomised Control Trial	0	4	0	30/09/2024	
25	Ethnic variations in accessing treatment for Eating Disorders (EVATE)	0	10	0	30/09/2024	
26	Recollect 2 (National evaluation of Recovery Colleges)	8	26	31%	30/09/2024	

For 2024/25, we will continue to deliver the above portfolio plus, we already have 11 NIHR studies in set up and 9 undergoing a feasibility assessment; further details on these projects can be found in Appendix 1. Section 9.0 highlights the impact that these projects have had on the patients, carers and clinical teams involved.

It is recognised nationally that the more studies on the NIHR Portfolio are becoming complex and this is even more so for mental health. In order for us to continue to offer our service users access to hight quality research and potentially improved clinical care or treatments, we need to work differently to cover our varied teams and geography. In order to do so, we need to expand our workforce beyond that of the R&D department.

5.1.1 New in 2024/25: Research champion programme across the trust

As projects become more complex, there is a requirement for more involvement and support from colleagues across the organisation; anyone who is interested can be involved in research and we need to make this happen. Not only because it will allow research to be offered and available to more of our service users, it will not be solely reliant upon the capacity of the R&D team but also because of the benefits supporting research brings to staff (see section 9.4 for further detail). We will develop a model that will provide training and peer support to staff members who could be more involved in research. This could be as little as signposting to research studies, to identifying participants for inclusion and, for some simple questionnaire studies, supporting study delivery. We would also look to extend the Research Champion offer to our EBE (Expert by Experience) colleagues.

5.2 NIHR Portfolio Project Performance: Participant Research Experience Survey (PRES)
The PRES has been developed by the National Institute for Health and Care Research (NIHR) Clinical Research Coordinating Centre (CRNCC) and measures the experiences of participants involved in portfolio research. A high-level objective (target c) as outlined in section 5.0) and although there is no local numerical target, we are expected to provide all our participants with the opportunity to provide such feedback. Feedback can be given online or now also via a paper copy. The national target for this year is 18,000.

For the year 2023-24 we have received 18 responses to the questionnaire with ALL participants stating they would consider taking part in research again. We will continue to push the use of the survey. Whilst the responses have been extremely positive, the received returns represent less than 10% of service users who have participated in research across the Trust.

In 2024/25 we will need to give this a big push alongside our recruitment to ensure that all our participants are being given the opportunity to put their view across. The Research Delivery Team will continue to offer the survey to all participants at the end of study participation. For service users who are involved in 'light touch' research such as questionnaires or who are identified locally but receive interventions via the study team, we need to find smart ways to engage them with the PRES. For detailed results from the live PRES dashboard please see Appendix 2.

6.0 Non-NIHR Portfolio Research Activity
Non-NIHR Portfolio Research does not have the financial backing of the NIHR and therefore unless funding is identified from another source, the majority of work is undertaken by the Principal Investigator themselves. This is in contrast to the portfolio projects that receive local delivery team support. The majority of these projects fall into the academic category, with miost at master's level with the remainder being research projects that require a full HRA (Health Research Authority) and ethical review, but for which no external funding has been provided to allow adoption onto the NIHR portfolio. A full list of the 10 ongoing non portfolio projects is found in table 2:

Table 2. Ongoing non-portfolio research Projects financial year, May 2024

Project Short title	**Study information**	**Principal Investigator**	**Recruitment end date:**	**Project Type:**
Impact of apathy on caregiving in HD. Version 1.	Huntington's disease (HD) can affect motivation. People with HD may not wash often, keep their house clean and tidy, or eating healthy food. This loss of motivation, or apathy, can also affect the way they talk to people and how willing they are to be in social situations. There are thought to be four different subtypes of apathy. These include reduced (1) motivation for planning and organising, (2) emotional reactions, (3) thoughts and actions and (4) social interaction.	Prof Hugh Rickards	31/08/2024	Non-commercial, non-portfolio

	It is clear from talking to patients and their families in clinic that apathy has a big impact. It is often a source of distress for the people around the patient, who are trying to support and care for them. We know from previous research, that having good social support helps people with Huntington's disease to live independently for longer. This research aims to understand the ways in which apathy can impact the levels of burden felt by caregivers of people with HD. Caregivers will be asked to take part in a single interview. They will be asked questions about caring for someone with apathy. There will also be the opportunity to share their own first-hand experiences. These interviews will be analysed for common themes using framework analysis. Attention will be given to the relationship between burden and the different types of apathy. Understanding the factors that lead to increased caregiver burden is the first step towards finding way to support caregivers of people with HD.			
Forensic mental healthcare staff's self-criticism and self-compassion	The objective of the research is to investigate the impact of forensic mental healthcare staff's self-criticism and self-reassurance on compassion fatigue and compassion satisfaction, and whether there is a subsequent impact on ward climate. The study will involve mental healthcare staff working at male medium and low secure hospitals in Birmingham and Solihull Mental Health Foundation Trust. Staff participating in the study will need to have been working at one of the participating sites, in a direct clinical	Dr Victoria Wilkes	30/12/2024	Academic/student

	role (i.e. nurses, occupational therapists, psychologists etc.).			
BEBAS	The purpose of this research is to gain a rich understanding of British Pakistani women's personal experiences of postnatal depression. Postnatal depression is a type of depression that affects a woman, often weeks or months after giving birth. It can include a combination of symptoms such as low mood, irritability, fatigue, changes in sleep and appetite, feelings of anxiety and hopelessness and in some cases, thoughts of suicide. In terms of personal experiences, the research will aim to explore how British Pakistani women define their own reality of living with postnatal depression.	Dr Elizabeth Penny	30/09/2024	Academic/student
Ethnicity, birth experience and post-traumatic stress symptomology	This study aims to understand whether in there are differences in women's birth experiences (in particular, whether birth is experienced as traumatic) and whether these differences can be explained by factors such as ethnicity. We also aim to understand whether post-traumatic stress symptoms are experienced by women who may have had more difficult or challenging birth experiences. Lastly, we aim to understand what might be important to women during (and after) their maternity care. Participants will be black, asian and white women 6-12 post-birth. To investigate whether ethnicity is related to birth experience and birth trauma. To identify whether compared to white women, women from ethnic minority groups (WEMG) experience more obstetric complications, interventions, and procedures during childbirth.	No local investigator	30/09/2024	Academic/student
Relationship Challenges in Behavioural-Variant	This qualitative research aims to explore what it is about the challenging behaviours and personality characteristics, resultant from bvFTD, that cause challenges	No local investigator	30/09/2024	Academic/student

Frontotemporal Dementia	in the spousal/partner relationship. Additionally, the research aims to identify how this experience may threaten relationship continuity.			
Experiences of administrative staff working in Forensic Mental Health	This research aims to understand the emotional experiences and wellbeing of administrative members of staff who work in Forensic Mental Health services, in order to understand whether administrative staff members could be supported further, in line with the NHS Long Term Plan and the People Plan. The study will recruit administrative staff working in Forensic Mental Health Services in the West Midlands. Semi-structured interviews will be conducted, which will involve the participant discussing their experiences of working in their role. The interviews will be transcribed and analysed using interpretive phenomenological analysis.	Michelle Douglas	02/09/2024	Academic/student
Restorative Just Culture: implementation and effectiveness	Restorative Just Culture (RJC). RJC is an approach to adverse events, incidents, and other employee relations matters, that enables a response based on collective and balanced accountability, fairness, and learning, which can reduce harm in patient safety and billions of pounds in care costs. The programme teaches organisations and their agents to consider the contributing role of flawed, chaotic, and complex organisational systems and extent to which this has been the cause.	No local investigator	31/08/2024	Non-commercial non-portfolio
Self-Harm in Adolescent Tertiary Care: Staff & Service User Views 0.1	This study aims to address and expand the limited available literature by conducting the first multi-perspective study on the views of adolescent in-patients and ward-based staff on their views regarding the function of adolescent self-harm and its management within secure inpatient mental health settings.	Dr Elizabeth Fitzmaurice	28/06/2024	Academic/student
Predictors of Staff Wellbeing	The purpose of this research is to build on the existing literature and	Joanne Everill	03/05/2024	Non-commercial non-portfolio

in NHS Talking Therapies Services	to develop recommendations for IAPT workers and organisations to enhance work wellbeing, thus in turn improving the service user experience. These predictors chosen to be measures were based on previous research, and the measures chosen were based on previous literature using published, reliable and valid scales of measurement.			
CLASP PNA	The overall aim is to improve the identification, management, and quality of care for women with perinatal anxiety (PNA). The qualitative component of the study aims to explore the perspectives of women with PNA and healthcare professionals on being labelled as "high risk" and identify clinical training needs.	Maureen Nduka	19/04/2024	Academic/student

For 2024/25, we will support the governance arrangements for our non-NIHR portfolio studies, ensuring that they continue to adhere to the appropriate protocols and guidelines. In addition, we have 3 studies in set up and 5 undergoing feasibility assessment.

7.0 Service Evaluations

The R&D department provide a service evaluation service, ensuring that all projects are registered and that they adhere to the appropriate levels of information and research governance. A total of 55 service evaluation applications for approval were made to R&D within the financial year. This converted to 22 which were approved and are now closed, 19 that are still in progress and 14 which are still under review. A list of all approved service evaluations can be found in Appendix 3.

We are collaborating with colleagues in Audit and QI to move our service evaluation process onto the new Audit Management and Tracking (AMaT) system purchased by the Trust for Clinical Audits. The system will benefit both the person undertaking the evaluation and the person reviewing it as it will be a live management system. The system can also produce template reports and will enable better tracking of project outputs. We currently have a database of 221 completed evaluations (192 for which we have corresponding reports) and we will include these on the AMAT tool to support the management of outputs. The Service Evaluation Standard Operating Procedure will be updated accordingly.

The team are supporting our colleagues in Corporate Psychology to undertake 10-month project to deliver the, “Psychological Professions Trust-wide R&D activity scoping and needs identification project”. The key objectives are as follows:

- To define a relevant R&D and service evaluation activity framework and baseline scoping data gathering tool for Psychological Professions
- To audit 23/24 and current R&D and service evaluation activity using the baseline scoping tool

- To identify training / learning/ information needs of Psychological Professionals in scope to progress R&D activity
- To develop an action plan to meet identified need

The project is currently due to end in February 2025

We are currently working with our Nursing Professors at the University of Birmingham to support the Health and Social Care students (MSc and MNurs) in identifying projects that are of need within our clinical services and for which a significant amount of data needs to be collected. The idea being that the students work with clinical teams to draft a project brief and then collect the data and contribute to the write up. We are currently advertising for projects to be delivered in the Autumn with final write-ups expected in April 2025. In the past, these students have supported projects to include Vicarious trauma amongst staff, to evaluate Burnout at SOLAR and successful discharges from Rookery gardens. Working with our Higher Education departments to identify projects is a great way to collect data to inform and improve care, and demonstrate the value of good evaluation practices to both students as well as clinical teams. We will share the impacts of this partnership in the next annual report.

8.0 Developing Research Capacity:

This section highlights work being undertaken with key stakeholders and partners, local initiatives, projects and systems to develop our ability to both deliver and develop high quality research.

8.1 Birmingham Health Partners: In 2023 we officially became a member of Birmingham Health Partners, a strategic alliance between University and NHS members who collaborate to deliver groundbreaking translational research, world-class education and training, and the highest quality patient care. For further information on the partnership visit, https://www.birminghamhealthpartners.co.uk/. New to the partnership, we need to realise the benefits that this alliance brings and ensure that it is embedded in our local governance structures. We will add a section on BHP to the R&D Management Board Terms of Reference and ensure regular reporting to (and from) the R&D Management Board. We are already collaborating with the partners to streamline the arrangements for the set up of locally sponsored clinical trials and, for the new financial year, we are part of a collaborative west midlands wide bid to become an NIHR Commercial Research Delivery Centre[1].

8.2 Mental Health Mission: The Mental Health Mission (MHM) is part of the Government initiative to fund new research that aids diagnosis, monitoring, and treatment of Mental ill-health. The MHM will be delivered through the National Institute for Health and Care Research (NIHR) Mental Health Translational Research Collaboration (NIHR MH-TRC), a UK wide network of leading investigators specialising in mental health research. It is hoped that the MHM will identify, and solve, the problems that currently slow and disincentivise industry research such as, issues with research capability, patient recruitment and contracting. The MHM offers a unique opportunity to develop a connected Infrastructure specifically designed to meet the needs of service users, NHS staff and clinicians and innovators by working collaboratively to make the UK a leading

[1] Further information on the role and purpose of the NIHR CRDC's can be found at https://www.nihr.ac.uk/funding/nihr-commercial-research-delivery-centres/35501

location in which to test and trial new products. In Birmingham, diverse industry stakeholders (pharma, device, tech), academia and the NHS will come together to co-create and drive a clinical ecosystem with providers and regulators that will enable faster translation of drug/device/digital advancement into real world settings with an initial focus on intervention for early psychosis and Difficult to Treat Depression (DTD). Co-Directed by Professor Steven Marwaha, Professor in Psychiatry in the Institute for Mental Health at the University of Birmingham and Honorary Consultant Psychiatrist at the Trust, work undertaken to date at BSMHT to deliver the mission's objectives on Difficult to Treat Depression is outlined below:

8.2.1 *Treatment Resistant Depression (TRD) or Difficult to Treat Depression (DTD) Research Platform:* One of the missions aims is to develop a digital research platform (live database) for DTD which will support the delivery of research, provide genomics to support in the development of novel treatment and ongoing management of DTD. It is hoped that the digital research platform will make it easier to conduct large scale studies from real world data and generate knowledge to advance development of new therapies and products about DTD from a diverse population setting. To date, we have conducted multi-stakeholder consultation on the data specification, including clinicians, academics and experts by experience. We have agreed the minimum data set and are in talks with providers to develop the platform. Work to build the platform and start data collection in line with relevant research and information governance policies will begin in earnest in the new financial year.

8.2.2 *Neuromodulation Research Clinic:* An overarching mission objective is to increase the NHS's capacity to deliver novel commercially sponsored research at pace and the development of a neuromodulation clinic within BSMHFT will support this. Based within the ECT suite at the Oleaster, the clinic is being set up to offer Ketamine/Esketamine and rTMS (repetitive transcranial magnetic stimulation) and will be run in collaboration with the Acute Clinical care team and the Mood Disorders Research team. A project manager has been appointed to support the delivery of the new research service that will be up and running within the financial year. To date, we have drawn up the initial protocols for the management of a Ketamine service and taken these through Trust Clinical Governance, we are underway with the procurement process for the rTMS machines and working with our estates colleagues to adapt existing space to site them. Once up and running, BSMHFT will be the only Trust within the West Midlands to offer these services to our patient population.

8.3 Oxford Biomedical Research Centre: – In 2022, BSMHFT (in partnership with the Institute for Mental Health (IMH)) became a member of the NIHR Biomedical Research Centre; this was contractually formalised in 2023. Our partnership is on the theme around Depression therapeutics, whose aim is, to use human neurocognitive models to identify and develop new and improved treatments for depression and is led at the Trust by Professor Steven Marwaha. To support delivery of this theme, work to date has been around the development of a research ready clinic, with standardised data collection in line with a national DTD (Difficult to Treat or Treatment Resistant Depression) dataset. This work links closely with the Mental Health Mission's work on establishing a neuromodulation clinic. Work in 2024/5 will focus digitising data collection.

8.4 UK-CRIS: In 2018 R&D implemented a system called CRIS - Clinical Record Interactive Search. CRIS allows us to safely and securely retrieve data from the Trusts Electronic Medical Record System (Rio), de-identify it to protect service user identities, and then upload it to a secure database. This then allows us to query the data in a much more sophisticated way and we can conduct research, clinical audits and service evaluations for the benefits of our services and service users. CRIS does not involve the collection of any new data. Through CRIS we are also able to safely share de-identified data with other CRIS activated Trusts to accelerate research work in dementia and mental health on a larger scale. The system upgraded in 2019 and due to issues with the upgrade, the pandemic and changing priorities, wide scale awareness around the platform was withdrawn. In 2023 however, we have successfully aligned our data to the new CRIS platform and with Akrivia Health (Oxford University Spin out company) who now manage CRIS, we are working to relaunch the system. In 2024/5 we intend to relaunch the platform with refreshed governance arrangements, ensuring operational support and oversight, understanding the benefits of Natural Language Processing and ensuring a training programme is put in place. This work is slightly hampered by the fact that BSMHFT now manages Rio data for Forward Thinking Birmingham and the data cannot be split. We are working with Akrivia to hold discussions with FTB, to either bring them onto the platform or, to ensure governance arrangements are in place to allow our CRIS system access to their data.

Finally, there is an option to link de-identified data from primary care with that of our service via the Optimum Patient Care Research Database (OPCRD), this comes with a cost of £10K and we will evaluate the benefits of implementing this.

8.5 Increasing our Local Investigator Pool: This year we have had nine new local principal investigators (PI's) supporting the delivery of research studies. The new PIs are from varied disciplines such as, Spiritual Care, Art Psychotherapy, Consultant Clinical Psychologists and junior doctors. All new PIs have access to training provided by the local Clinical Research Network, and some training provided by the University of Birmingham as part of the Mental Health Mission's capacity building theme. In 2024/5 however, we hope to expand on current training and develop a local PI training model for the main staff groups (nurses, doctors and AHPs) that is more relevant to our Trust, it's specialties, services, geography and demography. Whilst this is under development, we will continue to identify and support new PIs to deliver the local portfolio.

8.6 Developing an application for University/Teaching Trust Status:

As agreed at the Trust Board Development Day in March, the R&D team have begun working with appropriate stakeholders to develop a full options appraisal with regards to officially attaining Teaching Trust or University Hospital Status. We will explore the clinical, reputational and financial benefits that come with this status. Primary discussions have been held with the R&D Management Board and a sub-committee/working group will take this forward.

8.7 Lived Experience Active Research (LEAR) Group: Established in 2019, the LEAR group continues to be a huge asset to the Research department and to BSMHFT. It comprises of approximately fifteen 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, and we have been pleased to welcome newer members to the group over the past months. The meeting is chaired by Rekha Lodhia and Maureen Johnson as vice chair, (EBE and Carer respectively) with the support of the Trusts Lead for recovery, service user, carer and

family experience and R&Ds Research Delivery Manager. The group currently meets monthly and over the last 6 months we have seen a steady increase in the amount of interest in having engagement and input form the group at the research development phase. Having service user engagement in the early stages of developing research demonstrates a more collaborative approach rather than a tokenistic or tick box exercise. This is of great testament to the work of the LEAR group to date and shows that their input is invaluable.

The main activities to support LEAR in 2024/5 are as follows:

- Develop a business case to obtain funding to make the group sustainable in the long term
- To update the evaluation documentation used by the LEAR group to monitor their impact on research grants and proposals
- To co-produce a revamped Research Strategy and to explore key areas of research that align to the Trust's strategic priorities as well as areas of those that are of importance and interest to the group. These include:
    - Reducing digital exclusion
    - Demand signalling- identifying key areas of research whereby expert by experience collaboration and co-design is paramount
    - Reducing restrictive practices
    - Treatment resistant depression and the development of improved service user care pathways in this speciality
- To hold an EBE research celebration event

8.8 R&D Profile and Communications

In order to increase our capacity to deliver research, we need to ensure that staff across the Trust are aware and informed about the local portfolio, how they can support delivery of the portfolio and/or how they can be supported to develop their research, be it as a one off or as part of career development. In the last year, we have undertaken a number of steps to increase our profile across the Trust.

8.8.1 *R&D Showcase:* in September 2023 we held an R&D showcase, the first event to be held since lockdown. The event was attended by over 100 guests and of those in attendance, 88% would attend a future event. The purpose of the day was to highlight work that had been developed locally, in house research and service evaluations, collaborations with partners (Institute for Mental Health, University of Birmingham and Aston University) and a whole session delivered and developed by our LEAR group. A full evaluation of the event can be found at Appendix 4. Due to the positive feedback received from the event and the need to continually promote the initiatives outlined in this report, we are planning a Showcase for May 2025.

8.8.2 *Monthly R&D Bulletins and Colleague Brief:* We have been producing monthly R&D Bulletins since July 2023. The bulletins allow us to share information on open projects, to highlight findings from research studies, offer thanks to clinical teams who are supporting the delivery of our trials and to ensure we maintain a profile. The Bulletin is shared on Connect, via the colleague briefing and to our R&D mailing list. Alongside the bulletin, we have put featured posts in 19 of the weekly colleague briefings since March 2023. Again, this is a great vehicle to showcase work that is being undertaken, to encourage people to join and participate in R&D activities, to highlight key achievements and to demonstrate our alignment to the Trusts strategy. We will continue to have a

communications profile as outlined above and we are also exploring the use of social media platforms to launch by year end.

8.8.3 *Trust Induction days*: R&D are part of the Trust induction, having a stand in the main hall and supporting the 'a day in the life' section of the day. To date, we have supported 16 induction days completed 9 'a day in the life' presentations and have had 55 new starters sign up to our monthly e-bulletin. Unfortunately, this represents less than 10% of all inductees. Staff report that the sessions are extremely positive and for those that are interested in research, they are really engaged. Moving forward, we need to find ways to maximise the impact of our involvement in the induction day and we will work with our colleagues in L&D in the new financial year to do this.

8.8.4 New for 2024/5, we will introduce a series of *Research Seminars*. These could feature presentations on research outputs (findings and putting outputs into practice), opportunities to develop research, guest speakers on specific topics or open/drop-in awareness sessions. A programme will be implemented by the end of the financial year.

9.0 Research: Impacts and Outputs:

Trusts that are research active have better outcomes for all patients, reduced mortality and improved overall care quality not just for those who are participating in clinical research trials. Research creates a happier workforce with meaningful work reducing burnout, attracts a high calibre of staff who are keen to drive innovative and improved patient care and it aids staff retention. Research benefits the wider care system, transforming care by improving clinical practice and ultimately reducing the cost of healthcare. This section highlights the outputs of research such as grant awards and publications and local impacts in addition to those highlighted above. These include the impacts of locally developed research lead by our Chief Investigators such as contribution to guidelines and changes in practice (improving clinical practice) and the impacts of participation in research for our service users (improved or perceived improved quality of care) and engaged (happy) clinicians and support staff.

9.1 Impacts on national/local guidance, changes to local practice and key achievements:

The following impacts have been realised this financial year as a result of research activity within BSMHFT. In addition, our researchers have presented at key national and international meetings to disseminate their findings:

9.1.1 **Addictions Research:** Led by Professor Alex Copello and Dr Ed Day the addictions research programme is a long-established programme within the trust research portfolio and is focused on a number of important key questions for treatments and the reduction of harms associated.

BSMHFT addiction services (Solihull and Wolverhampton) have recently finished recruiting to two large multicentre opioid studies. Whilst these studies are led elsewhere, there is a strong collaboration between our sites, with Dr Day regularly a co-applicant on major trials that (as demonstrated below) have a direct benefit to our service users, their families and potentially to national policy.

The first, *EXPO (the EXtended-release Pharmacotherapy for Opioid use disorder (EXPO)* study has now finished, and the final academic paper has been published. EXPO was an open-label, multicentre, phase III randomised controlled trial comparing monthly subcutaneously injected slow-release buprenorphine (BUP-XR) with daily oral buprenorphine or methadone (standard of care, SoC) for reducing opioid use. This study has thrown up major implications of the UK drug treatment system as the Government implements the new drug strategy (From Harm to Hope). A version of monthly depot buprenorphine (Buvidal) is now available nationally, and clinicians are trying to work out how best to use this expensive but effective medication. Evaluated against the daily oral SoC, monthly BUP-XR is clinically superior, delivering greater abstinence from opioids, longer treatment retention, less opioid craving, greater likelihood of early OUD (Opioid Use Disorder) remission, and with a comparable safety profile. Further trials are needed to evaluate if BUP-XR is associated with better clinical and health economic outcomes over the longer term.

The *Naloxone Prospective Observational Research Study (NalPORS)* is a multi-national, prospective mixed methods study of the effectiveness of naloxone (including intranasal Nyxoid) administration by lay people in reversing opioid overdose. Recently closed to recruitment, this study aims to find out more about the use of take-home naloxone overdose reversals by lay persons in a lay setting. The trial is being run in six European countries with up to 6000 individuals either receiving or in contact with those receiving the treatment and to determine the effectiveness of overdose reversals in a lay setting. Both Solihull and Wolverhampton recruited patients to the study over two periods, ending in March 2024. The process has enabled SIAS to review its entire caseload and ensure that all patients who use opioids have been issued with naloxone if required, and that their current dose is within its expiry date. Intranasal naloxone has now largely replaced the intramuscular version. The findings of this study will be reported in the next financial year.

Professor Alex Copello has successfully completed two NIHR funded studies this year, both of which will have had or will in the future have potential impacts on the services we provide for both Mental Health and Addictions.

NIHR128128T - The RECO study: This research was funded by the NIHR and consisted of a 'Realist Evaluation of service models and systems for CO- existing serious mental health and substance use conditions. Alex was one of the Investigators. The overall aim of the study was to generate a programme theory using realist methods to identify and describe the contexts and associated mechanisms by which engagement and other health outcomes are achieved for people with co-occurring mental health and drug/alcohol use. The two-year study had three interconnecting work-packages: realist review, service mapping and stakeholder consultation leading to a final synthesis and programme theory. All packages were successfully completed and have been reported both as an NIHR final report and in academic publications. A national conference was also organised where the findings were reported and discussed.

NIHR200477 - Co-developing Improving Access to Psychological Therapies (IAPT) services to improve the response to Family Members affected by relatives with alcohol and drug problems (IAPT-FMs). Alex Copello was Chief Investigator for this Study funded by NIHR.

NHS Talking Therapies provide psychological therapies to people with mild to moderate anxiety or depression. Over 20% of people using NHS Talking Therapies services are concerned about a relative's alcohol/drug problem (affected family members), but these services are not really equipped to deal with these specific issues. This study aimed to address this gap; we designed new guidance for service providers in responding to affected family members. We aimed to make services more effective at providing help. We used a participatory approach to intervention development called experience-based co-design in which we worked in close and equal collaboration with stakeholders.

Four areas were found to be important for us to work on (1) Addressing stigma, raising awareness, and improving access, (2) Improving identification, assessment and treatment, (3) Upskilling and training the workforce, (4) Establishing links with and information about other support organisations.

The study team developed new guidance for NHS Talking Therapies services to address each area. They consulted widely to make sure the guidance addressed the concerns raised during the research. They told people working in NHS Talking Therapies services about the guidance so that they could consider implementation. They plan to apply for further funding so that we can work with some services to implement the guidance to see how it works in practice.

Publications referred to in this section can be found at Appendix 5.

As one of the co-investigators, Professor Alex Copello will support the delivery of, NIHR*206721 - Development, evaluation and testing of a Virtual Reality-enhanced Cue Exposure Treatment integrated with a wearable device to address craving, prevent relapse and improve treatment outcomes of people with cocaine dependence*, commencing in March 2024. Treatment for cocaine dependence relies on psychological interventions. However, these interventions suffer from poor engagement and high rates of relapse where craving plays a significant role. There is existing evidence in alcohol dependence, and an emerging literature in cocaine dependence, that cue exposure treatment (CET) can reduce craving and hence, reduce the risk of relapse to drug use. This research aims to develop and test a technology-based, theory-driven Virtual Reality (VR)-enhanced CET for cocaine craving. This innovative approach incorporates the use of VR technology to simulate substance-related cues and environments within a therapeutic context, allowing individuals to confront and manage their cravings and responses in a controlled setting. The study also plans to utilise wearable devices to monitor and identify craving and relapse in the natural environment. Paired with Ecological Momentary Assessment (EMA) and just-in-time adaptive interventions (EMI), these wearable devices offer novel ways to support patients in their recovery. Progress on this study will be reported in the next financial year.

Finally, Alex Copello is supervising two doctoral theses at the University of Birmingham.

9.1.2 **Art Psychotherapy:**

Dr Jed Jerwood, one of the Trusts Senior Art Psychotherapists has undertaken research work that has led to the development of the End-of-Life Care (e-ELCA) - Palliative care for people with mental ill health, a course now available for staff at BSMHFT.

The training module has been developed from a book chapter in the Handbook of Palliative Care published by NHS England and supported by the research that Jed undertook as part of his Trust supported doctoral and post-doc work on palliative and end of life care for people with mental ill health.

Jed continues his research journey having been awarded an NIHR Senior Clinical Practitioner Research Award in 2023. The grant will support 50% of Jed's salary for three years and will allow him to continue to develop work in support of mental ill health and end of life care.

In 2023 he was made Honorary Clinical Associate Professor at the University of Birmingham, he was the winner of the Markel 3rd Sector Care Development and Innovation Award and the winner of the NHS Improvement Award for improvement for his work on, 'No Barriers Here', for which he was the Lead Researcher and Co-founder. For further information, visit No Barriers Here© - Advance Care Planning.

Publications relevant to in this section can be found at Appendix 5.

9.1.3 Mood Disorders: Bipolar Disorder

Dr Lizzie Newton heads the Psychology Bipolar Trust services and is developing clinical research in collaboration with the R&D department evaluating two interventions for those with bipolar problems. One intervention involves the evaluation of a 'Compassion Focused Therapy' (CFT) group program. Working with Professor Paul Gilbert (founder of CFT) an initial proof of principle study has been completed and published and an application to NIHR for a pilot random allocation trial is currently in preparation.

In addition, an online delivered protocol driven intervention 'Mood on Track' (a nationally recognised group psychological treatment developed in Birmingham and in need of more research evidence), had been the focus of a preliminary evaluation study and a grant application will be prepared to conduct a full Randomised Control Trial (RCT). The work on the 'Mood on Track' intervention was in the final shortlist for the Health Service Journal (HSJ) 2023 awards within the category of Improving Mental Health through Digital.

Publications relevant to in this section can be found at Appendix 5.

9.1.4 Mood Disorders: Difficult to Treat or Treatment Resistant Depression

Led by Professor Steve Marwaha, this area of research has gained significant momentum within the last financial year. As co-director for the Mental Health Mission and our lead with the BRC, Steve has attracted significant financial support to the Midlands and the Trust to develop work predominantly on and involving difficult to treat depression (see sections 8.2 and 8.3). This work will lead to the development of a specialist research clinic for DTD that is in line with the national DTD network, the development of a DTD research platform and the establishment of a neuromodulation clinic.

He continues to attain high level grants (see section 9.3) and has produced a number of academic publications (see Appendix 5).

He is currently supervising three postgraduate students, 9 MSC students and teaches medical students on Mood disorders and holds the following relevant positions of esteem:

- British Association of Psychopharmacology (elected) committee member
- Bipolar UK Clinical Advisory Panel Steering Group
- Institute for Mental Health Postgraduate Research Lead: 2020-ongoing
- Regional Advisory Panel member for NIHR: Research for Patient Benefit West Midlands. January 2018-ongoing
- University of Birmingham Psychiatry Integrated Academic Training Lead: 2020-ongoing
- International Society for Bipolar Disorder Task Force on Early Intervention in Bipolar Disorder Co-Chair. 2020-ongoing
- Frontiers in Psychiatry (Journal) Review Editor

9.1.5 **Neuro: Epilepsy and Sleep:**

Dr Bagary is president of the International League Against Epilepsy (ILAE) - British chapter and continues to work at a national level representing epilepsy clinicians and research scientists. This includes work to support implementation of the new MHRA guidelines for prescribing of Valproate. They are also engaged with NICE regarding technology assessments for new antiseizure medicines and novel applications. The ILAE is an inaugural member of the newly established Epilepsy Research Institute which was officially launched in October 2023 by Minister for Science, Research and Innovation, George Freeman MP. The Institute is the world's first national research institute dedicated to epilepsy and will serve as the central hub for epilepsy research.

Dr Bagary continues to collaborate nationally on epilepsy research projects including studies exploring novel antiseizure medicines in drug -resistant epilepsy, the tolerability and efficacy of antiseizure medicine in an intellectual disability population who have the highest mortality rates from epilepsy. He is also collaborating with the University of Birmingham using novel biomarkers for epilepsy diagnostics estimating the likelihood of epilepsy from clinically non-contributory EEG using novel network computational analysis.

Following analysis of data comparing novel digital technologies in sleep medicine, the Sleep service have introduced WatchPAT technology as a rapid diagnostic tool. WatchPAT allows for in home sleep apnoea testing, it monitors sleep staging, sleep efficiency and sleep latency providing detailed information on the level of true sleep time rather than the recorded time available with most available home sleep tests.

Dr Bagary was part of the successful application for NIHR capital funding for rTMS (repetitive Transcranial Magnetic Stimulation) and will be using TMS for both epilepsy and sleep research studies. The equipment is currently in the procurement phase with implementation likely by the end of the calendar year.

Publications relevant to in this section can be found at Appendix 5.

9.1.6 **Neuro: Huntington's Disease (HD)**

Led by Professor Hugh Rickards, our HD service continues to be on the cutting edge of clinical research in Huntington's disease, being an active site in almost all the available clinical trials of disease modifying treatments in Huntington's disease.
Hugh is an active contributor to the international Clinical trials taskforce in HD, which involves reviewing trials protocols at the development stage and providing feedback to

biotechnology and pharmaceutical companies on trials methodology. Being a member of the taskforce really increases the chances of being selected for ongoing trials; in fact, to date, we have been selected for most of the HD trials apart from the ones involving neurosurgery.

He is an active contributor to the ENROLL Scientific operating Committee. This is a global group which provides feedback for observational studies from around the world, including a range of studies attached to the ENROLL case registry study which has around 25,000 participants. We are an exemplar site for ENROLL and the highest recruiting UK site for HD CLARITY[2] (the CSF study).

He founded the HEATED project (Huntington's Disease Equal Access to Effective Drugs) which he currently leads. This global group looks at barriers to access to disease modifying therapies and how they might be overcome.

He is the current chair of the UK Huntington's Disease Network and Chairs the board of trustees for the Huntington's Disease Association (England and Wales). They are currently working on policies to improve access to mental health services for people with HD. There has already been guidance from the Department of Health to all mental health providers as a result of the work the network have done with Hillary Benn MP (who has organised a Westminster Hall debate on the subject). The policy is designed to ensure access to mental health care for people with HD Nationally. The work is ongoing and involves discussion with Hillary Benn (Commons) and Philip Hunt (Lords).

The HD clinical team have had input into a range of international guidelines, in particular international Occupational Therapy (OT) guidelines. The latest guideline (H09) is led by Alex Fisher, an academic OT, and Honorary Clinical Lecturer.

The biggest change in local practice in relation to our research activity is that all of our patients are given the opportunity to participate in cutting edge research and the conversation about research is part of the clinical care of our patients at each clinic visit. Specifically, people with incurable, progressive and inherited diseases are desperate to participate in research for the following reasons:

a. It gives them hope for themselves
b. It helps to remove the burden of guilt in patients who have had children as there is a high chance that the next generation will have access to disease modifying therapies.
c. It means that they can feel that they are doing something to help the whole community, rather than being passive recipients of care.

Hugh is supervising 2 PhD students; one is an ethnographic study of couple interactions in HD, the other, the prevalence of pain in HD. In addition, he supports 10 MSc students.

Additional projects in for development in the new financial year are:

1. Working with Birmingham University computing department. Using machine learning to detect early changes in speech patterns in HD
2. With Cambridge University computing department. Using machine learning to develop staging systems for HD to produce accurate health economic models

[2] This study involves sampling cervical spinal fluid and is run at University Hospital Birmingham's Clinical Trials Unit. BSMHFT are a participation identification site only, despite Prof Rickards being the PI.

which I hope will help with access to disease modifying therapies, when they are licenced.

Publications relevant to in this section can be found at Appendix 5.

9.1.7 **Neuro: Tourette Syndrome and Social Cognition**

Dr Clare Eddy, Senior Research Fellow in the R&D Department is the Trusts lead on research into Tourette Syndrome and Social Cognition.

She is currently delivering her awarded grant, '*Social cognition and quality of life in Huntington's disease*', recruiting participants from the HD service. This research is looking to develop a measure of the impact of social cognition on quality of life. The data from this piece of work will be used to form the basis of a larger grant application that will aim to test and trial the measure.

Becoming recognised as being a leader in her field, Clare has been invited to support the following initiatives:

- Invited speaker at Université Catholique de Louvain workshop: From self-knowledge to knowing others. August 2023
- Invited expert panel member pursuing a change to international HD diagnostic criteria. Paper published (Bird et al, 2022, Neurology) and paper under submission (Considine et al, Neurology Clinical Practice).
- Invited expert panel member contributing to new international positive mental health taxonomy as author of one of the top 150 most highly cited articles referring to positive mental health (Lead: Iasiello, South Australian Health and Medical Research Institute and Flinders University)
- Invited expert panel member for consensus battery social assessments for use in schizophrenia (Lead: Pinkham, University of Texas, Schizophrenia International Research Society)
- Invited expert consultant for development of new assessment scale to measure self-other distinction (Lead: Bukowski, Université Catholique de Louvain)

She is Vice Chair of The Black Country Research Ethics Committee (Health Research Authority) and regularly provides training and guidance sessions to our R&D team and the wider non-medical research community.

She is an Assistant Editor for Frontiers in Psychiatry, Frontiers in Psychology and PLOS One, Reviewer for journals including (2023-2024): Neuroscience and Biobehavioural Reviews, The Royal Society Open, Brain Communications, Neuroimage Clinical, Brain and Behaviour, British Journal of Clinical Psychology, Nature Scientific Reports, Current Psychology, Psychonomic Bulletin and Review, Journal of the International Neuropsychological Society, Journal of Affective Disorders, Personality Disorders: Theory Research and Treatment, Frontiers in Psychiatry and Frontiers in Psychology. And reviewer for international grants/fellowships on behalf of the National Science Foundation (USA), National Fund for Scientific Research (Belgium) and National Science Centre (Poland).

Publications relevant to in this section can be found at Appendix 5.

9.1.8 **Nurse-led research: meeting the needs of international nurses**

In 2022, Dr Analisa Smythe, Research Nurse (R&D) received funding from the West Midlands Clinical Research Network's Scholars Programme to support research which focusses on international nurses. With previous work undertaken on preceptorship and burnout, Analisa has a track record of delivering research with implementable outputs.

To deliver this project, she has brought together a group of academics and practitioners from across the Midlands to develop, "PHAISE", the International Policy and Practice Research Collaboration". Members include Professor Annie Topping, University of Birmingham, School of Nursing and Midwifery, academics from Nottingham Trent University (NTU) including Professor Jon Gorry, Head of Department for Social and Political Sciences at NTU; Professor Ann-Marie Cannaby, Pro-Vice Chancellor at Coventry University; Aquiline Chivinge MBE, Institute Clinical Lead for Shared Governance and Inclusive Leadership at Nottingham University Hospitals (NUH) NHS Trust; Dr Louise Bramley, Assistant Director of Nursing, NUH NHS Trust; Kevamae Sobers, International Council of Nurses, NUH NHS Trust; Rich Pickford Nottingham Civic Exchange; Daphne Laing, Independent consultant: international education and cultural understanding. The PHAISE project page is available at PHAISE – International Nursing Workforce Policy and Practice Research Collaboration. The collaboration will seek to understand and explore issues across the UK faced by international nurses and the organisations and communities they work with.

To support these activities at NTU, Dr Smythe has been appointed as Visiting Fellow. The group are working on smaller projects and outputs with the long term aim to be in receipt of an NIHR fellowship. There are 3 papers (outputs of this work) in review.

9.1.9 **Perinatal Mental Health:**

In 2023, the Perinatal Mental Health research team have submitted two research grants; one an NIHR Programme Grant with Dr Jelena Jankovic as a co-appliant, "*PREventing PretErM Birth in nulliParous women Through cervical length screening (PRE-EMPT)"* is pending outcome. The other, an NIHR Fellowship application, led by Sarah Bicknell, Perinatal Research Fellow was successfully awarded in year. The fellowship provides funding for 18 months salary, allowing her to complete a comprehensive research methods course whilst developing a research project to develop a risk tool for mothers at risk of self-harm/inflicting harm after birth. The data from this piece of work will likely be used to form the basis of a larger grant application.

The perinatal team are supporting a Research Fellow from the University of Birmingham (UoB), Ellie Jones, to deliver her NIHR fellowship on smoking cessation in women with perinatal mental health problems.

In addition, they will host a PhD student from UoB who was awarded a Midlands Graduate School ESRC Doctoral Training Partnership Collaborative Studentship for a collaborative proposal with the Mother and Baby Unit. The project will focus on Neurodiversity in women with perinatal mental health problems and will start in September 2024.

Publications relevant to in this section can be found at Appendix 5.

9.2 Impact of NIHR Portfolio Participation on staff, service users and/or carers:

The benefits of participating in research are far reaching; in addition to the ability of offering service users a possible new treatment, research can also impact on their carers, the relationship with their clinician and can have positive impacts on the clinical care team. For the studies that are managed and delivered by the Trusts Research Delivery Team, we have collected evidence on the impacts our involvement in the NHS has had across the Trust and they are far reaching. The table below provides a snapshot of the CAFI (Culturally Adapted Family Intervention) Trial and the Community Navigator Trial. Both examples show the breadth of teams involved in supporting the delivery of these two pieces of research and the wider implications:

List specific Teams/clinical leads across the Trust engaged with for this study:	Support the study provided to the service area? (New interventions, staff training, CPD etc):	What impact has this study had on patient care?	Any other feedback? Perhaps from patients being involved in the study?
Study Title: The effect on relapse of Culturally-adapted Family Intervention (CaFI) compared to usual care among African & Caribbean people diagnosed with psychosis in the UK: a Randomised Controlled Trial:			
Orsborn house - Aston & Nechells CMHT, Ladywood & Handsworth CMHT (Paulette Clarke, Manager & Sibusisiwe Ndhlovu, Clinical Lead) Sutton CMHT Zinna CMHT Yewcroft CMHT Longbridge CMHT Small Heath CMHT	New Culturally adapted Family intervention which has been designed for African and Caribbean people with schizophrenia and psychosis related mental health disorders. Opportunity for staff to train and work as therapists on the trial contributing towards their continued professional development (CPD) and embedding cultural awareness and competence in usual care.	Therapists – become culturally aware/becoming more culturally competent in everyday care learning new techniques to help service users and understand them better due to CaFI. Service Users - potential to receive improved, tailored, culturally relevant therapy Family – have a greater understanding, feel able to provide specific support to loved ones have sense of value The study has been valuable in prompting conversations and awareness around the barriers to treatment that are rooted in	Service Users (SU's) who felt they could benefit of CaFI, fed back that they were very disappointed when they were randomised to treatment as usual and that they would not receive CaFI if in control group or at the end of trial. This led to some withdrawals from the study and was fed back to the study team. Very difficult to engage SU's; some expressed they were not interested in the intervention or did not feel like they needed it Some SU's fed back the study was asking for too much of a commitment and did

Tamarind Centre inpatient wards (Dawn Sutherland, Family and Carers Lead) Reaside inpatient wards Hillis Lodge Hertford House David Bromley Community Perinatal Team- West (Becky Guest, Clinical Psychologist) Deaf Service AOTs PCREF advisors – Catalyst4Change	CaFI also offers experience to those who wish to gain skills in working with service users via the Family Support or allocated Family Support Member (FSM) role.	cultural differences (staff, Service Users and carers)	not have time – again, this was fed back to the study team Valuable to build links with community partners (Catalyst 4 Change) and great to discuss and map out how PCREF advisors may be able to get more involved and support with future projects, acting as research champions. Staff capacity issues, both to support recruitment, and to train as therapists to support the trial. Capacity issues within delivery team- only one funded RA, needed unblinded RA, and someone manage recruitment of all staff to therapist roles and aFSMS (allocated family support members) to deliver the study. The trial was significantly under-resourced, and this was fed back to the study team. Despite all the challenges outlined above, some SUs involved expressed feeling that they felt ‘seen’. They were appreciative of the recognition that there is a need for culturally adapted therapy and treatment, and the efforts made to address this. Catalyst4Change expressed a lot of interest and passion for the project. They

			gave a lot of time and resources to push for recruitment within their own communities to support the study. They also provided input in our recruitment strategies
Study Title: Randomised controlled trial of the Community Navigator programme to reduce loneliness and depression for adults with treatment resistant depression in secondary mental health services			
Tracey Green/Sarah Turton Longbridge, Zinna and Warstock lane CMHT	Line Management, Staff training and supervision of the Navigator Monthly community navigator meetings	Engaging service users with new local hobbies and activities Engagement within the community Actively reducing isolation This study recognises the role of social factors such as loneliness in treatment-resistant depression (TRD) and aims to address a critical research gap regarding effective social interventions through a biopsychosocial approach alongside existing treatments. This study has the potential to provide mental health teams with an evidence-based intervention to support individuals with TRD with their social recovery and mental wellbeing.	Different approach to other studies and allowing for more tailored 1-2-1 sessions Participants have valued participation in this trial as they particularly enjoyed having the opportunity to work on their social recovery, an area which is often overlooked as physical and mental health are prioritised.

A full list of studies, the proposed impact of the research and the additional benefits realised can be found at Appendix 6. We will continue to collate this information for every project the delivery team supports as it provides excellent data to feed back to study teams, allows us to share the reported benefits to clinical teams and to capture the overall value of each project to the Trust, our staff and service users.

9.3 Research Grants:

In the financial year our research leads submitted 13 grant applications (as lead or co-applicant) six of these were successful (see lists below) with grant awards totalling £5,058,693 for the duration of the grant; four are still awaiting an outcome. In addition, four infrastructure bids were submitted and awarded totalling £11,426,211 for the duration of the projects. Full details of all grants submitted, and pending outcome can be found in Appendix 7.

Grants awarded in 2023/24:

- Bicknell, Sarah (Lead), **NIHR re-Doctoral Fellowship Round 5**, NIHR, £89,707
- Eddy, Dr Clare, **Social cognition and quality of life in Huntington's disease**, EHDN (European Huntington's Disease Network), £52,000
- Marwaha, Prof Steven (Lead), **The effectiveness of Lithium plus Quetiapine COMBination versus LithIum versus QuetiapiNe monothErapy in the maintenance treatment of bipolaR disorder: the COMBINER trial**. HTA (Health Technology Assessment), £2,379,404
- Marwaha, Prof Steven (Co-Investigator), **Aripiprazole/ sertraline combination: Clinical and cost-effectiveness in comparison with quetiapine for the treatment of bipolar depression. An open label randomised controlled trial. (ASCEnD)** NIHR HTA £2,070,985.77. Local PI. (5%).
- Hallet, Nutmeg (Lead), **A realist synthesis to explain how, for whom and in what circumstances post-incident support ('debriefing') works following restrictive intervention use in mental health patient settings: Debriefing after Restrictive InterVEntions (DRIVE-MH)**, NIHR RfPB (Research for Patient Benefit), £147,827
- Jerwood, Jed (Lead), **NIHR Senior Clinical and Practitioner Research Award R1**, NIHR Senior Clinical and Practitioner Research Award, £140,204
- Copello, Alex (Co-applicant) **Development, evaluation and testing of a Virtual Reality-enhanced Cue Exposure Treatment integrated with a wearable device to address craving, prevent relapse and improve treatment outcomes of people with cocaine dependence**, NIHR Invention for Innovation, £1,772,942

In addition to traditional grants, we successfully attained infrastructure and development funding as follows:

- Marwaha, Prof Steven (Co-applicant & Co-Director), **Mental Health Mission: Midlands Translational Research Centre of Excellence: (Midlands-TRCoE)** £9,920,921.
- Patterson, Emma (Lead), Marwaha, Prof Steven & Bagary, Dr Manny (Co-Leads) **NIHR Capital Bid: rTMS (repetitive Transcranial Magnetic Stimulation) for Treatment Resistant Depression, Epilepsy and Sleep**, NIHR CRN, £660,000
- Patterson, Emma (Lead), **NIHR CRN – Research Nurse Award**, NIHR CRN, £39,290
- Marwaha, Prof Steven (Lead), **Mental Health Mission 2**: Increasing Commercial Research Readiness (TRCoE), £800,000 NB. Contracting will begin in April 2025.

Of the awarded grants/bids, £1.3m will be direct income to the department (plus £0.6m capital), with approximately £2.5m to be subcontracted to cover collaboration costs and/or to provide the infrastructure to deliver the projects.

9.4 Publications:

Publication metrics support the author in their personal career development and support funding bids. In addition, they promote the research activity of the Trust which helps to attract staff with similar or aspirational research interests. During the financial year, we have published ***84*** articles in academic journals. A full list of in-year publications can be found in Appendix 5.

10.0 Summary of Goals for 2024/25:

This section provides as summary of the goals for the department as outlined in this annual report and identifies the lead member of staff to take each item forward. This is effectively the departments Business Plan for 2024/25, the delivery of which will be overseen by the R&D Management Board.

Finance and Resources:	
- R&D and Finance joint SOP - Pharmacy to use EDGE - Implementing the NIHR income distribution model	Research Governance Manager
- New departmental appointments: Delivery Team Manager (B7)	Head of Research & Development
- New departmental appointments: Clinical Research Nurse (B6), R&D Assistant (B5), Project Support Officer (B4), EBE Research Delivery Post (band tbc)	Delivery and Performance Manager
- Working with Academic Partners and Collaborators to ensure costs of ongoing management and support of trial delivery staff are covered.	Head of Research & Development
Research Governance:	
- National Data Opt out – improved management on Rio/Electronic Health Record - Updated National Data Opt Out SOP - Research Passport SOP	Research Governance Manager
NIHR Objectives:	
- Implement Research Champion programme - Strategy to engage all research teams in PRES	Delivery and Performance Manager
Service Evaluations:	
- HSCE (MSc and MNurs) projects	Research Governance Manager
- Delivering psychological therapies Service Evaluation	Delivery and Performance Manager
- Implementation of AMAT, tracking and capturing outputs - Updating the Service Evaluation SOP	Research Governance Manager
Birmingham Health Partners:	

- Ensuring BHP is included in the R&D Governance Structure - Regional bid to host a Commercial Research Delivery Centre	Head of Research & Development
Mental Health Mission:	
- Difficult to Tread Depression Research Platform – build platform begin regulatory approvals, data collection and testing - Ketamine Clinic protocols, SOPs and guidelines to be developed - Clinic established, up and running and being evaluated (research grade) - rTMS machines procured with protocols, SOPS and guidelines to be developed - Building works undertaken to house the rTMS machines finalised - rTMS research service running and being evaluated (research grade)	Mood Disorders Project Manager
Oxford BRC:	
- Digitising data collection in line with the standard DTD dataset	Mood Disorders Project Manager
UK-CRIS:	
- IG arrangements with FTB due to shared Rio/explore FTB usage - Revisit and revamp governance processes - Identify designated staff to undertake CRIS admin and daily operations	Research Governance Manager
- Consider linkage to Primary Care data for all of our service users via the Optimum Patient Care Research Database (OPCRD), this comes with a cost of £10K	Mood Disorders Project Manager
Increasing our local investigator pool:	
- Locally developed PI training	Delivery and Performance Manager
Application for University/Teaching Trust Status:	
- R&D Management Board Sub-Committee/working group established - Benefits/options appraisal to be completed within 6 months	Associate director for Research and Head of Research & Development
LEAR (Lived Experience Action Research) Group:	
- Develop a business case to obtain funding to make the group sustainable in the long term - To update the evaluation documentation used by the LEAR group to monitor their impact on research grants and proposals	Delivery and Performance Manager

<table>
<tr><td>- To co-produce a revamped Research Strategy and to explore key areas of research that align to the Trust's strategic priorities as well as areas of those that are of importance and interest to the group. These include:
o Reducing digital exclusion
o Demand signalling- identifying key areas of research whereby expert by experience collaboration and co-design is paramount
o Reducing restrictive practices
o Treatment resistant depression and the development of improved service user care pathways in this speciality
- To hold an EBE research celebration event</td><td></td></tr>
<tr><td colspan="2">R&D Profile and Communications:</td></tr>
<tr><td>- R&D Communications – social media scoping & Trust Inductions
- R&D Showcase 2025
- Seminar Series</td><td>Delivery and Performance Manager</td></tr>
<tr><td colspan="2">Impacts on national/local guidance, changes to local practice and key achievements:</td></tr>
<tr><td>- Follow up and ongoing monitoring of activity as outlined in each programme area</td><td>Associate Director for Research</td></tr>
<tr><td colspan="2">Impact of NIHR Portfolio Participation on staff, service users and/or carers:</td></tr>
<tr><td>- Maintain an ongoing assessment for each NIHR project supported by the Research Delivery team to monitor intended and unintended impacts</td><td>Delivery and Performance Manager</td></tr>
</table>

Appendix 1 – NIHR Pending Studies in set up and undergoing feasibility assessment

NIHR Portfolio Studies in set up - 11

Study Title	Principal Investigator	Further detail
1. **CLEAR - A Multi-Centre, Randomised Controlled trial of Clozapine for Young People with Treatment Resistant Psychosis in Real World Settings.**	Dr Rowena Jones	Local Information Pack now received – review in progress.
2. **PURVIEW - A Phase 3, multicentre, open label safety study to evaluate the long term safety and tolerability of SAGE-718 in participants with Huntingtons Disease.**	Professor Hugh Rickards	Waiting for the contract and final costs.
3. **PEAGUSUS - Reducing risk of cardiovascular disease in people with severe mental illness: development, feasibility testing and trial of a peer supported group clinic intervention**	Professor Steve Gillard	Discussions around work packages and funding.
4. **ASCEND - Randomised Controlled Trial of Aripiprazole + Sertraline vs Quetiapine for people with Bipolar Depression.**	Professor Steve Marwaha	About to go into Quality Control.
5. **Predictive factors of outcomes in medium secure FCAMHS - Ardenleigh FCAMHS Research Database**	Dr Lizzie Fitzmaurice, Lauren Barkey	To create a secure, central location for storage of information gathered during routine clinical care that may be mined in the future to explore predictors of outcomes within FCAMHS services. 5 data collection centres. A lot of progress has been made – submission to IRAS required.
6. **GOTHIC2 - A multi-centre randomised placebo-controlled trial of glycopyrrolate and hyoscine hydrobromide for the treatment of clozapine-induced hypersalivation.**	Dr Rowena Jones	BSMHFT will be the research site, and Forward Thinking Birmingham (FTB) will act as a Participant Identification Centre (PIC). Discussions around Research Assistant.

7. **ACORN - A multi-site randomised COntrolled trial to evaluate the impact of a group tReatment for aNtenatal anxiety**	Possibly Jo Everill	This is an antenatal anxiety trial where we will be recruiting women at scanning clinics attending their first trimester scan appointments and then the intervention will be delivered through a Talking Therapies service (in the catchment of the hospital) by a PWP worker and a maternity worker. The total number the Trust will need to recruit is around 97 participants (half allocated to intervention; half allocated to treatment as usual). Local Document Pack pending but discussions being had.
8. **Life Coaching - Programme to offer time-limited, goal-directed coaching to 'at risk' autistic and 'autistic-like' individuals managed by Prevent Case Management**	Dr Nicki Fowler	Funding discussions with AT Autism due to the length of time this has been in set up.
9. **Vision-Quest**	Hannah Lui TBC	NEW STUDY – BSMHFT agreed to take part 07/05/24. Looking at PI. It is a cross-sectional questionnaire study, aiming to look at psychological factors associated with visual hallucinations in psychosis, recruiting across inpatient and outpatient settings.
10. **Implementation Evaluation of Mindfulness for Adolescents and Carers (MAC) within ATTEND: Adolescent and carers using mindfulness Therapy to END depression.**	Unknown	BSMHFT will act as a Participant Identification Centre, to identify the relevant person or people within the geographical area to answer a short online survey. The person or people should have knowledge of Mindfulness Based Interventions and approaches in the Trust/area, an understanding of local emotional disorders care pathways, and will understand the local system well. Example roles may include a CAMHS Service Manager, a Mental Health Commissioning Manager or a Mental Health Support Team Manager.
11. **Preparedness of International Medical**	Unknown	NEW STUDY – BSMHFT agreed to take part on 07/05/24.

Graduates (IMGs) working in the National Health Service (NHS): An exploration of the Midland's Region, England		Invites those who obtained their primary medical qualification outside of the UK and who currently work in an NHS Trust to attend either one semi-structured in-depth interview or a survey. Also invites those who are a clinical supervisor of an international medical graduate to attend either one semi-structured in-depth interview or a survey. R&D will assist with advertising via our R&D Assistant.

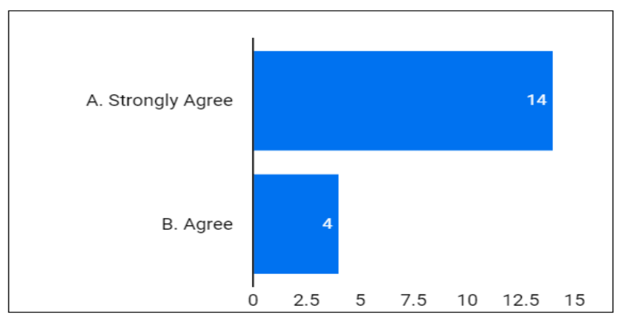
<u>NIHR Portfolio Studies in Feasibility – 9</u>

Study Title	Principal Investigator	Further detail
1. DIGG-HD	Professor Hugh Rickards	Potentially opening as a research site. Sperm and blood collection study with University College London. BSMHFT will be running the blood collection.
2. CECILIA - An evaluation of C(E)TRs for people with learning disabilities and autistic people.	Dr Rachel Upton	Grant application stage. Trust staff member acting as a co-applicant.
3. Psychedelic CT using 5-MeO-DMT for people with Treatment Resistant Depression	Professor Steven Marwaha	We were in the process of being set up as a PIC but this is on hold. The Sponsor is currently decided whether or not they want PIC sites.
4. A realist synthesis to explain how, for whom and in what circumstances post-incident support ('debriefing') works following restrictive intervention use in mental health inpatient settings: Debriefing after Restrictive InterVEntions (DRIVE-MH) - DRIVE-MH	Dr Nutmeg Hallet and Dr Analisa Smythe	Funding awarded – IRAS applications being made. We are the Lead NHS Trust but not the Sponsor.
5. Syrian refugee experiences	Hewa Khebir	Syrian refugee experiences database. Initial meeting held but nothing since.
6. Biogen Akrivia (health data)	TBC	Approached by Akrivia to be involved in a data study with UKCRIS.

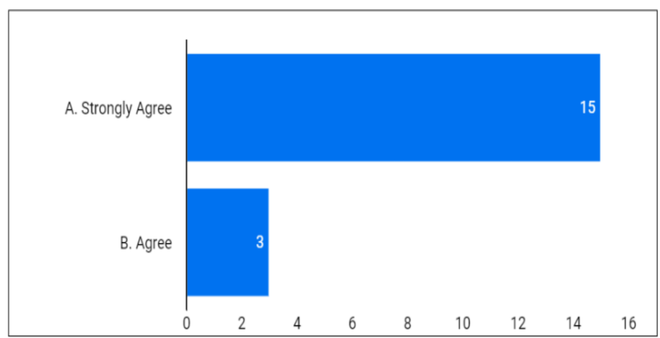
7. Esketamine (Spravato) for treatment-resistant depression in adults	Professor Steven Marwaha	Local discussions taking place regarding the drug.
8. COMBINER / TRIDENT	Professor Steven Marwaha	Grant application stage. Initial application unsuccessful, but second submission recently successful.
9. Informing the successful Culturally Appropriate Advocacy, improving access, experience and outcomes for racialised people in mental health services	Anthony Salla	Study evaluating the UK governments culturally appropriate advocacy pilot – one of the pilots contractors (POhWER) is working across adult services in BSMHFT. Central study team are still going through the national approvals process.

Appendix 2: PRES Dashboard

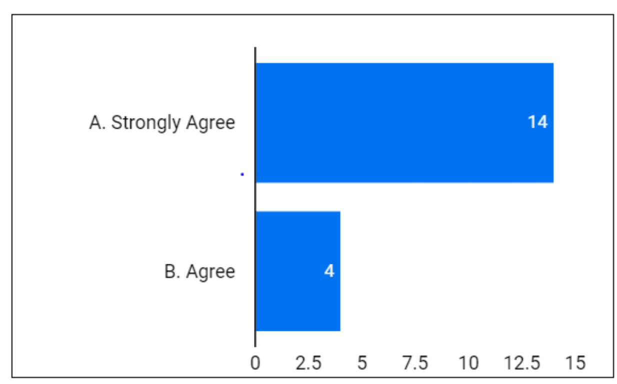
Research staff have always treated me with courtesy and respect.



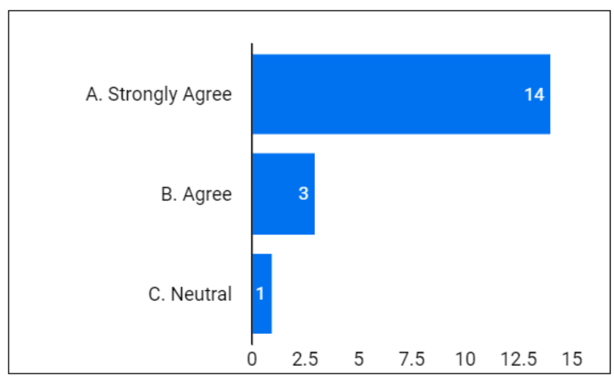
I would consider taking part in research again.



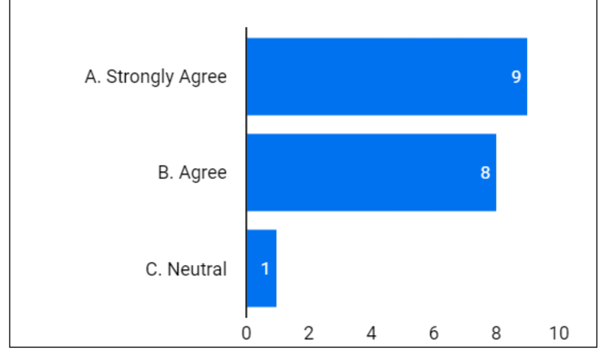
The information that I received before taking part prepared me for my experience on the study.



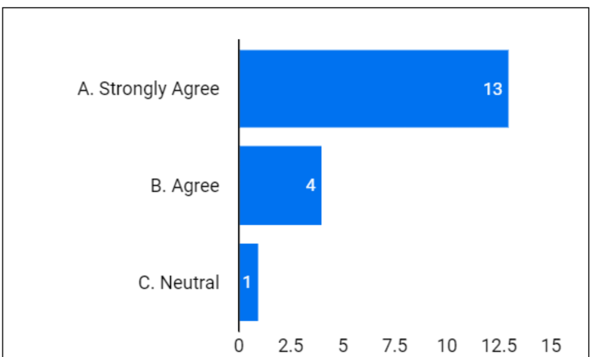
I feel I have been kept updated about the research.



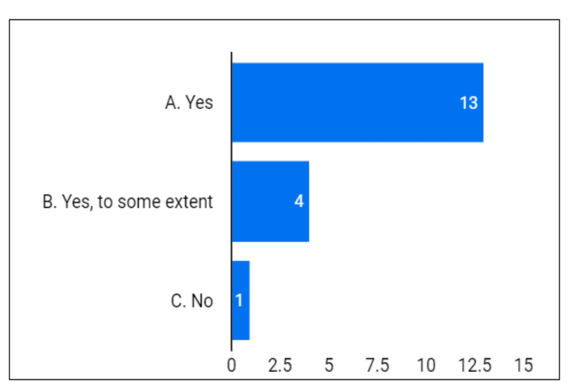
I know how to contact someone from the research team if I have any questions or concerns.



I feel research staff have valued my taking part in this research study.



I know how I will receive the results of this research study.



Appendix 3: Approved and ongoing Service Evaluations across BSMHFT:

ID No.	Service Evaluation Title	Service Area(s)	Team/Service	Full Name	Other Staff Involved
SE0118	AOT service evaluation	Integrated Community Care And Recovery	AOT	Lisa Bird	N/A
SE0125	Evaluating the Effectiveness of Reflective Practice Groups for University Students On Placement	Trust-wide	Various teams – trust-wide	Sonia Dhinse	N/A
SE0128	Frequent attenders to mental health liaison service	Acute and Urgent Care	RAID Teams	Semhar Abraha	N/A
SE0131	Evaluation of the efficacy of psychotherapy for complex presentations in the homeless population	Integrated Community Care And Recovery	Homeless Primary Care Team	Karen Loly	N/A
SE0153	Service User Satisfaction in AOT	Integrated Community Care And Recovery	AOT	Ramharakh Sanjeev B	Dr Hermine Graham, Brenda Taylor
SE0179	Service Evaluation of the mental health service provided at Elliott House Approved Premises	Secure Care and Offender Health	Reaside	Katy Mason (since left the Trust)	Rebekah Bourne (since left the Trust)
SE0203	What is helpful and unhelpful about psychological therapy from North Community Mental Health Team: Service user views	Integrated Community Care And Recovery	CMHTs	Nisa Hussain (no longer working in the trust), handed over to Kathryn Walsh	Nina Ahuja
SE0246	Inequalities Service Evaluation fFIRSTor REACH OUT Provider Organisations	Secure Care and Offender Health	REACH OUT	Mary Eliffe	Emachi Eneje
SE0256	‘Moving Lives, Healthy Minds’: An evaluation of a Birmingham-based Mental Health and Sport Project.	Integrated Community Care And Recovery	Community Mental Health Teams	Dr Adam Benkwitz/ Dr Amanda Gatherer	N/A
SE0281	A service evaluation focusing on the efficacy of interventions offered under	Secure Care and	Psychology	Dr Victoria Wilkes	N/A

	the auspices of the SCALE Risk Reduction Programme within Secure Care and Offender Health.	Offender Health			
SE0287	Mapping out the current service provision and clinical needs for Treatment-Resistant Depression (TRD) in BSMHFT	Specialties	Mood Disorders	Danielle Hett	N/A
SE0296	Self-help and guided self-help for psychosis using the stay at home self-help pack, during the Covid-19 pandemic	Integrated Community Care And Recovery	Rehab and Recovery	Sundeep Sandhu	N/A
SE0311	BAME Dropout and Inclusion in BSMHFT Community DBT service	Integrated Community Care And Recovery	DBT Service	Jennifer Watson	N/A
SE0320	The experiences of Compassion focussed staff support groups for BSMHFT Perinatal staff.	Specialties	Perinatal	Rebecca Boddy	N/A
SE0333	Maternal ADHD during the perinatal period: Treatment and care within adult mental health services	Specialties	Perinatal Mental Health Service	Dr Sabah Ahmed	Sarah Bicknell & Natalie Thompson
SE0340	An evaluation of the psychologically informed and evidence-based interventions offered and delivered at PROSPER (IIRMS)	Secure Care and Offender Health	PROSPER	Clare Strickland	N/A
SE0349	Service evaluation to establish how effective we are assessing and managing in service users with chronic and enduring mental illness who are under the care of South Assertive Outreach Team and S2R services with in BSMHFT.	Integrated Community Care And Recovery	South Assertive Outreach Team	Dr Kozara Nader & Dr Nuzhat Butt	N/A
SE0364	What are the barriers and facilitators to participation in employee Health and Wellbeing initiatives? A qualitative study based on the Theory of Planned Behaviour	Integrated Community Care And Recovery	Health and Wellbeing Steering Group	Dr Helen Brown & Caitlin Robbins	N/A
SE0366	Exploring inequalities in accessing secondary care services	Specialties	CMHT	Dr Maria Mato & Zobia khalil	N/A
SE0367	Evaluating multidisciplinary knowledge and preferences of group	Integrated Community	Small Heath CMHT	Reham Al Taher & Keith Aherne	N/A

	psychotherapies within adult community care teams	Care And Recovery			
SE0368	Exploring the experiences of health care support workers in mental health inpatient settings	Acute and Urgent Care	Juniper	Alison Jowett	N/A
SE0369	An audit on the patterns of drug overdose and evaluation of relevant services at Birmingham Health Exchange	Unknown	Health Xchange	Vibhu Paudyal & Jenny Anderson	N/A
SE0370	Veteran's experience of completing a new Compassion Focussed Therapy Group within the Complex Treatment Service (Op Courage).	Specialties	Veterans Complex Treatment Service	Dr Joseph Spry	N/A
SE0371	A needs assessment of parent-infant relationship help and support in Solihull Metropolitan Borough	Integrated Community Care And Recovery	SOLAR (CAMHS)	Dr Claire Forsyth/Laura Stanford	N/A
SE0372	Adherence to Discharge Processes in Home Treatment – Barriers and Facilitators	Acute and Urgent Care	Home Treatment	Kiah Bould	N/A
SE0377	F.I.R.S.T Casebusting Evaluation	Secure Care and Offender Health	Reaside	Tarnveer Bhogal/ Camille Mclean	N/A
SE0378	A Quantitative Service Evaluation looking at the Demographics of Patients Accessing Psychological Services within the Solihull Home Treatment Team	Acute and Urgent Care	Home Treatment	Sarah Mooney	N/A
SE0379	How we can improve the accuracy of PCREF data collection, with a focus on ethnicity and language	Specialties	Older People Acute Assessment	Mohammed Tayib	N/A
SE0380	An Evaluation of Psychological Consultation for Staff Working with Personality-related Experiences	Specialties	Enhanced Pathway for Personality Disorders	Sianna Banks	N/A
SE0381	Exploring the experiences of those who have accessed the Dads and Partners pilot pathway.	Specialties	Perinatal Mental Health	Rebecca Boddy & Sara Fradley	N/A
SE0384	How effective do team members within a forensic CAMHS inpatient unit consider current weekly multidisciplinary meetings?	Secure Care and Offender Health	Ardenleigh CAMHS	Ishmael Jabber	N/A

Appendix 3: PRES Dashboard

Appendix 4: R&D Showcase 2023 Feedback Report

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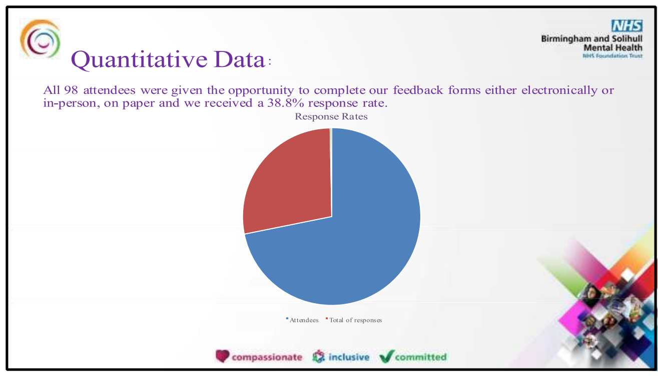

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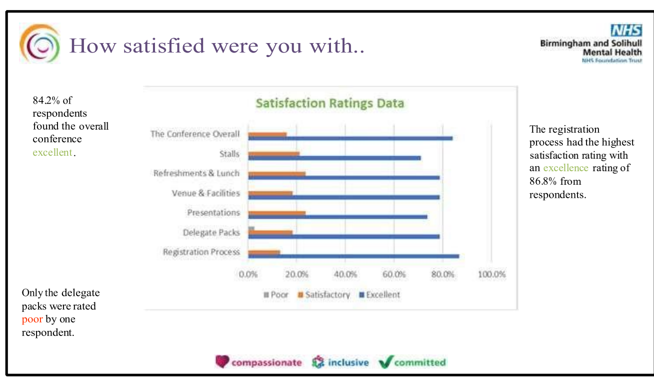

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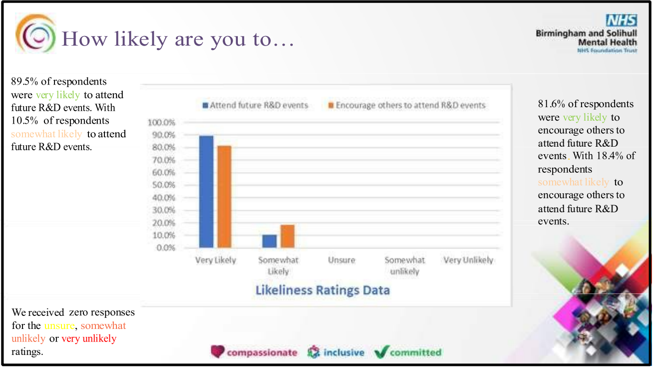

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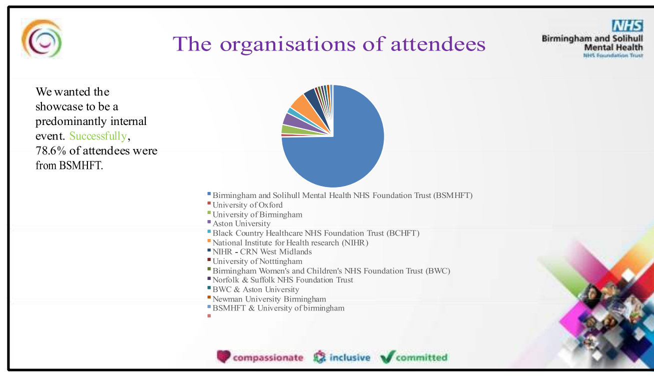

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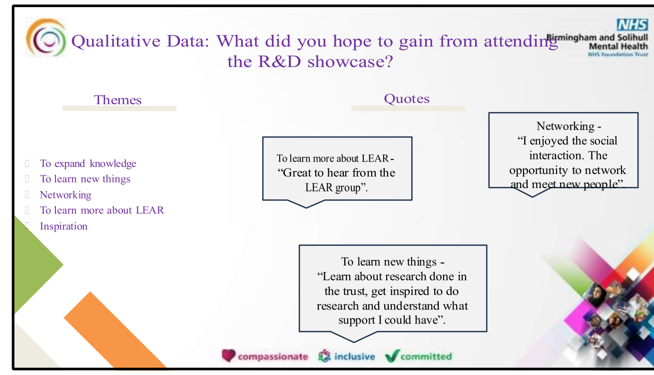

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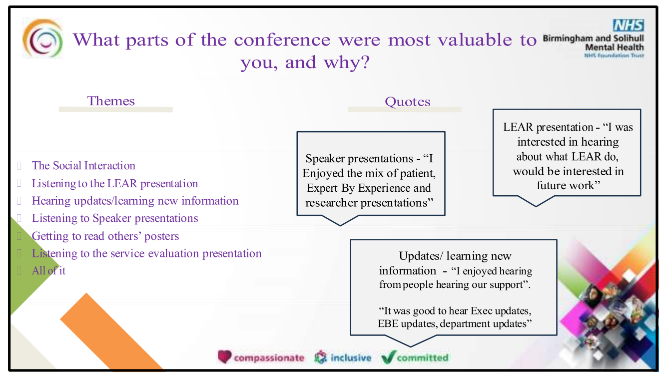

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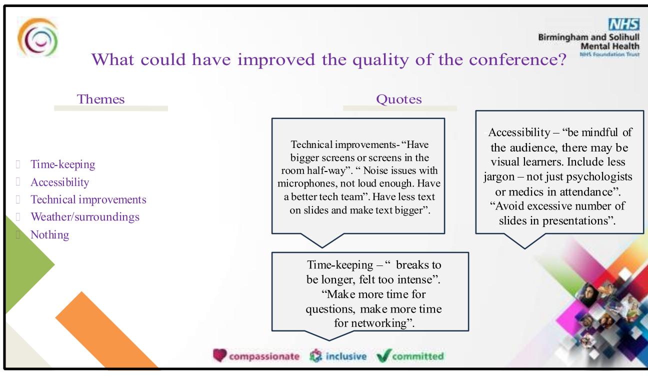

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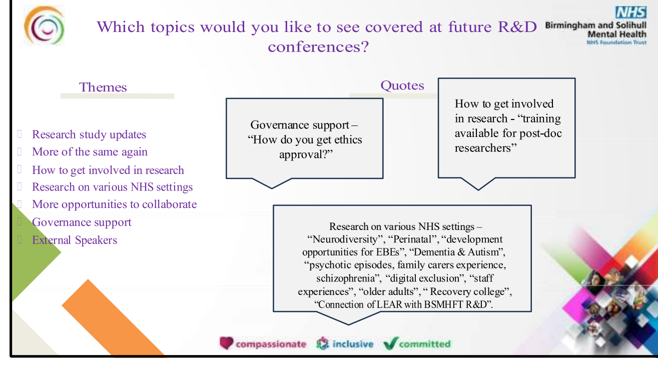

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Appendix 5: BSMHFT Journal Publications: 2023-2024

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Book chapters

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Appendix 6: Impact of NIHR Portfolio Participation on staff, service users and/or carers:

Study name	List specific Teams/clinical leads across the Trust you engaged with for this study	Support the study provided to the service area? (New interventions, staff training, CPD etc)	Can you think of any impact this study had on patient care?	Any other feedback? Perhaps from patients being involved in the study?
NalPORS	SIAS (Dr Ed Day -PI) Recovery Near You Homeless Health Exchange Change Grow Live Central & West (Dr David Pang)	Naloxone refresher training Study specific training (screening, enrolment \questionnaires etc.) Collecting data for post-market surveillance on Nyxoid (naloxone nasal spray)	Boosted naloxone rollout to clients and non-clinical staff Encouraged staff to provide naloxone training to clients and staff Encouraged clients and staff to carry their own naloxone wherever they go in case of emergencies	Participants and staff expressed interest in Nyxoid as a take-home naloxone kit, preferring to carry and potentially use the nasal spray version over the alternatives (namely Prenoxad – prefilled syringe) Lots of them had never been offered take-home naloxone/ had expired kits (and training) before taking part in the study
Pathfinder	Abdul Patel - CMHT, MAS	Specific PATH training. Exploring how participating in activities/interventions can improve the cognition of those with AD	Encoraged patient/carer to participate in interventions. Empowered the carer to help deliver 121 interventions with their relative.	Many carers stated that they valued the added health care support and guidance in providing coordinated care and care coordination with other agencies.

UK Minds	MHSOA – Patients within the Older Adult directorate with Mild Cognitive Impairment Small Heath/ Zinnia/Bipolar Service/ EIS service	Moca training, UK Minds training.	Empowering patients to take control and assist future treatments of MCI patients. There is no medication for patients with MCI. This study offers patients some hope for future treatments.	Happy to help the with the potential of finding genetic markers for future MCI patients.
Join Dementia Research	MHSOA – Mary Keddy Alzheimer's Society	Enabling patients and their carers to take part in research studies: clinical trials and other studies within their study area that they would otherwise have no chance of participating in.	The numbers recruited onto JDR have increased dramatically over the last 2 years. People feel that they want to help future generations in bettering care and treatments.	Improving an understanding of links between lifestyle and dementia risk.
Culturally adapted Family Intervention (CaFI)	Orsborn house Aston & Nechells CMHT, Ladywood & Handsworth CMHT Paulette Clarke, Manager Sibusisiwe Ndhlovu, Clinical Lead Sutton CMHT	New Culturally adapted Family intervention which has been designed for African and Caribbean people with schizophrenia and psychosis related mental health disorders. Opportunity for staff to train and work as therapists on the trial contributing towards	Therapists – become culturally aware/becoming more culturally competent in everyday care learning new techniques to help service users and understand them better due to CaFI Service Users - potential to receive improved, tailored, culturally relevant therapy	SU's who felt they could benefit of CaFI, fed back very disappointed would not receive CaFI if in control group or at the end of trial. Led to some withdrawals from the study. Very difficult to engage SU's, some expressed they were not interested in the intervention or did not feel like they needed it. Some SU's fed back the study was

	Zinna CMHT Yewcroft CMHT Longbridge CMHT Small Heath CMHT Tamarind Centre inpatient wards Dawn Sutherland, Family and Carers Lead Reaside inpatient wards Hillis Lodge Hertford House David Bromley	their continued professional development (CPD) and embedding cultural awareness and competence in usual care. CaFI also offers experience to those who wish to gain skills in working with service users via the Family Support Member (FSM) role.	Family – have a greater understanding, feel able to provide specific support to loved ones have sense of value The study has been valuable in prompting conversations and awareness around the barriers to treatment that are rooted in cultural differences (staff, SUs and carers)	asking for too much of a commitment and did not have time. Valuable to build links with community partners (Catalyst 4 Change) and great to discuss and map out how PCREF advisors may be able to get more involved and support with future projects, acting as research champions. Staff capacity issues, both to support recruitment, and to train as therapists to support the trial. Capacity issues within delivery team- only one funded RA, needed unblinded RA, and someone manage recruitment of all staff to therapist roles and aFSMS (allocated family support members) to deliver the study. Some SUs involved expressed feeling ‘seen’ – they were appreciative of the recognition that there is a need for culturally adapted therapy and treatment, and the efforts made to address this

	Community Perinatal Team- West Becky Guest, Clinical Psychologist Deaf Service AOTs PCREF advisors – Catalyst4Change			Catalyst4Change expressed a lot of interest and passion for the project. They gave a lot of time and resources to push for recruitment within their own communities to support the study. They also provided input in our recruitment strategies
EMIN-Covid-19	Recruited via connect. Staff recruited from different teams across the Trust	Gain better understanding of staff's experience working throughout the covid-19 to inform trust policies and procedures.	Research suggests staff wellbeing is linked to standard of patient care. Ensuring staff are being heard and needs being met is vital.	Participants showed appreciation as they were given a space to speak about their experiences working for the Trust during the pandemic.
STARS	Epilepsy Team- Dr Bagary	New Nasal spray intervention for prolonged seizures.	Staccato alprazolam may improve your seizure-related signs and symptoms.	Caregiver burden too high- services users reported don't have appropriate care giver to take part

			Findings may be helpful the future treatments.	with, or caregiver not present enough of the time when have seizures to be able to complete all required study activities.
Diamonds	CMHTS	External self-management programme for people who have type 2 diabetes and a mental illness.	Potentially make a difference to blood markers, body weight, blood pressure, physical activity, diabetes complications and psychological well-being. Potential to have an additional intervention provided external to their clinical team	On face value there seem to be quite a few service users who are interested In the study and may find intervention beneficial – but as yet, they have not yet recruited into this study.
Enroll-HD	HD team	Collecting site specific data which can now potentially be used for further projects.	Patients seen more frequently meaning any issues can be picked up, referred to clinical team and dealt with quicker.	Patients enjoy being part of enrol and being able to contribute to research and feel like they're doing their part for themselves, families, and other people with HD. Gives patients opportunity to get more involved in research, get regular updates and opportunity to take part in clinical trials also being ran.

IAPT	Collaboration with UOB and stakeholders/IAPT teams from other trusts	Co-production Engagement with external IAPT services	Contribution to research Co-production Sharing of experiences	Allowing service users to have an active role in sharing their experience of IAPT with professionals in workshops
Community Navigator	Tracey Green/Sarah Turton Longbridge, Zinna and Warstock lane CMHT	Staff training Supervision Monthly community navigator meetings	Engaging service users with new local hobbies and activities Engagement within the community Actively reducing isolation This study recognises the role of social factors such as loneliness in treatment-resistant depression (TRD) and aims to address a critical research gap regarding effective social interventions through a biopsychosocial approach alongside existing treatments. This study has the potential to provide mental health teams with an evidence-based intervention to support individuals with TRD with their social recovery and mental wellbeing.	Different approach to other studies and allowing for more tailored 1-2-1 sessions Participants have valued participation in this trial as they particularly enjoyed having the opportunity to work on their social recovery. This is often overlooked as physical and mental health are prioritised.

Recollect	Recovery college/ Trustwide	Weekly check in meetings	Encouraging engagement with recovery college Allowing for skill set development and education	
Understanding Anger and Aggression (UAA)	Early intervention service Solihull (Dr Arsal Rana) and Forensic services (Dr Manjinder Padda)	New intervention	The aim of this study is to develop a new psychological intervention specially tailored to reduce aggression in forensic patients with psychosis. The new intervention would fill in a significant treatment gap for this population and improve outcomes for patient care e.g. reducing offending/reoffending, reducing antisocial and aggressive behaviours etc.	Through the study questionnaires, participants have enjoyed having the opportunity to reflect on behaviours that are angry/aggressive and why they may exhibit those behaviours. This is an important factor in their recovery and would support their engagement with their mental health team.
Antidepressant for the prevention of DEPression following first episode Psychosis trial (ADEPP)	Early intervention service Solihull (Dr Erin Turner)	Cost-effective treatment	This study aims to support mental health services by addressing the significant issue of depression following first episode psychosis which has several adverse outcomes including suicidality. This study aims to leverage existing evidence to offer a potentially cost-effective and	Not yet recruited – very strict eligibility criteria. All patients eligible have been approached.

			accessible treatment to improve outcomes for this cohort. It also highlights the need for evidence-based treatment options in the early stages of psychosis.	
RESOLVE- REalist Synthesis Of non-pharmacologicaL interVEntions for antipsychotic-induced weight gain (RESOLVE)	CMHTs	New intervention/pathway	This study aims to understand how non-pharmacological interventions can help service users with serious mental illness (SMI) manage weight gain which is a significant side effect of antipsychotics. This work will inform a new pathway to address the physical health needs of this population thus, potentially improving adherence to antipsychotics and subsequently outcomes, whilst meeting the priorities outlined in the NHS Long-Term Plan and the Mental Health Implementation Plan.	PIC site only – did not have the opportunity to receive feedback post interviews. However, pre-interviews, participants were really excited about the prospects of exploring strategies to manage antipsychotic induced weight gain as it significantly impacts all aspects of their lives including social relationships and work productivity.
Cognitive Remediation in Bipolar (CRiB2): a randomised trial assessing efficacy	Trust wide	New intervention	This study aims to support mental health teams by addressing the pressing issue of cognitive deficits in individuals with bipolar	

and mechanisms of cognitive remediation therapy compared to treatment as usual.			disorder (BD), potentially leading to better long-term management of the condition and reducing healthcare utilisation. It also aims to investigate the potential biomarkers associated with BD in order to better understand its underlying mechanisms. This work could inform the development of targeted interventions and personalised treatment approaches for this population.	
PHOENIx	Homeless Health Exchange	New intervention	Impacted wellbeing of service users receiving treatment, who received additional support on top of regular care, focusing on holistic support for health and housing.	Study indicated the intervention was well received by participants. Data collection outside of the trust was difficult and varied massively from GP to GP surgery. HeX (Health Exchange) were excellent at providing medical records when requested.
PROOF	HD service only	Evaluate the safety and effectiveness of the study drug, pridopidine, on	Potential to experience reduced decline, and being a part of the clinical trials means the patient will have more contact and intense	Participants on the programme report experiencing some benefits

		everyday functioning and daily activities, as well as movement and behaviour in participants with early-stage Huntington Disease – this is something additional to care they receive from the clinical team, as at present there is no therapy proven to affect the functional decline of the disease.	contact with the specialist consultant/ Three participants consented and completed treatment and are now in Compassionate Use stage (open label)	Some participants may not experience worsening of their condition in comparison to baseline.
Dimensions SAGE: A Randomized, Placebo-Controlled, Double-Blind Study to Evaluate the Effect of SAGE-718 on Cognitive Function in Participants with Huntington's Disease. (Clinical Trial)	HD service only	Trialling new drug intervention to target cognitive function in HD	Potential benefits with new medication not yet approved. Likely benefits will more be for future generations of HD patients	Increased contact with HD specialist

Appendix 7: BSMHFT Grant Applications: Unsuccessful or Pending Outcome

Research	Research Title or Stream	Funder	Submission Date	Stage 1	Amount
Dr Jack Rogers (Lead)	The clinical and cost-effectiveness of intermittent THeta-burst REpetitive transcranial magnetic stimulation for the treatment of Adolescent Depression: iTHREAD,	HTA (Health Technology Assessment)	May 2023	Unsuccessful	£2.3m
Dr Yetunde Ataiyero (Lead)	A mixed methods study exploring hand hygiene practices among healthcare workers in care homes	RfPB (Research for Patient Benefit)	August 2023	Unsuccessful	£150,000
Dr Clare Eddy (Lead)	Social cognition and quality of life in HD (Seed Grant)	European Huntington's Disease Network	Nov 2023	Unsuccessful	£29,000
Jankovic, Jelena (Co-applicant	PREventing PretErM Birth in nulliParous women Through cervical length screening (PRE-EMPT)"	NIHR Programme Grant	Nov 2023	Pending	£2.5m
Marwaha, Prof Steven (Lead)	Theta buRst stImulation for aDolescent dEpressioN feasibility sTudy: TRIDENT.	HTA (Health Technology Assessment)	Mar 2024	Pending	£77,5371.8
Heath, Helena (Lead)	Pre-doctoral Fellowship Round 6	Pre-doctoral Fellowship Round 6	Mar 2024	Pending	£129,653.00
Bicknell, Sarah (Co-applicant)	NIHR Team Science Award Round 1	NIHR Team Science	Mar 2024	Pending	£1,205.16

Integrated Performance Report

Context

All SPC-related charts and detailed commentaries can be accessed if you are on the Trust network via http://wh-info-live/PowerBI_report/IntegratedDashboard.html - please copy and paste this link into your browser.

Charts and commentaries for key areas of under performance are attached as appendices.

At the February 2023 FPPC meeting members requested a more detailed update on the key themes, factors affecting performance, actions and improvement trajectories for the following metrics:

- Active In appropriate Adult Mental health Out of area Placements (Previously Inappropriate Out of Area Bed Days)
- Talking Therapies – service users seen within 6 and 18 weeks (** improving trends for 6 weeks**)
- Referrals over 3 months with no contact
- Service users with a CPA review in the last 12 months (** now significantly improved and reaching target**)
- People metrics – Vacancies, Sickness absence, Appraisals and Bank & Agency fill rates

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

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

2024/25 NHS Planning guidance – national metrics

The 2024/25 national planning guidance has introduced a number of new metrics specific to the Trust and also updated the definition for some existing metrics.

A detailed breakdown and definitions is available in Appendix IIa, along with details of other current and supporting metrics. A summary of the changes is outlined below:

National metrics	Replaces/ changes	2024/25 Target	IPD
Active Inappropriate Adult Mental Health Out of Area Placements	Inappropriate Out of Area bed days	Trajectory agreed with NHSE is zero acute (from April 2024) and 10 inappropriate PICU placements only from June 2024	✓

3 day follow	7 day follow up	80%	✓
Talking Therapies - Recovery Rate (50%)	Target change	52% by March 2025	✓
Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness	New metric	48%	✓
Talking Therapies - Reliable improvement rate for those completing a course of treatment	New metric	67%	✓
Other Changes			
Clinically Ready for discharge – new definition	Delayed Transfers of care definitions	Not applicable	✓

For the new Trust specific metrics in the above table, reporting of these has been added to the IPD.

In addition, FPPC is asked to note that population health-based access measures for transformed community mental health services, Talking Therapies and Children and Young People will be assessed on a system wide basis. Additional metrics have been added which include: , Adults and older adults with long length of stay (over 60/90 days for adult/older adult admissions), People with severe mental illness receiving a full annual physical health check and Number of people accessing Individual Placement and support.

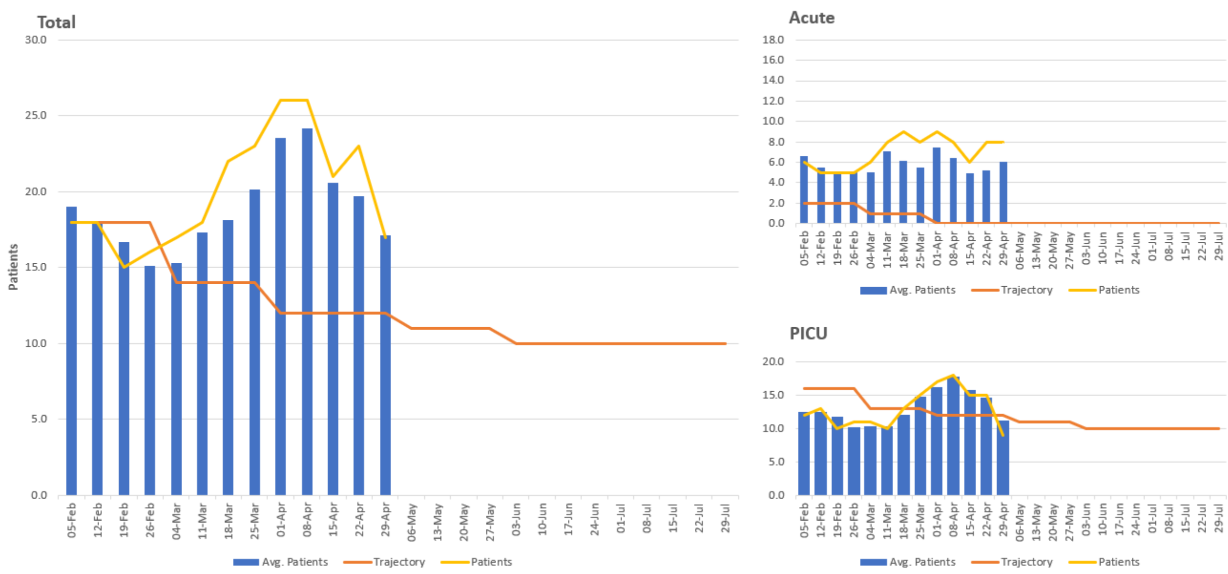
Performance in April 2024

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

Active Inappropriate Out of Area placements – The 2024/25 NHS planning guidance has introduced a revised metric for assessing the reduction of inappropriate out of area placements. This will now be based on the number of inappropriate out of area placements at each month end.

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

Process improvements being implemented as part of the Productivity action plan are helping to address underlying issues, but the level of demand and increased Clinically Ready for Discharge patients has impaired our ability to eliminate inappropriate out of area placements. Post New Year, the service has seen an increase in demand for acute and PICU beds leading to use of inappropriate placements during March and the level has been maintained in April 2024. The granular level weekly data, see chart below for end April 2024 shows that there are 8 remaining inappropriate placements for acute beds and 15 in PICU beds, above the trajectory of 12 placements for April.



Out of Area Steering Group -Action plan updates:

- **Locality model** – Rolled out to all localities
- **Contract procurement exercise** – completed, extending Priory capacity to include an additional 20 beds for BSOL system.
- **Demand Management/Gatekeeping -** local pilot implemented in two localities to gatekeep all admissions and ensure that alternatives to hospital admission are reviewed and offered. Further meetings to consider how these gatekeeping principles can be implemented across all 'doors' to inpatient admissions.

  Clinical Oversight Team - senior medical cover to have oversight of patients on the bed list, meeting with Kings Norton medical team and Bed Management to discuss placement of patients in area.

Longer term or requires additional support form ICB.

- **Reducing Length Of Stay/Clinically Ready For Discharges (CRFD)** - weekly internal bed management, ICB deep dive weekly, Estimated Discharge Date confirm and challenge process (more proactive approach being taken for patients with longer Length of Stay.
- Looking to embed social workers into the locality model. 5 hours of social work time has been agreed for locality CRFD bed flow meeting by Local Authority

- **Joined up 18+ bed management process** – options appraisal exercise in progress – due end of November 2024.

Talking Therapies waits – Trust performance has improved and is now above the national waiting time standards for 6 weeks (75%) with April at 77.28% due to the successful drive of the action plan which has led to an over achievement of the trajectory.

The 18-week standard is planned to be met by end of June 2024 (95%) and this remains challenging, however April 2024 has shown a continued improved position at 90.07%. Both recovery plans are heavily reliant on recruitment plans. New staff are beginning to embed and positively impact on the improving trends observed. The number of contacts in April was 15% higher than the same month in 2023.

The 2024/25 NHS planning guidance has introduced 2 new metrics focused on recovery covering reliable recovery and reliable improvement, these are in addition to the current recovery rate, all three rates are currently below national targets.

New referrals not seen within 3 months – Both Adult and Older Adult CMHTs have made progress against their improvement plans focusing on reducing long waits. Challenges in both services remain in particular around managing high caseload levels and pressures arising from staffing levels.

ICCR Adult CMHTs – Progress against the 2023/24 improvement trajectory to achieve a 20% reduction in new referrals not seen within 3 months has been slower than anticipated and the trajectory has not been reached. April 2024 at 748 service users waiting for an appointment and remains above trajectory of 726. The service lead has provided a revised trajectory to meet 622 by June 2024. is in the process of reviewing the existing plan and updating the actions and improvement trajectories for 2024/25. A revised action plan includes the following: Long Waits – progress made on reducing the over 52 week waits and focus has moved to those waiting from more than 18 weeks, ensuring that service users have appointments booked. Within Solihull there has been a focus on 26-52 week waits and appointments are being are booked in 5 weeks in advance as part of the ongoing pilot with admin leads reviewing waits at 52 weeks to ensure plans are in place. This has positively impacted on medical DNA rates in April with a 3% reduction for first appointments.

Staffing – The Neighbourhood mental health teams (NMHTs) are working to achieve a baseline staffing number. 2 PCNS served notice on their ARRS roles resulting in these roles having to be converted into full transformation funded roles.

Demand – All referrals are screened by the NMHTs and only referred into CMHT if SMI, complexity or risk is present and CMHT intervention is indicated. CMHT caseloads remain the same as overall demand across the system has increased (in line with the national position) and testing due to take place in the East piloting discharge clinics to support step down/discharge.

Early discussions are taking place as part of the NMHT development to move towards an MDT focussed Triage hub which will allow an MDT discussion to take place around formulation and where the best support might be offered for the service user.

Older Adult CMHTs – the 2023/24 action plan focused on reducing long waits in the first instance and to achieve a 20% reduction in the 18 week plus cohort by the end of April 2024. Good progress continues to be made and April 2024 position is at 178 service users waiting over 18 weeks, below the trajectory of 188.

There has been a focus on long waits over 26 and 52+ weeks and these have reduced from 86 in November 2023 to 55 in April 2024. The recovery plan is focused on staffing and increasing capacity and leadership within existing teams.

The service lead is in the process of reviewing the existing plan and updating the actions and improvement trajectories for 2024/25. This will be shared at the next FPPC meeting.

CPA with formal review in last 12 months - Performance has been on a gradually improving and upward trend following the implementation of recovery plans within adult and older adult CMHTs. The trust performance standard of 95% has been met and maintained for the last 4 months with April 2024 at 95.5%. As the 95% standard has been met this metric will remain as an area of improvement to ensure continued maintenance and if this achieved on a sustainable basis over the next 3 months, the metric can then be monitored as BAU. This approach has been supported by both service area ADs.

Clinically Ready For Discharge (CRFD) - bed days lost to CRFD have been on an increasing trend, with the latest Trust position at 8.4%. The main drivers for this are the delays in both adult and older adult acute services. CRFD in April 2024 in Adult Acute & Urgent Care is at 8.3% (22 patients) and in Older Adult Services at 20%. The number of delays in Acute and Urgent care have reduced this month. The main reasons for the delays in adult acute are lack of public funding and social worker allocation and in older adults is due to waits for a nursing home placement.

Quality the detailed position on these metric areas is discussed at QPES committee. A summary of the metric outliers is outlined below.

- Incidents resulting in harm (patients) has remained at 28%.

People Workforce measures – The detailed position on these metrics is discussed at the People Committee. FPPC is asked to note that there is an adverse variance against most of the set performance standards although there have been improving trends in reducing sickness absence and increasing bank and agency fill rates.

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

Summary position is outlined below:

- Staff sickness levels have increased to 5% in April 2024 below the improvement trajectory of 5.1%. Long term sickness has increased to 3% and short-term sickness to 2.02%.

- Bank and Agency WTE reduction – Trajectory to be provided next month.

- Staff Appraisals at 75.5% as at April 2024 and remains below the 90% Trust standard.

- A task and finish group in place to review and address any emerging themes or barriers within services.
- Additional support for operational areas has been offered to outlier areas to include, VBA demonstration, ESR support and SMART card access.
- A QI project has commenced and is currently identifying the areas for focus.

- Staff vacancy levels Vacancy data for April 2024 not available at time of writing.

Sustainability (detail in finance report).

- Capital expenditure - No major issue with achieving the agreed capital programme is envisaged at this stage
- Cash balance continues to be high.
- CIP YTD efficiencies are £600 against £1,251k plan, improved trend, but insufficient pipeline of potential savings.
- Agency YTD expenditure now below NHSE ceiling of 3.7% of pay bill.
- Operating Surplus - YTD surplus of £422k against plan of £114. Significant pressures in terms of out of area bed usage, temporary staffing and undelivered recurrent savings.

Integrated Performance Dashboard

Top Line Commentary (Trust level)

Performance: IAPT waiting times, Out of Area

People: Appraisals

Quality: Incidents resulting in harm (patients)

Sustainability: Savings plans yet to be identified

Division: A: All

A: All

April 2024

Performance

Measure	Value	Trend
Active Inappropriate Adult Mental Health Out of Area Placements	23	
Clinically Ready for discharge, Number of Delayed Days	1334	
Clinically Ready for Discharge, Percentage of Bed days	8.4%	
CPA 3 day FU	89.6%	
CPA 7 day FU	92.8%	
CPA with Formal Review last 12 mths	95.6%	↑
Eating Disorders Routine	100.0%	
Eating Disorders Urgent	100.0%	
First episode psychosis	100.0%	↑
Out of Area Bed Days	730	
Referrals over 3 mths with no contact	3521	↓
Talking Therapies into Recovery	47.5%	
Talking Therapies seen in 18 weeks	90.1%	↓
Talking Therapies seen in 6 weeks	77.2%	↓
Talking Therapies, Reliable Improvement rate	63.4%	↓
Talking Therapies, Reliable Recovery Rate	43.4%	↓

People

Measure	Value	Trend
Bank & Agency Fill Rate	91.8%	
Fundamental Training	93.4%	↓
Rolling 12m Turnover	7.2%	↑
Staff Appraisals	75.6%	↓
Staff Sickness	5.0%	

Quality

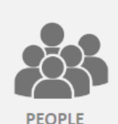
Measure	Value	Trend
Absconsions from inpatient units	1	
Commissioner reportable incidents	0	
Community confirmed suicides	0	
Community suspected suicides	0	
Failure to return	15	↑
Incidents of self harm	162	
Incidents resulting in harm (other)	11.4%	↑
Incidents resulting in harm (patients)	28.0%	↓
Inpatient confirmed suicides	0	
Inpatient suspected suicides	0	
Ligature no anchor point	18	
Ligature with anchor point	0	
Patient ssaults / 1000 OBD	2.1	
Physical restraints	183	↑
Physical restraints/ 1000 OBD	9.9	
Prone restraints	35	↑
Prone restraints/ 1000 OBD	1.9	↑
Reported incidents	2078	↑
Staff assaults	73	
Staff assaults / 1000 OBD	3.9	

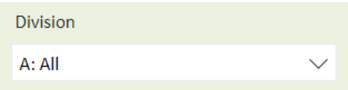
Sustainability

Measure	Value	Trend
CAP Ex	£1,213k	↗
Cash	£83,423k	↑
CIP	£600k	↑
Info Governance	92.5%	
Monthly Agency	£607k	
Operating Surplus	£422k	↓
SOF rating	3	↑

Key	
(pink)	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Integrated Performance Dashboard





A: All

Measure	Latest Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Active Inappropriate Adult Mental Health Out of Area Placements	12.00	18	13	23	15	23	23
Clinically Ready for discharge, Number of Delayed Days							1334
Clinically Ready for Discharge, Percentage of Bed days							8.4%
CPA 3 day FU	80.00	87.0%	88.3%	78.9%	81.8%	82.5%	89.6%
CPA 7 day FU	95.00	90.3%	95.8%	89.8%	92.7%	91.7%	92.8%
CPA with Formal Review last 12 mths	95.00	95.3%	94.8%	96.2%	96.2%	95.7%	95.6% ↑
Eating Disorders Routine	95.00	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%
Eating Disorders Urgent	95.00	100.0%		100.0%		100.0%	100.0%
First episode psychosis	60.00	100.0%	100.0%	100.0%	100.0%	75.0%	100.0% ↑
Out of Area Bed Days	328.00	604	402	561	519	578	730
Referrals over 3 mths with no contact		3412	3484	3310	3420	3623	3521 ↓
Talking Therapies into Recovery	50.00	47.7%	52.4%	45.0%	46.5%	45.3%	47.5%
Talking Therapies seen in 18 weeks	95.00	78.4%	84.3%	85.3%	83.6%	87.5%	90.1% ↓
Talking Therapies seen in 6 weeks	75.00	48.0%	66.6%	67.2%	70.0%	74.8%	77.2% ↓
Talking Therapies, Reliable Improvement rate	67.00	65.7%	67.3%	68.3%	67.9%	64.0%	63.4% ↓
Talking Therapies, Reliable Recovery Rate	48.00	44.3%	47.1%	44.3%	44.8%	40.8%	43.4% ↓

Top Line Commentary (Trust level)

KEY CONCERN:

* Out of Area is improving
* IAPT
* New referrals not seen in 3 months

(pink)	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Birmingham and Solihull Mental Health NHS Foundation Trust

QUALITY

A: All

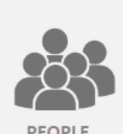
Measure	Latest Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Staff Vacancies		11.1 %	11.0 %	10.2 %	8.6%	11.9%	
Staff Sickness	4.28	5.6%	5.7%	5.6%	5.0%	4.7%	5.0%
Staff Appraisals	90.00	78.8 %	78.2 %	75.8 %	76.7 %	74.1%	75.6% ↓
Rolling 12m Turnover		8.0%	7.7%	7.4%	7.2%	7.5%	7.2% ↑
Fundamental Training	95.00	92.3 %	92.8 %	92.5 %	92.3 %	92.7%	93.4% ↓
Bank & Agency Fill Rate		88.5 %	90.3 %	90.3 %	91.7 %	93.5%	91.8%

KEY CONCERNS

* Vacancies
* Shift fill rates
* Fundamental training
* Sickness
* Appraisal rates

(pink)	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Integrated Performance Dashboard



Division

A: All

A: All

Measure	Latest Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Absconsions from inpatient units		3	6	1	9	2	1
Commissioner reportable incidents		0	0	0	0	0	0
Community confirmed suicides		0	0	0	0	0	0
Community suspected suicides		0	0	0	0	0	0
Failure to return		19	19	17	10	20	15 ↑
Incidents of self harm		187	150	160	160	198	162
Incidents resulting in harm (other)		9.9%	9.5%	9.8%	9.8%	9.5%	11.4% ↑
Incidents resulting in harm (patients)		23.3%	28.5%	26.1%	27.1%	28.2%	28.0% ↓
Inpatient confirmed suicides		0	0	0	0	0	0
Inpatient suspected suicides		0	0	0	0	0	0
Ligature no anchor point		47	25	21	10	31	18
Ligature with anchor point		1	1	0	0	0	0
Patient assaults		42	52	44	27	46	38
Patient ssaults / 1000 OBD		2.3	2.7	2.3	1.5	2.4	2.1
Physical restraints		221	224	213	214	276	183 ↑
Physical restraints/ 1000 OBD		12.1	11.8	11.0	11.9	14.4	9.9
Prone restraints		47	56	50	44	46	35 ↑
Prone restraints/ 1000 OBD		2.6	3.0	2.6	2.4	2.4	1.9 ↑
Reported incidents		2361	2235	2359	2128	2310	2078 ↑
Staff assaults		118	113	97	99	79	73
Staff assaults / 1000 OBD		6.4	6.0	5.0	5.5	4.1	3.9

Top Line Commentary (Trust level)

KEY CONCERNS

* Incidents resulting in harm (patients)

(pink)	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	
CAP Ex		£515k	£672k	£394k	£704k	£1,157k	£1,213k	↗
Cash		£88,274k	£86,507k	£86,186k	£92,306k	£92,228k	£83,423k	↑
CIP		£1,666k	£962k	£2,049k	£1,518k	£1,319k	£600k	↑
Info Governance		87.0%	88.6%	95.8%	94.5%	94.9%	92.5%	
Monthly Agency		£824k	£857k	£765k	£763k	£625k	£607k	
Operating Surplus		-£614k	-£580k	-£606k	-£616k	-£680k	£422k	↓
SOF rating		3	3	3	3	3	3	↑

KEY CONCERNS:

* CIP under achievement
* National financial uncertainty

(pink)	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Active Inappropriate Adult Mental Health Out of Area Placements

Divisions

Statistical Process Control (SPC)

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
A: All	18	13	23	15	23	23
B: Acute and Urgent Care	18	13	23	15	23	23

Commentary

From April 2024 the 2024/25 NHS planning guidance has introduced a revised metric for assessing the reduction of Inappropriate Out of Area Placements. This will now be based on the number of inappropriate out of area placements at each month end. A Trust trajectory has been agreed with NHSE as part of the 2024/25 national planning requirements. The trajectory is for zero acute in appropriate placements from April 2024 and to reduce and not exceed 10 PICU inappropriate placements from June 2024 onwards.

At the end of April there were 23 Inappropriate Out Of Area Placements with 8 in acute beds and 15 in PICU beds

The 2024/25 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE.The 2024/25 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE. This enables a reclassification of such beds as being 'appropriate' as they meet the qualitative requirements of an 'appropriate' placement. Internal reporting reflects those currently identified as 'appropriate'. However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHSE currently does not recognise these bespoke SOP arrangements

Detailed Commentary

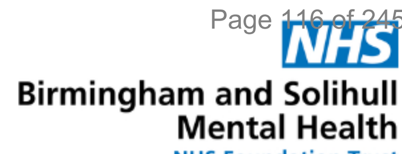
NHS Birmingham and Solihull Mental Health NHS Foundation Trust

Active Inappropriate Adult Mental Health Out

April 2024

Question	Answers
A: What has happened?	From April 2024 the 2024/25 NHS planning guidance has introduced a revised metric for assessing the reduction of Inappropriate Out of Area Placements. This will now be based on the number of inappropriate out of area placements at each month end. A Trust trajectory has been agreed with NHSE as part of the 2024/25 national planning requirements. The trajectory is for zero acute in appropriate placements from April 2024 and to reduce and not exceed 10 PICU inappropriate placements from June 2024 onwards. At the end of April there were 23 Inappropriate Out Of Area Placements with 8 in acute beds and 15 in PICU beds The 2024/25 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE.The 2024/25 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE. This enables a reclassification of such beds as being 'appropriate' as they meet the qualitative requirements of an 'appropriate' placement. Internal reporting reflects those currently identified as 'appropriate'. However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHSE currently does not recognise these bespoke SOP arrangements agreed via NHSE. NHSE and Commissioners are aware of these issues and acknowledge that until this issue is resolved, there will be differences between national reporting using MHSDS as the data source and local Trust reporting.
B: Why has it happened?	NHS Benchmarking data confirms that BSMHFT has one of the lowest number of inpatient beds per 100,000 population indicating the need for additional capacity to meet the needs of the BSOL population. In addition, the service continues to face pressure on its inpatient capacity, with bed occupancy levels consistently at 95%, the inpatient admission and discharge ratio largely on a 1:1 basis, lengths of stay generally higher than other Providers due to high levels of acuity requiring a higher number of observations and the challenges of reducing delayed transfers of care, where the reason for the delay is not in the Trust's immediate control. CRFD at 1334 overall in April, with adults at 545 lost bed days. Adult bed occupancy reduced to 95.7% and length of stay increased to an average of 108 days in April. The bed waiting list for service users being managed by Home Treatment Teams in the community are a further added pressure to capacity requirements. These combination of these challenges and their inter dependencies continually impact on creating sufficient flow within the acute and urgent care pathway in particular to allow repatriation of out of area placements. Demand for PICU beds remains high resulting in patients being placed in units further away from Birmingham. Staffing has also remained a challenge in terms of sickness and vacancies levels.
C: What are the implications and consequences?	Without a system wide approach and a review of patient flow across MH pathways, demand will continue to exceed available Trust capacity and risks to patients and staff potentially increasing without the reconfiguration of services needed to manage demand and manage patients in community teams that also have the staffing and skill mix levels to support. The bed waiting list identifies patients who are waiting to be admitted and are being risk managed in the community. Action plans continue to receive national and commissioner scrutiny which remain at a high level due to performance being above trajectory.

Question	Answers
D: What are we doing about it?	An update on the project plan was shared at the Performance Delivery group in November 2023 outlining progress within the 3 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. The 3 workstreams are : Demand Management/Gatekeeping • Managing demand, with local pilot implemented in two localities now to gatekeep all admissions and ensure that alternatives to hospital admission are offered. Further meetings arranged to review how gatekeeping can be more thoroughly implemented across all 'doors' to inpatients. High volume users project to identify high volume users and employ management plan to prevent admission and support/enable these users to avoid inpatient bed referral • Clinical Oversight Team - senior medical cover to have oversight of patients on the bed list, meeting with Kings Norton medical team and Bed Management to discuss placement of patients in area. Locality model development • There has been positive progress in East, with the bed waiting list reducing and repatriation to locality beds from other localities & OOA starting to take place. The locality model has now been rolled out to all other localities. New bed management function to support the locality model being developed. CRFD Workstream and length of stay • Renewed focus on Clinically Ready for Discharge (replaced DTOC). Action plan in place, and suggestions of how to improve internal management of CRFD being presented via OOA Steering Group. • weekly internal bed management, ICB deep dive weekly, Estimated Discharge Date confirm and challenge process (more proactive approach being taken for patients with longer Length of Stay. • Looking to embed social workers into the locality model. 5 hours of social work time has been agreed for locality CRFD bed flow meeting by Local Authority Work has been undertaken to extend the current contracts for appropriate placements with the number of beds available increasing for 2024/45, this should help reduce the number our of area placements in the future A new trajectory has been agreed with commissioners for reductions in inappropriate out of area placements for 2024/25. This is based on the new national metric introduced in April which will look at the number of OOA placements at month end.
E: What do we expect to happen?	Monthly use of inappropriate out of area beds is expected to continue but reducing as the range of actions being taken forward get implemented and embedded and progress is made toward achieving the agreed trajectory of using only 10 or less PICU placements.
F: How will we know when we have addressed issues?	When the numbers of inappropriate OOA placements reduce in line with the trajectory submitted in the action plan. Actions being taken forward by the workstreams begin to impact on creating capacity and flow to support repatriation of out of area placements.



Detailed Commentary

Clinically Ready for discharge, Number of

April 2024

Question	Answers
A: What has happened?	From April 2024 there has been a national move away from the current DTOC definition to Clinically Ready for Discharge (CRFD) which is a more tailored definition for mental health, covering both internal and external delays. The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. The number of CRFD bed days for April 2024 was 1334, with 545 days in acute adults which represents 22 patients and 403 days in older adults.
B: Why has it happened?	The main reasons for the delays across both services include lack of social care support and awaiting nursing home placements which also requires social care input. These are system wide challenges and partnership working is taking place with local authority and ICS colleagues daily and weekly to review current barriers to discharge for each individual patient. However it is recognised that the ability of partners to aid timely discharge of service users is a continual challenge due to availability of appropriate alternatives. The majority of those CRFD are awaiting nursing home placements or care packages which requires social services input to facilitate this process.
C: What are the implications and consequences?	Failure to discharge patients in a timely way reduces the flow within in-patients, contributing to out of area placements and leads to an increased waiting time for beds and impacts on patient experience.
D: What are we doing about it?	Reviewing patient flow and activities as part of operational and strategic management of demand and capacity as part of both community and acute and urgent care transformation work plans. A multi-agency bed management meeting has been introduced to support improved bed flow across inpatient services, along with production boards which provide an update on each patient's delay, identifying progress and tasks required to support discharge. Regular discussions with colleagues in the ICS and local authorities to assist in addressing the 'system' wide challenges and identifying alternatives to aid discharge for service users waiting for social care and nursing home placements. More recently a 'system' wide CRFD task and finish group has been established to support partnership discussions to assist in facilitating discharges. 5 hours of social work time has been agreed for locality CRFD bed flow meeting by Local Authority. From April 2024 there is a national move away from the current DTOC definition to a more tailored definition for mental health. The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. Rio has been updated to capture this data and from April onwards we will be reporting on those Clinically Ready for discharge.
E: What do we expect to happen?	Via the partnership working, to begin to see reductions in delays due to availability of alternatives including social care support and nursing home capacity that is not in our immediate control.
F: How will we know when we have addressed issues?	Begin to see partnership and system wide solutions being implemented contributing to a reduction in these delayed discharges.

Referrals over 3 mths with no contact

Divisions

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
A: All	3412	3484	3310	3420	3623	3521
C: ICCR	1262	1272	1245	1297	1365	1306
D: Secure Serv & Offender Health	164	168	79	77	75	75
E: Specialties	1866	1925	1951	2012	2143	2100

Commentary

The number of patients who have not been seen after 3 months of referral has fluctuated over the last 5 months and has shown an increase over the last 2 months with March 2024 at 3623. The number of referrals not seen within 3 months of referral has decreased in Solar primary care but has increased in SOLAR, Neuropsychiatry, memory Assessment and in both adult and older adult CMHTs.

Neuropsychiatry service accounts for 23.5% and Adult CMHTs 21.9% of referrals open for over 3 months without a contact.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

April 2024

Referrals over 3 mths with no contact

Question	Answers
A: What has happened?	The number of patients who have not been seen after 3 months of referral has fluctuated over the last 5 months and has shown an increase over the last 2 months with March 2024 at 3623. The number of referrals not seen within 3 months of referral has decreased in Solar primary care but has increased in SOLAR, Neuropsychiatry, memory Assessment and in both adult and older adult CMHTs. Neuropsychiatry service accounts for 23.5% and Adult CMHTs 21.9% of referrals open for over 3 months without a contact.
B: Why has it happened?	During the COVID period, face to face contacts reduced with staff using telephone contact and digital solutions such as AccruRx to conduct appointments. However a backlog was created as a result. In addition, in line with available research, new demand is also arising as a result of the impact from Covid -19 resulting in increased referrals to CMHTs adding pressure on ability to see service users within 3 months of referral. This indicator also relies on teams outcoming appointments on Rio and work is being undertaken with services on an ongoing basis to reduce the number outstanding. ICCR: Caseloads in CMHT have increased by 4000 patients since 2019 but there has not been an increase in CMHT medical staffing to meet the need for appointments. The service has high rates of DNA for first and follow up appointments meaning appointment slots not being utilised (medical DNA rates for first appointments were 37% in March. Plans have been implemented to reduce DNA rates, actions include moving to opt out rather than opt in arrangements for our patients for text message reminders, a review of hybrid mail as many patients say they do not receive appointment letters, increasing the capacity of admin staff to complete telephone reminders, discharging patients, if appropriate after repeat DNAs. We also see numbers within this category of patients who are transfers from other teams so are being seen in other services . Future reporting will enable us to identify those service users who have had no contact at all from mental heath services. Due to the high number of patients waiting to be seen for a first appointment, the initial focus for the ICCR CMHTs is to reduce the long waits. The revised trajectory is based on achieving a 20% reduction in the new referrals not seen within 3 months by the end of January 2024. Progress has been slower than expected and a revised trajectory has been put in place as the original trajectory to meet the 20% reduction at the end of January has not been achieved. April 2024 at 748. Specialties: We currently have an aging population and better awareness of mental health concerns within the population and at primary care level. This has led to a consistent increase in number of referrals to our Older Adult CMHT, particularly for patients with dementia, but has not been accompanied with any increase in the Older Adult CMHT workforce. Caseloads of care coordinators are currently high (some CPNs have 50+ against an ideal maximum of 35) reducing CPN capacity to see new assessments and take new patients on. There has also been a reduction in the number of discharges with some patients being kept on for supportive monitoring where they could be appropriately discharged. There are discrepancies in medical workforce numbers between the teams causing higher waits for medical outpatient clinics in some teams. There is also a significant number of patients in care homes where, due to pandemic restrictions, our service was unable to see or communicate with service users directly however, through carers were able to provide consultation and commence treatment, however these have remained on the waiting list. For all services, it is important to note that where patients DNA, they are likely to have been provided with an appointment within 3 months - this is a particular issue for perinatal patients where due to having an infant, patients frequently cancel or DNA appointments prior to eventually being seen. In bi-polar service, patients will already be under a CMHT in order to access their service. Waiting times being over 3 months will be due to having to wait for the next group cohort to commence which may be after 3 months depending on when they are referred. Due to immediate staffing pressures Older Adults did not initially have a trajectory set, but due to an improved staffing position they are now aiming to focus on the long waits and to achieve a 20% reduction in the 18 week plus cohort by the end of April 2024. April 2024 at 178 below the trajectory of 188.There are long waiting times within neuropsychiatry with the

Question	Answers
C: What are the implications and consequences?	The implications are delayed assessment and therefore access to mental health services/treatments prolonging their difficulties. All referrals within ICCR are triaged and risk assessed at the point of referral, so although delays may occur for a first appointment, if risks are identified referrals are fast tracked for assessment. All referrals receive information around crisis access, should their situation deteriorate into crisis whilst waiting . Waiting times for neuropsychiatry are to be expected as this is a tertiary specialist service where patients are seen for highly specialist consultation and, if they require secondary mental health care, would be under a local CMHT service
D: What are we doing about it?	ICCR: Are continuing to review CMHT activity via twice monthly waiting list & KPI oversight meeting. Clinical service managers review the numbers waiting and how many appointment slots are being offered and take away actions for their teams. These actions including cleansing the data, discharging, or prioritising appointments for service users who need an appointment with community mental health services. There has been a focus on those waiting over 52 weeks and these have now been reduced and will now allow a focus on those waiting for more than 26 weeks, however, this is a much larger group and will take time to work through. There are currently 251 in this group with 145 who have been offered an appointment and in some cases multiple appointments. All referrals are now first screened by the NMHT and only referred into CMHT if SMI, complexity or risk is present and CMHT intervention is indicated. We envisage over the next 12 months as the NMHTs grow that this will have a significant impact on reducing waits and capacity within CMHT. The 5 NMHTs are at varying levels of staffing and are working through recruitment plans ,it is hoped that they will be fully recruited to be Mid year 2024 (May 2024) .In the medium term, a plan is in place that includes engaging Talking Therapies to divert referrals from NMHTs thus creating capacity for the NMHT to take on low level CMHT cases (we have noted in NMHT data that 70% of referrals to our NMHT function are for presentations of depression & anxiety who should be signposted to talking therapies as the correct service to meet the service users needs), reducing DNA rates for first appointments to 20% by May 2024, reduce numbers not seen over 3 months by 20% by end January 2024.The Longer term plan is to achieve capacity within CMHTs and to achieve a 4 week wait by end of 2024. By end of 2024 we will have complete coverage of all PCNs and will therefore have greater impact on our ability to manage referrals effectively. Solar: have had a focus on new referrals and have reduced those waiting for an initial appointment and have created some additional capacity for assessments using the 3rd sector, however this will result in longer waits for treatment. They are planning a circuit breaker In April to help improve waiting times and are going to undertake a QI project to look at their processes. Specialties: A caseload audit is currently being undertaken picking up patients who have been waiting longer than 3 months. Regular contact (every 2 weeks) is being made with these patients by the duty clinician, offering telephone support and prioritising appointments if there has been a deterioration in presentation. Regular management supervision is focussing on care coordinator capacity, looking at where patients could be stepped down from care coordination to free staff up to do new assessments. Admin lead supporting the management of care support patients using Rio to identify where patients do not have follow up appointments (where they have missed the appointment) and booking these in through med secs. Due to immediate staffing pressures Older Adults did not initially have a trajectory set, but due to an improved staffing position they are aiming to achieving a 20% reduction in the 18 week plus cohort by the end of April 2024. Within Memory Assessment service, triage is taking place with those on the waiting list and if any risks are identified they will be referred to an appropriate team or signposted to other services. Following the national planning guidance for 204/25 and the implementation of the waiting times, there is an ask to review all long waiters over 104 weeks in the first instance.
E: What do we expect to happen?	Within adult CMHTs we expect referrals for assessment to our Community mental health service to be reduced to meet the 4 week window as set out by the Long term plan, although this measure has not been implemented as yet we would hope to achieve this by end December 2024 when all new funding has been utilised to grow capacity in our community mental health services. We expect DNAs to be effectively managed and reduced to below 20% for both first appointments within 6 months (May 2024). The Neighbourhood function of our community mental health service is expected to divert activity for lower complexity work and to ensure referrals are signposted to correct services such as talking therapies rather than CMHT , this will lead to CMHT activity being reduced and support with ensuring timely access in the CMHT function. We will also be ensuring that NMHT data is included within the whole data set to give a complete picture for our Community mental health service. We are already noting that the majority of patients seen by the NMHT function are seen within 2- 4 weeks. Within older adult CMHTs we expect there to be some improvement in waiting lists, as staffing position has improved, however this remains challenging.
F: How will we know when we have addressed issues?	For adult services when we have reduced numbers being referred to the CMHT function and are seeing activity for the community mental health service (including NMHT function as a whole) and we have reduced the numbers not seen over three months by 20% by end January 2024. For Older Adults they would have seen a reduction of those waiting for more than 18 weeks by 20% by end April 2024.

Talking Therapies seen in 6 weeks

Divisions

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
A: All	48.0%	66.6%	67.2%	70.0%	74.8%	77.2%
E: Specialties	48.0%	66.6%	67.2%	70.0%	74.8%	77.2%

Commentary

Performance has been on a gradual increasing trend for the last 12 months and is now above the 75% target for the first time in the last 3 years. April 2024 position has increased to 77.16%, which is above the recovery plan trajectory for April and the target.

Talking Therapies seen in 18 weeks

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
A: All	78.4%	84.3%	85.3%	83.6%	87.5%	90.1%
E: Specialties	78.4%	84.3%	85.3%	83.6%	87.5%	90.1%

Commentary

Performance has been on a gradual increasing trend for the last 12 months but remains below the 95% target. April 2024 has increased to 90.11% and remains below the trajectory

Detailed Commentary

Talking Therapies seen in 18 weeks

April 2024

Question	Answers
A: What has happened?	Performance has been on a gradual increasing trend for the last 12 months but remains below the 95% target. April 2024 has increased to 90.11%, and remains below the trajectory.
B: Why has it happened?	The service has a large number of vacancies following staff leavers and retirements. Significant challenges have been faced around retention with staff leaving to take further training and work opportunities outside of the NHS or moving to posts which attract higher bandings in other Trusts. This has particularly impacted our ability to retain trainees who complete their training with BHM but then take higher banded position in other Trusts. There is also a national workforce challenge in specialised IAPT roles meaning the service is limited to recruiting from existing trained staff and available trainees. There is an action plan in place which is heavily reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times. New staff have commenced, and this has been reflected in an increased number of contacts being recorded. However, as the waiting times are measured when therapy finishes it will take time for the improvements to come through in the data. Contact data for April 2024 shows 15% compared to the same month in 2023.
C: What are the implications and consequences?	Patients are not being able to access services in a timely way and are currently waiting longer than the national target.
D: What are we doing about it?	The trajectory for 18 weeks was due to be met by November 2023, but progress has been slower than anticipated due to staffing challenges and a revised trajectory has been put in place to reach 95% by the end of June 2024 to align with recruitment and retention plans. The action plan in place is heavily reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times. New staff have commenced in October (including the trainees for the year), and this has been reflected in an increased number of contacts being recorded, however as the waiting times are measured when therapy finishes it will take time for the increased staffing to take effect, and this will help in the medium term. The increase in staff has had a positive impact on the number of patient contacts with April 2024 seeing a 15% increase compared with the same month in 2023. There still remain challenges in staffing with a large number of vacancies which is impacting the level of activity which can be undertaken. A system wide forum has been set up with the support from the national IAPT team which brings together Providers and the lead commissioner to work on an integrated approach across BSol and to address how we can work together to address demand and capacity. A rolling programme of recruitment is in place and the managers are working hard to promote staff wellbeing with initiatives to foster retention within the service. Additional capacity has been sourced through Xyla (a digital service) and service users are given the option of using this service. A clinical development lead is supporting the team to screen referrals and identify barriers to recovery planning and developing existing relationships with neighbourhood mental health teams to enable further support. A bespoke CPD training package has been purchased to help contribute to recruitment and retention of staff. Following recommendation from the Talking Therapies lead for Commissioning, a change to the way that our data is recorded aligned to recording utilised by other trusts and services has been implemented and backdated to June 2023. Appointments with a treatment element will now be counted as 'treatment'. The effect of this change has improved the waiting times position. The moving to recovery rate was initially affected, falling to 42% in August, below the 50% national standard, however, this has improved with December at 52.44% but has fallen again in April to 47.48%. The change in recording of activity has been applied to internal and external reporting.
	BHM are instigating a number of initiatives to reduce the waits for HI CBT and are in the process of registering this as a QI project. It is hoped this work, alongside the above, will mean that waits for HI CBT in the service are reduced, offsetting the negative impact on recovery and reducing the number of single session contacts.
E: What do we expect to happen?	The service expects to see a continuing improvement and to reach the 95% target by end June 2024 as the contacts undertaken by the new staff begin to come through. This will not be immediate due to working with service users to reach recovery and will take some months before progress through the data is visible.
F: How will we know when we have addressed issues?	The national standard of 95% is met and maintained.

Talking Therapies, Reliable Improvement rate

Divisions

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
A: All	65.7%	67.3%	68.3%	67.9%	64.0%	63.4%
E: Specialties	65.7%	67.3%	68.3%	67.9%	64.0%	63.4%

Commentary

This is a new national metric for 2024/25 with an increased focus on recovery. April 2024 at 63.36% below the target of 67%. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression has reliably improved at the end of their treatment. April 2024 position has shown an deterioration from March and remains below the 67% target at 63.36%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies, Reliable Improvement rate

April 2024

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. April 2024 at 63.36% below the target of 67%. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression has reliably improved at the end of their treatment. April 2024 position has shown an deterioration from March and remains below the 67% target at 63.36%.
B: Why has it happened?	The Reliable Improvement rate is currently outside the lower control limit for the last 2 months. The target for reliable improvement is 67% of all patients who complete a course of therapy. A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria. A person has shown reliable improvement if their scores on the depression and/ or the relevant anxiety/ medically unexplained symptoms measure have reduced by a reliable amount, whether or not they met caseness at the start of treatment.
C: What are the implications and consequences?	Service users needs are not being met and the national 67% standard is not being met.
D: What are we doing about it?	The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable improvement rate.
E: What do we expect to happen?	The local needs of service users and challenges presented are routinely discussed and monitored within the service to support actions to aid reliable Improvement.
F: How will we know when we have addressed issues?	Maintain/exceed the 67% Reliable Improvement rate.

Talking Therapies, Reliable Recovery Rate

Divisions

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
A: All	44.3%	47.1%	44.3%	44.8%	40.8%	43.4%
E: Specialties	44.3%	47.1%	44.3%	44.8%	40.8%	43.4%

Commentary

This is a new national metric for 2024/25 with an increased focus on recovery. The Reliable Recovery rate has fluctuated and is not meeting the 48% target. Reliable Recovery Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment. April 2024 position has shown an improvement from March but remains below the 48% target at 43.46%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies, Reliable Recovery Rate

April 2024

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. The Reliable Recovery rate has fluctuated and is not meeting the 48% target. Reliable Recovery Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment. April 2024 position has shown an improvement from March but remains below the 48% target at 43.46%.
B: Why has it happened?	The target for recovery is 48% of all patients who complete a course of therapy. A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria that met caseness at the start of treatment. Patients are considered reliably recovered if they meet both criteria for reliable improvement and for recovery.
C: What are the implications and consequences?	Service users needs are not being met and the national 48% standard is not being met.
D: What are we doing about it?	The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable recovery rate.
E: What do we expect to happen?	The local needs of service users and challenges presented are routinely discussed and monitored within the service to support actions to aid Reliable recovery
F: How will we know when we have addressed issues?	Maintain/exceed the48% Reliable Recovery rate.

Staff Vacancies

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
A: All	11.1%	11.0%	10.2%	8.6%	11.9%
B: Acute and Urgent Care	12.8%	13.0%	12.5%	7.4%	10.3%
C: ICCR	11.0%	10.7%	10.3%	12.9%	16.8%
D: Secure Serv & Offender Health	14.9%	15.0%	14.2%	11.6%	11.7%
E: Specialties	15.5%	15.4%	14.1%	7.2%	7.2%
F: Corporate	-2.5%	-3.2%	-4.3%	0.3%	5.4%

Commentary

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Note: data for April 2024 not available. Included chart to provide update on March 2024 position

Detailed Commentary

Staff Vacancies

February 2024

Question	Answers
A: What has happened?	We are awaiting February data but the vacancy rate in January was 10.02% and was above the KPI target of 6.0%. The HCA vacancy rate was 0.0% and the band 5 vacancy rate was 39.8% - down from 47% between June and September in 2023.
B: Why has it happened?	The national shortage of registered nurses particularly band 5 has not changed and this is reflected in our local data, despite some progress with the reduced vacancy rate.
C: What are the implications and consequences?	Unsafe staffing levels continue to pose the risk to both service users and our workforce alike.
D: What are we doing about it?	BSMHFT's People Partner for Resourcing and Temporary Staffing met and presented to Nursing Students at the University of Birmingham and hosted a stand at both the Birmingham City University and University of Wolverhampton Nursing Careers Recruitment Events. Approximately 40 students in their final year were spoken to in detail at both recruitment events and their names and contact details were collected, with a view to being able to facilitate making offers to them upon completion of their studies and them acquiring their PIN's. BSMHFT will be hosting a stand at the RCNI Recruitment event on the 11th March with up to 500 Nurses in attendance, with a proportion of those being Mental Health Nurses. Interviews will be held of the day with a view to makings offers to those successful. The ICB and NHSE have introduced instruction on vacancy levels and agency reduction - A by-product of the weekly vacancy control panel (now in its 6th full month) is the highlighting of if the correct processes and procedures are being used to ensure like for like permanent / fixed term vacancies are being requested and put in place. Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are being rolled out throughout the recruitment process to: -Ensure flexibility is promoted in internal advertisements and vacancy information. - Enhance training for hiring managers to equip them to discuss flexible working at interview. -Update recruitment processes and training to ensure that the drop down menu for different types of flexible arrangement are used on NHS Jobs / TRAC when vacancies are created. -Upskill hiring managers / resourcing teams to be able to identify which forms of flexibility are appropriate for roles. - Draft and get sign off on an organisational statement about openness to flexible working arrangements, to be included in all vacancy packs. -Start monitoring number of new joiners who are recruited flexibly and collate this centrally. A sixth Recruitment Initiatives and Strategy meeting was held to ensure the department is maximising every opportunity to continuously improve processes and initiatives such as trac procedures, interview techniques training, flexible working, attraction strategy, social media, DBS expediency and proactiveness with vacancy filling.
E: What do we expect to happen?	There are national supply issues in relation to registered nursing staffing groups meaning we do need to recognise that this will limit the improvements that can be made in relation to vacancy rates. We are competing with private hospitals in the BSol area who are prepared to offer significant financial attraction packages which we currently are not able to match. However targeted work ongoing across the Trust, including recruitment events and bank and agency reduction programmes, will hopefully mean that we see a reduction in vacancy rates over time.
F: How will we know when we have addressed issues?	When the vacancy rate is at or below the 6% Trust target.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

Divisions

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
A: All	5.6%	5.7%	5.6%	5.0%	4.7%	5.0%
B: Acute and Urgent Care	7.1%	7.0%	7.1%	6.2%	5.6%	5.7%
C: ICCR	5.5%	5.4%	5.2%	5.5%	4.9%	4.6%
D: Secure Serv & Offender Health	6.5%	6.8%	7.7%	6.2%	6.1%	6.4%
E: Specialties	5.2%	5.5%	5.1%	3.8%	3.5%	4.4%
F: Corporate	3.6%	3.5%	2.9%	3.1%	3.1%	3.7%

Commentary

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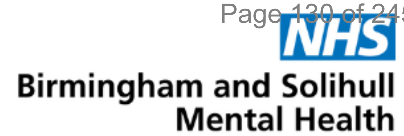

Detailed Commentary

Staff Sickness

April 2024

Question	Answers
A: What has happened?	Over the past six months reporting period (November 2023 to April 2024) there is evidence of consistent trend showing reduction in sickness absence levels, reduction from 5.9% to 4.6%, a reduction of 1.3% across the Trust. Longterm sickness absence over six months from 3.3% to 3.0% and short term sickness absence reduced from 2.7% to 1.6%. Although there are downward trends in working towards the Trust sickness absence targets, the Trust has not met its targets for sickness absence which is 3.9% for overall sickness absence, long term sickness absence 2.6% and shorterm sickness 1.3%.
C: What are the implications and consequences?	There is evidence, that managers continue to engage and support employees with sickness absence. However, our return to work contacts is 74.2% which is below the Trust target of 85%. The implication is that enough return contact are still low.
D: What are we doing about it?	The People Team continues to work with managers to ensure that return to work meetings are held regularly. Where meetings have been missed for several reasons that these meetings are rearranged as soon as possible. The People Team continue to train managers on the management of sickness absence.
E: What do we expect to happen?	That we maintain the downward trend for sickness absence management and for the Trust to meet its targets for the management of sickness absence.
F: How will we know when we have addressed issues?	When we see sickness abscence levels reduced and that the key reasons for sickness absence (anxiety and depression) are no longer the highest reasons recorded for absence.

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Staff Appraisals

Divisions

Statistical Process Control (SPC)

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
A: All	78.8%	78.2%	75.8%	76.7%	74.1%	75.6%
B: Acute and Urgent Care	68.1%	66.7%	65.8%	67.7%	63.2%	71.3%
C: ICCR	84.9%	85.5%	81.6%	80.3%	79.3%	80.0%
D: Secure Serv & Offender Health	85.6%	83.5%	80.7%	82.3%	80.3%	81.2%
E: Specialties	82.0%	82.4%	79.9%	81.3%	78.6%	77.7%
F: Corporate	68.3%	68.5%	67.9%	68.3%	65.4%	64.9%

Commentary

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Detailed Commentary

Staff Appraisals

April 2024

Question	Answers
A: What has happened?	The trust's Appraisal compliance for April is 75.9%. The trust remains below the Trust target of 90% and commissioner's target of 85%. The teams within the Trust that are below the compliance trajectory of 75% are: Acute And Urgent Care Services 71.9% Exec Dir - Medical 72.6% Exec Dir - Nursing 67.5% Exec Dir - Resources 67.5% New Care Models - 63.4%
B: Why has it happened?	The appraisal compliance figure has decreased due to staff reaching their 12 month expiry of appraisal, therefore an ongoing need to refresh their understanding/skill set to completed appraisal.
C: What are the implications and consequences?	We are not meeting our commissioner target of 85% and the Trust fails to demonstrate a holistic approach to reward (through personal development) to all employees, address inequalities, reflect and represent the communities served by the Trust.
D: What are we doing about it?	L&D continue to work with the Communication team to support both the QI project and continued appraisal work. Currently reviewing/developing actions arising from the QI project and continuing to work with comms team to support good news stories. BAU activities continue with L and D utilising reports to identify started but not completed appraisals (2 weekly) and Chase emails. In addition L&D will continue appraisal hotspot work targeting those teams below 75%. From the 1st May teams identified as repeatedly below 75%, will be contacted by an L&D manager/s to explore issues and offer alternative support and/link in with OD colleagues where appropriate. L&D are also continuing with te QI project work: A face-to-face workshop was held at Uffculme on the 22nd April with the working together group to discuss/action the following: 1) to map out their current appraisal journey; 2) To identify/explore where support is needed; 3) Developing our Driver diagram; 4) Any Quick win first order changes.
E: What do we expect to happen?	L&D consultancy/coaching conversations to support specific teams and QI change ideas 'quick wins' to provide improved appraisal journey for staff. Ongoing comms teams support.
F: How will we know when we have addressed issues?	The overall aim will be aligned to the appraisal process in achieving an improvement in the quality of values-based appraisal converstions, enabling the development of an inclusive, compassionate culture.

Fundamental Training

Divisions

Break down by Division (with pink background where target not met)

Division	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
A: All	92.5%	92.3%	92.8%	92.5%	92.3%	92.7%
B: Acute and Urgent Care	91.8%	91.6%	91.8%	91.6%	91.8%	92.1%
C: ICCR	93.1%	92.3%	92.9%	92.6%	92.7%	93.0%
D: Secure Serv & Offender Health	92.6%	92.5%	93.2%	92.8%	92.2%	92.7%
E: Specialties	93.0%	93.2%	93.6%	93.3%	92.7%	92.9%
F: Corporate	91.5%	91.7%	91.9%	91.9%	92.1%	93.0%

Commentary

The overall Fundamental Training compliance increased slightly from 92.5% in February 2024 to 92.7% in March. Overall, the trust has surpassed the Commissioners' target; nevertheless, we remain below of the 95% Trust target for substantive staff. With the exception of Executive Director-Resources and Executive Director- Medical, every area is still below the 95% Trust target. Temporary Staffing Compliance has decreased from 83.4% in February to 83.3% in March which remains above the Trust Target of 75%

- Chief Executive Locality – 75.4%,
- Exec Director - Medical Locality –95.9%,
- Exec Director - Nursing Locality – 92.3%,
- Exec Director – Operations
  - o Acute and Urgent Care –92.1%,
  - o ICCR – 92.8%,
  - o Secure Services and Offender Health – 92.8%

Detailed Commentary

Fundamental Training

April 2024

Question	Answers
A: What has happened?	The overall Fundamental Training compliance increased from 92.7% in March to 93.4% in April. Overall, the trust has surpassed the Commissioners' target; nevertheless, we remain below of the 95% Trust target for substantive staff. With the exception of Executive Director-Resources and Executive Director- Medical and Executive Director- Resources, every area is still below the 95% Trust target. Temporary Staffing Compliance has increased from 83.3% in March to 95.% in April which remains above the Trust Target of 75% • Chief Executive Locality – 85.5%, • Exec Director - Medical Locality –97%, • Exec Director - Nursing Locality – 93.5%, • Exec Director – Operations o Acute and Urgent Care –92.9%, o ICCR – 93.4%, o Secure Services and Offender Health – 93.1% o Specialties – 93.5% • Exec Director - Resources Locality – 96.4%, • Exec Director - Strategy People and Partnerships Locality – 92.6%
B: Why has it happened?	We have seen an increase in compliance due to externally procured courses which has enabled compliance to increase as we are now able to meet the increased demand for courses. We have introduced two new Fundamental Training subjects, SRS and Oliver McGowan E-Learning, these are currently in their grace period so we have not yet seen the drop in compliance. Temporary staffing have restricted those who have not kept up to date with their training which has led to their compliance increasingly significantly.
C: What are the implications and consequences?	• Low FT compliance is a risk to patient safety and the safety of our staff. There is a risk staff will not have the competence required to practice safely in clinical areas. • Breach of commissioners' compliance contracts which can result in financial penalties that can cost in excess of £210,000 per subject for every month that BSMHFT remains non-compliant. • TSS are not included in overall Trust compliance however are required to undertake training. The required training needs to provide TSS staff on time to be practice safely. If TSS staff cannot undertake the necessary training they will be unable to book to work on inpatient wards.
	• Rapid Tranquilisation training is now available via webinar once a month in addition to in person multiple times a month • Extra notifications about upcoming training are being sent out by the Fundamental Training staff.
E: What do we expect to happen?	• By the end of April 2024 we expect all courses except for Rapid Tranq, ILS and ELS to reach 90% • We expect the overall Trust compliance will remain above 90% however we are expecting new Fundamental Training subjects to come online in the next few months which will effect the overall compliance including Oliver McGowan and SRS- Conveyance
F: How will we know when we have addressed issues?	Once Substantive Fundamental Training compliance will reach 95% on Insight Reporting System

Incidents resulting in harm (patients)

Divisions

Statistical Process Control (SPC)

Break down by Division (with pink background where target not met)

Division	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
A: All	23.3%	28.5%	26.1%	27.1%	28.2%	28.0%
B: Acute and Urgent Care	25.9%	29.3%	28.6%	24.8%	27.5%	29.0%
C: ICCR	19.8%	23.1%	33.0%	33.3%	36.9%	27.4%
D: Secure Serv & Offender Health	21.3%	34.7%	24.0%	27.0%	27.2%	29.0%
E: Specialties	24.9%	24.8%	29.6%	34.6%	32.5%	31.7%

Commentary

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Appendix I - FPPC 22nd May 2024

2024/25 Performance metric Improvement Trajectory update

inclusive

2024/25 Performance Improvement metrics

- During 2023/24 the following metrics were identified by FPPC for improvement. Action plans and trajectory updates have been provided. The table below outlines changes to national metrics arising from the 2024/25 planning guidance.
- The 2024/25 metrics will be

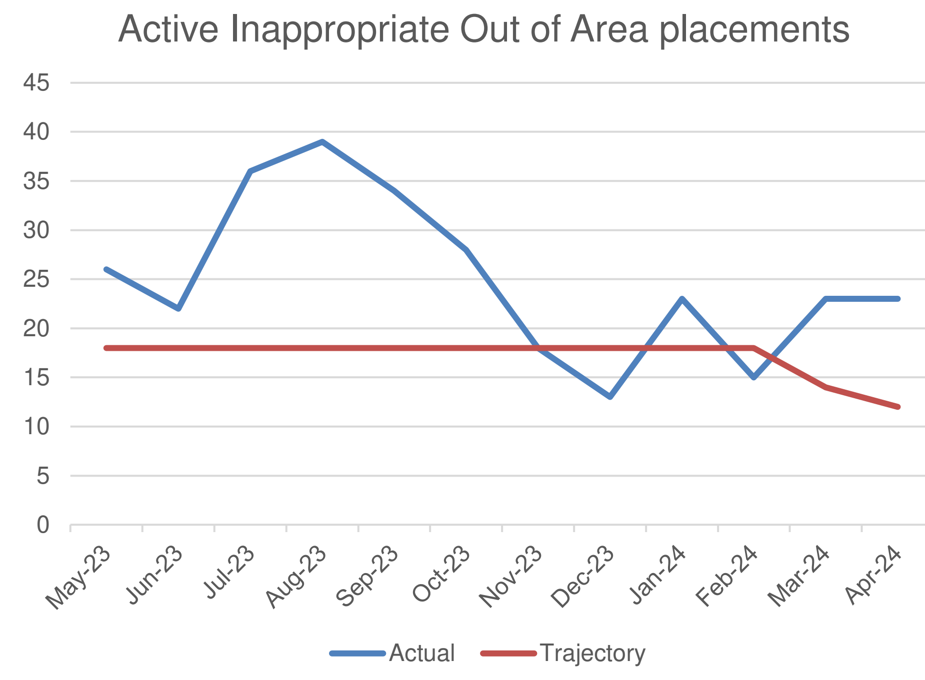
2023/24 metrics	2024/25 metrics
• Inappropriate Out of Area bed days	Replaced by Active Inappropriate Out of Area Placements
• IAPT waiting times 6 and 18 weeks	No change
• New Referrals not seen within 3 months	No change
• CPA 12-month Reviews	No change
• 7 Day follow up	Replaced by 3 day follow up
• Vacancies	No change
• Sickness	No change
• Appraisals	No change
• Bank and Agency fill rate	Replaced by reduction in bank and agency WTE used – People Committee

- The commentaries on the IPD and below have been updated for 2024/25 by the relevant service leads. A monthly update will continue to be provided on progress although as acknowledged there is unlikely to be significant change month on month due to the action plan timelines.

Active Inappropriate Out of Area Placements

Birmingham and Solihull Mental Health NHS Foundation Trust

New Metric for 2024/25



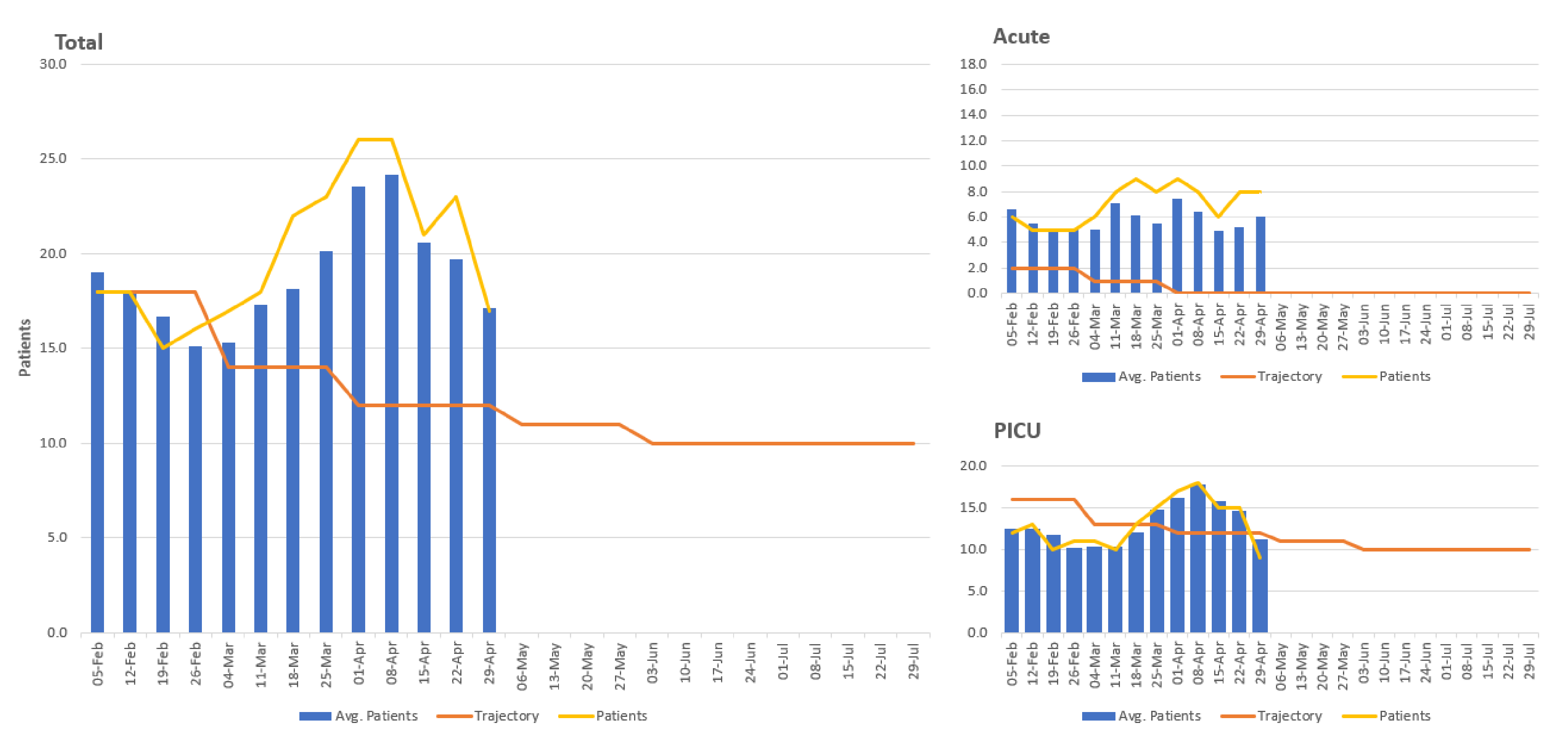
The 2024/25 planning guidance has introduced a revised metric for assessing the reduction of inappropriate out of area placements. This will now be based on the number of inappropriate Out of area placements at each month end. A Trust trajectory has been agreed as part of the 2024/25 national planning requirements to reduce and not exceed 10 PICU placements from June 2024 onwards. The target for inappropriate acute placements is zero from April 2024.

Performance for April is showing 23 inappropriate placements at month end with 8 acute and 15 PICU above the target.

The Trust's productivity action plan continues to focus on 3 key workstreams - better manage demand, reduce all OOA placements and related costs, improve patient experience and optimise services within the resources available. An update on progress is outlined below.

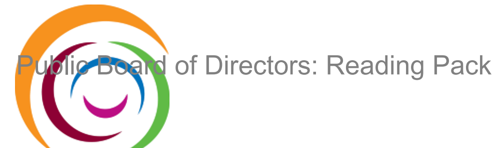
Slide 4 below highlights the weekly progress being achieved, monitored via the out of area steering group. A key pressure point remains the impact of those Clinically Ready for discharge (CRFD) that are not within Trust control, particularly social care impacting on reducing available Trust capacity to support repatriation.

2. Inappropriate Out of Area Bed Usage - BSMHFT



- The number of PICU patients reduced in April and the number of acute placements have remained at 8 for the second half of the month

A dedicated workstream has been established to focus on addressing system and partnership wide barriers related to reducing clinically ready for discharge. Slides 5 outlines progress in each of the above workstreams.



Action Plan - update

Birmingham and Solihull Mental Health NHS Foundation Trust

Completed

- **Locality Model** – ensuring that teams work within locality across the patient pathway – This has now been rolled out across all localities and feedback is that this is working well. FTB aligning with model where possible
- **Contract procurement exercise** – This has now been completed, extending the Priory contract to include an additional 20 beds available for the BSOL system and are now being utilized (shared between BSMHFT and FTB)

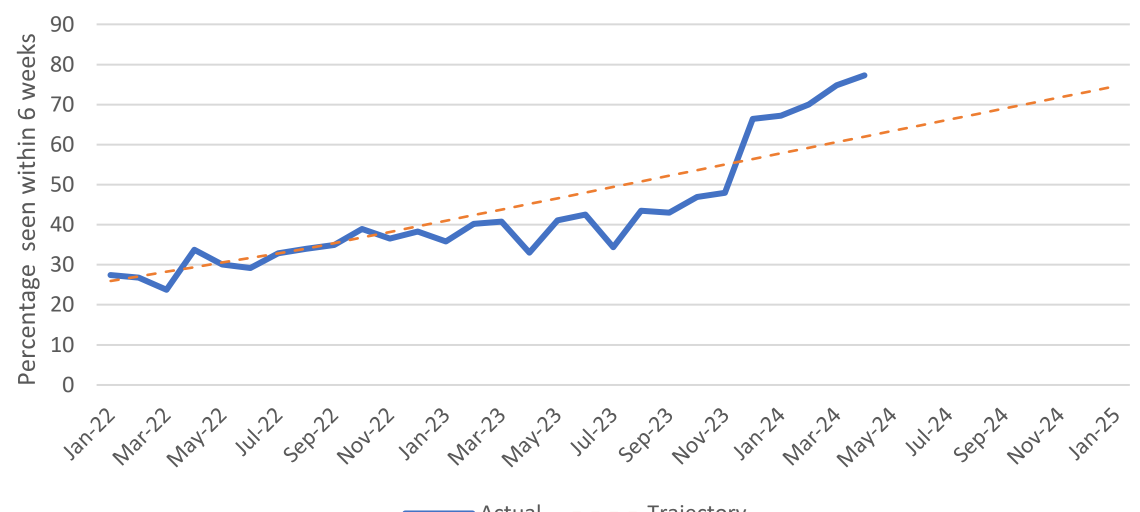
In progress

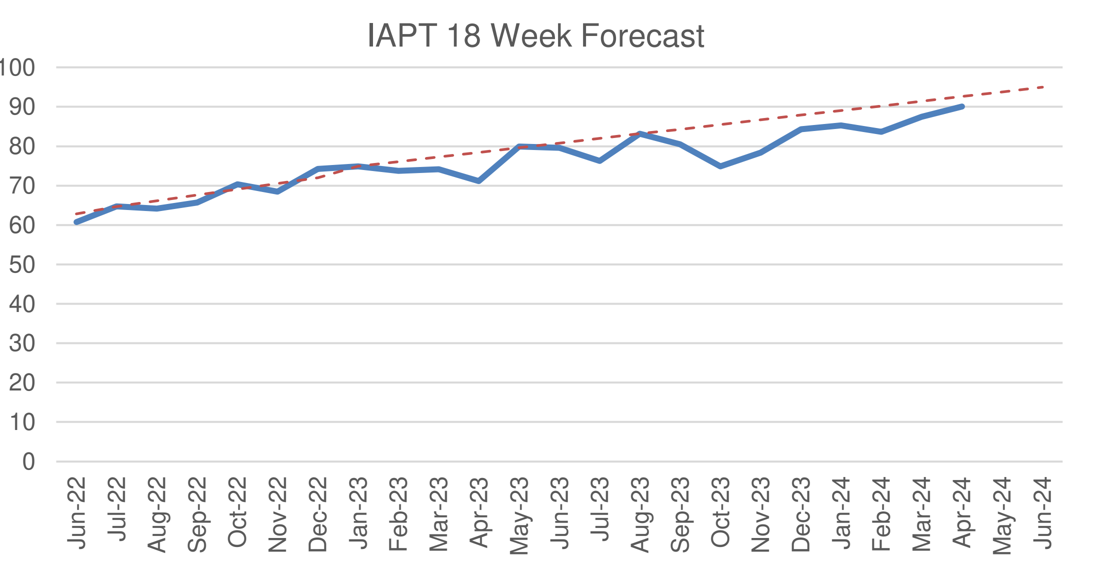
- **Demand Management/Gatekeeping -** Managing demand, with local pilot implemented in two localities now to gatekeep all admissions and ensure that alternatives to hospital admission are offered. Further meetings arranged to review how gatekeeping can be more thoroughly implemented across all 'doors' to inpatients, and more work on how we can capture this metric.
- High volume users project to identify high volume users and employ management plan to prevent admission and support/enable these users to avoid inpatient bed referral
- **Clinical Oversight Team -** senior medical cover to have oversight of patients on the bed list, meeting with Kings Norton medical team and Bed Management to discuss placement of patients – informal processes in place. Formal SOP was signed off, but capacity means that operationalisation of this has not been consistent.

Longer term or requires additional support from ICS

- **Reducing LOS/CRFDs** - weekly internal bed management, ICB deep dive weekly, EDD Confirm and challenge process (more proactive approach for patients with longer LoS) Renewed focus on Clinically Ready for Discharge (replaced DTOC). Action plan in place, and suggestions of how to improve internal management of CRFD being presented via OOA Steering Group.
- Looking to embed social workers into the locality model. 5 hours of social work time has been agreed for locality CRFD bed flow meeting by Local Authority
- **Joined up 18+ bed management process** – options appraisal exercise in process – due end of November 2024

Talking Therapies waiting times 6 &18 weeks





The service plan was to reach the 75% target by January 2025. However, successful drive of the action plan focusing on the new referrals has led to overachievement of the planned trajectory.
April 2024 performance is at 77.16%, a continued improving trend, above trajectory and now meeting the national 75% standard for the first time in the last 3 years.

The service plan improvement trajectory is to reach the 95% national standard by end June 2024 based on staffing plans being in place.
April 2024 performance shows good progress at 90.11% with a continued improving trend observed.

Trajectory provided by Associate Director for Specialties

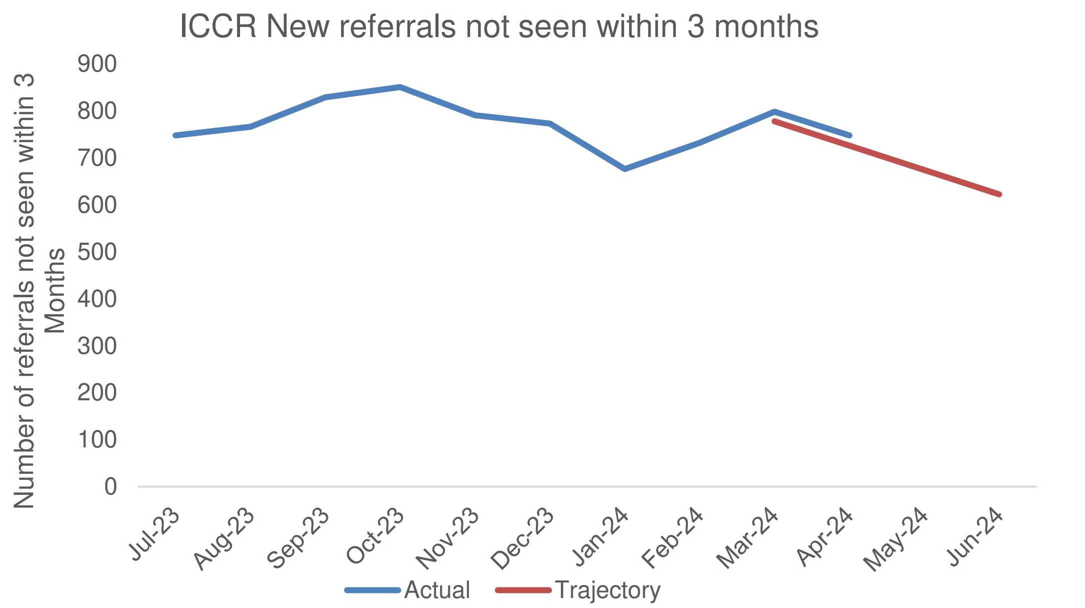
Talking Therapies – update on Service's action plan

Birmingham and Solihull Mental Health NHS Foundation Trust

- 6 week waiting time standard – ahead of planned trajectory, good progress and meeting the 75% national target for the first time in three years. The improvement also enabled the BSOL position to reach the 75% target in January 2024.
- 18 week waiting time standard - due to be met by June 2024, good progress in the last 4 months and on target to reach the 95% target by June 2024.
- The service is offering more follow ups appointments to patients who would ordinarily have been discharged after one session, as the service have a high number of single therapy sessions which then do not count towards waiting times.
- Significant improvements include - People joining the waiting list now for High Intensity CBT will wait less than 18 weeks to start treatment (previous wait was 6-12 months). However, patients are counted in the month they finish treatment, so this does not immediately show in the data.
- New staff have commenced, and this has been reflected in an increased number of contacts being recorded. However, as the waiting times are measured when therapy finishes it will take time for the improvements to come through in the data. Contact data for April 2024 shows 15% compared to the same month in 2023.
- A system wide forum has been set up with support from the national IAPT team which brings together Providers and the lead commissioner to work on an integrated approach across Bsol with good practice being shared. Recovery action plans are monitored by the Mental Health Provider Collaborative Steering Group and the ICB's Contract meeting.
- The service level recovery plan remains reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times and achieve improved outcomes. There are currently 21 vacancies within the service.

New Referrals not seen within 3 months

ICCR Due to the high number of patients waiting to be seen for a first appointment, the initial focus for ICCR CMHTs has been to reduce long waits. The 2023/24 trajectory was based on achieving a 20% reduction in new referrals not seen within 3 months by the end of January 2024, reducing to 622. However, progress has been slower than anticipated with March 2024 at 798 and April at 748 service users. A revised trajectory has been provided for 2024/25 which extends the improvement plan to reach the 20% reduction by June 2024.



Action Plan:

Short Term:

ICCR continue to review all CMHT activity via twice monthly waiting list & KPI oversight meetings, this includes reviewing waiting times and the number of slots being offered. Clinical service managers review the detail and take away actions for their teams.

Note - ICCR Trajectory provided by Associate Director for ICCR.

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New Referrals not seen within 3 months

Birmingham and Solihull Mental Health NHS Foundation Trust

Long Waits

- Progress achieved with waits over 52 weeks reduced by 70% since November 2023 from 94 to 22 in April 2024.
- Focus has now moved to waits over 18 weeks with Clinical Service Managers working with teams to ensure appointments are booked in
- Within Solihull there has been a focus on 26-52 week waits and appointments are being are booked in 5 weeks in advance as part of the ongoing pilot with admin leads reviewing waits at 52 weeks to ensure plans are in place. This has positively impacted on medical DNA rates in April with a 3% reduction for first appointments.

DNA Rates

- Other areas are also focusing on reducing DNA rates, cleansing the data, discharging or prioritising appointments for service users who need an appointment with community mental health services. MDTs have been streamlined with a focus on DNAs, with agreement of clear follow up actions when DNA's occur.

Staffing

- The 5 NMHTs are at varying levels of staffing and are working through recruitment plans, the aim to have all NMHTs equipped with a baseline staffing number.
- 2 PCNs (Primary care Networks) in the last financial year served notice on their ARRs roles (Additional Roles Reimbursement Scheme), these roles had to be converted into full transformation funded roles. The aim to ensure that as part of the baseline staffing sufficient number are transformation funded. Work is underway with informatics to support informing these numbers with the use of actual current demand and capacity data.

New Referrals not seen within 3 months

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

ICCR action plan cont:

Demand

- All referrals are screened by the NMHT and only referred into CMHT if SMI, complexity or risk is present and CMHT intervention is indicated. The service plan over the next 12 months as the NMHTs grow is that this will have a significant impact on reducing waits and capacity within CMHTs. Only 4% (data from Q4) are escalating into the CMHTs, CMHT caseloads however remain the same as overall demand across the system has increased (in line with the national position).
- Testing due to take place in the East piloting discharge clinics to support step down/discharge.
- Engaging Talking Therapies to divert referrals from NMHTs thus creating capacity for the NMHTs to take on low level CMHT cases (the service leads have noted that 70% of referrals to the NMHTs are for presentations of depression & anxiety who should be signposted to talking therapies as the appropriate service to meet service user needs)
- Early discussions are taking place as part of the NMHT development to move towards an MDT focussed Triage hub which will allow an MDT discussion to take place around formulation and where the best support might be offered for the service user.

New Referrals not seen within 3 months

ICCR action plan cont:

- The MDT Triage Hub would involve key contracted partners (Talking Therapies, CGL, SIAS, Shaw Trust, Mind) this will also enable the testing of trusted assessments. The aim is for clear patient centred DIALOG+ care plans to be created with service users at the earliest opportunity to capture their recovery focussed goals and improve engagement and outcomes.
- To help increase capacity within CMHTs and to work towards 4 week waits (dependant on national guidance), current plans are that by end of 2024, complete coverage of all PCNs will have been achieved and this will therefore have greater impact on ability to manage referrals effectively. Work will continue alongside informatics lead to oversee the roll out across CMHTs to bring parity across the Community Mental Health and Wellbeing Service (CMHTs and NMHT), this work involves linking with national leads to understand the impact of ReQuol and GBO and DIALOG+ on the clock stop.

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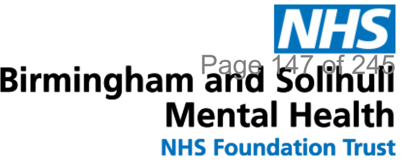
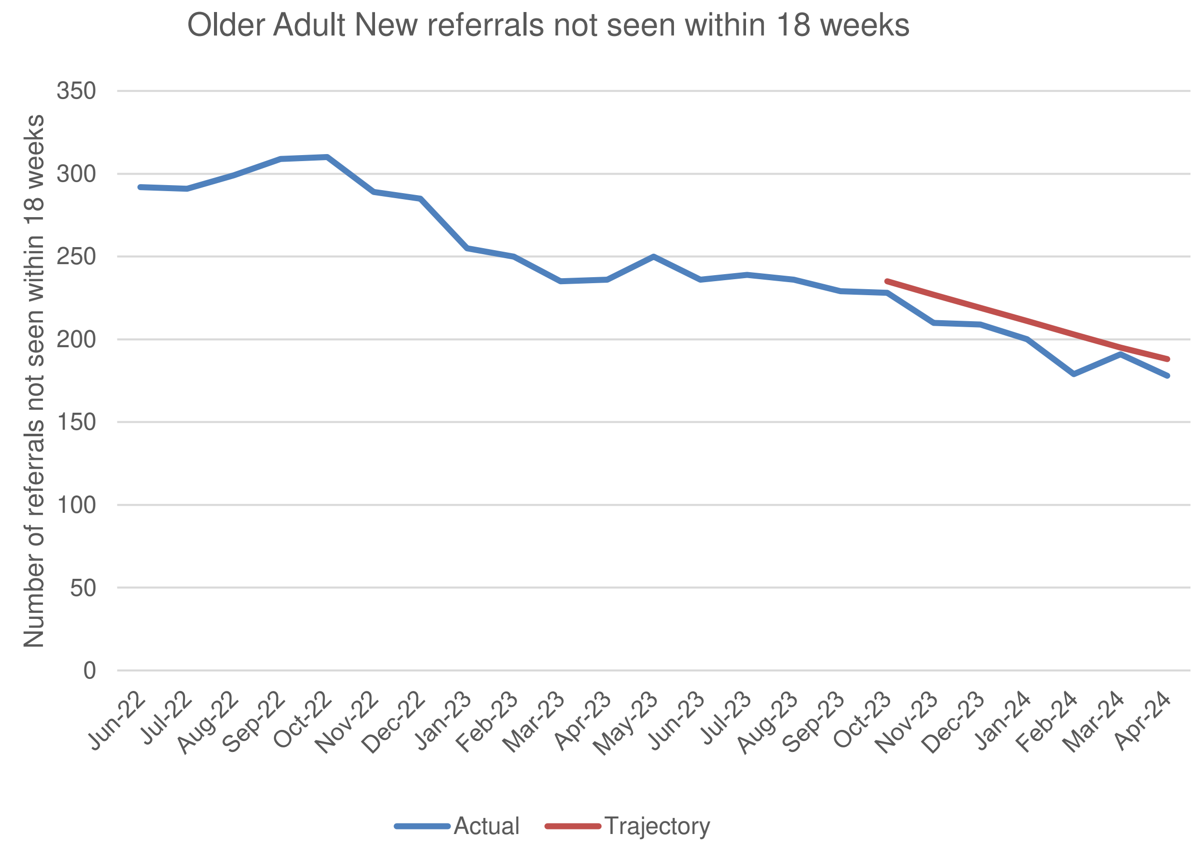
New Referrals not seen within 3 months- Older Adults



Older Adult CMHTs are focusing on achieving a 20% reduction in those waiting more than 18 weeks by the end of April 2024.
Progress is being made, April position at 178 service users waiting more than 18 weeks and below the trajectory of 188.
The service's 2024/25 plan will be confirmed at the next meeting.

The service continue to monitor waiting times and have focused initially on waits over 26 and 52 weeks which have both seen reductions.

Note: This is different to the metric data for new referrals not seen within 3 months as focus of improvement is on reducing long waits.



New Referrals not seen within 3 months

Older adults CMHTs Action Plan:

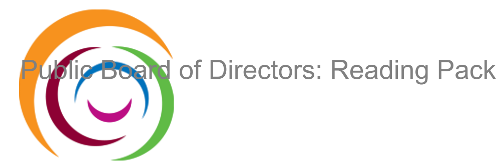
Demand challenges: Referrals in North Solihull and West are hotspots due to the numbers received. Caseloads remain high, resulting in patients waiting longer. Waiting times for first appointments with medical staff are between 4-6 months. They are being proactively managed by team managers to ensure that service users are being prioritised based on need and risk.

Capacity challenges: The service are requesting a safer staffing review and formal demand and capacity assessments for the CMHTs, as caseloads are above recommended levels by the CQC and there is a need to make jobs manageable to aid retention. This includes; looking at impact of new roles, Workforce skill mix and Leadership development.

Where there are current vacancies and waits for staff to join, bank shifts are being used to help address those staffing gaps.

It should be noted that there are a number of service users who have commenced treatment who are living in care homes where Trust staff had contact with care home staff only. This occurred especially during Covid. A number of these have been reviewed regularly but have not been seen directly with a member of Trust staff and have therefore remained on the waiting list. Appointments have been offered in clinic to this group, however, it is difficult for care home staff to bring patient to clinics and there will need home visits to facilitate face to face contact.

Note - Older Adult CMHT position confirmed by the Associate Director for Specialities.

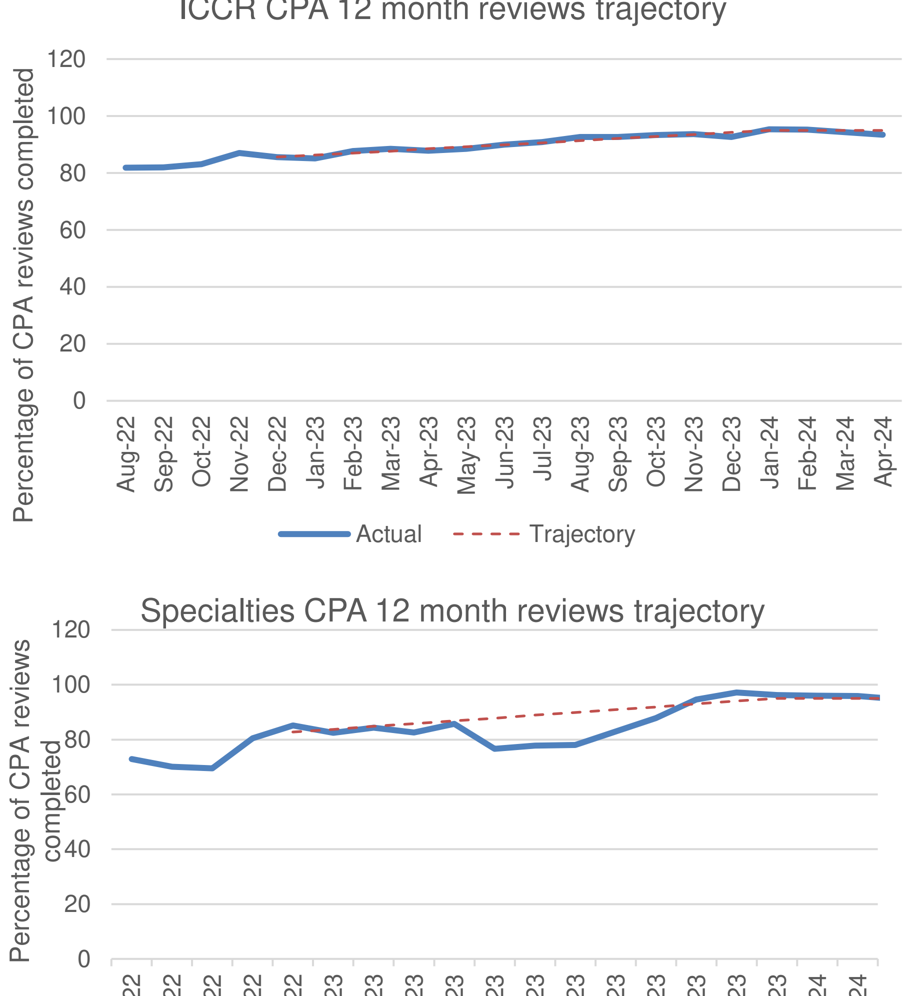


CPA 12-month reviews

Overall trust performance for CPA reviews has been improving for the last 12 months, mainly due to the implementation of the improvement plans by ICCR CMHTs and Older Adult CMHTs in 2023/24.

The CMHTs had trajectories to meet the 95% target which has been achieved with the overall Trust figure for April at 95.5%.

As the 95% standard has been met this metric will remain to ensure maintenance and if achieved for the next 3 months be monitored as BAU. This approach has been supported by both service ADs.



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2024/25 national standard - 3 day Follow up

- The national 3 day follow up standard will now be the primary metric to monitor the follow up of service users discharged from adult and older adult inpatient services.
- This new metric has been added to the Trust's IPD.
- April 2024 compliance is at 89.6% and above the national target of 80%. As we are meeting this standard on a regular basis, this metric will be removed from the improvement trajectories update from next month.
- FPPC is asked to note that 7 day follow up will continue to be monitored internally from a quality perspective. 7 day follow up for April 20024 at 92.8%.
- Note – Commentary above provided by the AD for Performance & Information

Workforce trajectories – 2024/25 update

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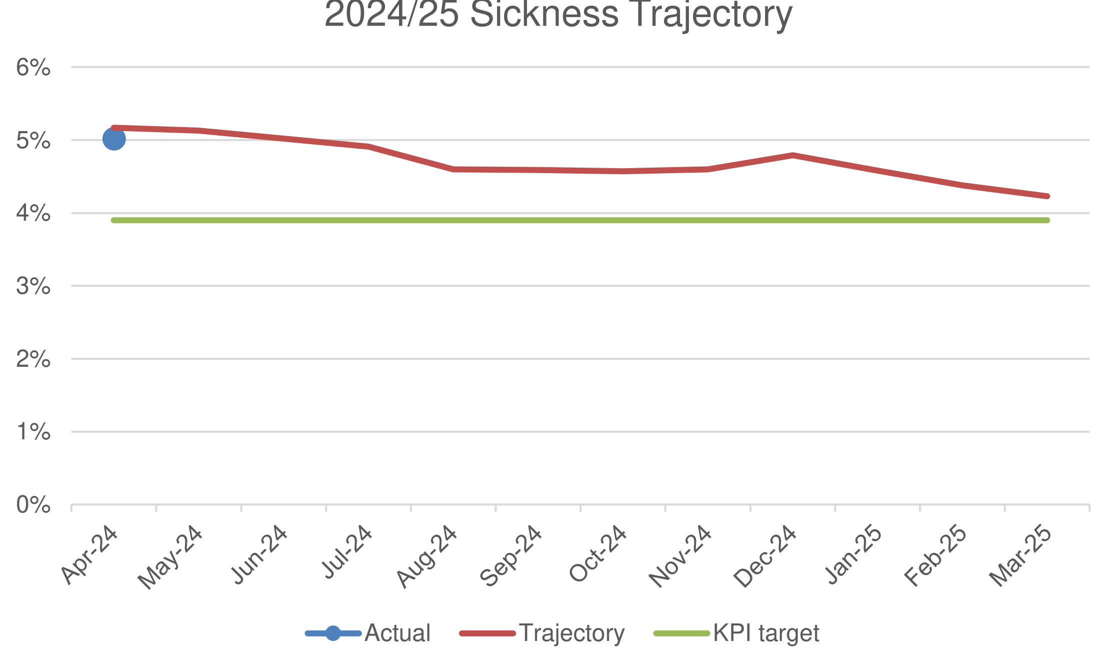
Sickness Absence

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



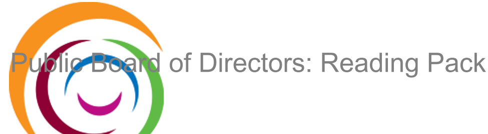
Increased trend in sickness levels observed and April 2024 to 5.02% below the improvement trajectory of 5.1%. Long-term sickness increased with April at 3% and short-term sickness at 2.02%.

Return to work contact has increased from 66.5% to 67%. Having these increased contacts is positive in supporting the health and wellbeing of staff.

Action Plan:

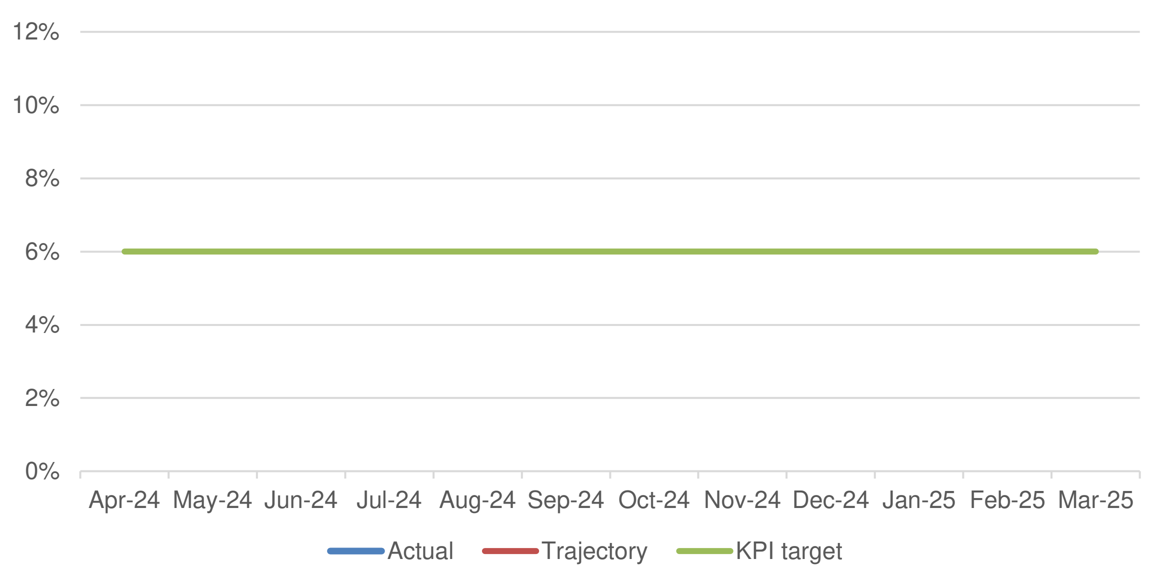
- HR clinics continue to run across divisions, supporting managers to manage sickness absence.
- Working with PAM (Occupational Health Provider) to provide bespoke support, dealing with stress and anxiety which are main reasons for sickness absence.
- People team continue training for sickness absence management for line managers. The People team continue to promote other health and wellbeing offers to support staff. Deep dives are planned and will commence into reasons for sickness for staff groups (nursing as a starting point).

Note - Trajectory and commentary provided by People team



Vacancies

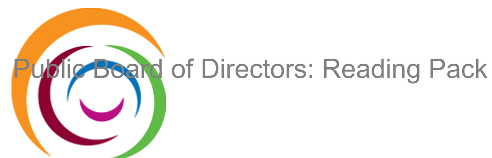
Updated 2024/25 vacancy trajectory in line with the workforce plan



The HR lead has confirmed that a trajectory for 2024/25 will be provided next month as awaiting the baseline data for April 2024 in order to establish trajectory. The KPI target is 6%.

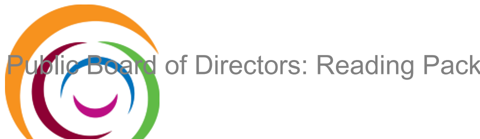
Recruitment initiatives: Following on from presenting to Nursing Students at the University of Birmingham and hosting stands at the Birmingham City University Nursing Careers event, University of Wolverhampton Nursing Careers Recruitment Event, and the RCNI Birmingham Recruitment event, students in their final year have had offers made to them pending completion of their studies and them acquiring of their PIN's.

Note - Trajectory and commentary provided by People team



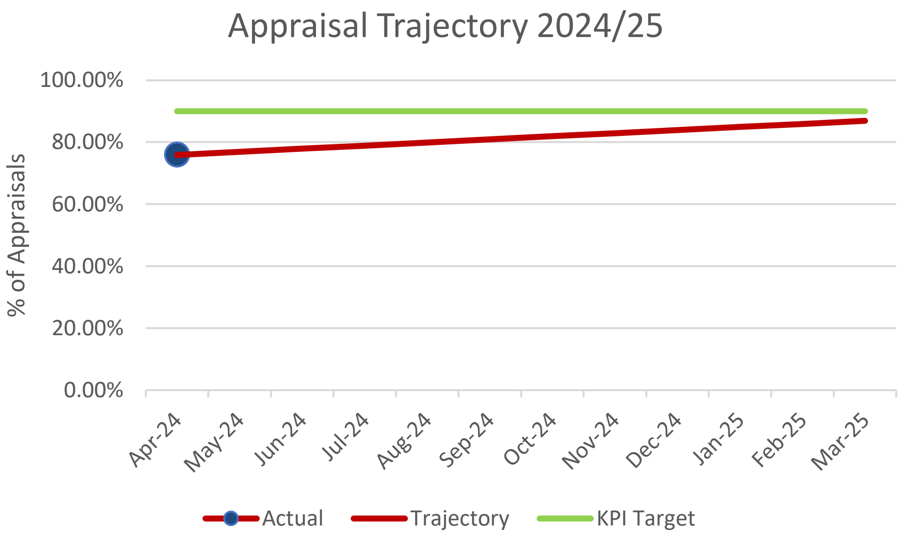
Vacancies

- The ICB and NHSE have introduced instruction on vacancy levels and agency reduction - A by-product of the weekly vacancy control panel (now in its 8th full month) is the highlighting of if the correct processes and procedures are being used to ensure like for like permanent / fixed term vacancies are being requested and put in place.
- Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:
  - Ensure flexibility is promoted in internal advertisements and vacancy information.
  - Enhance training for hiring managers to equip them to discuss flexible working at interview.
  - Update recruitment processes and training to ensure that the drop-down menu for different types of flexible arrangement are used on NHS Jobs / TRAC when vacancies are created.
  - Upskill hiring managers / resourcing teams to be able to identify which forms of flexibility are appropriate for roles.
  - Draft and get sign off on an organisational statement about openness to flexible working arrangements, to be included in all vacancy packs.
  - Start monitoring number of new joiners who are recruited flexibly and collate this centrally.
- An eighth Recruitment Initiatives and Strategy meeting was held to ensure the department is maximising every opportunity to continuously improve processes and initiatives such as trac procedures, interview techniques training, flexible working, attraction strategy, social media, DBS expediency and proactiveness with vacancy filling.



Appraisals

Updated 2024/25 Appraisal trajectory



A revised trajectory has been agreed for 2024/25 to increase appraisal performance by 1% each month moving from 75.9% to 90% in March 20025

April 2024 appraisal performance at 75.9%, showing an increase in last 2 months but remains below the Trust standard of 90%.

- BAU activities continue with L & D utilising reports to identify started but not completed appraisals (2 weekly) and Chase emails. In addition, L&D will continue appraisal hotspot work targeting those teams below 75%.
- From the 1st May teams identified as repeatedly below 75%, will be contacted by an L&D manager/s to explore issues and offer alternative support and/link in with OD colleagues where appropriate.
- L&D are also continuing with the QI project work: A face-to-face workshop was held at Uffculme on the 22nd April with the working together group to discuss/action the following: 1) to map out their current appraisal journey; 2) To identify/explore where support is needed; 3) Developing our Driver diagram; 4) Any Quick win first order changes.

Note - Trajectory and commentary provided by People team

Bank and Agency Reduction

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

Awaiting the baseline data for April 2024 in order to establish trajectory

Note - Trajectory and commentary provided by People team

Sustainability

Monthly Agency costs

- There has been a decrease in agency spend from c. £625K in March to c. £706K in April. In April an additional 23 bank workers started with the trust, alleviating the need for agency staff. HCA's usage per week had seen a decrease from 25 shifts per week in November to 0 for most weeks in March but this crept up to 2/3 shifts per week for most weeks in April. The overall non-medical weekly agency usage has fallen from 140 shifts per week on average in November to 83 in April.

- A detailed agency reduction programme is in progress working in conjunction with ICB policies and restrictions and the Midlands and Lancashire CSU. Two areas of renewed focus are the expediating of the TSS bank workers to substantive process and the reduced reliance on block bookings. Other initiatives to be considered include Finance, HR and AD sign-off being required for all future RMN agency block bookings (currently 80% of all expenditure via TSS is block bookings). Currently all HCA agency requests, and above cap block bookings require Exec approval.

- The TSS Management is going into partnership with NHS Professionals – who have considerably less charge rates than agency – with a view to transferring over high cost and long-term block bookings, which can be recorded as bank spend, rather than agency.

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

Appendix II Performance Management Framework

FPPC is asked to note that from March 2024, a revised framework is being implemented with service areas as part of the deep dive meetings. A service line review process has commenced to ensure that all services within the operational portfolios are covered. The process remains developmental and learning from the first round of meetings will be utilized to shape future meetings. As part of this framework, a service line RAG rating assessment is planned to be completed.

Performance Delivery Group meeting on 2nd May 2024

The agenda for the meeting focused on the following 2 areas:

1. 2024/25 NHS Planning guidance – National Mental Health Metrics

The Associate Director for Performance and Information provided an overview of the national planning guidance focusing on the metrics and assessment standards that mental health Providers are expected to achieve. A copy of the presentation is attached as Appendix IIa. This includes metrics which are seen as key to supporting implementation of transformed services and demonstrate progress towards achieving priorities outlined in the NHS plan.

The Trust's IPD from April 2024 includes the key changes to the national metrics and a further phase of work will be undertaken to replicate metrics which are currently only reported via the CSU or on national dashboards.

2. 2023 NHS Benchmarking reports

The Associate Director for Performance and Information presented the key themes highlighted in the NHS benchmarking publication covering Adult and Older Adult Inpatient and Community Services with a focus on the 'so what' question. An example of work which has been ongoing is around the inappropriate out of area as there is a connection between themes which are consistently experienced: higher lengths of stay, lower number of beds, high occupancy levels and higher proportions of admission under the mental health act. These themes are an integral consideration within the productivity plan for inappropriate out of area placements. In addition, where possible the benchmarking data is being used in the deep dive meetings with service areas. The presentation is attached as Appendix IIb

In addition, the Head of Workforce Transformation presented the workforce benchmarking report and it was agreed that the themes arising will be included in service level discussions where relevant as part of the discussions to understand and develop localised workforce service plans. The presentation is attached as Appendix IIc

Service Area Deep Dive Meetings – Update

1. Introduction

The Performance Delivery group has a rolling cycle of deep dives into services to allow time for in depth discussion on key operational issues and challenges. At the request of the Trust Board FPPC a summary of the deep dives is now being provided on a monthly basis.

Since the March 2024 FPPC meeting, the following service area deep dives have taken place:

- Secure and Offender Health deep dive on 11th April 2024
- Specialties deep dive on 2nd May 2024

Appendix II – Performance Management Framework

2. Secure and Offender health Deep dive – 11th May 2024

Reaside Men's Secure Service

Performance Framework Domain RAG Rating Assessment: overall - Red

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance
Reaside	Red	Amber	Green	Red	Red

Quality

- Continuous improvement strategy focus.
- 2 wards at Reaside participating in the 'Culture of Care' Programme developed by NHS England's Quality Transformation programme.
- The CGC for Reaside and Tamarind are being brought together to encourage parity across the men's pathway.
- Co-production workshops with staff and service users
- Need to replace the building at Reaside.
- Need Executive support in relation to the replacement of the building.
- Physical health assessments have declined and there is a need to understand and action.

Workforce

- Sickness rate at 9% with long terms sickness cases having a large impact.
- Qualified Nursing vacancies at 20%, service to be allocated 6 of the 20 internationally educated nurses.
- Appraisals at 74% - focused piece of work including actions to improve performance.
- Cultural issues – Organisational Development work underway to support.

Finance

- There is now Medical agency usage at Reaside and Bank use at 19%, agency at 1%.
- Plan to cost the safer staffing rosters to ensure cost effectiveness. Noted that the safer staffing assessments had not been fully completed yet for all services in the trust.
- The service is planning on completing a business case based on the previous MOHOST.
- Finance training for deputy managers planned.

Performance

Bed occupancy is high in Reaside and has improved through put.

Tamarind – Men's Medium Secure

Accountability framework Domain RAG Rating Assessment: Green

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance
Tamarind	Green	To be assessed separately	Green	Green	Green

FIRST (Forensic Intensive Recovery Support Team)

Appendix II. Performance Management Framework

Accountability framework Domain RAG Rating Assessment: Green

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance
FIRST	Green	To be assessed separately	Green	Green	Green

3. Specialties Deep Dive – 2nd May 2024

The focus for the deep dive this month was on the Deaf service and Neuropsychiatry and the presentations shared by the service managers can be found in Appendix IId and IIe.

Deaf Service

Accountability framework Domain RAG Rating Assessment:

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
Deaf	Not discussed	Amber	Amber	Amber	Red	Red

Service summary - a recovery-focused, culturally sensitive, accessible mental health service to deaf, hard of hearing and deafblind people aged 18 years and above with a mixture of deaf, hard of hearing and hearing staff, along with in house BSL interpreters. They are one of three nationally accredited services.

Finance

The service ended 2023/24 in deficit due to:

- Pay award not being funded in the budget.
- Income target not met and this has been reduced in 2024/25 along with the bank budget.

Operational and Clinical Risks

- The service has been working on an MDT pathway mapping project over the last 12 months supported by the transformation team.
- Plans to move to cost per case contract did not occur, service remains on a block contract.
- Bed occupancy is at 72% which has improved from last year when it was at 50%.
- No clear escalation support from commissioners.

Actions and Interventions

A range of actions and interventions shared to increase referrals given known need within BSOL population:

- A clearer referral process and structured screening of these to be widely shared across the Trust to reduce access delays for deaf people.
- Promoting the service - a new Service Website with 18 BSL signed & subtitled videos and self-referral options.
- A Capacity utilisation manager in post to help with delayed discharges (secondment) which has supported with reducing some significant delays.

- A Clinical Associate Psychologist (CAP) is in post. This is the first ever deaf CAP apprentice nationally and will be hugely beneficial to the service offer.
- In the last year caseload and activity has increased, whilst DNA rates reduced.

Workforce and Culture

Staff Survey – A meeting has taken place with the trust lead to review the staff survey results. These showed an increase in morale but further work required on wellbeing offers and impact of staff shortages within the service.

Support required

- Success of having a Capacity and Utilisation manager, currently on a secondment basis, would like to retain on a permanent basis to cover all the specialty wards.
- Deaf awareness Module for E-learning being constructed by deaf staff and Lead Nurse alongside the LD team - an internal training traffic light planned for staff in the Barberry initially and consideration for roll out in the Trust.
- Support with escalating issues to NHSE.

Neuropsychiatry

Accountability framework Domain RAG Rating Assessment:

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
Neuropsychiatry		Amber	Amber	Green	Red	Amber

Service summary - a regional service, receiving over 3,080 referrals in 2023, with subspecialties covering: sleep, chronic fatigue, Huntington's Disease, Tourette's, non-epileptic attack disorder, epilepsy and general neuropsychiatry. There has been an increase in referrals for chronic fatigue syndrome (CFS) due to those with Long-Covid, being relabelled as CFS after 12 months. Overall, there is high demand for the service with long waiting times and an overspend on the drugs budget due to new treatments.

The team are also small and this carries a risk that the sub specialties can be destabilised by sickness or staff retention.

A recovery action plan is in place which includes:

- Specialist Nurse to carry out additional new patient assessments per week.
- In negotiation with Clinical Lead to increase assessment numbers per week.
- New policy to manage patient cancellations – two appointments maximum to be offered and then discharge back to referrer with option of re-referral.
- Introduction of a one-stop clinic in epilepsy and Non-Epileptic Attack Disorder (NEAD) where the diagnosis is unclear – there are already one stop clinics in sleep and HD, saving on multiple appointments.

Areas requiring Support

- A financial review of the drugs budget requested, due to consistent overspend.
- Support from the trust board in application for blueteq access (reclaim certain drug charges)
- Demand for the service is high. We need to invest in staffing disciplines and look at future proofing the team.

2024/25 planning guidance

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2024/25 Planning Guidance MH Specific Objectives overview

Area	Objective
Mental Health	• Improve patient flow and work towards eliminating inappropriate out of area placements
	• Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)
	• Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery
	• Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025
	• Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025

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NHS Birmingham and Solihull Mental Health NHS Foundation Trust

Activity and Performance technical definitions 2024/25

Inpatients		Target	Reporting available
E.A.5	**Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)**	**Maintain10 (PICU only)**	**OOA steering group pack/ IPD/Trust Indicator report**
	Percentage of those who are clinically ready for discharge but occupying beds		IPD/Trust indicator Report
	Adults and older adults with long length of stay (over 60/90 days for adult/older adult admissions)	Adults rate of below 32 per 100k Older Adults rate of 43 per 100k	ICS reporting via CSU
	Adult mental health inpatients receiving a follow up within 72hrs of discharge	80%	IPD/Trust indicator Report
	Bed Occupancy		Trust indicator Report
	Inpatient admissions for people who have had no previous contact with community mental health services		ICS reporting via CSU
Talking Therapies			
E.A.4	**TT Access rate (now based on 2 contacts)**	**BSOL target of 19428**	**ICS reporting via CSU**
E.A.4a	**Reliable recovery rate for those completing a course of treatment and meeting caseness**	**48%**	**IPD/Trust indicator Report/ TT scorecard**
E.A.4b	**Reliable improvement rate for those completing a course of treatment.**	**67%**	**IPD/Trust indicator Report/ TT scorecard**
	Recovery rate	52% by end of 2024/25	IPD/Trust indicator Report/ TT scorecard
	Number of people aged 65+ accessing TT		ICS reporting via CSU
	6 TT week waiting time	75%	IPD/Trust indicator Report/ TT scorecard
	18 TT week waiting time	95%	IPD/Trust indicator Report/ TT scorecard
	TT in-treatment pathway waits	<10%	ICS reporting via CSU
CYP			
E.H.9	Access to Children and Young People's Mental Health Services (1 Contact)	BSOL target 24834	
	18- 24 Access		ICS reporting via CSU
	CYP outcomes		ICS reporting via CSU
	CYP ED waiting times – Urgent (7 days)	95%	IPD/Trust indicator Report
	CYP ED waiting times – Routine (28 days)	95%	IPD/Trust indicator Report

Activity and Performance metrics 2024/25

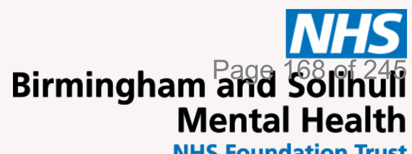
Impact of transformed community services			Reporting available
E.H.31	**Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (2+ contacts)**	**BSOL target 22990**	**Transformation data**
E.H.13	People with severe mental illness receiving a full annual physical health check	60% on SMI register	ICS reporting via CSU
	Number of people accessing Individual Placement and support		ICS reporting via CSU
	% of people receiving, assessment, baseline outcome score, and social/clinical support OR personalised/co-produced care plan	No target initial focus on data quality	ICS reporting via CSU
	First Episode of Psychosis	60%	IPD/Trust indicator Report
	Outcome scores in community mental health services		ICS reporting via CSU
Perinatal Mental health			
E.H.15	Women Accessing Specialist Community Perinatal Mental Health Services (1+ contact)	1953 BSOL	ICS reporting via CSU
Dementia			
E.A.S.1	Estimated Diagnosis Rate for People with Dementia	66.7% (ICS)	ICS reporting via CSU

2024/25 Planning Guidance – Key actions

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

- **Improve patient flow and reduce average length of stay in adult acute mental** health wards, delivering more timely access to local beds. The mental health discharge challenge identified 10 high impact actions to drive improvements in flow and reduce delayed discharge.
- support **improvements in the quality and safety of all-age inpatient care**, by finalising and publishing system 3-year plans to localise and realign inpatient care in line with the mental health inpatient commissioning framework by June 2024
- **embed digital technology** to transform mental health care pathways, provide more personalised and joined-up care, improve clinical productivity, and support improvements in access, waiting times and outcomes.
- improve **timeliness and quality of mental health activity, outcomes and equality** data to evidence the expansion and transformation of mental health services, and the impact on population health.
- **Eliminate long waiters** for community mental health services

2024/25 Planning Guidance



- Review community services by Q2 2024/25 to ensure that they have clear **policies and practice in place for patients with serious mental illness, who require intensive community treatment** and follow-up but where **engagement is a challenge**
- Put systems in place to **monitor performance and effectiveness of 111** *2 for mental health NHS crisis line services being rolled out in April 2024, including unanswered calls, wait times and patient feedback by Q2 2024/25
- Work closely **with ICS partners**, including primary care, provider collaboratives and the VCSE sector, to **develop and deliver a workforce plan** that supports the system's mental health and NHS Long Term Workforce Plan growth ambitions. This includes actions to build supervisory and placement capacity, retain existing staff, and improve productivity
- **Implement the patient and carers race equality framework (PCREF**) by the end of 2024/25, including establishing the governance structure and reporting metrics at trust level to monitor the access, experience and outcomes of ethnic minority groups and build organisational competencies

Appendix 1

Metric Definitions

compassionate

Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)

Definition

- Numerator: Number of active inappropriate adult acute OAPs that are either 'internal' or 'external' to the sending provider. An Active inappropriate OAP is a snapshot count of inappropriate out of area placements that have not been discharged on the last day of the reporting period. Includes the following bed types:
  - Acute adult mental health care
  - Acute older adult mental health care (organic and functional)
  - Adult Psychiatric Intensive Care Unit (acute mental health care)

NHS Talking Therapies for anxiety and depression - number of adults and older adults receiving a course of treatment (Access)

- Based on the number of people who have a course of treatment (2+ contacts) and of those the number achieving reliable recovery and reliable improvement (previously based on 1 contact)

Reliable recovery rate for those completing a course of treatment and meeting caseness

- Numerator: Number of patients that achieved reliable recovery
- Denominator: Number of patients discharged having received at least 2 treatment appointments in the reporting period, that meet caseness at the start of treatment.

Patients are considered reliably recovered if they meet both criteria for reliable improvement and for recovery.

Talking Therapies - Access and Recovery

Birmingham and Solihull Mental Health NHS Foundation Trust

Reliable improvement rate for those completing a course of treatment

- Numerator: Number of patients that achieved reliable improvement
- Denominator: Number of people who are discharged having received at least 2 treatment appointments in the reporting period.

A person has shown reliable improvement if their scores on the depression and/ or the relevant anxiety/ MUS measure have reduced by a reliable amount and neither measure has shown a reliable increase. The calculation applies to everyone who has a course of treatment irrespective of whether they meet caseness criteria at the start of treatment.

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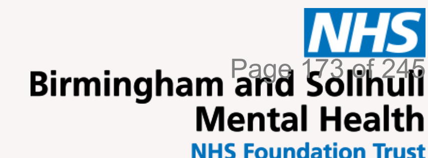
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (2+ contacts)



Definition:

Numerator only: Number of people who receive two or more contacts from transformed NHS or NHS commissioned community mental health services (in transformed PCNs) for adults and older adults with severe mental illnesses. Includes the following team types:

- A05 - Primary Care Mental Health Service
- A06 - Community Mental Health Team – Functional
- A08 - Assertive Outreach Team
- A09 - Community Rehabilitation Service
- A12 - Psychotherapy Service
- A13 - Psychological Therapy Service (non NHS TT)
- A16 - Personality Disorder Service
- C10 - Community Eating Disorders Service
- A14 – Early Intervention Team for Psychosis
- D05 – Individual Placement and Support Service

Birmingham and Solihull Mental Health NHS Foundation Trust

People with severe mental illness receiving a full annual physical health check

Definition

- Numerator: The number of people on the General Practice SMI registers who have received a full physical health check in the 12 months to the end of the period. Denominator: Total number of people on the General Practice SMI registers by quarter

Core six elements of the full physical health checks:

- 1. a measurement of weight
- 2. a blood pressure and pulse check
- 3. a blood lipid including cholesterol test
- 4. a blood glucose / HbA1c test (as clinically appropriate)
- 5. an assessment of alcohol consumption
- 6. an assessment of smoking status

Performance Delivery Group –

NHS Mental Health Benchmarking 2022/23

Adult & Older Adult Inpatient service & Community Mental Health Teams

Weighted & Resident based Population Reports Published &
an Online Toolkit

What do they tell us about BSMHFT?.....And the 'So What?'

Tasnim Kiddy & Julie Keith

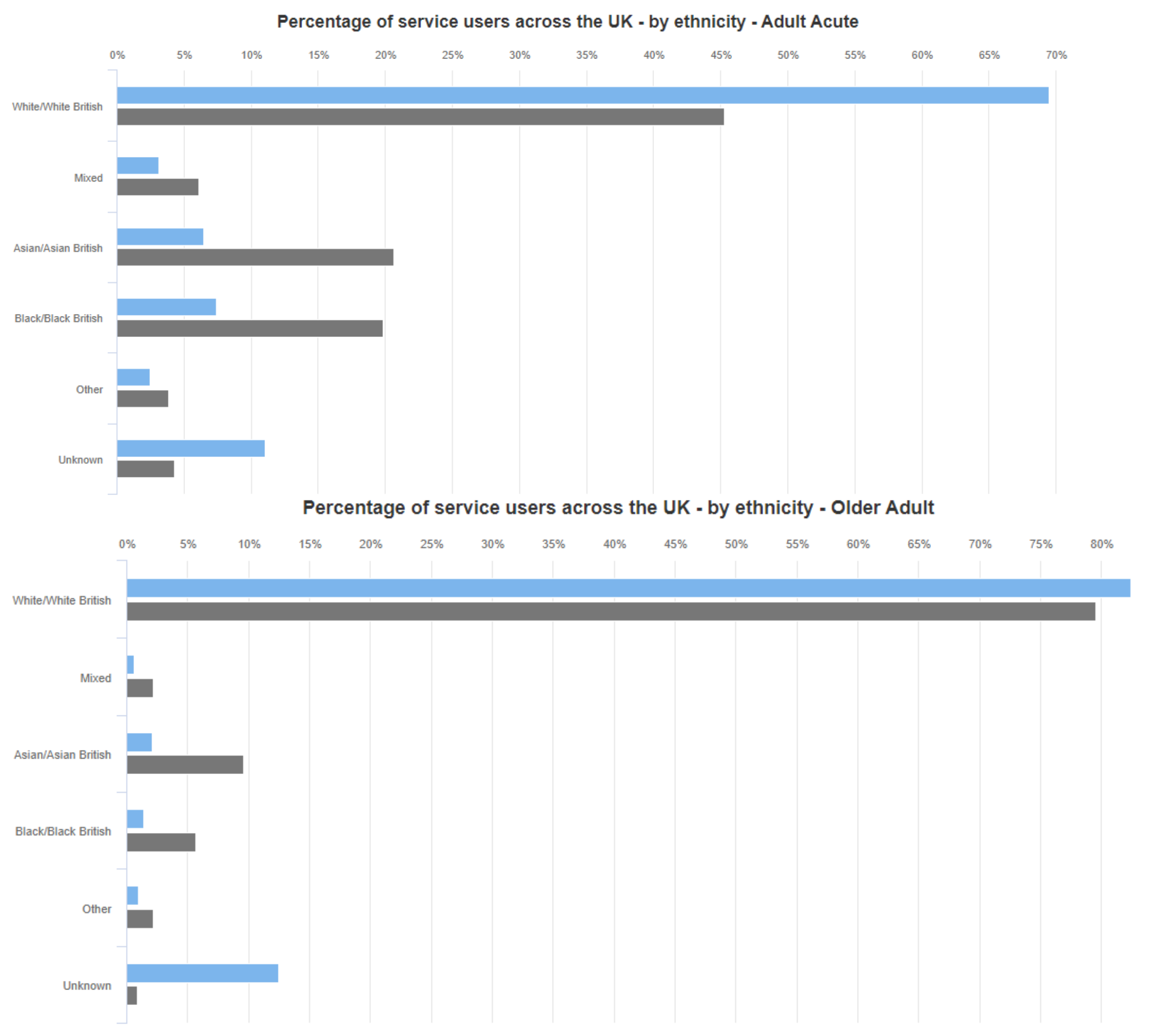
Background

- Annual National benchmarking
- Based on 2022/23 financial year.
- Covers activity , finance, workforce and quality
- High participation - 53 English Providers, 12 Scottish health Boards, 6 Wales health Boards, 3 trusts from northern Ireland, State of Jersey and 2 Independent providers. (Weighted population reports not published for Wales, Northern Ireland and Scotland (with the exception of 1 board).)
- Note – The national mean for all metrics will be affected by number of Trusts responding – therefore variable/low participation response to some metrics
- Key metrics covered in presentation - further data available
- Clusters have been removed
- Benchmarking on outcomes and waiting times in development

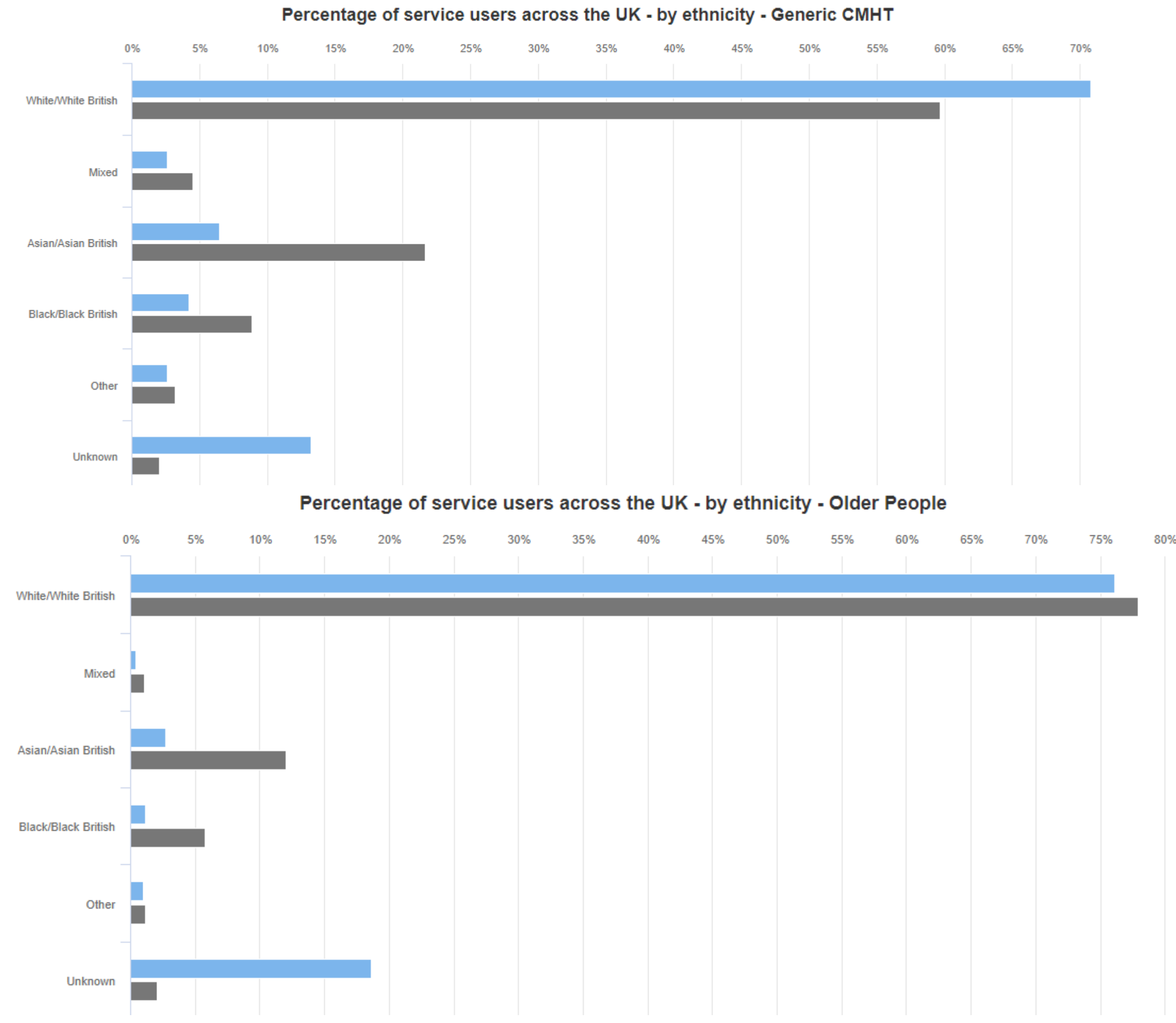
Ethnicity – Admissions and community caseload

(blue bar is BSMHFT)

Inpatients



Community



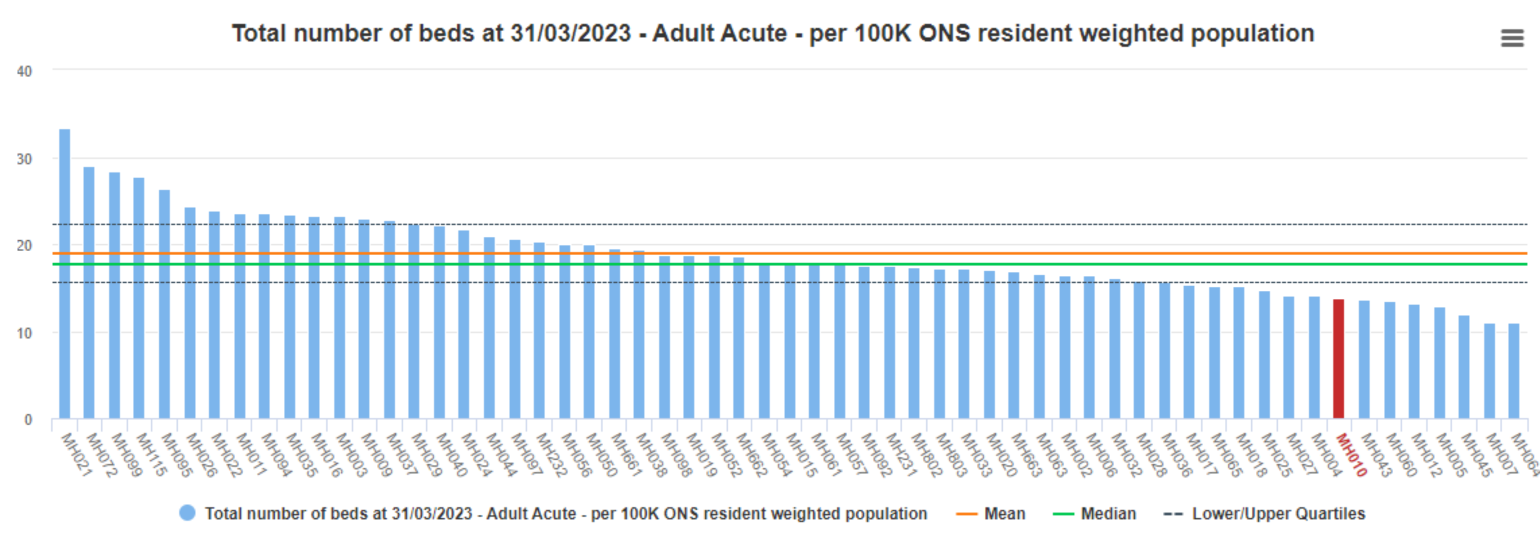
Adult Acute inpatients

Adult Acute Inpatients themes

Metric	Low High	MH010	Mean	Median
Beds per 100,000 resident population at 31st March 2023		20	23	22
Adult acute beds per 100,000 weighted population at 31st March 2023		13.8	18.9	17.9
Bed occupancy rates (excluding leave)		96%	93%	94%
Admissions per 100,000 resident population		143	206	214
Adult acute admissions per 100,000 weighted population		97.2	164.6	170.3
Admissions - patients not previously known to services (as a % of all patients admitted)		8%	12%	8%
Admissions - patients of no fixed abode (as a % of all patients admitted)		1%	3%	2%
Average length of stay (excluding leave)		52	38	39
Admissions under the Mental Health Act as a proportion of all admissions		66%	50%	52%
Admissions under the Mental Health Act per 100,000 resident population		94	93	81
Average length of stay for Mental Health Act detentions		58	42	43
Delayed transfers of care as a proportion of occupied bed days		6%	7%	6%
Readmission rate within 30 days		4%	9%	8%

- **Low number of beds** – below lower quartile
- **High levels of occupancy** – above mean
- **Low number of admissions** – below the lower quartile
- **Long length of stay** – above the upper quartile and LOS increases for those admitted under the MHA
- **14% of patients whose stay is longer than 90 days occupied 53% of all bed days** on adult acute wards
- **Admissions under the MHA** 66% compared to national average of 50%.
- **Prone Restraint** higher than the national average
- **Readmission rate** lower than national average

Adult Acute: Number of beds and Occupied Bed Days



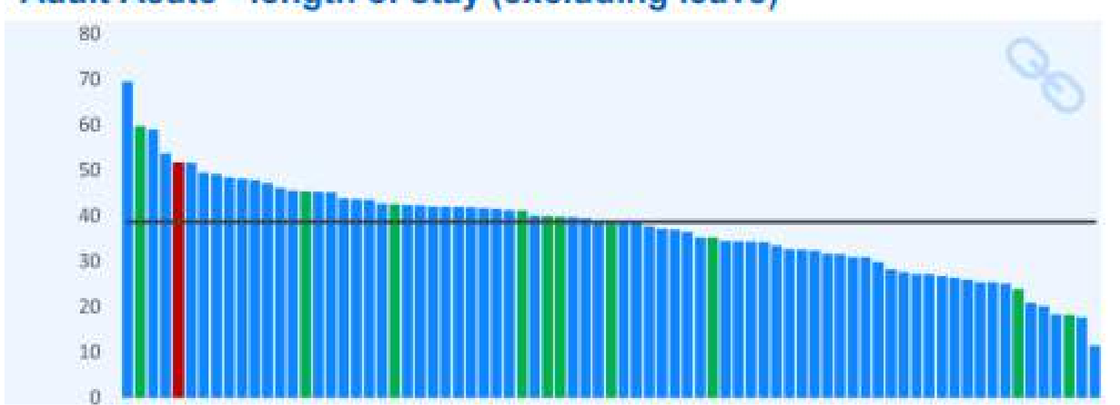
The number of beds based on resident population is 20 below the national average of 23. (based on 81 responses) however this drops to only **13.8** based on weighted population compared to the national average of 18.9. **The trust is 8th lowest based on 59 responses.** Combined with the **long length of stay** leads to a low number of admissions – **3rd lowest**

Bed occupancy rate is 96% compared to a national average of 93%.

Readmissions are in the bottom quartile at 4% compared to a national average of 9% and in the bottom quartile

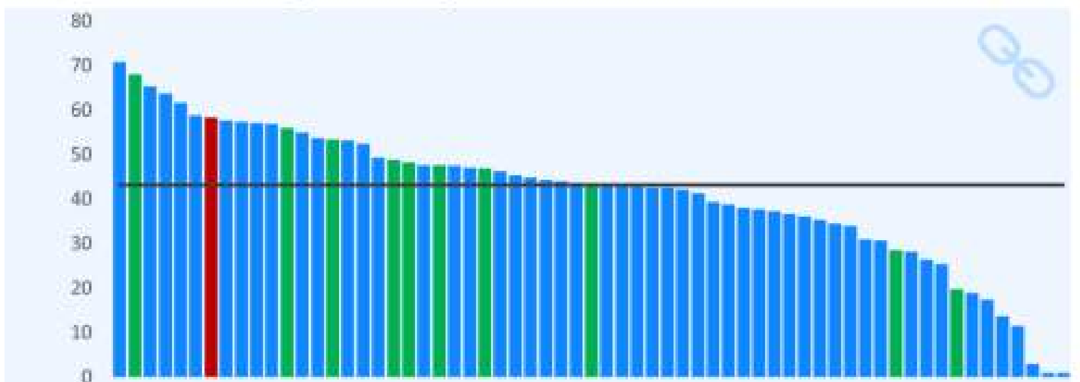
Adult Acute: Length of Stay/ DTOC

Adult Acute - length of stay (excluding leave)



MH010	52
Mean	38
Median	39
Upper quartile	44
Lower quartile	31
N	77

Adult Acute - length of stay for Mental Health Act detentions



MH010	58
Mean	42
Median	43
Upper quartile	53
Lower quartile	35
N	63

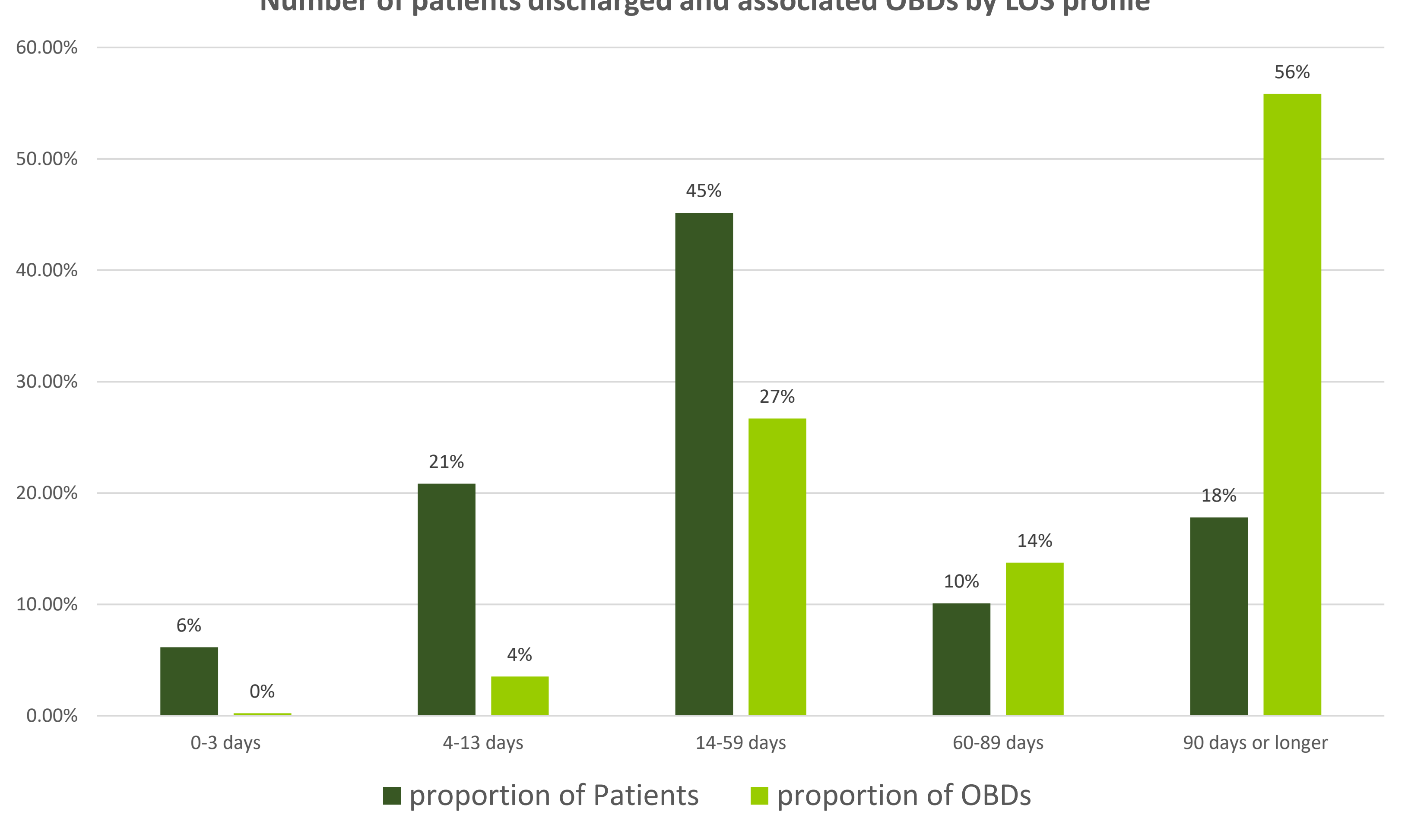
The average length of stay was **52 days** compared to a national average of 38 days This is in the top quartile and the 5th highest.

Admissions under the MHA increase the LOS experienced and increase our figures to 58 days remaining above the national average of 42 days
The average LOS for those admitted outside our beds is **42.5** days compared to a national average of 40.2

The number of admissions under the MHA is 7th highest and in the top quartile.

The number of bed days lost to delayed transfers of care is 6% below the mean of 7%

Adult Acute: Occupied bed days and LOS within provider footprint



45% of patients discharged within 14-59 days, occupy 27% of bed days.

18% of patients whose stay is longer than 90 days occupied 56% of all bed days on adult acute wards

Adult Acute: Restraint

Incidents of restraint per 10,000 occupied bed days are below the mean.

Prone restraint is the 11th highest at 35.8 in the top quartile against the national average of 15.8. This is a reduction from 21/22 which of 54.9

Deaths of services users per 10,000 occupied bed days has been included for the first time and are below the mean

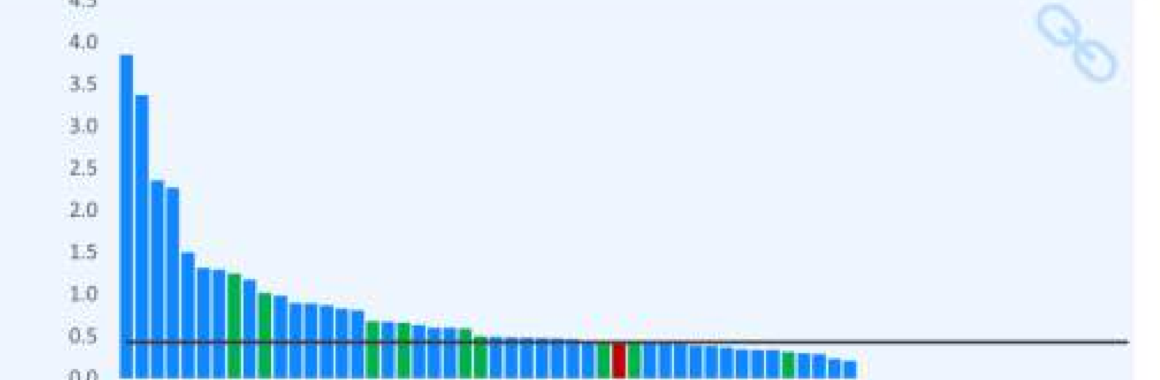
Adult Acute – incidences of restraint per 10,000 occupied bed days

MH010	110.4
Mean	155.1
Median	123.9
Upper quartile	191.5
Lower quartile	87.9
N	76

Adult Acute – incidences of prone restraint per 10,000 occupied bed days

MH010	35.8
Mean	15.8
Median	9.6
Upper quartile	20.0
Lower quartile	4.2
N	75

Adult Acute - deaths in inpatient care per 10,000 occupied bed days



MH010	0.4
Mean	0.6
Median	0.4
Upper quartile	0.7
Lower quartile	0.0
N	66

Adult acute IP workforce

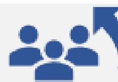
- Staff Vacancy and staff turnover below national average
- Staff sickness above the national average but below the upper quartile
- The total workforce per 10 beds (16.5) is lower than the national average (23.6) and drops to being the lowest when weighted population is applied. Both are in the bottom quartile
- The total of qualified nurses per 10 beds is just in the lower quartile and when weighted population is applied moves to the 5th lowest at 7.3 compared to the national mean of 13.

16.51

18th lowest

Mean 23.64

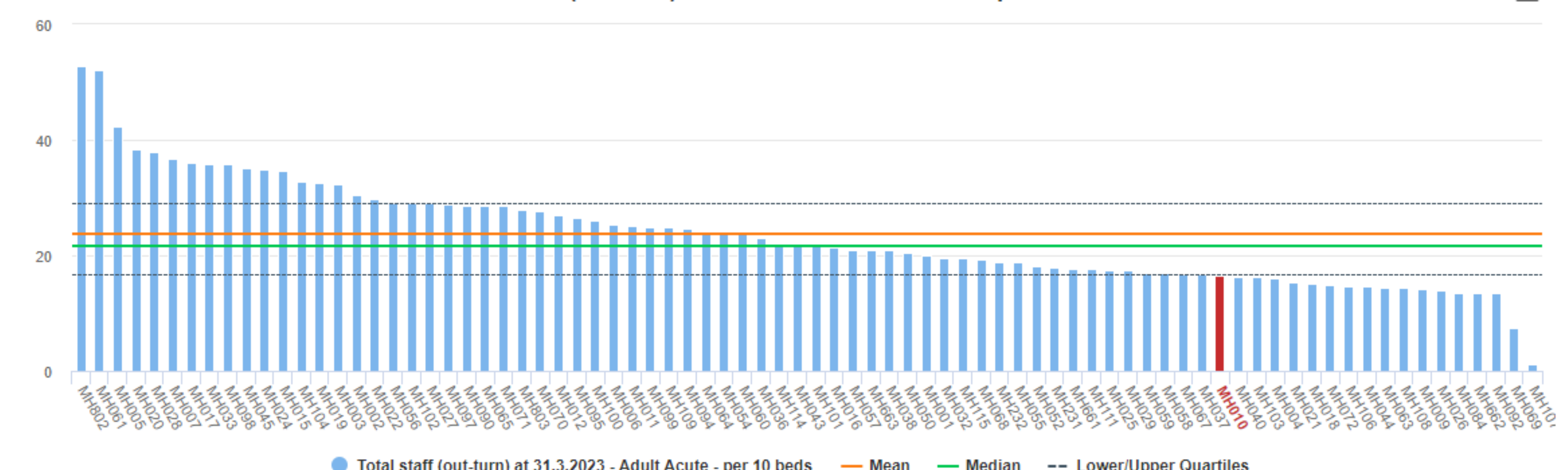
Workforce per 10 beds



11.8%

Mean 15.81%

Staff Turnover



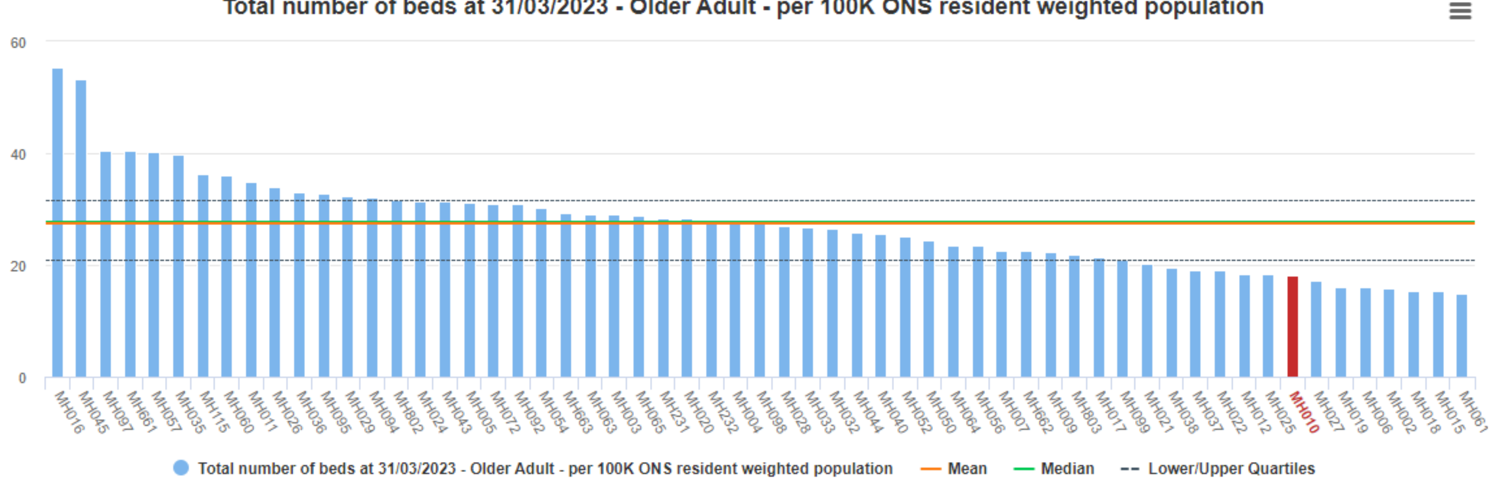
Older Adult Inpatients

Older Adult IP Acute: themes

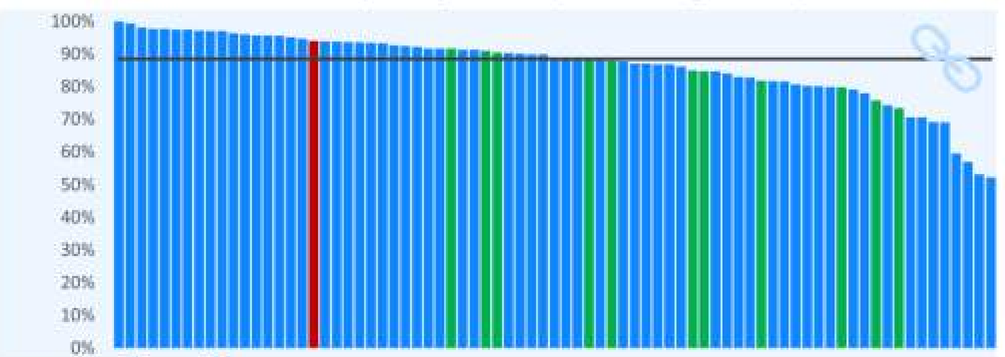
Metric	Low / High	MH010	Mean	Median
Beds per 100,000 resident population at 31 March 2023		29	43	37
Older adult beds per 100,000 weighted population at 31 March 2023		18.1	27.3	27.2
Bed occupancy rates (excluding leave)		94%	87%	88%
Admissions per 100,000 resident population		96	155	128
Older adult admissions per 100,000 weighted population		60.0	102.9	92.9
Admissions - patients not previously known to services (as a % of all patients admitted)		5%	15%	7%
Average length of stay (excluding leave)		110	86	88
Admissions under the Mental Health Act as a proportion of all admissions		73%	58%	63%
Admissions under the Mental Health Act per 100,000 resident population		70	81	73
Average length of stay for Mental Health Act detentions		118	90	89
Delayed transfers of care as a proportion of occupied bed days		11%	12%	11%
Readmission rate within 30 days		3%	5%	4%

- **Low number of beds** – in bottom quartile
- **High levels of occupancy** – above mean
- **Low number of admissions** – below the lower quartile
- **Long length of stay** – in top quartile and LOS increases slightly when service users admitted under the MHA
- 48% of patients who **stay is longer than 90 days occupied 76% of all bed days on** older adult acute wards
- **Restraint** higher than the national average but prone restraint in line with national average
- Low **readmission rate**
- **DTOC days** lower than the national average

Older Adult: Number of beds



Older Adult - bed occupancy rates (excluding leave)



MH010	94%
Mean	87%
Median	88%
Upper quartile	94%
Lower quartile	82%
N	77

The number of beds is lower than the national average using the weighted population – 8th lowest in the bottom quartile
This increases for registered population to 29 beds with a national average of 43

The number of admissions using weighted population (60) is 41% less than the national average of 102

Bed occupancy rate is 94% above the mean but looking at the total number of occupied bed days we are below the mean and above the lower quartile. **Applying the weighted population, it moves us to be the 8th lowest, in the bottom quartile** with 6,223 compared to a national average of 8,753

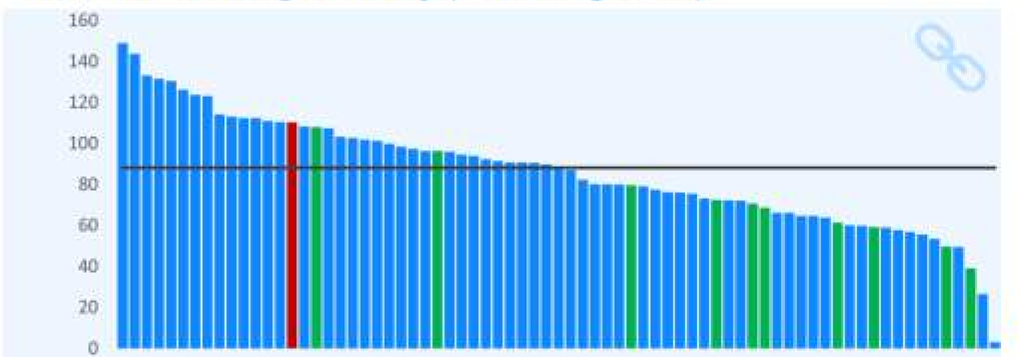
Readmissions within 30 days are below the lower quartile at 3%.

Older Adult: IP Length of Stay and DTOC

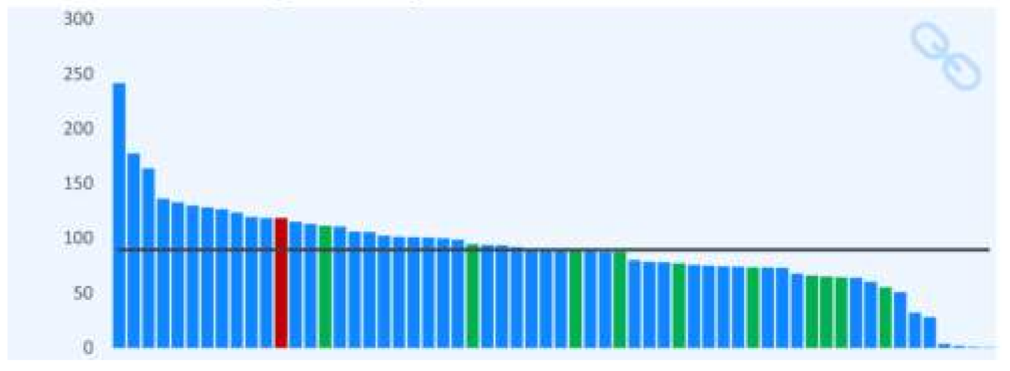
The average length of stay was 110 days compared to a national average of 86 days - In the top quartile.

Admissions under the MHA increase the LOS experienced to 118 days remaining above the national average of 90 days.

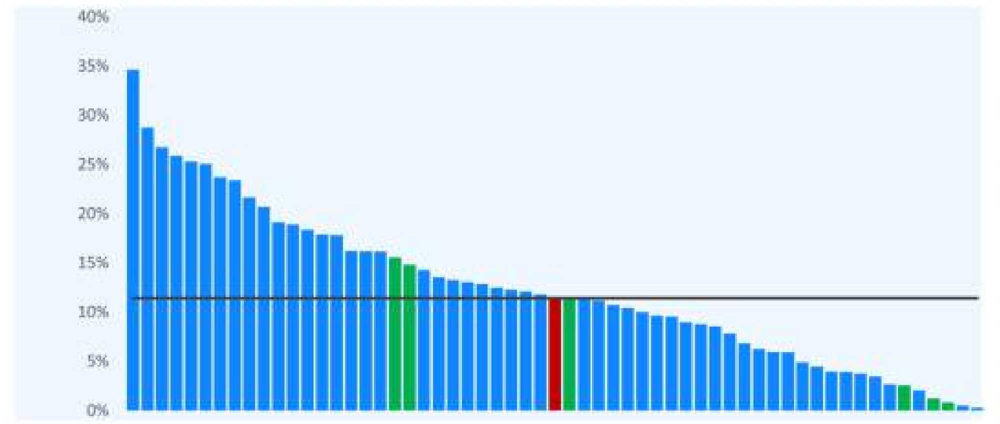
The number of bed days lost to delayed transfers of care is 11% just below the national average at 12%



MH010	110
Mean	86
Median	88
Upper quartile	103
Lower quartile	66
N	73

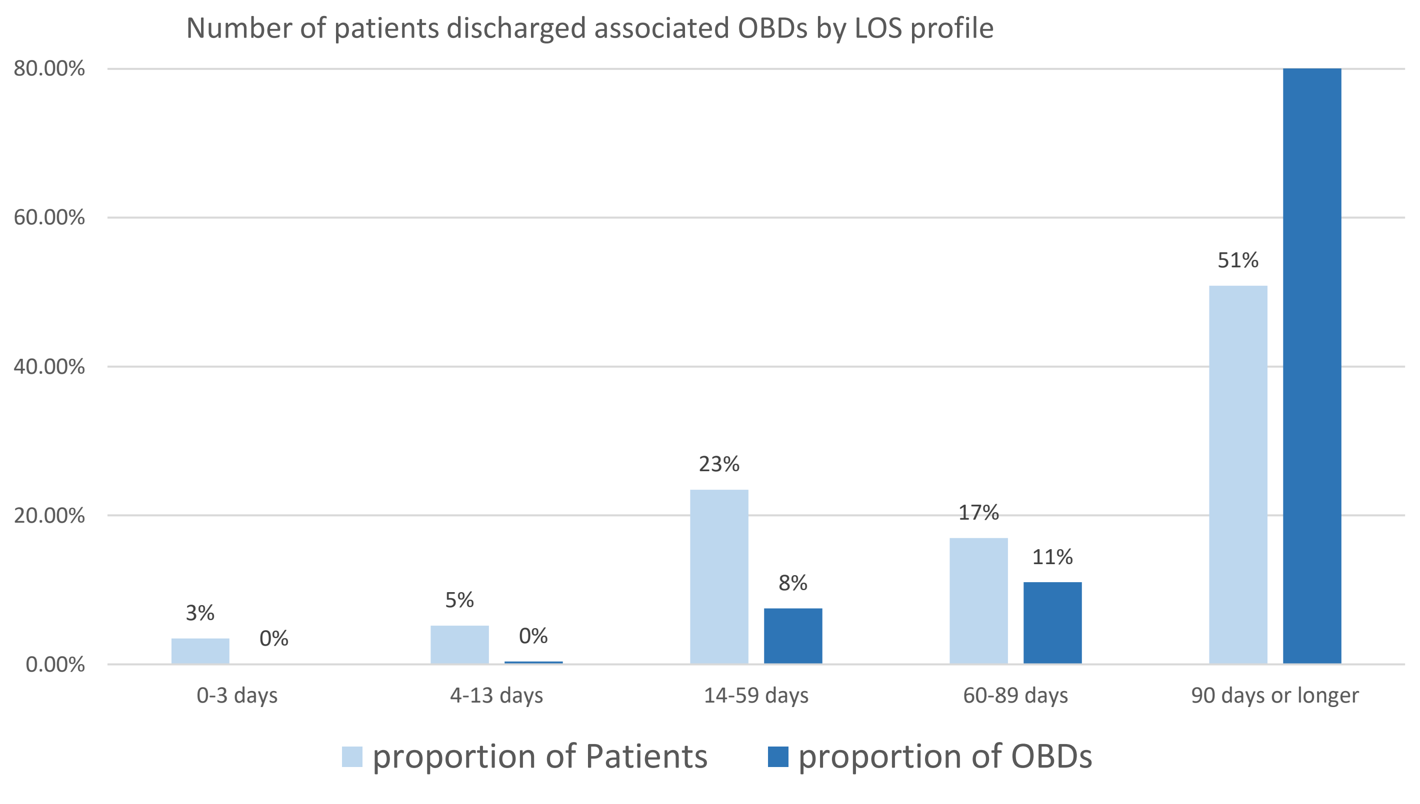


MH010	118
Mean	90
Median	89
Upper quartile	111
Lower quartile	74
N	60



MH010	11%
Mean	12%
Median	11%
Upper quartile	17%
Lower quartile	6%
N	59

Older adult Occupied bed days / LOS



23% of patients discharged between 14-59 days, occupy 8% of bed days.

51% of patients whose stay is longer than 90 days occupied 81% of all bed days on older adult acute wards

Older adult: IP workforce

0%
Mean 13.99%
Vacancy rate (all staff)

21.5
Mean 25.89
Workforce per 10 beds as at 31/03/2023

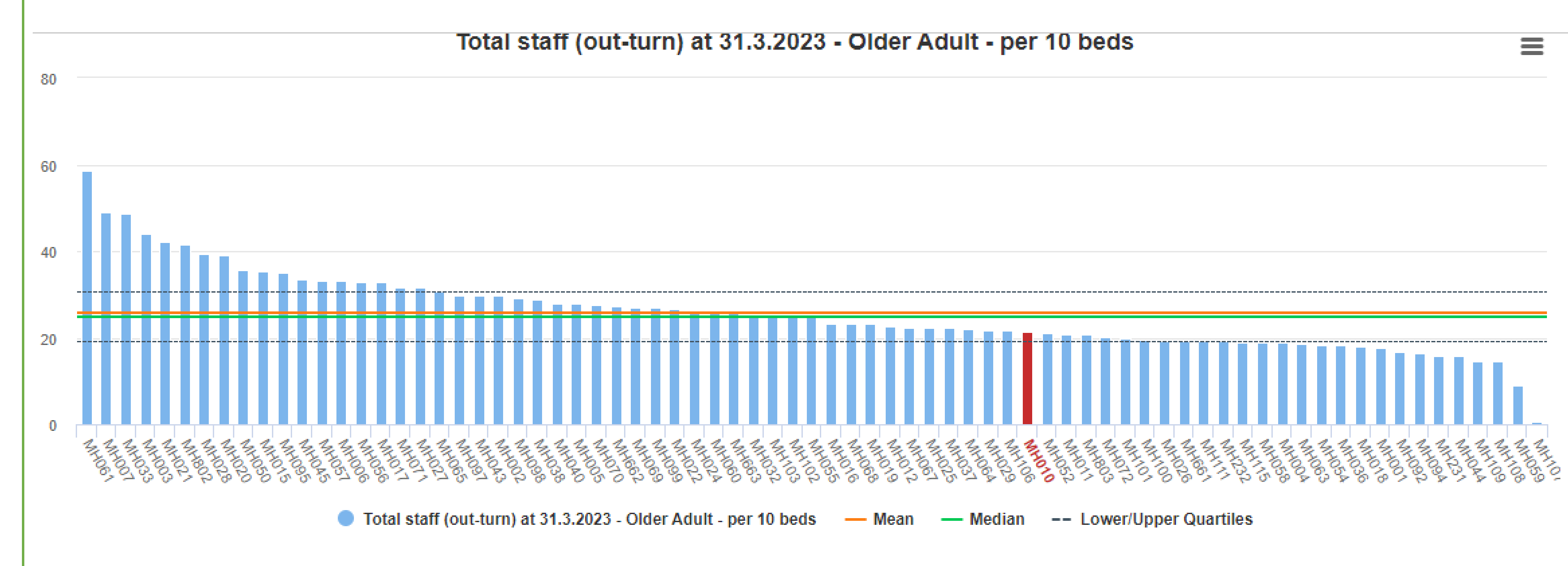
8.36%
Mean 9.47%
Sickness absence

7.9%
Mean 12.7%
Staff Turnover

Staff **Vacancy** below the mean and below the lower quartile. This is % due to the over recruitment of HCA's
Staff **sickness** below the mean and above the lower quartile
Staff **turnover** is below the mean and below the lower quartile

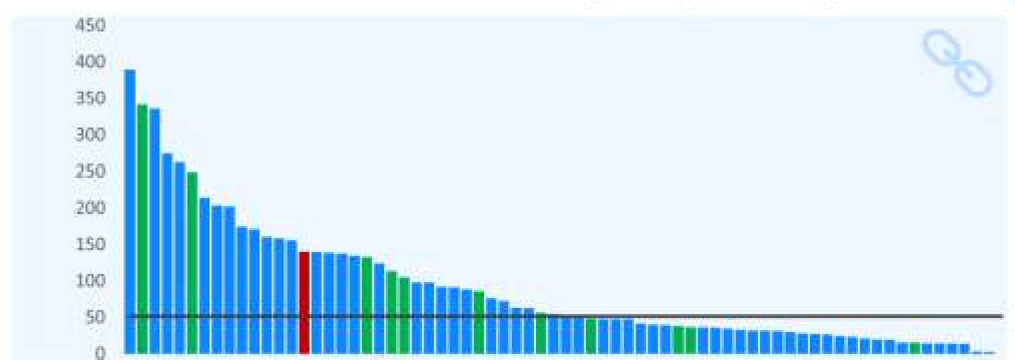
The **total workforce** per 10 beds is lower than the national average and drops to being the 3rd lowest when weighted population is applied.

The **total of qualified nurses** per 10 beds is below the lower quartile and when weighted population is applied moves to the 5th lowest



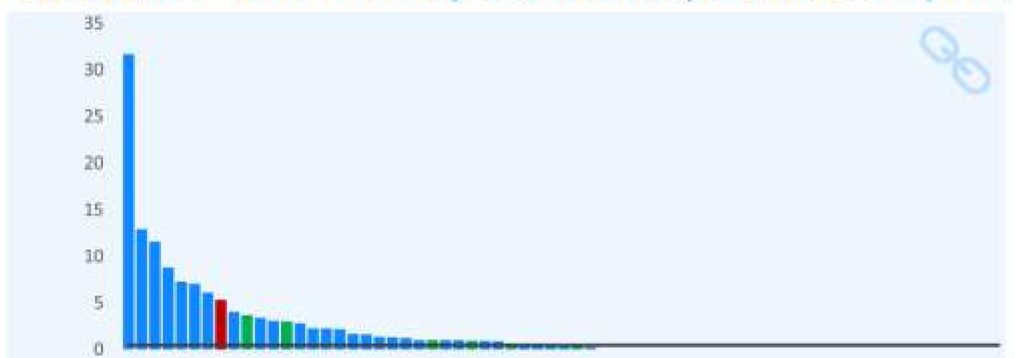
Older Adult IP : Restraint

Older Adult – incidences of restraint per 10,000 occupied bed days



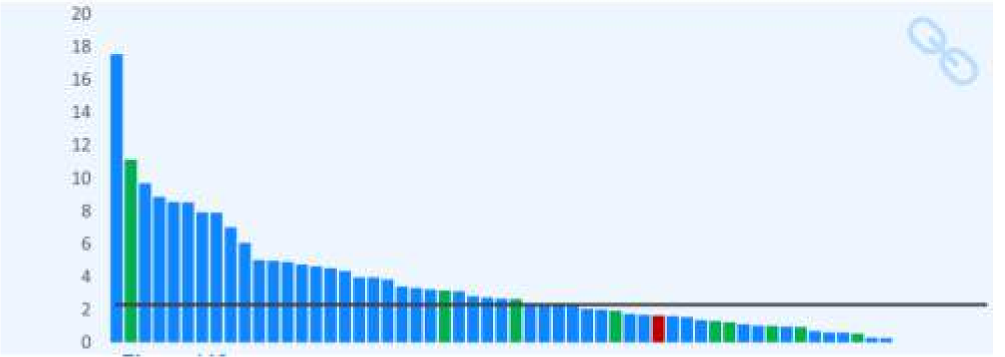
MH010	140.3
Mean	90.7
Median	51.8
Upper quartile	136.3
Lower quartile	30.8
N	71

Older Adult – incidences of prone restraint per 10,000 occupied bed days



MH010	5.3
Mean	2.0
Median	0.5
Upper quartile	1.9
Lower quartile	0.0
N	67

Older Adult - deaths in inpatient care per 10,000 occupied bed days



MH010	1.6
Mean	3.2
Median	2.3
Upper quartile	4.5
Lower quartile	1.0
N	62

Incidents of restraint per 10,000 occupied bed days are above the mean and in the upper quartile at 140.3 compared to the national average of 90.7.

Prone restraint is the 8th highest at 5.3 above the national average of 2.0. This is an increase from 21/22 which was 4.3.

We are in the top quartile for both restraint and prone restraint.

For the first time they have included deaths per 10,000 occupied bed days. Older adults are at 1.6 below the national average of 3.2 and in the bottom quartile.

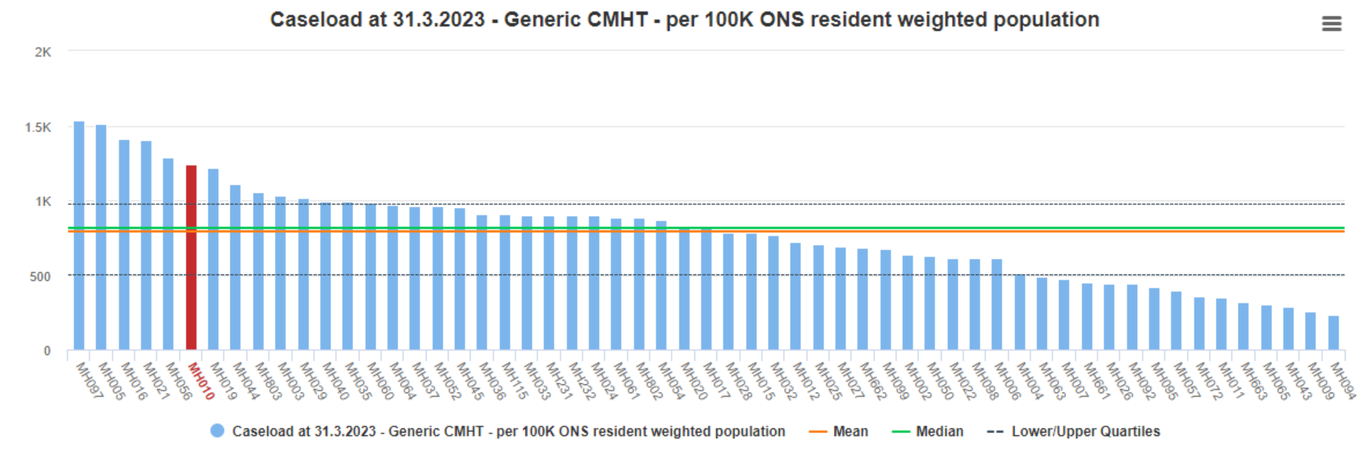
Adult Community

Adult community: Caseload/ Referrals/ Contacts

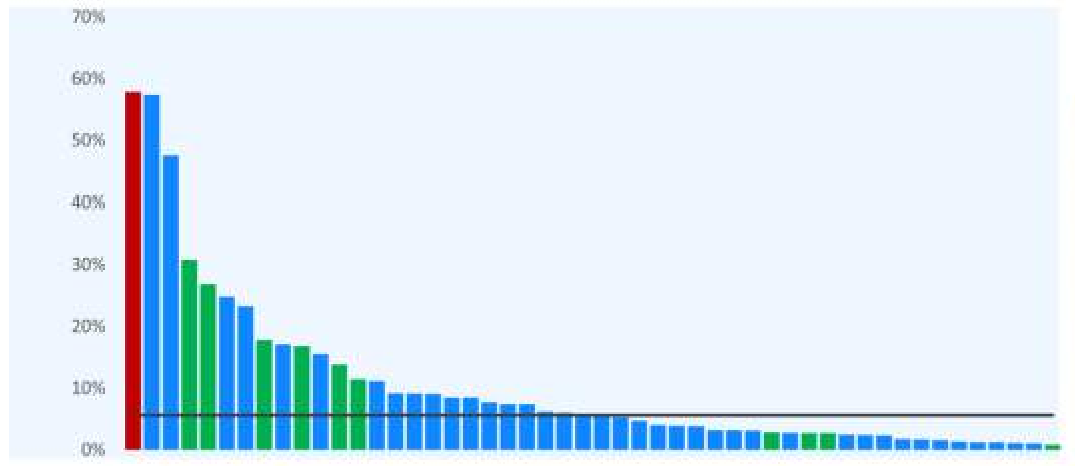
Metric	Low – High	MH010	Mean	Median
Referrals received per 100,000 population		1,489	1,755	1,559
Referral acceptance rate		48%	80%	86%
Median waiting time referral to 1st appointment		…	8.4	4.0
Median waiting time referral to 2nd appointment		…	14.0	8.0
Community caseload per 100,000 resident population at 31st March 2023		1,830	1,064	911
Patients on caseload who have not received a contact in the 12 month period		58%	10%	6%
Contacts delivered per 100,000 population		16,369	15,415	14,666
Proportion of contacts delivered non-face-to-face		39%	38%	38%
Proportion of non-face-to-face contacts delivered digitally		3%	6%	4%
Deaths per 10,000 patients on caseload (Caseload at 31st March 2023)		114.5	122.9	112.6
Community WTE per 100,000 population		24.0	49.7	47.0
Cost per contact		£194	£311	£248
Cost per patient on caseload (Caseload at 31st March 2023)		£1,734	£4,568	£4,688

- 6th highest Caseload above the mean and in the top quartile for weighted population at 1,240 compared to the national average of 788.
- The number of referrals we receive is just below the national average, the **acceptance rate** is **48%** against a national average of 80%
- Number of contacts at 12,473 is below the national average of 14,462
- **58%** of the caseload had not been seen in previous 12 months compared to the national average of 10%
- **61%** of patients were seen face to face compared to the national average of 62% (below the national average) This is an improvement from last year at 47%
- Adult CMHT had lowest total number of staff (16.25) at 31.03.2023 compared to a national average of 39.26 based on weighted population – 6th lowest and in the lowest quartile

Adult community: Caseload/ Referrals/ Contacts



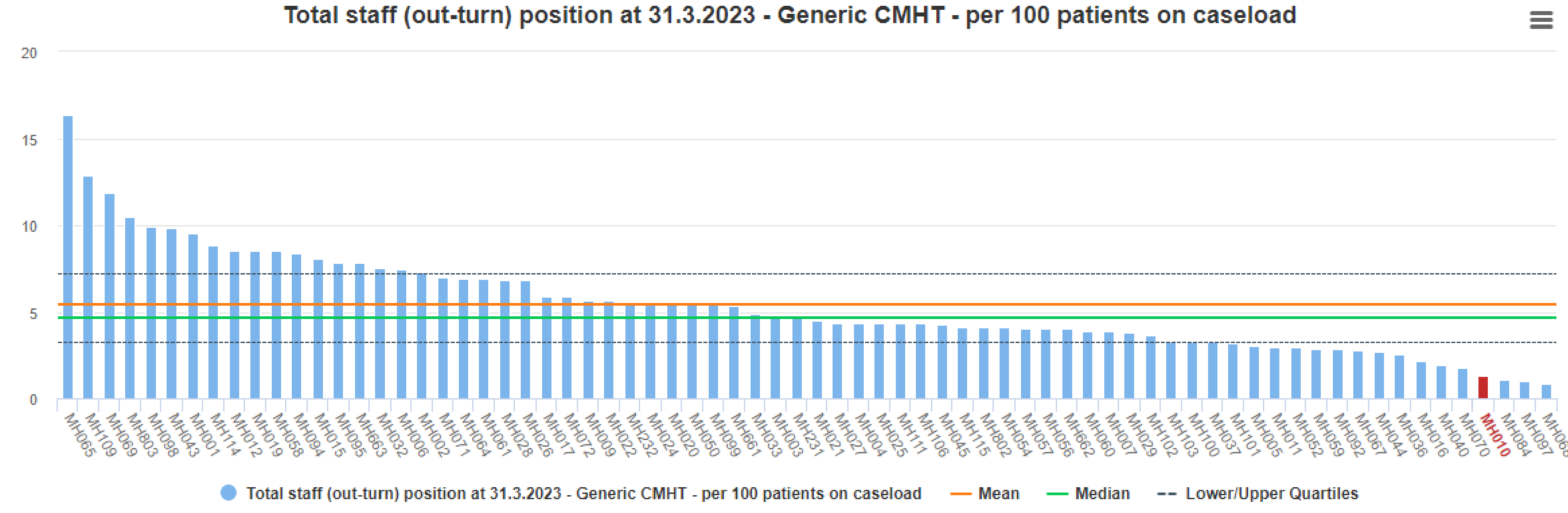
Generic CMHTs – patients on caseload who have not received a contact in the 12 month period



MH010	58%
Mean	10%
Median	6%
Upper quartile	11%
Lower quartile	3%
N	50

- 6th highest Caseload above the mean and in the top quartile for weighted population at 1,240 compared to the national average of 788.
- The number of referrals we receive is just below the national average, the acceptance rate is 48% against a national average of 80%
- Number of contacts at 12,473 is below the national average of 14,462
- **58%** of the caseload had not been seen in previous 12 months compared to the national average of 10%
- **61%** of patients were seen face to face compared to the national average of 62% (below the national average) This is an improvement from last year at 47%
- Adult CMHT had lowest total number of staff (16.25) at 31.03.2023 compared to a national average of 39.26 based on weighted population – 6th lowest and in the lowest quartile

Adult CMHT: staffing

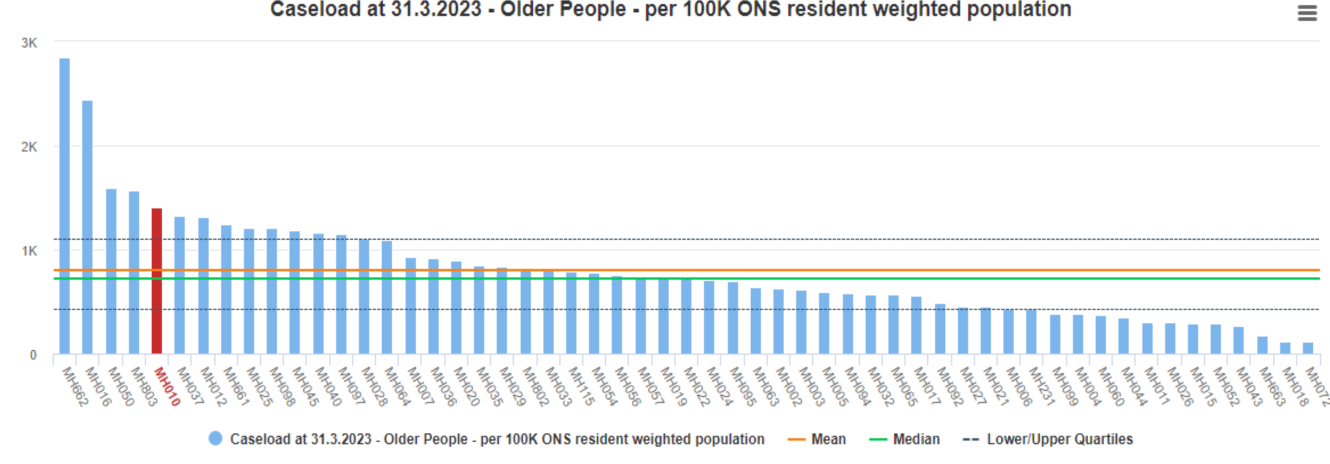


Per 100 people on the caseload staffing is the 4th lowest

MH010	**2.2**
Mean	8.4
Median	7.3
Upper quartile	10.6
Lower quartile	4.3
N	65

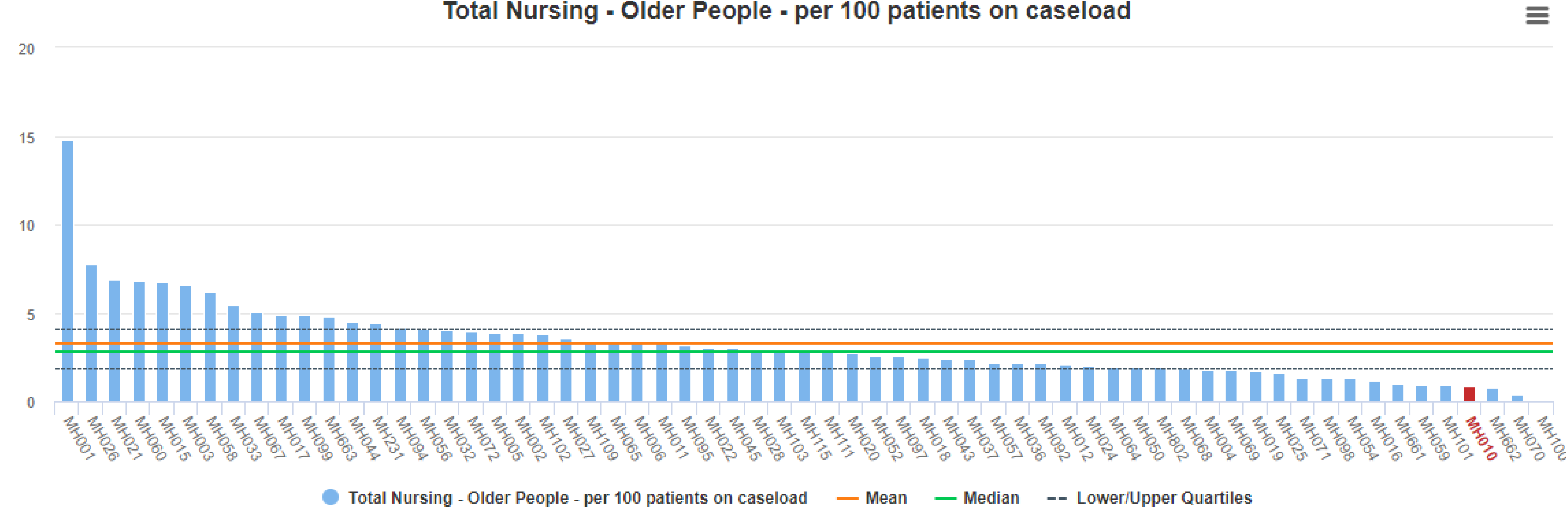
Older Adult Community

Older Adult community: Caseload/Referrals/ Contacts



- **Caseload** above the mean and the upper quartile for weighted population at 1,409 compared to the national average of 804 – **6th highest**
- The number of referrals we receive is below the national average and the acceptance rate is 74% against a national average of 85%
- **Number of contacts** at 11,481 is below the national average of 14,832 (weighted population) but above the lower quartile
- **57%** of the caseload **have not been seen** in previous 12 months compared to the national average of 6.6% (as a proportion of all patients on the caseload)
- **63%** of patients were seen face to face compared to the national average of 62.6% and is a 10% increase from last year

Older Adult CMHT: Staffing



MH010	4
Mean	3.2
Median	2.8
Upper quartile	4
Lower quartile	1.8
N	63

- Low level of qualified nursing staffing per 100 people on the caseload
- Applying weighted population moves the Trust to above the lower quartile, 10th lowest at 12.2 compared to a national average of 20.37.
- The number of Consultants per 100 patients on the caseload is the 6th lowest at 0.14 compared to the national average of 0.64

Appendix

Summary of key metrics:

- PICU
- Home Treatment
- Secure
- AOT

Summary of key metrics: PICU

Metric	Low / High	MH010	Mean	Median
Bed occupancy rates (excluding leave)		98%	88%	91%
Average length of stay (excluding leave)		48	61	49
Admissions under the Mental Health Act as a proportion of all admissions		57%	84%	91%
Delayed transfers of care as a proportion of occupied bed days		0%	6%	4%
WTE vacancies as % of staff in post		18%	21%	19%
Cost per 10 beds		£3,886,476	£3,699,750	£3,621,750
Restraint per 10,000 occupied bed days		563.7	565.0	424.4
Prone restraint per 10,000 occupied bed days		165.9	64.5	38.5
Deaths in inpatient care per 10,000 occupied bed days		0.0	0.4	0.0

Summary of Key metrics: Home Treatment (*based on registered population*)

Metric	Low / High	MH010	Mean	Median
Referrals received per 100,000 population		730	1,666	1,037
Referral acceptance rate		78%	90%	96%
Median waiting time referral to 1st appointment		...	0.1	0.0
Median waiting time referral to 2nd appointment		...	0.3	0.0
Community caseload per 100,000 resident population at 31st March 2023		26	38	26
Patients on caseload with no contact in the 12 month period		2%	11%	5%
Contacts delivered per 100,000 population		6,274	6,076	5,478
Proportion of contacts delivered non-face-to-face		15%	37%	36%
Proportion of non-face-to-face contacts delivered digitally		0%	1%	0%
Deaths per 10,000 patients on caseload (Caseload at 31st March 2023)		337.1	1,000.6	841.7
Community WTE per 100,000 population		10.7	22.4	20.4
Cost per contact		£203	£453	£338
Cost per patient on caseload (Caseload at 31st March 2023)		£49,481	£81,089	£66,727

Summary of key metrics: Medium Secure

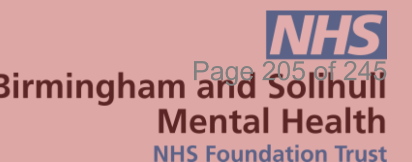
Metric	Low High	MH010	Mean	Median
Bed occupancy rates (excluding leave)		91%	87%	88%
Average length of stay (excluding leave)		767	634	644
Admissions under the Mental Health Act as a proportion of all admissions		86%	92%	100%
Delayed transfers of care		4%	4%	3%
WTE vacancies as % of staff in post		...	16%	15%
Cost per 10 beds		£2,616,348	£2,589,229	£2,464,988
Restraint per 10,000 occupied bed days		85.7	53.8	45.3
Prone restraint per 10,000 occupied bed days		25.5	9.9	7.0
Deaths in inpatient care per 10,000 occupied bed days		0.1	0.2	0.0

Summary of key metrics: Low Secure

Metric	Low – High	MH010	Mean	Median
Bed occupancy rates (excluding leave)		95%	88%	91%
Average length of stay (excluding leave)		1,401	840	621
Admissions under the Mental Health Act as a proportion of all admissions		100%	88%	100%
Delayed transfers of care as a proportion of occupied bed days		12%	6%	5%
WTE vacancies as % of staff in post		9%	14%	14%
Cost per 10 beds		£1,660,161	£1,981,534	£1,991,845
Restraint per 10,000 occupied bed days		0.0	55.3	16.8
Prone restraint per 10,000 occupied bed days		0.0	6.0	2.2
Deaths in inpatient care per 10,000 occupied bed days		0.0	0.2	0.0

Summary of key metrics: AOT (based on registered population)

Metric	Low / High	MH010	Mean	Median
Referrals received per 100,000 population		4	11	9
Referral acceptance rate		57%	80%	88%
Median waiting time referral to 1st appointment		...	2.7	2
Median waiting time referral to 2nd appointment		...	4.5	3
Community caseload per 100,000 resident population at 31st March 2023		54	28	25
Patients on caseload with no contact in the 12 month period		...	3%	1%
Contacts delivered per 100,000 population		3,194	1,312	992
Proportion of contacts delivered non-face-to-face		14%	23%	19%
Proportion of non-face-to-face contacts delivered digitally		3%	1%	1%
Deaths per 10,000 patients on caseload (Caseload at 31st March 2023)		142.1	463.5	160.0
Community WTE per 100,000 population		8.7	5.5	5
Cost per contact		£341	£356	£294
Cost per patient on caseload (Caseload at 31st March 2023)		£20,030	£18,457	£17,647



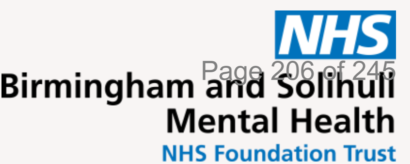
Adult and Older People Workforce in Mental Health Services 2023 Bespoke Report

February 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

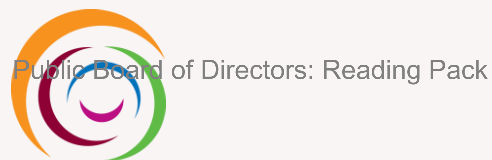
MH010

Sarah Emery- Head of Workforce Transformation



INTRODUCTION

- The Report this relates to is the Adult & Older People Census at 31st March 2023- NHS Benchmarking Network
- Data is collected from multiple sources.
- Data is already over 12 months old and should not be used in isolation
- Provides useful benchmarking over a range of metrics.
- Presentation pulls out the high level comparison data



Overview

Adult and Older People Workforce in Mental Health Services 2023

NHS Benchmarking Network

45,834
Number of WTE in an inpatient setting

44,532
Number of WTE in a community setting

34%
Workforce who were registered nurses across community & inpatient settings

20.0
Total WTE per 10,000 population in England

22.1
Community WTE per 1,000 referrals accepted

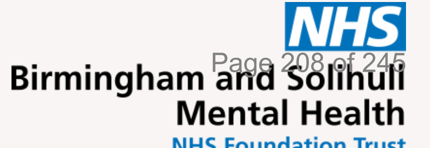
516
Inpatient WTE per 1,000 admissions

15.1%
Mean inpatient vacancy rate across all team types

14.5%
Mean community vacancy rate across all team types

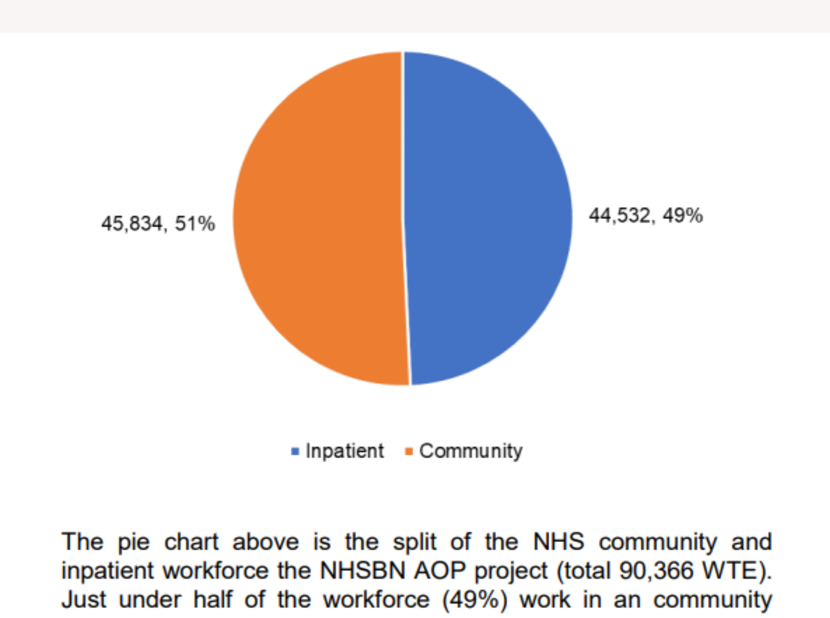
7%
Workforce who were psychological professions across community & inpatient settings

	BSMHFT
WTE inpats	1501.5
WTE Community	914.6
% Reg Nurses	36%
WTE per 10k population	18.9
Community WTE per 1K referrals accepted	40.6
Inpats WTE per £1K admissions	601
Mean Inpats vacancy rate	18.5%
Mean community vacancy rate	16.4%
% wforce Psychological Professions	6%



Community/ Inpatient split

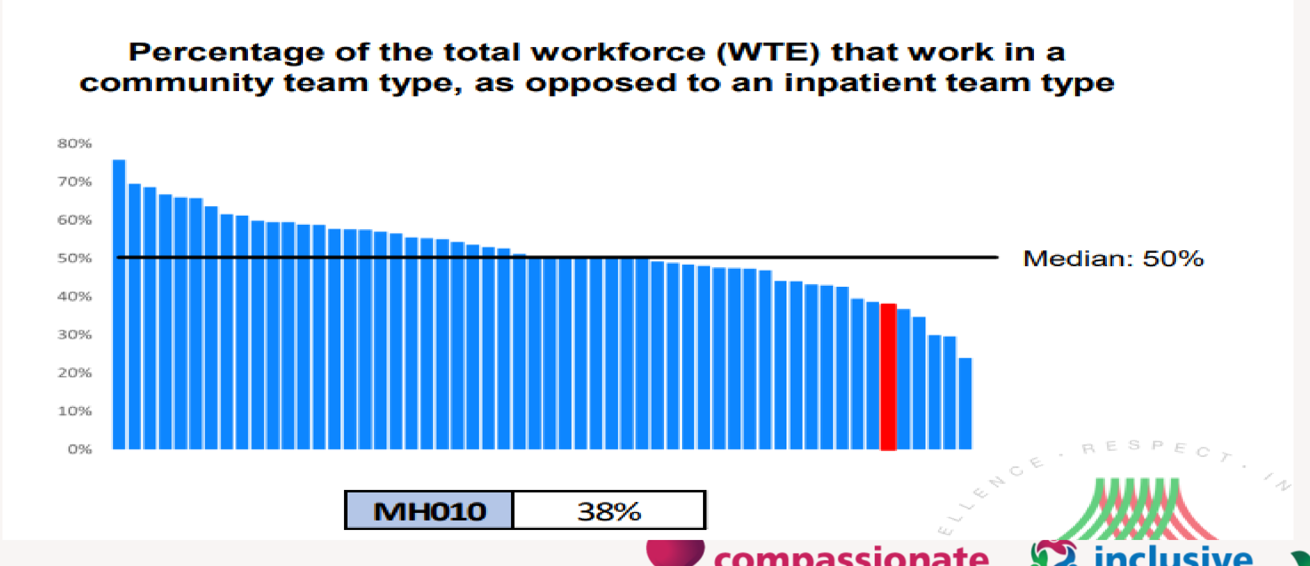
National v Trust



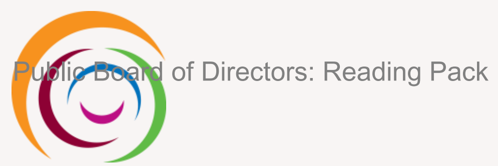
	WTE	%
Community	914.6	38%
Inpatient	1501.5	62%

- Why are we such an outlier?
- Is it worth benchmarking to similar mental health Trusts
- What are the implications?
- What will the impact of community transformation investment be?

Nationally just under half of the workforce work in the community as a Trust this is 11% lower



compassionate inclusive committed



Discipline mix

Across both community and inpatient settings, 34% of the staff were registered nurses, 31% were support workers & unregistered nursing staff and 7% were psychological professions.

Over a third (39%) of the staff in a community setting were registered nurses, whilst in an inpatient setting this was 30%. Just under half (48%) of staff working in inpatient settings were support workers & unregistered nursing staff. Twelve percent of staff in community settings were psychological professions compared to 2% of staff in inpatient settings.

The staff roles captured in each staff groups are available in appendix D and E.

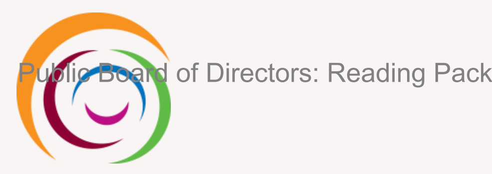
Community and inpatient workforce discipline mix

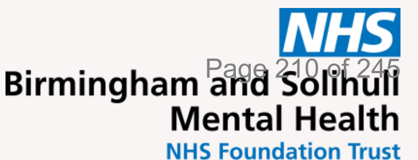
	Admin and Management	Registered Nursing	Psychiatry	Support workers & unreg. nursing staff	Psychological professions	Other aggregated
Community & Inpatient	10%	34%	6%	31%	7%	11%
Community	14%	39%	8%	14%	12%	14%
Inpatient	7%	30%	5%	48%	2%	8%

MH010 community and inpatient workforce discipline mix

	Admin and Management	Registered Nursing	Psychiatry	Support workers & unreg. nursing staff	Psychological professions	Other aggregated
Community & Inpatient	12%	36%	8%	32%	6%	7%
Community	18%	41%	10%	15%	9%	7%
Inpatient	8%	33%	6%	43%	4%	7%

The graph on the right is BSMHFT discipline split – admin, nursing and psychiatry were higher % at BSMHFT benchmarked against National. Support staff in inpats units 5% lower at BSMHFT. Psychological professions above National on wards but 3% below in the community. Could be worth exploring other aggregated on community setting which is double % Nationally than at BSMHFT- Why?





HR Metrics- Vacancy rates

Vacancy rates for generic CMHT and CRHT community teams by region (median)

Region	Generic CMHT	CRHT
East of England	19.2%	17.6%
London	19.8%	25.2%
Midlands	13.0%	15.1%
North East & Yorkshire	9.1%	10.7%
North West	18.7%	19.4%
South East	7.8%	25.9%
South West	8.8%	23.9%
England	12.7%	19.4%

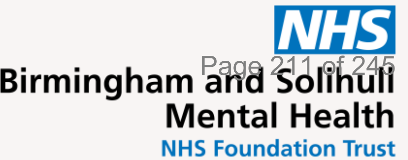
MH010	
Generic CMHT	19.7%
CRHT	...

Vacancy rates for adult acute and older adult inpatient teams by region (median)

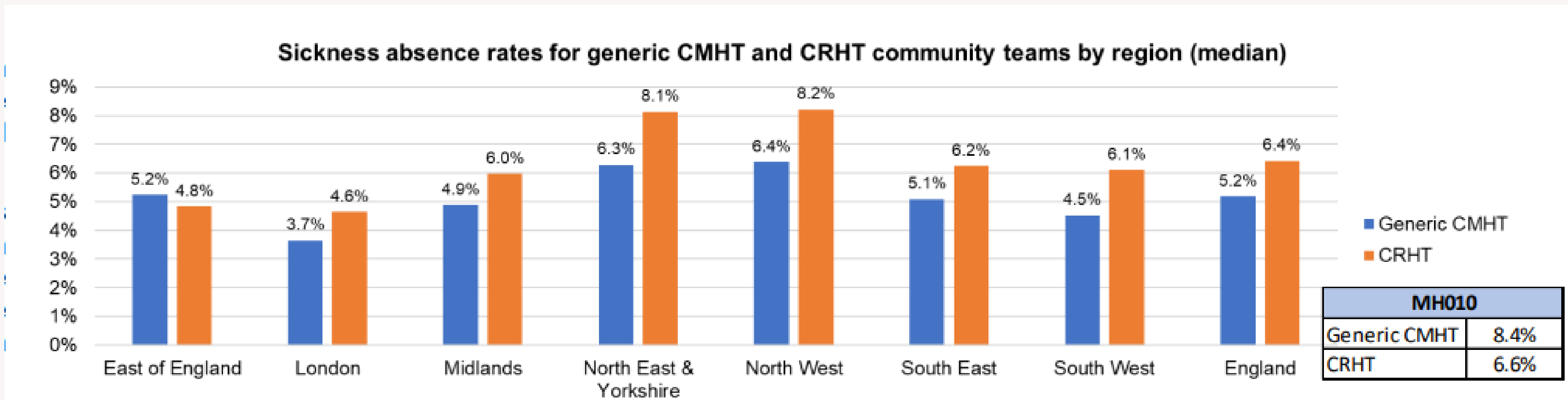
Region	Adult Acute	Older Adult
East of England	18.9%	15.1%
London	21.2%	17.8%
Midlands	15.5%	15.0%
North East & Yorkshire	6.8%	5.9%
North West	15.8%	16.8%
South East	19.7%	18.5%
South West	19.0%	16.6%
England	15.6%	15.1%

MH010	
Adult Acute	15.5%
Older Adult	...

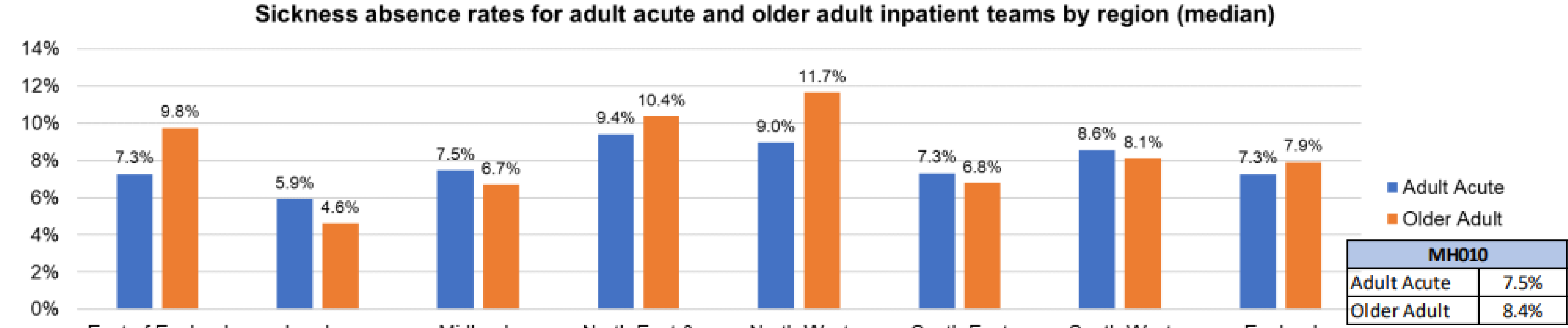
Our generic CMHT is high compared to the midlands average. The inpatients in line with Midlands average which is one of the lowest in the country. However higher compared to the National on the infographic slide



HR Metrics- Sickness rates



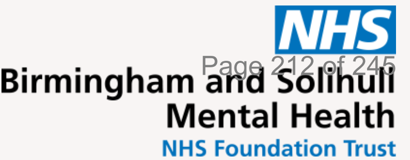
MH010	
Generic CMHT	8.4%
CRHT	6.6%



MH010	
Adult Acute	7.5%
Older Adult	8.4%

BSMHFTs generic CMHT sickness was higher than the regional rates which ranged from 3.7 to 6.4% CRHT around average.

Adult inpatients in line with regional averages. Regionally really varied for older adults ranging from 4.6 -11.7% 8.4 above average.



HR Metrics- Turnover

Turnover rates for generic CMHT and CRHT community teams by region (median)

Region	Generic CMHT	CRHT
East of England	18.7%	15.2%
London	20.0%	18.0%
Midlands	15.0%	7.1%
North East & Yorkshire	9.3%	5.7%
North West	17.3%	14.4%
South East	15.2%	13.7%
South West	12.9%	9.6%
England	14.1%	10.8%

MH010	
Generic CMHT	15.8%
CRHT	5.3%

Turnover rates for adult acute and older adult inpatient teams by region (median)

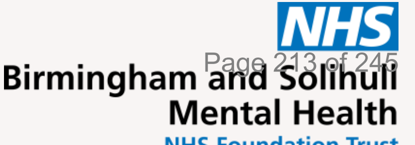
Region	Adult Acute	Older Adult
East of England	15.8%	13.5%
London	19.3%	18.3%
Midlands	16.7%	9.8%
North East & Yorkshire	12.3%	9.2%
North West	13.6%	12.6%
South East	19.6%	18.3%
South West	16.8%	10.3%
England	16.5%	10.7%

MH010	
Adult Acute	11.8%
Older Adult	7.9%

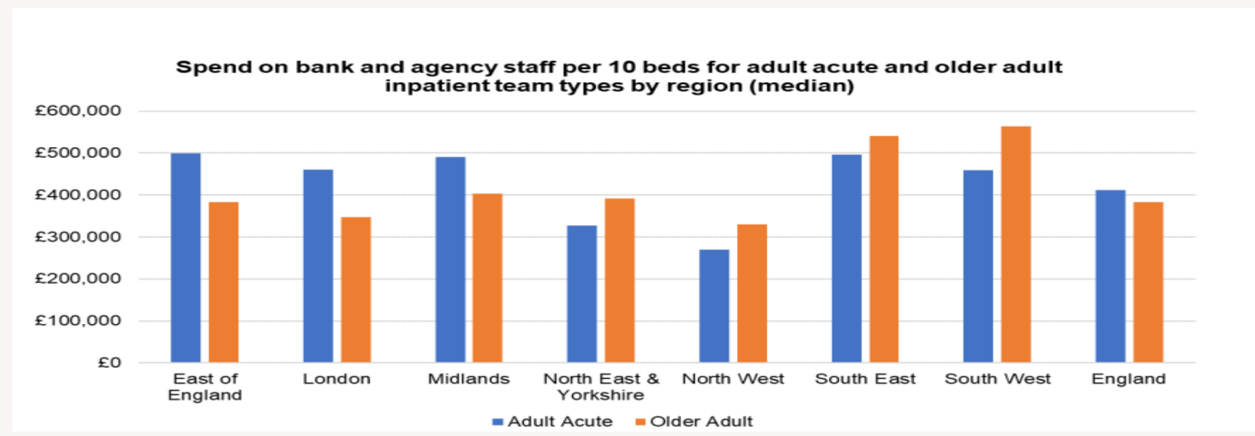
Turnover rates varied. BSMHFT were below the Midlands average in CRHT, adult and older adult inpatients.

DATA ALERT- No generic way that all Trusts are measuring turnover. Issue particularly in exclusions i.e. leavers who stay on the bank.

compassionate inclusive



Bank & Agency Spend



MH010	
Adult Acute	£321,931
Older Adult	£460,837

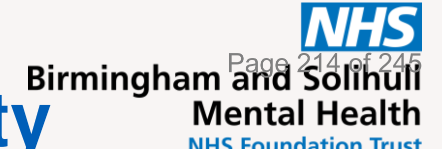
Worth noting data is at March 2023 bank and agency usage at BSMHFT has increased significantly.

Spend on bank & agency staff per referral accepted for generic CMHT and CRHT community team types (median)

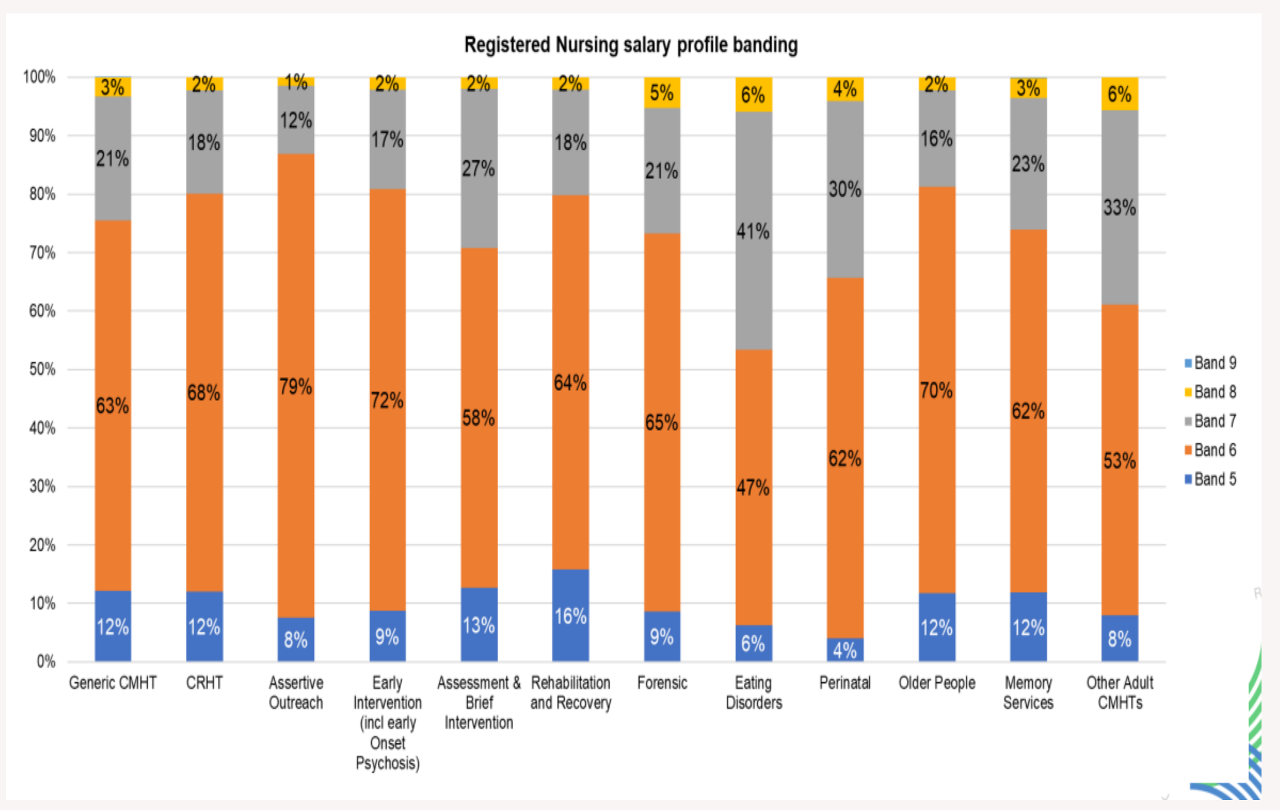
Region	Generic CMHT	CRHT
East of England	£168	£62
London	£516	£359
Midlands	£139	£118
North East & Yorkshire	£257	£77
North West	£393	£97
South East	£328	£476
South West	£258	£195
England	£272	£167

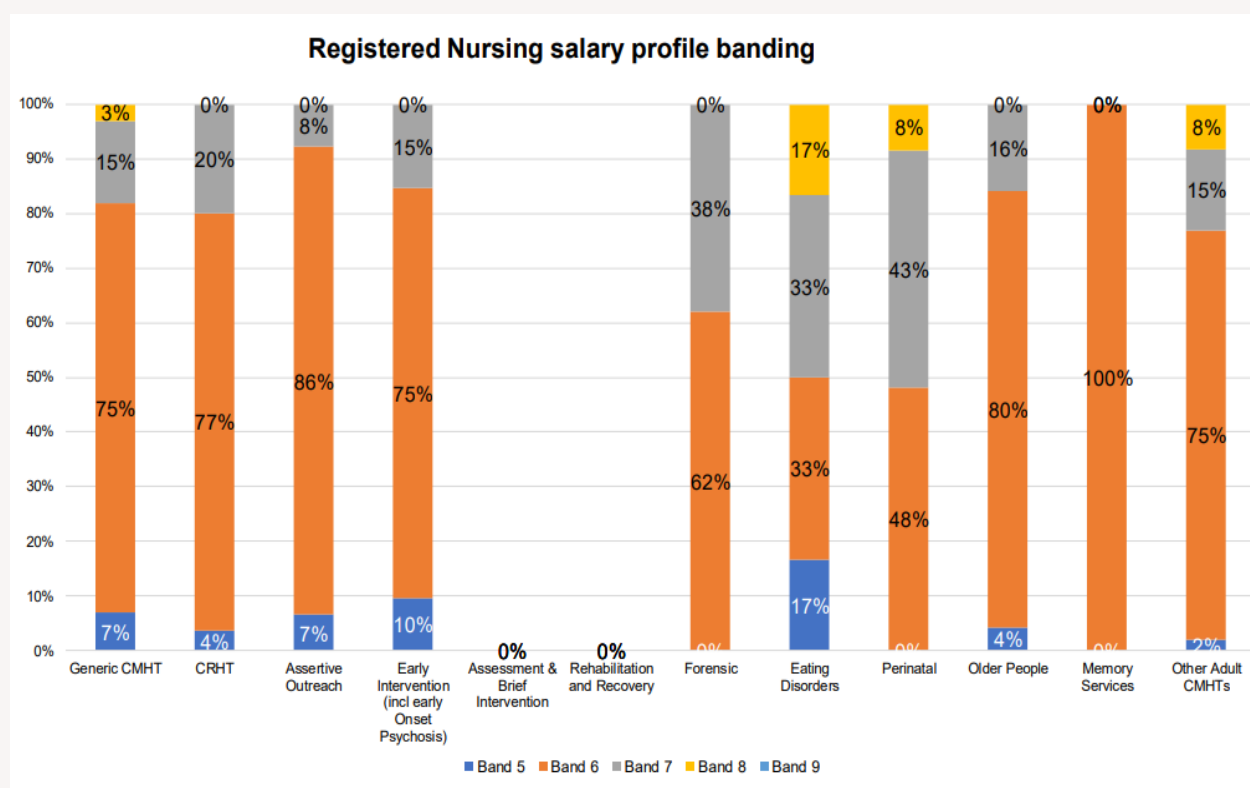
MH010	
Generic CMHT	£414
CRHT	...

At the time adult acute below regional median however higher for older adult. Generic CMHTs was significantly higher.



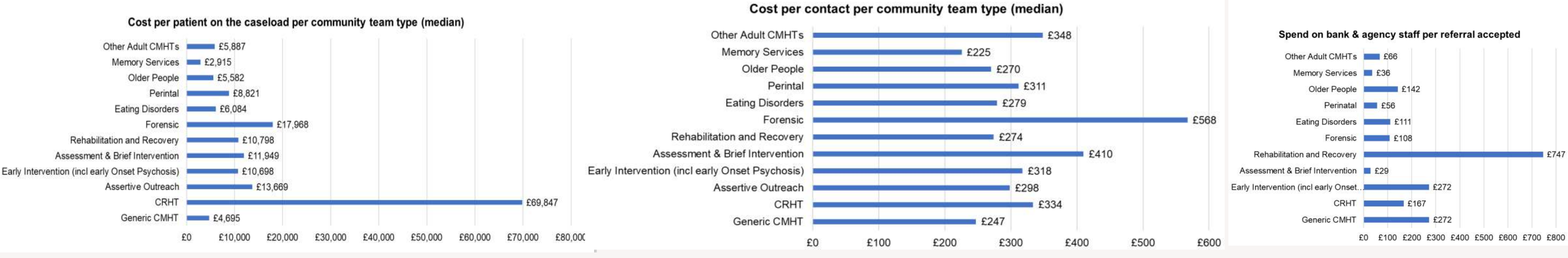
Registered Nursing Salary Profile- Community





Enables us to benchmark banding in community teams. BSMHFT seem to have a lower proportion of community band 5 posts than the National benchmarking data. Band 6 community posts is one of our biggest vacancy gaps.

Finance Benchmarking-Community



Cost per patient on the caseload

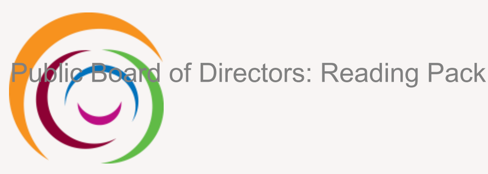
MH010	Spend
Other Adult CMHTs	£4,179
Memory Services	£7,788
Older People	£2,573
Perinatal	£7,528
Eating Disorders	£5,264
Forensic	£22,446
Rehabilitation and Recovery	...
Assessment & Brief Intervention	...
Early Intervention (incl early Onset Psychosis)	£15,020
Assertive Outreach	£20,030
CRHT	£49,481
Generic CMHT	£1,734

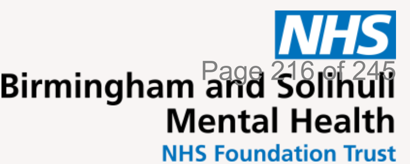
Cost per contact

MH010	Spend
Other Adult CMHTs	£294
Memory Services	£390
Older People	£316
Perinatal	£319
Eating Disorders	£279
Forensic	£397
Rehabilitation and Recovery	...
Assessment & Brief Intervention	...
Early Intervention (incl early Onset Psychosis)	£169
Assertive Outreach	£341
CRHT	£203
Generic CMHT	£194

Spend on bank and agency staff per referral accepted

MH010	Spend
Other Adult CMHTs	£15
Memory Services	£0
Older People	£168
Perinatal	£0
Eating Disorders	£0
Forensic	£0
Rehabilitation and Recovery	...
Assessment & Brief Intervention	...
Early Intervention (incl early Onset Psychosis)	£36
Assertive Outreach	£16,248
CRHT	£127
Generic CMHT	£414





Summary

- Do you find the data useful?
- How might you use the data? i.e. skill mix reviews/ business cases/workforce planning activity
- Anything differently you would like to see presented
- Any areas we want to explore further and why?

National Deaf Services Birmingham

SERVICE OVERVIEW-

GRANT BUDGE/ SPECIALITIES LEAD NURSE

What We Provide

- We provide a recovery-focused, culturally sensitive accessible mental health service to deaf, hard of hearing and deafblind people aged 18 years and above.
- Having a highly experienced passionate and dedicated MDT team with over 140 years collective experience specifically working within deaf mental health care.
- 11 million people in the UK are deaf or hard of hearing (one in 6).
- There are over 151,000 BSL users within the UK

"Mental Health and Deafness: Toward Equity and Access" (2015)

Service Setup

- We have a 12-bed inpatient specialist ward along with a tertiary community team, we cover a third of England as one of only three nationally accredited NHSE commissioned deaf services.

- The other 2 National Deaf Services are based in London and Manchester.

- We have deaf, hard of hearing and hearing staff within our team along with in house BSL interpreters.

Current Financial Snapshot

Our Deaf Service ended FY 23/24 in £140k deficit

- This is because the Deaf service was not budgeted for the 5% Pay Award hit [estimated 90k budget missing] and the COVID bonus [estimated 50k hit]
- Due to previous years outperformance on Access to Work [ATW] income, the income target was increased for 23/24, and as a result the bank staff budget for us was increased significantly as a counter entry
- Our service fell short of the income target for 23/24 [131k loss], and so for 24/25 the income target has been tapered back down, as well as the bank budget in response as the counter entry.
- If the Deaf service had the pay award budget built in, and the COVID bonus hadn't happened, we say the service would be near break-even - but this is because of vacancies in the Pay budget, and a generous bank budget.
- If our service recruits to its vacancies, we will be in deficit. This would mainly be driven by interpreter spend. The deaf service only recoups part of its interpreter spend [directly linked to deaf staff performing duties] but cannot reclaim costs for general interpreter spend [for patients more widely, the ward etc]

Operational & Clinical Challenges/Risks

- No clear referral/triage process or pathway map in place which requires full consensus from the MDT (Strategy Goals Q4 RAG rating-Red)
- Lack of engagement of local teams and local authority resources which compromises patient's safety and quality of care along with delayed discharge.
- No clear escalation policy /support from our commissioners to remove these barriers/delays.
- Severe lack of available community supported accommodation for deaf people nationally.
- Lack of deaf awareness within our own trust, local and out of area services and adjoining barriers with access to health care for deaf people.
- NHSE are focused on our performance on annual review & despite being informed we will stay on Block for another year- we need to provide assurance. We need to demonstrate how we will increase our activity and ensure our pathway is capturing patients who may be out there not receiving MH care, or within hearing environments which is discriminatory in line with the Equality Act.

Our Risk Interventions

- We have held a trust wide MDT Pathway Mapping project over the last 12 months supported by the transformation team
- NHSE, finance, Contracts, Senior management, Specialist lead nurse, Deaf MDT (in partial attendance)
- Solutions our new proposed pathway has generated are NOT LIMITED TO :

A clearer referral process for professionals to be widely shared limiting access delays for deaf people ending up in hearing wards or lost in the system.

Discharge our patients when clinically ready to capture recovery- we have patients on our medical caseload since 1995

Structured screening of received referrals- triage forms for Rio

Routine and consistently active use of our Deaf Service generic inbox

A new Service Website with 18 BSL signed & subtitled videos to promote the service and as a hub for referrals- Now live completed by deaf staff, IT and Specialities Lead nurse

Referral forms being available that are visible and accessible for both hearing and deaf people- Forms constructed

Self-referral options

- Ensuring we are exploring other routes for us to gain referrals for triage from our existing flow- we now run a successful drop-in service with increased uptake

- Widening our AHP group to receive and support with referrals/Screening/assessment- just the RC at present

- Recording our referrals regardless of triage outcome – we need to improve this as referrals are getting added to word documents

- Promotion of our Service to increase awareness and referrals and the appointment of a substantive Deaf Advisor to mirror the other national services- JD PS done froze due to budget constraints

- Continuing to be clear with our level of input after our assessments determine the outcome: full care package/limited care package- our plans need to be clearer and captured

- Escalating any delays experienced with secondary services for Care coordination/funding/keyworker needs upwards internally and externally- NHSE need to be visible

Create clear parameters for re-access to our service in line with rapid re access. E.g.- If an assessment deems the referral is not suitable after liaising with current care providers and GP

Biweekly audits carried out for community clinicians to remind them of any non-outcome appointments reported for urgent action- this is now in place and has seen vast improvement in the capture for the MDT.

New outcome codes will be created by the service transformation team

The need to measure our performance-
we can develop a suite of reports at both operational (work lists, outliers etc) and service performance (average waits, outcomes, activity) reporting.

Recent Achievements & Opportunities

Service Development

Deaf awareness Module for E-learning being constructed by deaf staff and the Lead Nurse alongside the LD team- we want this as a statutory traffic light within the Barberry then cascaded wider.

- Proposed Pathway changes for finalising

Recruitment

- Capacity utilisation manager in post to help with delayed discharges (secondment) which has supported with some significant delays
- Vast improvement in inpatient nursing staff recruitment driven by our ward manager- 1 x B5 vacancy & OT post remains to fill
- We now have a Clinical Associate Psychologist (CAP)in post. We believe this will be the first ever deaf CAP apprentice nationally and will be hugely beneficial in terms of what the service is able to offer.
- We filled empty vacancies for OT assistant, assistant psychologist with highly experienced people, both Deaf themselves and this has improved the quality of care.

KPI & Clinical Effectiveness

- Incidents being closed in timely manner No open SI actions ,Complaints are low.
- Audit outcomes- MHA audits, resus audits and simulations passed and submitted on time. Deaf community KPI stat training at 98%, all have active ADR & clinical supervision compliance high

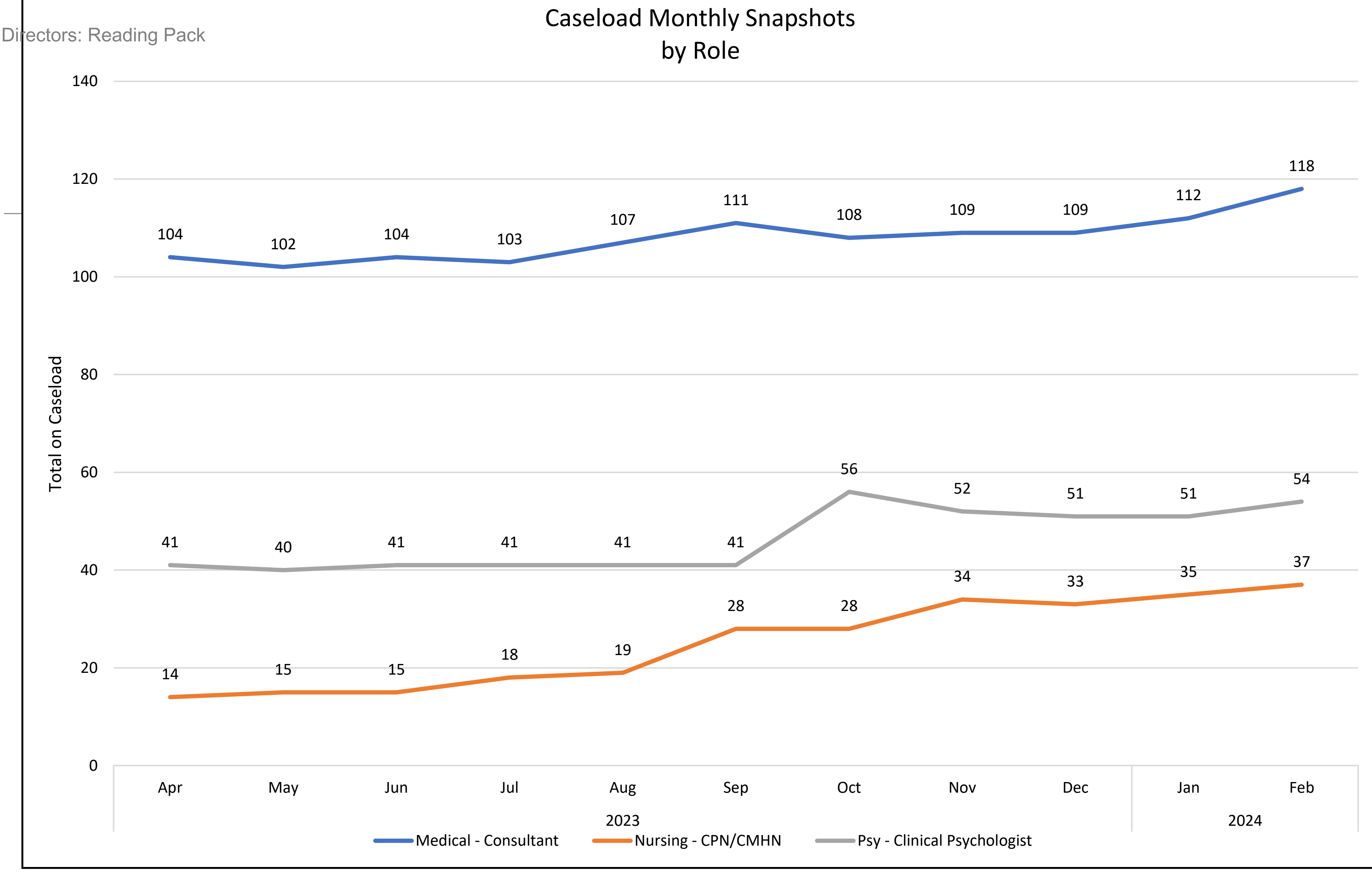
Representation & Service Promotion

- Psychology hosted the national network of psychologists working with deaf people, sharing work on our recent First Episode of Psychosis pathway.
- Our medics had a poster accepted by the European conference for deaf mental health relating to our work on improving the pathway for deaf people with a first episode of psychosis. Due to budget constraints, we were unable to see this through
- Recent keynote presentation at national conference about improving services for deaf adults with ASD given by Dr Ben Holmes, Clinical Psychologist.
- Presentations are held for wider trust services in relation to deaf awareness by community deaf staff and our Clinical Nurse Specialist

New Data generated by Laurie Quant 1st May 2024

The next 3 slides demonstrate that since operational changes with appointment of our CNS and Lead Nurse:

- **Collectively MDT caseloads have increased in comparison to last year**
- **The CPN caseload has doubled**
- **Month on month we have seen a small increase in overall activity**
- **DNAs this Quarter have dropped significantly**
- **Captured contacts this year have increased month on month**



Caseload Monthly Snapshots
by Role
Total on Caseload
0
20
40
60
80
100
120
140
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2023
2024
104
102
104
103
107
111
108
109
109
112
118
41
40
41
41
41
41
56
52
51
51
54
14
15
15
18
19
28
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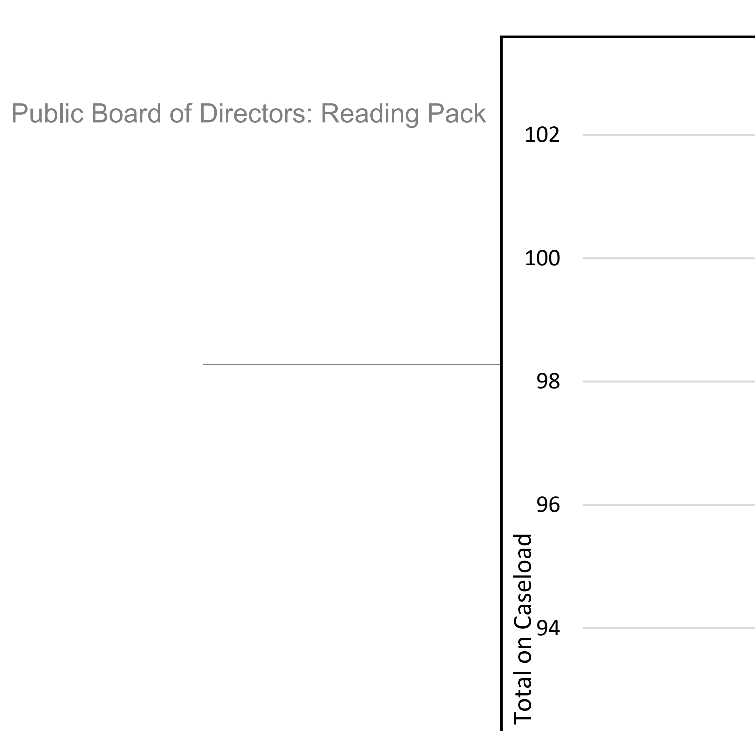
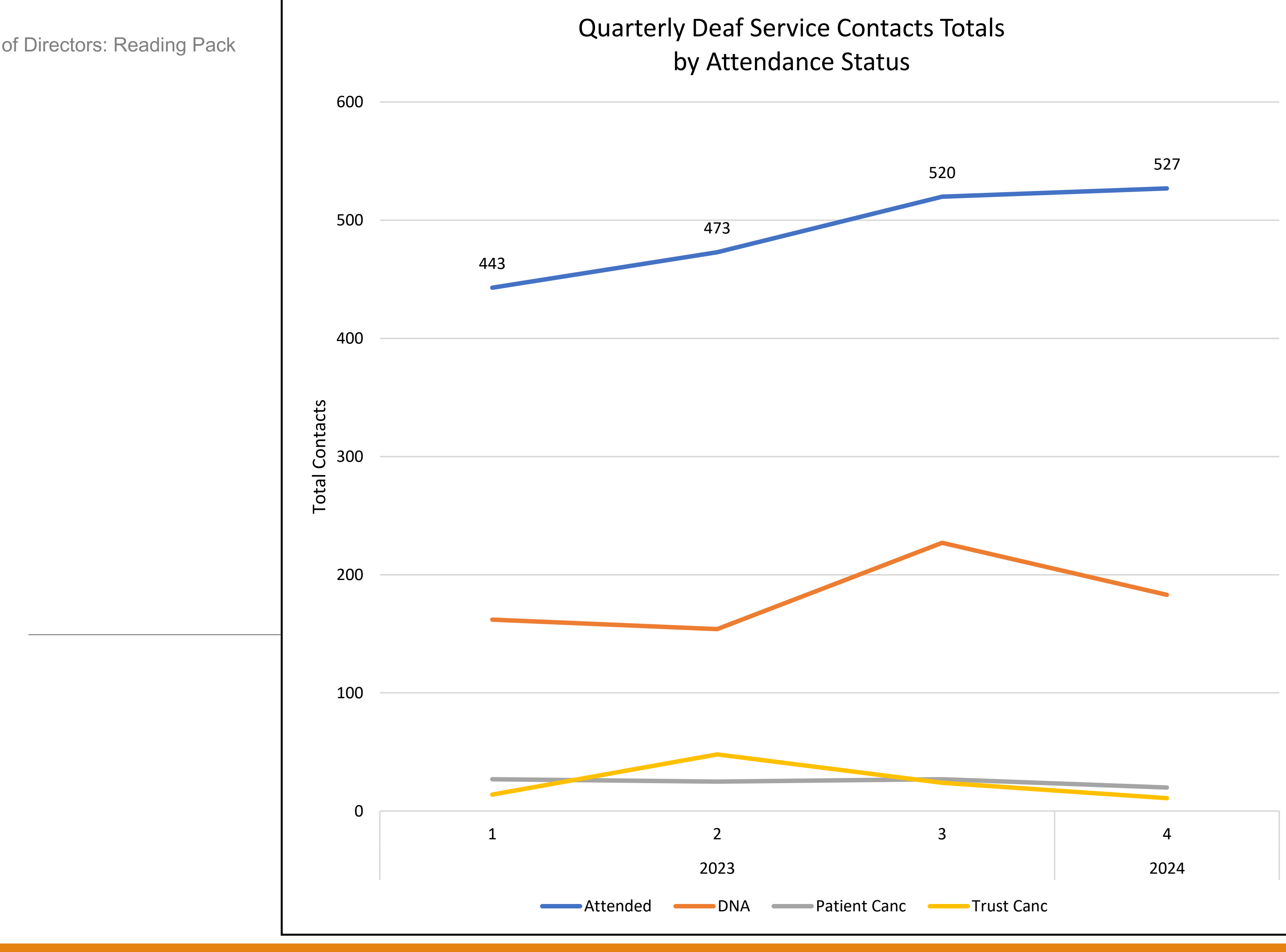
34
33
35
37
Medical - Consultant
Nursing - CPN/CMHN
Psy - Clinical Psychologist


Caseload Monthly Snapshots
Deaf Service Community Team
Total on Caseload
102
100
98
96
94
92
90
88
86
91
91
93
94
97
97
97
94
93
95
98
99
100
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
2023
2024
Total


Quarterly Deaf Service Contacts Totals
by Attendance Status
Total Contacts
600
500
400
300
200
100
0
443
473
520
527
1
2
3
4
2023
2024
Attended
DNA
Patient Canc
Trust Canc

Conclusion & Questions?

We have a long standing, highly specialist deaf service with a passionate and very dedicated, experienced team.

Without us, deaf patients would not have access to the specific knowledge tools and awareness required for accurate assessment diagnosis and treatment, as a recognised service of excellence.

We need to finalise our operating structure and plans- to move with the times alongside bed pressures and financial constraints, which all services experience within the current climate.

If we do this- we can increase our resources as our performance and activity will then justify the need and ensure the service continues to thrive to support recovery for deaf people.

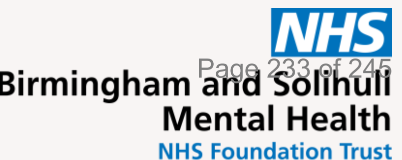
Neuropsychiatry

Let’s celebrate that Neuropsychiatry sits within BSMHFT.

We are a specialist team with a fabulous reputation for clinical excellence.

We serve a diverse and ever-changing population and consistently deliver a high-quality personalised experience for ALL our service users.

Reputation



Neuropsychiatry has great staff….

Epilepsy – Dr Bagary is the President of the UK Chapter of the International League Against Epilepsy (ILAE) which is the most prestigious clinical body in epilepsy

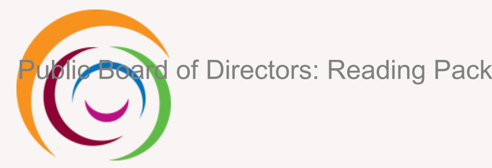
Huntington's Disease – Prof Rickards has an international reputation as a leader in this area. Alex Fisher (OT) is renowned in the world of HD and due to complete her PhD imminently.

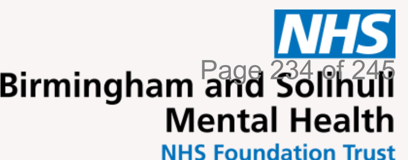
Prof Cavanna is a leading contributor to journals and has presented his work on Tourette's across the world

The service has close links with Birmingham University and the MSc Neuropsychiatry is led by Prof Rickards and Prof Cavanna, with input from Dr Silva, Alex and Dr Khalsa.

Dr Sakh Khalsa is Consultant Scientist Neurophysiologist specialising neurosomnology.
We are approached by disciplines throughout the medical, nursing and AHP field for our expertise.

We receive excellent feedback from Nursing and Occupational Therapy students, and other professionals. We consistently have low levels of complaints and achieve positive feedback from service users.



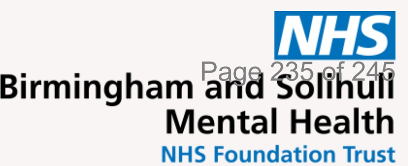


The team…

The team is divided into seven sub-specialties which cover a range of Neuropsychiatric conditions – sleep, chronic fatigue, Huntington's Disease, Tourette's, non-epileptic attack disorder, epilepsy and general neuropsychiatry

VT also sits with Neuropsychiatry

Vetiver Video Telemetry unit is a specialised investigation unit for diagnosis and study of sleep disorders and epilepsy / NEAD.



Occupational therapy staff work across sub-specialities. The service is also supported by junior medics.

Sub-speciality	
Sleep	2 x B6 nurses (P/T), 3 x Consultants (P/T)
Huntington’s Disease	1 x B7 nurse (P/T), 1 x Consultant (P/T)
Tourette’s	1 x Consultant (F/T)
Chronic fatigue	1 x B7 nurse (P/T), 1 x Consultant (F/T)
Non-epileptic attack disorder	1 x B7 nurse (F/T), 2 x Consultant (P/T)
Epilepsy	1 x B8a ESN (F/T), 1 x Consultant (P/T)
General Neuro	1 x Consultant (F/T)

Referrals

Neuropsychiatry is a regional service that takes referrals from BSOL and other ICBs across the UK

In 2023 we received over 3,080 referrals.

Due to our tertiary nature much of our work is for our expertise in assessment and second opinion.

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- Neuropsychiatry has not had a budget review for 12 years
- We have a £250k overspend on the drugs budget – this is due to the specialist nature of our service – we have to use novel treatments
- We are a very small team. There is a huge risk that the sub-specialities can be destabilised by sickness or staff retention issues.

- Demand for the service is high. There are long waiting times throughout the whole of neuropsychiatry.
- There are very few such specialised units as VT in the UK, as such, our referral base is extensive.
- Covid has had a significant impact on CFS referrals
- There is an overspend on the medic budget.

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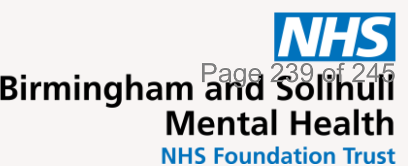
Interventions



- We continue to be proactive – we have a capacity/demand flow model for nursing/OT.
- We empower team members to devise new and innovative ways of working.
- We have weekly MDTs throughout the service and pride ourselves on communication and collaborative working.
- We actively discourage hierarchies and value the contribution of everyone.
- Regular discussions about waiting lists at team meetings is a fixed agenda item.

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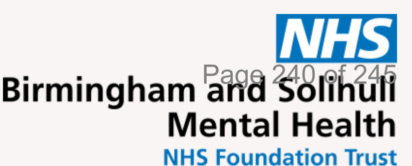
Interventions



- Job plans for medics have been readdressed

- Therapeutic team members have reviewed the number of new patient assessments they can provide.

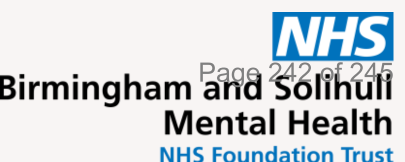
- Admin team following up appointment bookings – text reminders introduced in a bid to reduce DNA rates.

- Increase fluidity in monthly appointment schedules. More new patient assessments if capacity available.

Interventions

- Admin auditing how many service users are seen each week.
- DNA rates – identified via Insight and audit by SPR. Identified problem and introduction of text messaging.
- Hours of working mirror the needs of the service, e.g. Tourette's clinic offers evening appointments.
- Regular audits of contacts, shared amongst the team via meetings.
- Bi-monthly business meeting with colleagues from Finance and Contracting – transparency around business intelligence.
- Working with pharmacy on the possible costing changes for high cost drugs

Recovery plan 2024 update



Staffing

Specialist Nurse to carry out additional new patient assessments per week.

In negotiation with Clinical Lead for further uptake of assessment numbers per week.

Recovery plan 2024 update

Change of discharge policy:

Current policy is one DNA and discharge if no risk factors/concerns identified – this will remain unchanged

New policy around cancellations – two appointments maximum to be offered and then discharge back to referrer with option of re-referral. Information to be added to appointment letter.

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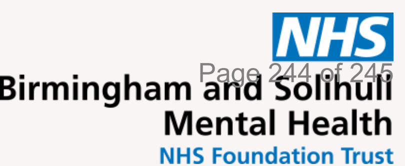
Recovery plan 2024 update



Revising ways of working

Introduction of a one-stop clinic in epilepsy and NEAD where the diagnosis is unclear – there are already one stop clinics in sleep and HD. This would save on multiple appointments.

Rolling audit on a 6 monthly basis to ensure referrals stay on track and aid early identification of barriers to assessments taking place.

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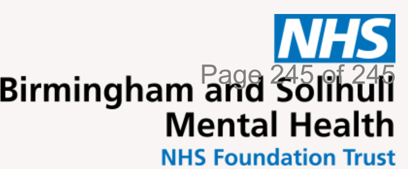
The future…



- We need a financial review of our pharmacy budget, or we will consistently be overspent.
- Support from the trust board in application for blueteq access (reclaim certain drug charges)
- Demand for the service is high. We need to invest in staff and look at future proofing the team taking into account progression planning. We need additional nursing staff.

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