NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Quality Account Report 2022/23

compassionate inclusive committed

Contents

Quality Account Report

Quality Report

1. Statement on Quality from the Chief Executive

I am delighted to present our Quality Account for 2022/23. It looks back at our performance over the last year and gives details of our priorities for improvement in 2023/24.

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

Whilst it has been a challenging time, we continue to learn from our achievements and recognise areas where we can improve. We are striving to build a community with our service users, staff and carers that inform the actions that we take to drive improvement in relation to patient safety and quality.

Through our reconfiguration and transformation programme we are taking the opportunity to secure much needed investment in our buildings and equipment, ensuring safer and more therapeutic environments for those who use our services. We have agreed a plan that will reshape our environments over the next year. This is inclusive of taking full advantage of the opportunities that technology offers us and to learn the lessons from the pandemic to design facilities which can be used flexibly.

This Quality Account sets out what we have achieved during 2022/23 including progress against our five quality priorities and sets out our ambitions for 2023/24

1. Improving service user experience
2. Preventing harm
3. A patient safety culture
4. Quality assurance
5. Using our time more effectively

We are continuing to drive improvements across all services and taking every opportunity available to embed a culture where we learn lessons from our practices and behaviours. Collectively working with all partners that use and work in our services, we are identifying opportunities where we can improve our systems and processes.

As I close this introduction, I reiterate my thanks and that of my fellow Board members, to our compassionate and committed staff, our service users, families and carers, our stakeholders, our partners in the Integrated Care System and our Council of Governors and look forward to continuing to tackle our challenges, build on our successes and make progress in 2023/24.

To the best of our knowledge the information in this document is accurate.

We thank you all.

Roísìn Fallon-Williams
Chief Executive Officer

Phil Gayle
Chair

Background

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

Our aim in this Quality Account Report is to make sure that everyone who wants to know about what we do, can access that information. All Quality Account Reports are presented to Parliament before they are made available to service users, carers and members of the public on the NHS Choices website.

NHS Choices is the UK's biggest health website. It provides information about symptoms conditions, medicines and treatment, NHS services and advice about how to live as well as possible at www.nhs.uk

What the Quality Report includes

- What we plan to do next year (2023/24), what our priorities are, and how we intend to address them.
- How we performed last year (2022/23), including where our services improved.
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS Trusts
- Stakeholder and external assurance statements.

Purpose and activities of our Trust

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

One vision

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

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

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

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

Our ambition

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

Our aims

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

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

This section contains:

- Our priorities for improvement as agreed by the Board of Directors for 2023/24
- Progress made since publication of our 2021/22 quality report including performance against each of the 2022/23 quality priorities
- The monitoring, reporting and measurement approach to progressing achievement of our priorities
- A series of statements of assurance from the Board of Directors including:
    - Participation in National and Local Clinical Audit Programmes
    - Research
    - Commissioning for Quality and Innovation 2022/22
    - Registration with the Care Quality Commission
    - Improving Data Quality
    - Learning from Deaths
    - Reporting against Core Indicators

2.1.1 Priorities for improvement during 2023/24

Information from a number of sources and consideration of national improvement plans and priorities have helped inform the Trust's priorities for 2023/24.

BSMHFT is committed to continuous quality improvement. This section of the report describes our priority areas for improvement in the quality of our health service provision in 2023/24.

In creating our quality priorities and goals, we have considered the aspirations in the NHS Long Term Plan, NHS England's Five Year Forward View for Mental Health and NHS Improvement Planning. The focused goals included below have been

selected as priorities for 2023/24 in discussion with our Trust Governors, from a wide ranging and comprehensive list of goals for the coming year. These are aligned with each of the five strategic aims for quality, that are described in our Trust Five Year Strategy and underpin all our work to improve quality:

- Improving service user experience
- Preventing harm
- A patient safety culture
- Quality assurance
- Using our time more effectively

During 2023/24 we will:

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

Why is this a priority?

NHS England and Improvement published a Framework for Involving Patients in Patient Safety in June 2021. The framework is in two parts: the involvement of patients on an individual level in their own safety, and the involvement of patients strategically via the role of patient safety partners (PSPs). This is a key part of the new Patient Safety Incident Response Framework (PSIRF) which will ensure that patients, families and carers have a powerful and equal voice in their own care, as well as helping to shape and influence future developments at the Trust to improve patient experience.

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

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

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

Why is this a priority?

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

Implementation commenced in September 2022 with the aim of completing the transition phase by Autumn 2023. To support this an implementation plan has been developed which is governed through our Patient Safety Advisory Group (PSAG).

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

Why is this a priority?

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

We are committed to creating a positive safety culture in which we work collaboratively so that everyone – including staff, patients, families and carers - can flourish to ensure, safe, high quality care.

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all.

This means a culture of fairness, openness and learning across our organisation by making staff feel confident to speak up when things go wrong, rather than fearing blame. This allows valuable lessons to be learnt so errors can be prevented from being repeated.

Quality assurance	
Develop and embed the principles of 'Think Family'. Embed a system wide open door approach increasing coordination between children and adult services.	Measures of success: Consultation regarding measures with EBE and carers is planned in the coming weeks Number of staff trained in this approach as part of safeguarding training

Why is this a priority?

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

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

- No wrong door – contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children's services.

- Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities.
- Providing support tailored to need – working with families to agree a package of support best suited to their particular situation.
- Building on family strengths – working in partnerships with families recognising and promoting resilience and helping them to build their capabilities.

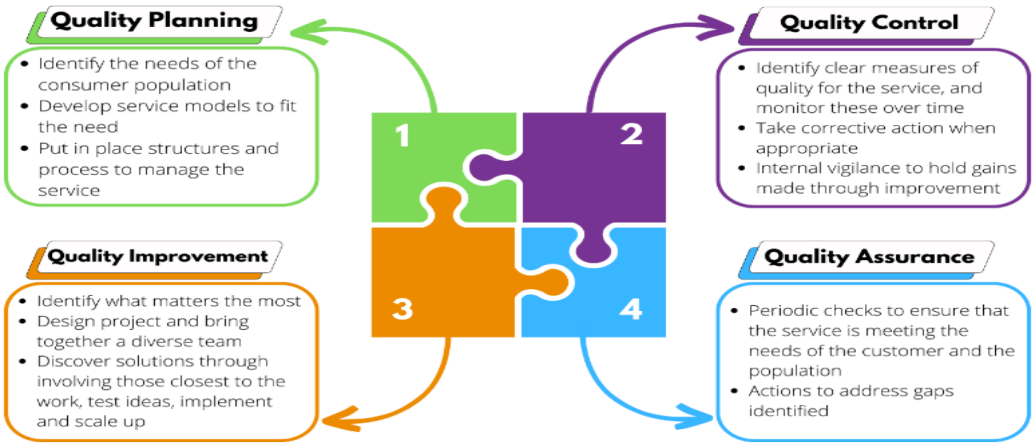
Using our time more effectively	
Engage colleagues and scope how we can use quality improvement methodologies to release time to care	Measures of success: • Number of individuals trained in QI approaches. • Key areas for improvement identified through a process mapping programme. • Reduction in time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

Why is this a priority?

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

As a Trust we have invested in our approach to quality improvement and want to ensure we are using that methodology and associated tools to identify where we can improve our processes and systems to release more time for direct patient care, to improve their experience and the experience of our clinicians.

We aim to develop a quality management framework to underpin and assure us of the quality of our services and care on a continual basis, to identify opportunities for quality improvement and to embed quality planning. We will do this with staff, service users, families and carers. This will help us to act quickly to recognise good care and practice, and equally act quickly where improvement is needed.



2.1.2 Monitoring, Measuring and Reporting Progress on the Priorities

Monitoring measuring and reporting progress on the above priorities takes place through a quarterly report to the Quality Patient Experience and Safety Committee at Birmingham and Solihull Mental Health NHS Foundation Trust.

2.1.3 Progress Made since Publication of the 2020/21 Quality Report

Priority for Improvement 1: Improve Patient Safety by Reducing Harm

What this means: We will reduce unwarranted variations and reduce harm across our services. We want to reduce the level of harm and suicide rate amongst our most vulnerable patients ensuring appropriate and consistent application of the Mental Health Act, good access to crisis care and effective community care pathways. We want to understand health inequalities or aspects of discrimination in our current delivery of mental health care so that we can improve and meet the needs of all of our service users.

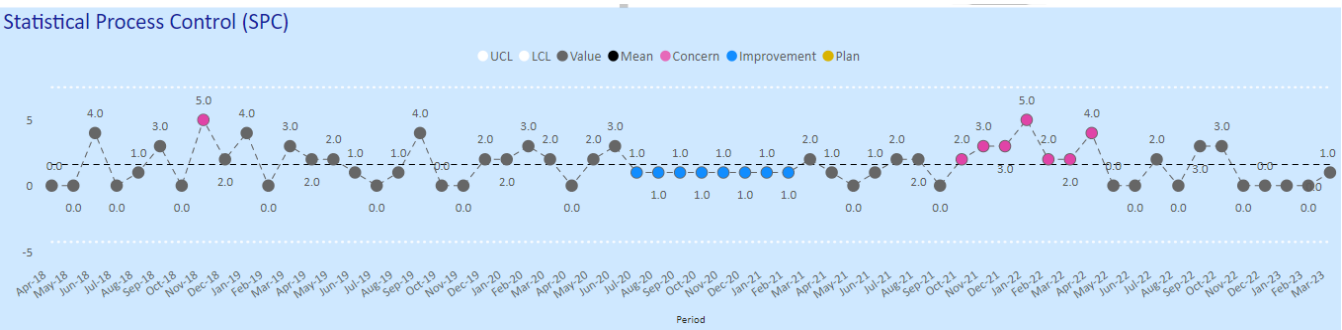
During 2022/23 we agreed to:

- Improve the safety of our acute inpatient wards by installing ligature alarm systems on the ensuite doors and bedrooms doors of our highest risk acute inpatient wards
- Measure of success; reduced level of ligature incidents utilising an anchor point which result in moderate, severe or catastrophic harm to patients

Update

As an organisation we identified that the level of ligature incidents was a concern particularly within our inpatient services with bedroom doors featuring in most incidents and following risk assessment processes a capital programme has been fully implemented to put in place door top alarms systems to reduce the risk of utilising doors as anchor points and increase the response time to emergency situations. Further work in terms of the broader physical environment agenda has taken place and the capital programme for 2023/24 has been agreed to deliver a range of capital projects that will support the prevention of harm. Other ligature risk reduction activities have included the strengthening of risk assessment and care planning processes and regular monitoring of this to not only ensure that this is taking place but that service users are engaged with this and understand their care plan.

The chart below shows the number of ligatures that have occurred with an anchor point during 2022/23. There were no incidents resulting in severe or catastrophic harm.

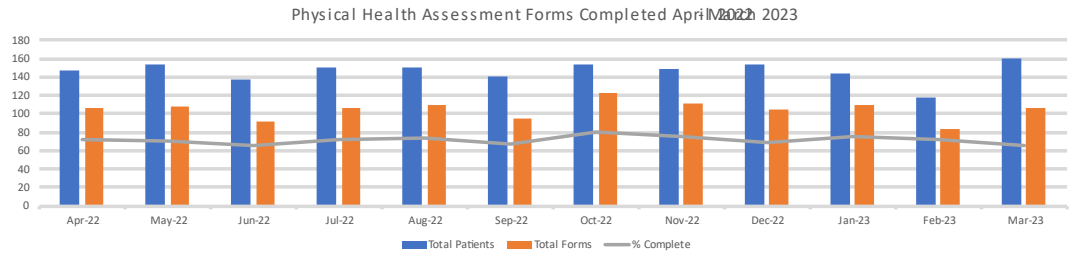


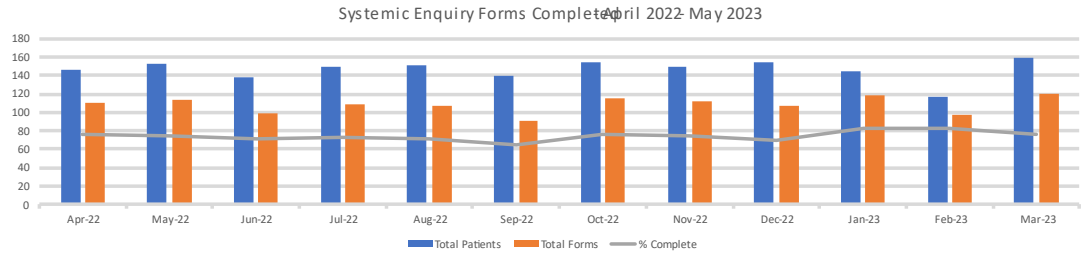
Within this domain, we also pledged to improve the physical health monitoring of patients in our care

- Measure of success; to ensure that all inpatients have the physical health assessment and systemic enquiry checks completed within 24 hours of admission

Update:
Over the last 12 months, we have been able to progress a number of workstreams designed to improve the physical health of service users under our

care, both on inpatient wards, and in the community. In terms of the key measure above, we now have quarterly reports to monitor completion of the forms, and we have a number of processes in place to improve the completion of these forms.





However, in order to improve the physical health of service users, the interventions that are carried out are the things that make the improvements, rather than just completion of forms. These are some of the processes we have developed, to improve physical health care:

- Physical health educators working directly with ward staff, to help them to identify training needs, raise awareness of key areas for improvement and improving confidence when managing physical health problems
- Specific physical health training within acute care wards for medical staff
- Physical health strategy supported by the monthly trust wide physical health committee, which oversees policy development, quarterly reports of key areas of assurance, presentation of QI projects and clinical audit
- Revision of one of the physical health forms to enable staff to complete this more easily, therefore improving completion rates
- Using Health Inequality data to focus on key areas of need, for example in diabetic care, obesity
- Development of a system wide physical health meeting, sitting under Community Transformation, which enables better pathways for managing physical health of community patients with primary care (this includes a QI project in a primary care practice, working with Experts by Experience, and the NHSE data team)
- Working group with local acute hospitals to learn from real cases of service users being transferred, including good practice and when things have not gone well

- We have recruited a Trust lead and deputy for tobacco dependency, and this team will develop our strategy regarding service users and staff becoming less dependent on tobacco
- We now have stronger system-wide pathways in regard to end of life care, with clearer processes for access to services. We have been commended within our Integrated System for the work we have undertaken embedding Respect forms for our service users.
- implementation of a new pathology system, making it easier to order investigations and to review and act upon results
- improved pathways for care of diabetic patients under our care, including foot care, in collaboration with partners.

Priority for Improvement 2: A Focus on a Positive Patient Experience

What this means: This aspect of our priorities puts a clear focus on delivering a high quality experience for service users, families and carers and largely focusses on ensuring that they have a powerful and equal voice in their own care, as well as helping to shape and influence future developments at the Trust to improve the patient experience. We have engaged groups of patients to help us to understand what they would like to see as priorities.

During 2022/23 we agreed we would :

- Improve the involvement of service users in MDT meetings and ensure that all service users have a copy of their care plan.

Measures of success: % of service users in receipt of their care plan
Qualitative measure to be established through EBE group and reporting

- Improve the involvement of carers in service user care and recovery

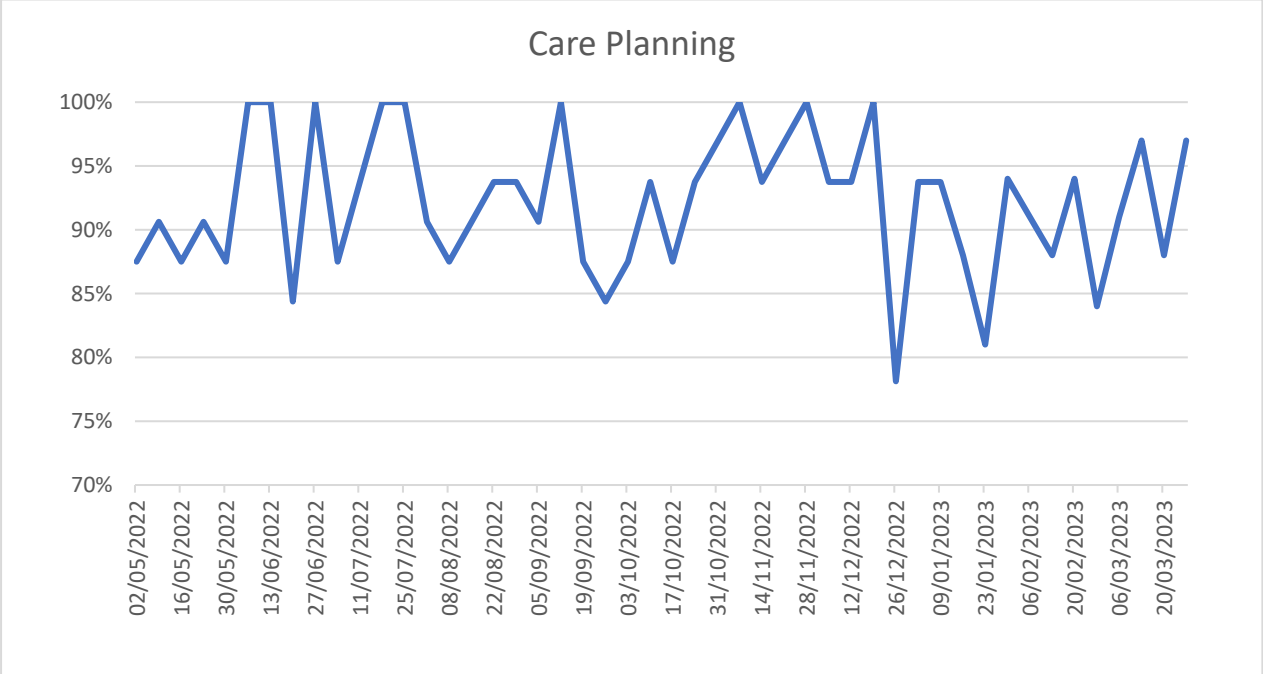
Measures of success: % of carer details on RIO

- Pilot the role of Patient Safety Partner in patient safety and patient experience aspects of governance meetings to ensure that service users have equal voice around the table

Measures of success: Number of patient safety partner roles established ; feedback from patient safety partners on their experience

Update:

We have completed significant work around care plans for service users within our acute wards, and how they can be more involved in coproducing them. Within acute wards, our matrons monitor this closely, as demonstrated by the table below:



Data has been collected via audit, with the Matron's auditing 2x patients/ward each week. Therefore, the % below is indicative, rather than encompassing all service users.

In addition, across the organisation, we have been monitoring the numbers of service users who are recorded on our Electronic Care Records (RiO) as having received a CPA Plan:

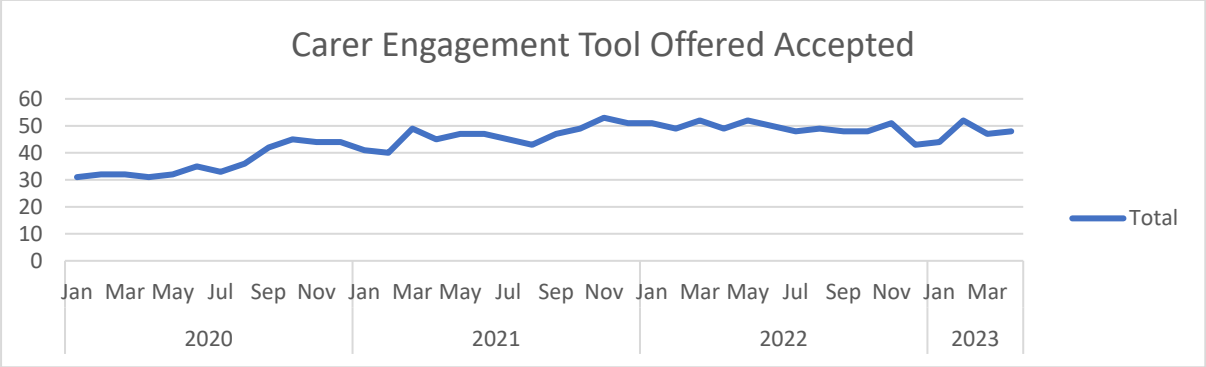
July 2022 – 59.8%
March 2023 – 59.1%
Current (June 2023) – 59.6%

Some service users are not subject to CPA, and therefore have a Care Support Plan:
July 2022 – 71.6%
March 2023 – 69.6%
Current – 69.0%

We have made some changes to inpatient care plans by embedding them into the Multi-Disciplinary Team discussion records, whereby the MDT action plan is actually the service user care plan- this is more targeted to actions needed to support the service user to make progress towards discharge and reflects a holistic approach, for example thinking about their future employment plans or making new relationships, rather than just being about medication or therapy.

Over the next year, we will be planning to extend our use of Dialog + to other parts of the organisation (see below: Improvement 5; Using our Time More Effectively)

When looking at the percentage of carers recorded on Rio, this chart below demonstrates our progress in this domain.



In regard to the patient safety partners, we have engaged with our Experts by Experience to identify training needs and the model we would want to adapt to embed in our organisation. We have secured funding for 4 posts; we have drafted the JD along with Experts by Experience and also developed a training programme and a peer support/supervision framework so that people have the skills to be a partner and feel supported. We will be looking to recruit to these posts and develop the roles over the next 12 months.

Significant work has been undertaken to ensure that we **improve patient experience.** Service users are actively involved in the care that they receive. A multi-disciplinary approach has been taken to ensure that service users have involvement in their plan for care and receive a copy to support delivery of care. In addition, work has been undertaken to involve carers in service user care and recovery and this is now being recorded on to the electronic systems.

During the last year

- The co -production of the reward and recognition policy has been developed which we consider will improve how we value our EBE partners and ensure that we pay more fairly. An important step in ensuring we have

sustainable way to co-produce and therefore improve experience and outcomes.

- 58 Experts by Experience (EBE) The same have received training and have opportunities to participate in improvement and transformation programmes.
- We have a more senior Participation and Experience team who are working in a much more integrated way in the service areas.
- Youth forums have been developed on young people's wards to build opportunities to engage and support their involvement in decision making.
- Training programmes and videos have been developed to educate staff on the concepts of co-production and how this can be applied to everyday practice.
- Questionnaires and focus groups have been formulated to increase the understanding of service users experience and implement learning.
- As part of the reviewed induction there is a greater presence of EBE and more time devoted to how staff can support co production

Priority for Improvement 3: A Focus on a Positive Patient Safety Culture

The link between workforce capacity, capability and safety has many factors, but workforce challenges clearly create pressures on the system. We must also recognise the importance of staff wellbeing to ensure a safe environment. This is becoming more and more important as we experience a significant increase in mental illness across our society which puts pressure on the services we provide. Many of our staff operate in a high-risk environment and in the course of day-to-day work they could face traumatic or potentially traumatic situations. We want all of us to work in a way that keeps everyone safe. For this to happen we need to ensure that we treat each other equitably, well and have good working conditions.

During 2022/23 we agreed to:

- Roll out Learning from Excellence across the Organisation to ensure systematic recognition of learning from excellent practice
  Measures of Success: Routine reporting of LFE submissions made in recognition of excellent practice.

- Strengthen the approach to confidence in incident reporting and learning from incidents resulting in an improved safety culture
  Measures of Success: embed a standard approach to sharing lessons learned from incidents

We consider that embedding a **Positive Patient Safety Culture** is essential**.** We value our workforce and recognise that our success as an organisation is dependent on their wellbeing and their ability to deliver care that they provide. In recognition of that we have introduced a system to acknowledge and learn from the wonderful work that our staff deliver. This is our Learning from Excellence (LFE) process. Staff members nominate their colleagues for excellent practice. On receipt of the nomination the staff member receives notification and a certificate alongside the patient safety team who receive the details to cascade learning.

Over the last year, our staff have made 742 submissions. Staff feedback about not only making recommendations but also receiving them has been very positive and is contributing to improving our organisational culture. We are therefore proposing that, as part of our Safety II culture, we will report on LFE events in the same way as we report other clinical incidents, so that we are learning from good practice in addition to when things do not go well.

The Patient Safety Team also have a framework for learning which include a regular Lessons Learned Bulletin, It Takes 3 videos, attendance at preceptorship training, individual learning, team learning, Partnership and Trustwide cascade of learning and relevant committees. For 2023/24 the Patient Safety Team are looking to utilise QI methodology to strengthen this further.

Priority for Improvement 4: A Focus on Quality Assurance

What this means: Quality Assurance is a process to help us continually check that we are meeting the standards of quality of care that we owe to our service users, families, carers and staff. Our regulators such as the Care Quality Commission also hold us to account for delivering these standards. The process also offers us the basis for assessing whether or not we are continually improving care and can help us identify areas where we need to celebrate great practice as well as focussing on areas that need improving.

We aim to develop a quality assurance framework to underpin and assure us of the quality of our services and care on a continual basis.
We will do this with staff, service users, families and carers. This will help us to act quickly to recognise good care and practice, and equally act quickly where improvement is needed.

During 2022/23 we agreed to:

- Roll out an internal quality assurance peer review scheme across the Trust involving staff and experts by experience

Measures of success: Number of peer review visits completed

Peer reviews have successfully been piloted in Acute Care and subsequent changes made based on feedback from the service. The Compliance Team then utilised the learning to roll the peer reviews out across the whole Trust and to date have completed 27 reviews:

· 8 reviews in Acute Care

· 12 in ICCR

· 7 in Secure Care

The programme will continue to enhance service user and staff well-being as an additional resource to identify any emergent issues to improve experiences.

In addition, the Compliance Team also have a programme of regular assurance testing across the Trust throughout the year to further support patient safety and provide assurance within the organisation. This is frequently updated in line with any emergent themes based on inspections, learning from incidents and feedback from the CQC.

In 2023/24 it is our intention to build the peer reviews into a ward accreditation programme that will ensure that we understand any challenges to the delivery of care and enable our teams to share good practices.

Priority for Improvement 5: A Focus on Using our Time More Effectively

What this means: We want to transform care using technology and quality improvement approaches to manage resources well without impacting on the quality of care we deliver. This includes improvements in patient flow and increasing clinical time to care.

By 2025:
We will have significantly reduced the amount of unwarranted variation, allowing us to focus on ensuring the right care and support is delivered for everyone at a consistently high standard. Unwarranted variation can be a sign of waste, missed opportunity and poor quality and can adversely affect outcomes, experience and resources.

During 2022/23 we agreed to:

- Implement a Community Care Planning Tool incorporating an outcome measure within our Community Services as an approach to improve the therapeutic effectiveness of service user interactions with our clinicians
  Measures of success: determine the approach to needs assessment and care planning using a Patient Rated Outcome Measure.

We have started to implement the use of Dialog Plus. This is not only a new format of service user centred care planning, but incorporates a patient rated outcome measure, which can be used as paired outcome measure to evaluate services and clinical effectiveness for individual service users. It has been specifically developed to make routine patient – clinician meetings therapeutically effective and is supported by an App to promote time effective communication. It is planned that this will be extended to other clinical areas in the coming months building on the learning from the pilot sites where is has been introduced.

We also monitor feedback from the national benchmarking data, including the NHS Community mental health survey benchmark report published by the CQC:

Section	Focus	Score (of 10)	Benchmark to other MH Trusts
1	Health and Social Care Workers	6.4	Somewhat worse than expected
2	Organising Care	7.8	Somewhat worse than expected
3	Planning Care	6.3	Worse than expected
4	Reviewing Care	6.6	About the same (as expected)
5	Crisis Care	6.2	About the same
6	Medicines	6.4	Worse than expected
7	NHS talking Therapies	6.9	Somewhat worse than expected
8	Support and wellbeing	3.7	Worse than expected
9	Feedback	1.4	About the same
10	Overall View of Care & Services	6.5	About the same
11	Overall Experience	6.4	About the same
12	Responsive Care	7.3	About the same

We are hopeful that our approach in increasing use of Dialog Plus in conjunction with our 2023-4 quality goals will have a positive impact upon the benchmarking data next year.

2.2 Statements of Assurance from the Board

This section of the report includes a series of statements of assurance from the Board of Directors. The exact form of the statements is prescribed and

specified by the ‘quality account regulations’ and as such the wording of these statements is statute and unable to be changed.

	Prescribed information	**Form of statement**
1.	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	During 2022/23 BSMHFT provided the following mental health services: A&E Liaison Adult Acute Ward Adult CMHT Adult Day Care AOT CAMHS Deaf Community Deaf Inpatient Eating Disorders Community Eating Disorders Inpatient Early Intervention
		Forensic CAMHS Community Forensic CAMHS LOW SEC Forensic CAMHS MED SEC Forensic Outreach High Dependency Wards Home Treatment IAPT Justice Liaison Low Secure Perinatal Community Perinatal Inpatient Medium Secure Wards Neuropsychiatry Older Adult Acute Ward Older Adult Community Memory Services OPIP (Older Adult Day Care) PICU

		Primary Care Prison Mental Health Care Rehab Ward Substance Misuse Services
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	BSMHFT has reviewed all the data available to them on the quality of care in these services.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2022/23 represents 90 % of the total income generated from the provision of relevant health services by BSMHFT for 2022/23

2. Participation in National Clinical Audits and National Confidential Enquiries

	Prescribed Information	**Form of statement**
2	The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period, and which covered the relevant health services that the provider provides or subcontracts.	During 2022/2023, 9 national clinical audits and 1 National confidential Enquiry covered relevant health services that Birmingham and Solihull Mental Health NHS Foundation Trust provides.
2.1	The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period Birmingham and Solihull Mental Health NHS Foundation Trust participated in **100%** of national clinical audits and **100%** of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in	The national clinical audits and national confidential enquiries that the Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in during 2022/23 are as follows: • National Audit of Care at End of Life (NACEL) • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) • National Audit of Dementia (NAD) - Spotlight on Memory Assessment Services • POMH Anti-Libidinal Medication Prescribing Practice • POMH 1h & 3e: Prescribing of Antipsychotic Medication in Adult Mental Health Services • POMH 7g: Monitoring of Patients Prescribed Lithium • POMH 19b: Prescribing for Depression in Adult Mental Health Services • POMH 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services POMH 21a: The Use of Melatonin
2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during 2022/2023, are listed below: • National Audit of Care at End of Life (NACEL) • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) • National Audit of Dementia (NAD)- Spotlight on Memory Assessment Services • POMH Anti-Libidinal Medication Prescribing Practice • POMH 1h & 3e: Prescribing of Antipsychotic Medication in Adult Mental Health Services • POMH 7g: Monitoring of Patients Prescribed Lithium • POMH 19b: Prescribing for Depression in Adult Mental Health Services

		• POMH 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services • POMH 21a: The Use of Melatonin

2.4	A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during April 2022 to March 2023 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:-

Title of National Clinical Audit	Eligible	Participated	% *
POMH Anti-Libidinal Medication Prescribing Practice	Yes	Yes	100% (2)
POMH 1h & 3e: Prescribing of Antipsychotic Medication in Adult Mental Health Services	Yes	Yes	100% (87)
POMH 19b: Prescribing for Depression in Adult Mental Health Services	Yes	Yes	100%(100)
POMH 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services	Yes	Yes	100% (100)
POMH 21a: The Use of Melatonin	Yes	Yes	100% (80)
National Audit of Care at End of Life (NACEL)	Yes	Yes	100%(24)
National Clinical Audit of Psychosis (Early Intervention Services) (NCAP)	Yes	Yes	100%(57)
National Audit of Dementia (NAD) - Spotlight on Memory Assessment Services (MAS)	Yes	Yes	98% (49)

2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of 7 national clinical audits were reviewed by the provider in 2022/23 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	

POMH 1h & 3e: Prescribing High Dose and Combined Antipsychotics

Aims: This audit was conducted to address the quality of prescribing of antipsychotic medications in adult mental health services, including high dose, combined and Pro re nata (PRN).

Methods: A data collection tool (DCT) was created based on the questions provided by POMH. A data sample was then requested through the Information Team of eligible patients.

Key Success(es):
• 87.5% (n=7) of patients had a review of their clinical response to their medication documented based on a sample of 8 patients within the past 3-6 months.
• Majority of the patients had at least 1 of the physical health measurements conducted in the past year.
• The maximum daily dose of PRN psychotropic medication that could be administered was clearly documented in 99% (n=74) of cases.
• Where regular antipsychotic medication is prescribed, the majority of patients should receive a single antipsychotic medication within the licensed dosage range. 78% (n=68) of the Trust of the patients were on a single antipsychotic medication at a standard dose.

Key Area(s) for Improvement:
• 19 (22%) patients were prescribed regular high-dose or combined antipsychotic medications. 6 (32%) of those 19 patients had documentation of the target symptoms/behaviours.
• 34 (45%) of patients had documented clinical reasoning for the administration of PRN medication.

Key Action(s):
• Investigate cause for low reasoning/rationale for administration of PRN (Pro Re Nata) medication.
• Explore potential changes to Multi-Disciplinary Team form, which contains consulting details from appointments. This could be in the form of dropdown boxes/prompts that provide more visually clear information from consultations about the prescription of the medication.

POMH 19b: Prescribing for Depression in Adult Mental Health Services

Aims: This Audit was conducted to address prescribing for depression in adult mental health services, in combination with alternative therapies.
Comparisons against the National Sample will also be reviewed to assess the Trust's position against other providers.

Methods: A data collection tool (DCT) was created based on the questions provided by POMH. A data sample was then requested through the Information Team of eligible patients.

Key Success(es):

• An Increase of 25% in the number of patients with a care plan in place (37% in 2019, to 62% in 2021)
• There was also a very encouraging improvement in the number of patients who didn't just have their triggers identified, but also had documentation of references on how to manage such triggers. 84% of patients with triggers identified fell under this category within the standard.
Results also showed we were more likely to try a different medication as opposed to simply increasing the dose of the patients current medication, where patients showed a poor response to medication.

Key Area(s) for Improvement:
• Whilst the trust saw local improvement for all three categories for documentation, we still fell below the national average for all but one of these (response to medication).
• Patients under medium/long-term care should have a documented and detailed care/crisis plan. We saw significant improvements compared to the previous audit but acknowledge there is still room for improvement in this aspect of care.

Key Action(s):
• Continuing improvement of annual reviews and the documentation of side-effects via discussion in local Clinical Governance Committee meetings.

POMH 21a: The Use of Melatonin

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

Methods: A data collection tool (DCT) was created based on the questions provided by POMH. A data sample was then requested through the Information Team of eligible patients.

Key Success(es):
• 74 (93%) patients had clinical reasons for prescribing melatonin documented in their notes.
• 75 patients of the trust sample had been on melatonin treatment for over the 12 months. 66 (88%) patients had a documented review of melatonin treatment in the last year.
• 5 patients in the trust sample had been prescribed melatonin, for between 3 and 12 months. Within in the first 3 months of starting melatonin, 4 of these patients had documented evidence of review of clinical response and therapeutic effect of melatonin on sleep. 1 of the 5 patients had a documented review of side effects within the first 3 months of starting melatonin.

Key Area(s) for Improvement:
• 55 (83%) patients had no documented evidence that they and/or parents/carers were informed that melatonin being prescribed is being used as off-label.
• There was no documented review of side effects for 46 (61%) patients in the past year.

Key Action(s):
No Actions as report was published in March 2023 and currently under review withing Trust.

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

Background: NCAP is a 5-year programme which runs until July 2022, commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). The standards for the EIP audit are based on the Implementing the Early Intervention in Psychosis Access and Waiting Time Standard Guidance by NICE, NHS England and the National Collaborating Centre for Mental Health (NCCMH), which details a NICE recommended package of EIP care for treating and managing psychosis.

Key Success(es):
• Overall Solihull EIS was scored as 'performing well' by NCAP. A strong improvement compared to 2019/20 audit, when the service was scored as 'needs improving'. We now score 'Top Performing' in the access and waiting time's domain and the outcome measures domain. Previously, in the 2019/20 audit, data for the access and waiting time domain was pulled from NHS digital. This commissioning level data was combined with Forward Thinking Birmingham (FTB) which EIS Solihull had no control over.
• EIS Solihull scored top performing in the Cognitive Behavioural Therapy for Psychosis (CBTp), family interventions and supported employment programmes domains.
• EIS Solihull scored 100% for the domain relating to clozapine treatment which is above the national average.

Key Area(s) for Improvement:
There are several domains were have scored 'Needs Improvement' , such as : not being able to provide CBT for At-Risk Mental State (ARMS), education and support programmes (58% reduction), relevant interventions where screening indicated a risk level requiring intervention (overall score of 75%). We were therefore below the national average for offered and accepted interventions for smoking cessation, substance misuse, weight gain/ obesity and hypertension.

Key Action(s) taken:
• At-Risk Mental States (ARMS) Implementation is ongoing within the Service
• Comprehensive Assessment of At-Risk Mental States (CAARMS) training- 6 staff have now completed the CAARMs assessment training with 1 staff member completing the supervisor training. 1 additional staff member due to complete the training in June.
• Dedicated staff to work with ARMS, along with some staff that will have mixed caseloads until the ARMS caseload increases.
• ARMS screening tool being used at the point of assessment for those referrals that are not FEP but indicate ARMS.
• RIO documentation has been amended to incorporate ARMs/CAARMS aspects. Internal processes for assessments and interventions being reviewed/evaluated.
• Specific groups being set up for the ARMs service users.
• Joint work with Forward Thinking Birmingham Early Intervention Service (FTB EIS) around the Single Point of Access (SPOA) aspect for screening.
• Welcome pack for ARMs referrals has been completed.

National Audit of Dementia (NAD) Spotlight Audit – Memory Assessment Service (MAS)

Background: The National Audit of Dementia (NAD) is a clinical audit programme commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. The audit was developed in collaboration with the London Dementia Clinical Network, NHS England. The audit is based on the London Dementia Clinical Network audit, which ran as a national audit in 2019. Additional questions were created by a service led working party to capture the impact of new ways of working.

Key Success(es):
• New ways of working - Nationally 35% patients had an appointment via phone or video call, 45% at their usual place of residence. In Birmingham MAS this was 53% having an appointment via phone or video call, 39% at their usual place of residence.
We were above the national average by 16% for discussing and recording falls history (National 76% and Birmingham MAS 92%) as part of patients initial assessment.

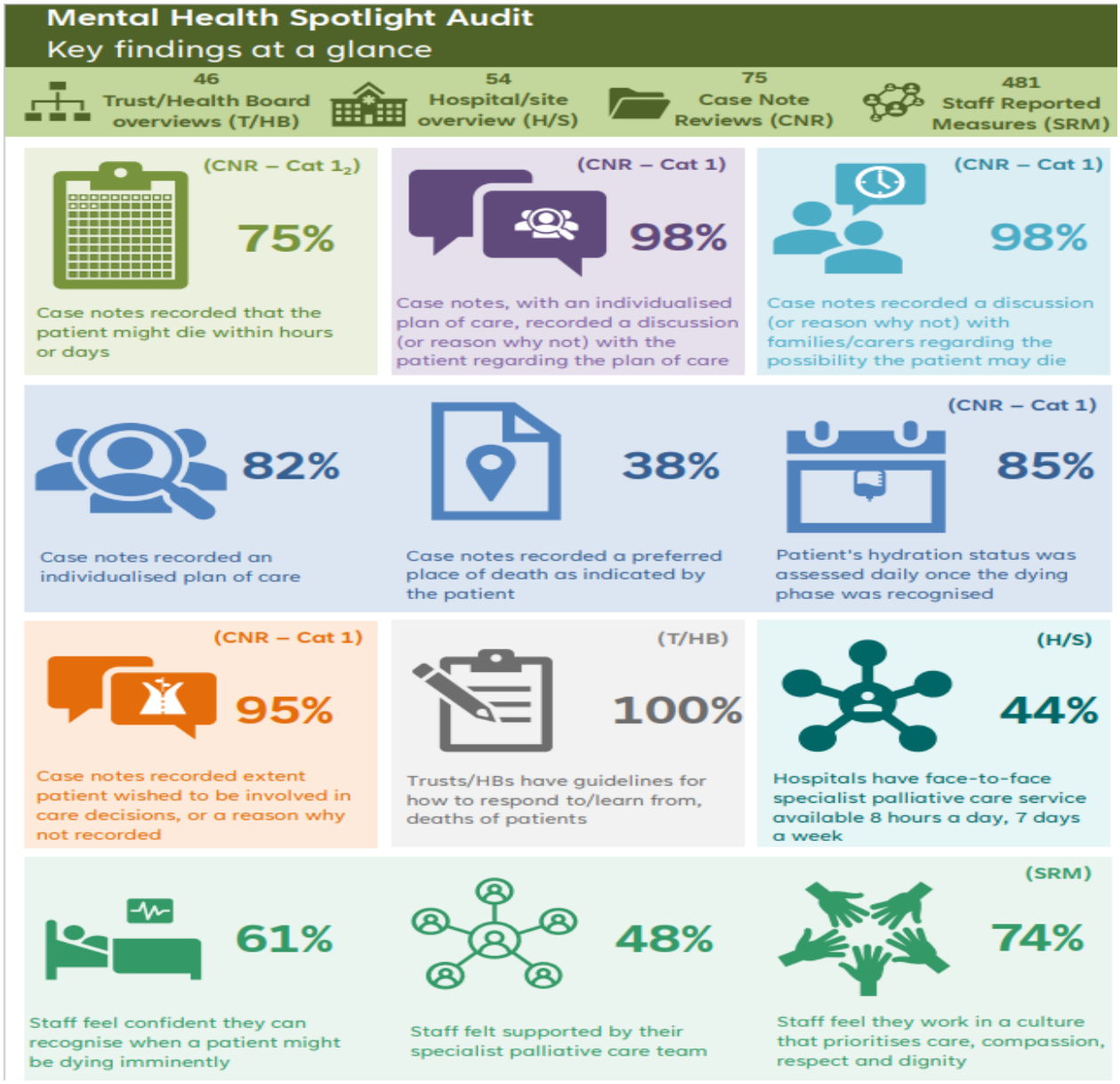
Key Area(s) for Improvement:
• Routine Assessments – Nationally as part of their initial assessment: 61% of patients had a discussion recorded about eyesight, compared to 49% at Birmingham MAS.
58% had a discussion recorded about hearing, compared to 53% at Birmingham MAS.
• Guidelines for Neuroimaging - Nationally CT/MRI scans were requested for 47% of patients, with variation in requests of 0-97.4% of patients per service. This range implies that variation is at service/protocol level, rather than assessed as appropriate in each case. For Birmingham MAS CT/MRI scans were requested for 27% of patients.
• Overall wait time and COVID-19 Impact - National average waiting time from referral to diagnosis has increased to 17.7 weeks since 2019, up from 13 weeks. In Birmingham MAS this was 33.4 weeks.

Key Action(s):

- We will be working with NHSE on a remote consultation pilot project to change the process pathway by incorporating a remote consultation appointment with the Service User/family following the referral being accepted in MAS. This should reduce waiting time for referral to diagnosis by 12-16 weeks.
- Discussions with University Hospital Birmingham (Acute Partner) to discuss scan contracts to improve waiting times.
- Exploration of a project around streamlining and increasing efficiencies through process mapping.
- Exploring ways to increased service user referral to Community Mental Health Teams. Which may support prescribing rates.
- Post diagnostic support explorations around Cognitive Stimulation Therapy, Other offerings to people with a diagnosis of Dementia, and those in the Mild Cognitive Impairment (MCI) category.

National Audit of Care at End of Life (NACEL) –

This was reported on nationally, so results/findings were a representation of all Trusts who took part, rather than individual findings. The below infographic depicts key results.



The key findings and recommendations below are therefore more general than if reports were produced for Trusts individually.

The below table represents what the Trust submitted.

	T/HB	H/S	CNR	SRM	QS
Birmingham and Solihull Mental Health NHS Foundation Trust	✓	✓	2	21	1

T/HB – Trust/Health Board H/S – Hospital/Site CNR – Case Note Review SRM – Staff Reported Measure QS – Quality Survey

Key Area(s) for Improvement:
• Case Note Review – **75%** of case notes recorded that the patient might die within hours or days. **82%** case notes recorded an individualised plan of care. **38%** of case notes recorded a preferred place of death as indicated by the patient. **85%** of patient's hydration status was assessed daily once the dying phase was recognised.

44% of hospitals have face-to-face specialist palliative care service available 8 hours a day, 7 days a week.
• **61%** of staff feel confident they can recognise when a patient might be dying immediately.
• **48%** of staff felt supported by their specialist palliative care team.
• **74%** of staff feel they work in a culture that prioritises care, compassion, respect, and dignity.

Key Action(s):
• Trusts should ensure policies and guidelines are in place to support care planning for the *Five Priorities for Care of the Dying Person*. Processes should be put in place to link policies and guidelines to frontline practice. In particular, staff should feel able to raise a concern about end-of-life care within their Trust.
• Chief Executives should ensure health and care staff, on wards that are more likely to care for patients at the end of life, have the appropriate training, managerial and emotional support to develop the competence and confidence to; recognise imminent death, communicate with the dying person and people important to them as early and sensitively as possible, and deliver end-of-life care.

National Confidential Inquiry into Suicide and Safety in Mental Health
Background:
We have reviewed the 2023 NCISH report alongside a refresh of our suicide prevention strategy and will incorporate the learning from the national review and a review of local incidents to continue to improve the safety of our service users. These will be disseminated locally to ensure learning is shared. It will also feed into the current review of our Level 1 suicide prevention e-learning, to provide an up to date clinical framework.

Key Messages/Findings:
• 27% of all people who died by suicide (between 2010-2020) had recent contact with mental health services
• **Clinical Risk** – 64% had previous self-harm, 48% lived alone, 23% missed final service contact.
Recommendation – Involve family and carers after loss of contact.
• **Acute Care Settings** – 464 deaths per year, half of in-patients on agreed leave, highest risk on day 3 after in-patient discharge.
Recommendation – Focus should be on step down from hospital to community.
• **Recent Economic Adversity** – 373 deaths per year, recent economic adversity has increased. Mainly financial, workplace and housing problems.
Recommendation – Services should signpost to support agencies.
• **Patients under 25** – 147 deaths per year. Higher rates of anxiety and autism (under 18s). More alcohol and drug misuse (18-24 year olds).
Recommendation – Access to self-harm services is crucial for young people.
• **Patients given a diagnosis of a Personality Disorder** – 174 deaths per year. Deaths in this group increasing for women. Past abuse, self-harm, alcohol, and drug use are common.
Recommendation – Better models of safe and compassionate care are needed.

• **LGB and Trans Groups** – 49 deaths per year. Younger than other patients; self-harm is common. Experience of child abuse and domestic violence.
Recommendation – Therapies addressing trauma to be offered.
• **Suicide-related Internet Use** – 73 deaths per year. Patients of all ages, mostly 25-44. Under 25s more likely to post suicide intent.
Recommendation – Online experience should be routine part of risk assessment.

Key Actions

- Clinicians should consider the impact of prejudice engagement, assessment and care plans should reflect this.
- Clinicians need to be aware that suicide-related internet use is a feature of suicide by mental health patients of all ages.
- We will be increasing involvement with family and carers after loss of contact
- Signposting to support agencies- to tackle economic adversity.
- Increasing self-harm support services for young people
- Raising more awareness on safe and compassionate care
- Offer Trauma therapies
- Include online experiences as part of assessments we do

2.7	The number of local under entry 2.5. clinical audit (a) reports that were reviewed by the provider during the reporting period.	The reports of 8 local clinical audits were reviewed by the provider in 2021/22 and Birmingham and Solihull Mental Health Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	

Psychiatric Intensive Care Unit (PICU) Prison Assessment Reaudit

Background:
This annual audit reviews the prison assessments which are carried out by PICU's across the trust. In this local audit we reviewed 8 PICU assessments to determine whether they have met the standards of the trusts approved PICU prison assessment guidelines.
The audit ran from January 2021 to June 2022. This has been through local committees and is due to go through CEAG in April 2023. There were 10 patients included in the sample.

Key Findings:
• **10** referrals came through the BSMHFT Single Point of Access (SPoA). **8** of these referrals were found to have a PICU assessment, and so this was the number audited.
• Of the 8 requests for admissions, **6** were made by a forensic psychiatrist, with **2** cases unknown as to who made the request for admission.
• It is expected that referrals are made by telephone to the medical secretary of the PICU consultant, in order to confirm receipt, with the details being followed up by email.

However, of the 8 requests, **5** referrals were made via letter response, **1** via email, and **2** unknowns.

• 3 of those requests were uploaded onto our patient records portal on the same day of the assessment, with 4 of these being late (over 7 days).
• **2** prison assessments were recorded within 7 days of the patient being referred. **4** records were not completed within the 7 days, and **2** cases were unknown. However, despite the 7-day target not being hit, once assessments were completed, they were all documented onto our patient records portal within 24 hours.
• **6** of the **8** referrals were completed by a consultant psychiatrist, and **1** case by a CT1 doctor. The remaining case was unknown.
• All cases (**8**) had a level 1 risk assessment completed and documented on RiO. They all considered the nature and severity of the offence and the offence history. However, Systm1 notes were accessible for **4** patients only.
• There was no evidence for any case of an MDT meeting being completed within 2 days of the assessment, and this was not documented on RiO within 24 hours.
• There were **6** cases with no evidence of the outcome of the decision/assessment being recorded on RiO within 24 hours of the MDT meeting.
• There were **5** cases whereby the prisoner was admitted to the PICU within 14 days of the assessment being undertaken.
• For all cases, there were **0** unresolved disputes between the prison and Acute Care in relation to the referral.

Key Action(s):

The audit highlighted that overall, there was poor compliance against the standards (with a few exceptions).

• Trust to make contact with Single Point of Access (SPoA) to ensure they include all staff in mailing list, as the prison referrals are not reaching all Psychiatric Intensive Care Unit (PICU) managers and Registered Clinicians (RC's).
• Ward managers of PICU's to ensure all band 6's is trained in prison assessments, to ensure we can send staff, managers of PICU can offer bank shifts for staff to attend so service need is managed when staff on assessments.
• Documentation of Multi-Disciplinary Team discussion on RiO within 24hours of assessment

Solihull Safeguarding Children Board Multi-agency case audit

BSMHFT are members of the Solihull LSCP Audit sub-group, we have participated in all the audits planned for 2022/2023. These included:-

-Domestic abuse
-Exploitation
-Strategy meeting attendance
-Physical abuse deep dive
-Sexual abuse
-Dip sample into children's meeting
-Strategy Discussions

There was not extensive involvement from BSMHFT due to the majority of cases within the Children safeguarding audit being child focussed, and cases included were predominantly relating to the parents who were service users of BSMHFT.

If there was any identified learning, the safeguarding team liaised with the teams/ practitioners directly. Learning was also shared in supervision with teams. Actions plans were also devised for learning to be implemented across the trust. This was also shared at the Safeguarding Management board.

Initial Child Protection Conference (ICPC) Audit

Background:
The focus of this audit was to review practitioners' involvement within child protection processes, primarily focusing on the Initial child protection conference (ICPC) procedure. ICPC conferences are initiated following a section 47 investigation, which have been completed and where concerns of significant harm have been substantiated.

Given the importance of collaborative working and BSMHFT wanting to improve participation at ICPC'S. The ICPC process has recently been embedded across the organisation, following the trust safeguarding team wanting to strengthen their relationship with both Birmingham and Solihull Children social care. It was an identified risk that BSMHFT were not always aware of children and families subject to statutory social care involvement. To reduce this risk the trust safeguarding team worked with both Birmingham and Solihull child protection teams to receive ICPC invites and ensure BSMHFT teams were participating in the process, when children or adults were open to services.

The audit is to review clinical team engagement within the child protection process.

Key Findings:
• **0** reports were shared with the family prior to the conference. Despite 11 practitioners attending the ICPC conference, only **5** official reports were uploaded on the service user's records.
• Within the 19 cases where clinicians had liaised with the allocated social worker for the family, only **9** practitioners had liaised with the social worker prior to the conference. It is evident from the clinical records that the remaining **10** cases had liaised with the social worker, due to being informed of the ICPC taking place.
• It is evident within the audit that 'Think Family' and 'Voice of the Child' has been considered in more than half of the cases audited. Which is show in; Practitioners thinking about the safety of children due to concerns regarding, Young people being seen alone for the voice of the child to be captured ,and Suitability of home environment explored by practitioners.
• Of the 11 practitioners that attended the ICPC, **8** clinicians documented some elements of the discussion and concerns. **3** cases had no ICPC documentation from the practitioner that attended. There were **9** cases where teams did not attend the conference.
• Out of the 8 cases where clinicians had documented some information regarding the discussions of the ICPC meeting, only **3** had made reference to the sliding scale scoring by professionals.

Key Action(s):

• To liaise with teams who were audited and to ascertain why they were not able to attend the conference or submit a report. Which will them allow us to implement any additional support identified around the ICPC process.

• Mandatory support sessions to be held to go through the ICPC process to strengthen clinicians' understanding and explain what is required of them.

• Clear guidance to be formulated regarding ICPC documentation.

• To review whether child protection cases are being brought to safeguarding or clinical supervision.

Risk to Patient's Physical Health and Monitoring the National Early Warning Score 2 (NEWS2) Trigger System

Background:

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

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

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

The latest reporting period ran from 1st October 2022 to 31st December 2022.

Key Success(es):

• The audit identified that **83.1% (2.4% increase since last Audit)** of the sample had the first set of observations completed within the first 24 hours of admission (as per policy). We then have an additional **14.9%** taken as soon as the service user's mental health allowed, however this was after the 24 hours guideline.

• The Trust now has a generic insight report so that the Heads of Nursing/ AHP and Matrons will have quicker/easier access to this information, so they can look to make improvements locally.

• With regards to the 'Managing the Deteriorating Patient' policy, this now links to the NEWS and SBARD guidelines.

• The Trust continues to have COVID guidance available to support the service as the pandemic changes

Key Area(s) for Improvement:

• **2.1%** did not have a recorded physical health observation on the digital ward system. However, after reviewing these service users, most had been discharged within the 48 hours; therefore, not allowing the staff time within the admission period.

Key Action(s) taken:
• The Trust has made huge improvements in the monitoring of basic physical health observations and NEWS2 scores in all areas of the inpatient units. We have better methods for quicker reporting and are now quicker at reviewing the service user's observation, as well as being acutely aware when there is a deterioration.
• The Trust has also made improvements in training for all staff, especially since the introduction of the Physical Health Clinical Educators. Face to face, 'Managing the Deteriorating Patient' training, harm reduction training and eLearning are proving to be very successful.
• The Trust is ensuring that the clinical guidelines are widely read and understood.
• With regards to the 'Managing the Deteriorating Patient' policy, this now links to the NEWS and SBARD guidelines.
    • The Trust continues to have COVID guidance available to support the service as the pandemic changes
• The Trust now has a generic insight report so that the Heads of Nursing/ AHP and Matrons will have quicker/easier access to this information, so they can look to make improvements locally.

Pharmacy/Medicines
(Inpatient Controlled Drugs Audit, Safe and Secure Handling of Medicines Inpatient Units, Antimicrobial Guidelines Audit)

Background:
Across the course of the past year, the trust carried out several pharmacy and medicines related audits to assess various topics. Ongoing local audits include the Hypnotics Audit and Medicines Reconciliation Audit. These are run by the pharmacy team to look at the Trust's compliance and adherence in various areas related to medicines.

Inpatient Controlled Drugs Audit
The Duthie Report and the RPSGB /DH report "Safe and Secure Handling of Medicines: A Team Approach" indicates that controlled drug audits should be carried out at least every 6 months. This also forms part of the assurance framework registration with the care quality commission. 49 wards were included in this audit.

The audit carried out covered 25 different questions covering the following aspects:
- Storage of controlled drugs
- Requisitioning of controlled drugs
- Receipt and record of controlled drugs
- Administration of controlled drugs
- Disposal of controlled drugs

Key Findings:
• Across the **49** wards, there was **86%** overall compliance, which is slightly lower than the 2021 and 2020 audits.

• **3** wards achieved **100%** compliance – Cilantro Ward, Chamomile Ward, Reservoir Court.
• The lowest compliance (by 19% compared to second lowest) was Ardenleigh, which had **68%** compliance. This saw a significant decline (13%) from the previous audit.

• **26** wards achieved under **90%** compliance.

Key Action(s):
• For each ward, action plans have been agreed with the senior ward manager and should be followed up by senior ward staff / pharmacy staff. Pharmacy can provide additional specific training on optimising the management of controller drugs where needed, especially for new ward staff. These are overseen and managed through central pharmacy team representation on each ward.

• The audit will be repeated in the next year to look at any changes in average compliance.

Safe and Secure Handling of Medicines Inpatient Units Audit

Background:
Health care organisations require assurance that medicines are stored safely and handled securely throughout their premises and organisation. Organisations should have clear procedures that are followed, monitored, and reviewed for safe storage, prescribing, dispensing, preparation, administration, monitoring and disposal.
For the safe and secure handling, organisations should broadly comply with the DH/RPSGB report "The Safe and Secure Handling of Medicines: A Team Approach" published in March 2005. In BSMHFT, the Medicines Code defines the standards and procedures that wards should observe in the storage and handling of medicines.

This audit report covers the audit carried out in February/March 2022. Audits were completed for 47 wards covering general adults, older adults, Steps to Recovery and Secure Care wards.

Key Findings:
• Overall compliance remains good in most areas, averaging **91%**.
• There was a fall in compliance in North Acute Adults wards, with **78%** compliance recorded.
• Five wards were **100%** compliant with the standards: Jasmine Inpatients, Kennett (Reaside), Swift (Reaside), Acacia (Tamarind), and Cedar (Tamarind).

Key Action(s):
• Pharmacy Services will continue to work with staff on Inpatient wards to provide training on key safe and secure handling of medicines issues.
• Pharmacy staff will work closer with those wards showing the greatest non-compliance with standards to support any shortfalls/gaps.
• In line with the recent Health Services building note, pharmacy will work with wards and estates to ensure that where medicines cabinets are non-compliant with BS2881 and are due to be replaced then suitable alternative cabinets that comply with the standard are procured.

Antimicrobial Guidelines

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

This audit is designed to look at the overall use of antibiotics in comparison to good prescribing practice and antimicrobial prescribing guidelines. Clinical pharmacists performed a snap-shot audit of all antimicrobial prescriptions they reviewed during the week of 14th March 2022.

There were 50 prescriptions for antimicrobials included in this audit which is similar to previous audits.

Key Findings:
• Of the 50 prescriptions reviewed, **24** were entirely consistent with the guidance (**48%**). Prescriptions that were considered outside the guidance were reviewed.
• At least **10** out of **26** of the prescriptions that were initially inconsistent with the guidance, had appropriate indications. This raised the overall compliance to **68%**.
• Of the 50 prescriptions, **27** (**54%**) were started promptly. Of the prescriptions where there was an initial delay in administration, the majority were where the medicine was not available on the ward or in out of hours cupboards. The majority of these were topical antimicrobials and would not normally be stocked on ward stock lists nor would be appropriate for inclusion on ward stock lists. In all cases, this is unlikely to be critical to the treatment outcome. A number of patients declined treatment doses and in one case, there was an initial prescription issue that required amendment.

• **22** (**44%**) prescriptions had a review date documented. Of these, 2 prescriptions had an actual outcome documented (4%). A further 22 prescriptions were reviewed by a pharmacist and discussed with the doctor or MDT. In most cases, the treatment course was ongoing.
• Of the **47** prescriptions where no outcome had been documented, this was because the treatment was either a long-term treatment (UTI prophylaxis, asthma, and toenail infection) or the course of treatment was not yet complete. There was only **1** prescription complete where no outcome was documented.
• This audit has shown that antimicrobial prescribing in March 2022 was similar compared to recent winter audits. This is due to an increase in the number of topical treatments compared to previous audits. Compliance with antimicrobial guidance in this audit was once again, well above the commissioner's target.

Key Action(s):
• No significant concerns were identified in the analysis of either delays in starting treatment or the number of missed doses.
• After analysis of treatment outcome documentation, two out of three completed courses were documented by either medical staff or clinical pharmacists. Remaining

treatments were ongoing. Clinical pharmacists will continue to work with medical staff to ensure that antimicrobial prescribing is appropriate, and the outcomes are documented.

Company Enablement and Recovery Team (CERTs) and Home Treatment Team (HTT) Policy Compliance Audit

Background:
CERT provides intensive, time-limited, enablement- and recovery-focused interventions for Dementia & Frailty services users with aim of preventing crisis and need for admission (and supporting timely discharge when admission has been required). This Audit is to scope joint working between CERT and HTT when older service users are placed on the bed waiting list (BWL).

Key findings:
• 99 cases identified (excluding. those e.g., open to adult services, coming via Psychiatric Liaison Team (PLT).
• CERT involved in **34.3%** (34) of cases prior to going onto BWL.
• Of those, **85.3%** (29) opened to HTT and CERT closed (joint working 14.7%).
• On review, joint working felt possible in **61.7%** (21) of cases.
• On review, joint working felt possible in **58%** of cases overall (57/99).

Key Actions:
• To develop the shared working protocol when explored through QI.
• Conduct a Quality Improvement project on a shared protocol for joint working between CERT and HTT.

Patient Transfer to Moseley Hall Hospital (MHH) and Queen Elizabeth Hospital (QEH) from Juniper Centre (Mental Health to Local General Hospitals)

Background:
The trust has identified some issues regarding transfer to QE/MHH; problems with general hospital not receiving transfer information, we have not received discharge information, and contacting MHH. Issues such as these are very time consuming for the team to work around and result in a poor patient experience. We aim to improve the experience of this process for doctors and nursing teams locally, as well as medical doctors at the general hospitals. The number of cases captured over 3 month was 46. Across several wards. Of these, 87% were admitted to the QE and 11% to MHH.

Key findings:
• 41% of cases were seen by duty doctor, 50% were seen by ward doctor and 9% of cases were seen by the nurse in charge.
• Reason of transfer include Falls (26%), High NEWS (17%), Dehydration (17%), Unresponsive episode (9%), Hypoxia (7%), seizure (7%) and others (17%).
• 15% of cases contacted bed management at MHH and 26% of cases contacted the on-call medics. When bed management at MHH was called, 71% of beds were available.
• For the transfer time, 74% of cases were transferred within 0-2 hours, 13% transferred within 2-4 hours and another 13% was transferred within 4-12%.

• 11% experience logistical problems upon transfer.
• 41% of cases were send to the hospital (QE/MHH) with doctor's transfer information.
• Upon coming back to Juniper Centre, 40% of cases were discharged with discharge letter. Out of this, 72% contained relevant information and the rest was inadequate in quality.
• Prior to transfer, 82% of cases was predetermined for QE and 18% was for MHH. Out of this, 11% of location had to be changed, the reasons are no beds availability in MHH (60%) and inappropriate transfer location (40%).

Key Actions:
• Training and education on best practice will be delivered in monthly medic's meetings.
• A reminder for duty doctors for out of hours transfers will be added in the doctor's induction handbook

3. Research

	Prescribed Information	**Form of statement**
3	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	The number of patients receiving relevant health services provided or subcontracted by **Birmingham and Solihull Mental Health NHS Foundation Trust** in **2022-2023** that were recruited during that period to participate in research approved by a research ethics committee is 369.

4. CQUIN

	Prescribed Information	**Form of statement**
4	Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services.	A proportion of BSMHFT income in 2022/23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because of the Covid Pandemic.
4.1	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	

4.2	If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	

5. CQC

Registration with the Care Quality Commission (CQC)

	Prescribed Information	**Form of statement**
5	Whether or not the provider is required to register with CQC under Section 10 of the Health and Social Care Act 2008.	Birmingham and Solihull Mental Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is conditional. BSMHFT has the following conditions on registration: 1. The registered provider must take steps to address the ligature risks across all wards by 18 June 2021 2. By 29 January 2021 the Registered provider must implement an effective system to improve risk assessments and care planning. The Registered Provider must report to the Commission on the steps it has taken in connection with this by 5 February 2021. 3. By 4 January 2021, the registered provider must inform the Commission of the order of priority in terms of addressing the ligature risks and timescales for addressing the ligature risks across each ward. 4. Commencing from 5 February 2021 the registered provider must report to the Commission on a monthly basis setting out progress being made in respect of including mitigating measures being put in place until all ligature risks are addressed. 5. Commencing from 1 March 2021, the Registered Provider must report to the Commission on a monthly basis the results of any monitoring data and audits undertaken that provide assurance that the system implemented is effective. The Care Quality Commission has taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2022 to 31 March 2023. A
5.1	If the provider is required to register with CQC: (a) whether at end of the reporting period the provider is: (i) registered with CQC with no conditions attached to registration (ii) registered with CQC with conditions attached to registration (b) if the provider's registration with CQC is subject to conditions, what those conditions are and (c) whether CQC has taken enforcement action against the provider during the reporting period.	

		Section 29 notice was issued and the Trust provided an action plan to the Care Quality Commission to address the points raised.

The Trust has satisfactorily completed all actions related to the above conditions and these include the installation of door monitoring alarm systems on all en-suite doors in Acute Care, development of new MDT standards, which have been used as a basis for auditing the quality of care planning in the Trust and the development of an annual capital programme that specifically focuses on the removal of ligature risks as prioritised by service areas based on level of risk. As a result of these actions and based on our last monthly submission in May, we are expecting the CQC to remove these conditions imminently.

The Care Quality Commission has taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2022 to 31 March 2023. A Section 29 notice was issued and the Trust provided an action plan to the Care Quality Commission to address the points raised. We have made good progress on the short-term actions to address the staffing challenges currently facing the Trust and have also made some progress with our longer-term plans.

	Prescribed Information	**Form of statement**
7	Whether or not the provider has taken part in any special reviews or investigations by CQC under Section 48 of the Health and Social Care Act 2008 during the reporting period.	Birmingham and Solihull Mental Health NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 1 April 2022 to 31 March 2023. Core Inspection of: o Acute wards for adults of working age and psychiatric intensive care units o Long stay/rehabilitation mental health wards for working age adults o Wards for older people with mental health problems o Mental health crisis services and health-based places of safety o Forensic inpatient or secure wards and a
7.1	If the provider has participated in a special review or investigation by CQC: (a) the subject matter of any review or investigation (b) the conclusions or requirements reported by CQC following any review or investigation (c) the action the provider intends to take to address the conclusions or requirements reported by CQC and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period.	

		Well-led inspection Birmingham and Solihull Mental Health NHS Foundation Trust has developed and submitted detailed action plans to the Care Quality Commission on the intended actions to address the Must and Should Do findings and these will be monitored using our agreed governance processes internally as well as monthly progress updates to the CQC.

8. Data Submission

	Prescribed Information	Form of statement
8	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider	Birmingham and Solihull Mental Health NHS Foundation Trust did not submit records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's: (i) valid NHS number (ii) General Medical Practice Code (b) the percentage of records relating to outpatient care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code (c) the percentage of records relating to accident and emergency care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code.	

9. Information Governance

	Prescribed Information	Form of statement

9	The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.5	Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Assessment Report for 2022 / 2023 is not due to be submitted until the 30th June 2023 in line with national submission timescales relating to the Data Security and Protection Toolkit. The 2021/22 Data Security and Protection Toolkit attainment level for the Trust was 'approaching standards' with an improvement plan submitted to NHS Digital in December 2022.

10. Payment by Results

	Prescribed Information	Form of statement
10	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.	Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.
10.1	If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	

11. Data Quality

	Prescribed Information	Form of statement
11	The action taken by the provider to improve data quality.	Birmingham and Solihull Mental Health NHS Foundation Trust will be taking the following actions to improve data quality: • Maintaining regular assessment of the quality of data underlying all key performance measures so that any issues can be addressed.

		• Continuing detailed audit and review of the accuracy of clinical case classification, activity monitoring and clinical outcome measurement information. • On-going comparison of service user contact and GP registration details with the national NHS Summary Care Record database to ensure information in our clinical systems stays up to date. • Close monitoring and continuous quality improvement work on a range of data quality performance indicators, with clinical and administrative staff using monitoring reports to identify and correct data errors. • Maintaining work on completeness and validity of MHSDS submissions in relation to the Data Quality Maturity Index • Undertaking preparatory work to improve the new experimental data items to be included in the DQMI from July 2024 • Improving the completeness of Restrictive interventions data submitted to the MHSDS. • Maintaining work on completeness and validity of the IAPT submissions and assessing the new experimental data set items added to the Data Quality Maturity Index • Active data quality support to operational services by service-aligned data analysts, bringing any data issues forward for attention and supporting and monitoring improvement actions. • Introduction of a Patient level Information Costing system (PLICS) to automate PLICS and service line reporting. The aim is to improve accuracy and efficiency in data gathering to enable more time to be spent on analysis and reporting across the Trust to help inform decision making.

12. Learning from Deaths

Prescribed information	Form of statement
1. The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2022/23, BSMHFT recorded 1,883 patient deaths. This comprised the following number of deaths which occurred in each quarter of that reporting period: 433 in the first quarter 448 in the second quarter

	514 in the third quarter 488 in the fourth quarter
The number of deaths included in item 1 above,f which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	At the date of submission, 20 case record reviews and 46 investigations have been carried out in relation to the 1,883 deaths included in item above. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 17 in the first quarter 13 in the second quarter 16 in the third quarter 20 in the fourth quarter
An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	No patient deaths were judged to be more likely than not to have been due to problems in the care provided to the patient, in this sample.

27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	Whilst no deaths were identified as more likely than not avoidable, there were overall learning themes identified as follows: Q1 1 – themes- use of alcohol, poor physical health monitoring Q2 1- suicide risk assessment in person with autism Q3 3- support for SU with drug and alcohol issues, poor physical health monitoring, risk of choking, interfaces between teams Q4 2 – ligature risk in prison, risk assessment, collateral information

27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	The following actions have been undertaken and are ongoing: - Substance misuse- we have set up a subgroup looking at various aspects of improving care for service users with drug and alcohol needs, which reports quarterly to our Clinical Effectiveness Advisory Committee. This oversees changes in training for detoxification, raising awareness of related patient safety issues and improving multi-agency working - Specific work has been completed in the prisons setting in relation to ligature risk assessments - Autism and learning disability- we have started a workstream relating to supporting service users with autism, including training, improving the environment for inpatients and raising awareness of patient safety related issues. - The clinical risk assessment and management policy is due for review and will make reference to how staff can improve their risk assessment and risk management for key groups of service suers, including where there is a risk of drug or alcohol use, service users with autism .

27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Due to the scale of work involved in the actions listed above it would be premature to evaluate the outcome.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	26 case record reviews and 30 investigations were completed after 31 March 2022 which relate to deaths before the start of the reporting period.

27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	6 representing 0.4 % of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the final avoidability score of 3 or less.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item	7 representing 0.47 % of the patient deaths during 2020-21 & 2021-22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting Against Core Indicators

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

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

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

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

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

into day-to-day life outside hospital. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health NHS Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2022-23	92.0%	*	*	*
2021-22	92.5%	*	*	*
2020-21	91.8%	*	*	*
2019-20**	94.7%	95.0%	100%	85.9%

Data Source: Rio - our internal clinical information system

* *No national comparator figures were collected or published for 2020-21 or 2021-22.*
** *Please note that national comparator figures for 2019-20 relate to the period Apr-Dec 2019 only as there was no national collection of this data for the last quarter of the financial year. Please note performance dipped sharply in March 2020 due to the impact of Covid-19*

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

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

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

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

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

of daily reports to senior managers and review at regular divisional performance meetings.

Whilst the trust has taken these actions to improve the percentage completion, 2022/23 compliance has remained impacted by Covid -19. To ease the burden on staff, where patients have been discharged to the care of another mental health trust, we have not asked them to contact the receiving trust to check to see if follow up has taken place. During this period a number of contacts have had to also be made indirectly with care home staff where it was not possible to visit or talk to service users directly in this setting.

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

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

	Birmingham and Solihull Mental Health Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2022-23	96.7%	*	*	*
2021-22	95.4%	*	*	*
2020-21	97.5%	*	*	*
2019-20**	96.0%	97.9%	100%	91.9%

Data Source: Rio - our internal clinical information system

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

****** *Please note that national comparator figures for 2019-20 relate to the period Apr-Dec 2019 only as there was no national collection of this data for the last quarter of the financial year.*

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

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

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

2.3.3 Readmissions to hospital within 28 days of discharge

The percentage of admissions to Trust hospitals of patients aged:

(i) 0 to 15 and
(ii) 16 or over

which were readmissions within 28 days of discharge from a hospital which forms part of the Trust. There is no national indicator meeting exactly this definition. Trust data is based on all readmissions happening on the same day as a discharge from Trust inpatient services or any of the following 27 days.

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

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

	Age 0-15	Age 16+
2022-23	0.0%	3.9%
2021-22	0.0%	5.3%
2020-21	0.0%	6.2%
2019-20	0.0%	5.8%

Data source: Rio – our internal clinical information system

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

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

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

2.3.4 Patient Experience of Community Mental Health Services

The Trust's mean 'Overall patient experience of community mental health services' indicator score (out of 10) as reported through the 2021 National Community Mental Health Service User Survey. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2022	6.4	6.9	7.9	5.9
2021	6.5	6.9	7.7	6.0
2020	6.9	n/a	7.8	6.1
2019	6.9	n/a	7.7	5.8
2018	7.1	6.8	7.7	5.9
2017	7.4	7.3	8.1	6.4
2016	7.5	7.5	8.1	6.9
2015	7.3	7.5	8.2	6.8

Data source: National Community Mental Health Service User Survey 2022

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

The survey is undertaken independently to the Trust by an external company in accordance with national survey requirements and the results are in line with our expectations.

2.3.5 Patient Safety Incidents

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

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

	Reported Patient Safety Incidents per 1000 bed days				Percentage of Patient Safety Incidents resulting in Severe Harm or Death			
	Trust	National Median	Highest National	Lowest National	Trust	National	Highest National	Lowest National
April 21-Mar 22	55	666	222	7	0.4	1.0%	57%	0.0%
Apr 20 – Mar 21*	58	64	236	21	0.3%	1.0%	58.8%	0.0%
Oct 19 – Mar 20	49	53	146	18	0.4%	1.0%	4.2%	0.0%
Apr 19 – Sep 19	51	56	131	17	0.5%	0.9%	3.3%	0.0%
Oct 18 – Mar 19	44	53	119	15	0.6%	1.0%	4.3%	0.0%

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

**Note: NRLS reporting is annual for 2020-21 figures.*

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

Data source: National Reporting and Learning System (NRLS)

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

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

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

- To transfer to Learning From Patient Safety Events (LFPSE)
- Continuing to deliver incidents reporting training via incidents awareness sessions and Incident Manager training.

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

Part three – Other Information

In this section of the report, we share other information relevant to the quality of the services we have provided during 2021/22 which together with sections 1 and 2 of this report, provide an overview of the quality of care offered by our Trust during this period.

3.1 Safety

The three indicators selected for patient safety are:

- Serious Incidents
- Never Events

3.1.1 Serious Incidents

During 2022/23 we have completed much of the groundwork to move the investigation of our serious incidents in line with the NHS Patient Safety Incident Response Framework in preparation for the national roll out of this programme. We continue to work closely with partners across various agencies which support health and social care in Birmingham and Solihull to complete multi-agency reviews where it was evident that a patient involved in a serious incident was receiving care, support or advice from more than one agency. This enables us to take a system wide view on opportunities to improve how agencies can work together for the benefit of patients. We will be developing and embedding a number of processes to aid learning, including safety summits within wards, and teams and also for key safety topics.

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

3.1.1.2 Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. We are pleased to report that the Trust has not reported any Never Events during 2022/23.

	2019/20	2020/2021	2021/22	2022/23
Number of Never Events Reported	0	0	0	0

3.2 Patient Experience

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

	2019/20	2020/21	2021/22
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	68%	59%	67%
Number of complaints	85	81	109
Timeliness of complaints	100%	100%	99.1%
% of dissatisfied complainants	18 returned (20%)	9 returned (11%)	9 returned (8%)
Number of referrals to the Ombudsman	2 0 accepted for re-investigation	2 0 accepted for re-investigation	2 0 accepted for re-investigation

FFT score	91%	94%*	79%

(National benchmark figure)

**Please note that the 2020-2021 figure is reflective of the period January 2021 to end March 2021 as NHS England paused collection of the Family and Friends Test during the Covid Pandemic. Data source for the patient survey is the National Patient Survey Results, using national definitions, timeliness of complaints is our ECLIPSE reporting system for complaints and for CPA reviews is our KPI report on INSIGHT, our internal reporting system.*

It has been a challenging year as we seek to learn from service user experience in the midst of high system pressures. This is reflected in a sharp rise in complaints in 2021/2022 to 109 cases, an increase of 34% from the previous year. Despite this our dissatisfied complainants have remained at 9 cases, which is a reduction of 3% from the previous year. For the third year running, the PHSO have received 2 complaints from service users, neither of which they have accepted for reinvestigation. We failed to meet the agreed timescale for a single complaint which was shared with the complainant a day late. We feel that our performance during 2021-22 demonstrates a positive record and improving picture of the way that we work with service users and their families to investigate their concerns and support their resolution. Work begun in 2020/21 on reviewing the carer experience of complaints was completed and will feed into the planned work for 2022/23 of a review of the Complaints Policy, including the establishment of an advisory panel of service users, carers, families, stakeholders and staff.

Strengthening lived experience role in inpatient quality oversight to Board

We have several workstreams underway to achieve this:

- Participation and experience teams established, working in services, connecting with service users and reporting to local and Trust governance quarterly.
- EBE
    - 58 Experts by Experience trained and available via a main data base. This is where EBEs can be offered opportunities to participate so this is equitable.
    - 7 FIRST EBE
    - 4 Perinatal EBE
    - There is a training session for new EBEs available every 2 months
    - 38 EBEs who support interview panels (in March 29 interviews and 15 EBEs – some did more than one)
    - 11 new people for the recruitment and selection have just completed training and will be able to support interview panels.
    - Lived Experience and Research (LEAR)
- QI and EBE participation (23 EBE trained in QI methodology and a third co-hort planned for May)

- Paper has been developed for Patient safety partners (PSIRF) still requires funding–cost £30k

- Expert by Experience Observers – A new programme that has been given £130k over 2 years supported and to be rolled out.
- Sensory friendly ward programme EBEs are key to the environmental assessment and review and co-produced and deliver the training
- We have trained 4 EBEs at EBE Educators (4-day training programme), to support Trust learning and development training and Trust Induction. Further training cohorts are planned for 2023
- We have 3 EBEs on the Recovery College Advisory Committee (monthly meeting, Quality Assure all Recovery College activity)
- We have 8 EBEs who are actively working / supporting Recovery College delivery of courses (and we have opportunities for more soon to be advertised)

Complaints

Data source for analysis: SafeGuard.

Date of analysis and selection criteria: Cases opened and cases closed between 01/04/2022 to 31/03/2023.

Responses to the requests for information:

In 2022/23 (April 2022 – March 2023) BSMHT received 115 formal complaints regarding services across the Trust, and 9 formal complaints were subsequently were withdrawn. At the end of March 2023 the number of active formal complaints was 39.

Formal complaints upheld/partially upheld:
118 formal complaints were closed, with the following outcomes:

Outcome	Count	%
Upheld	6	5.1%
Partially upheld	61	51.7%
Not upheld	26	22.0%
Withdrawn	13	11.0%
Not Categorised	1	0.8%
Early Resolution	11	9.3%
Total	**118**	**100.0%**

3.2.1 Performance against the relevant indicators and performance thresholds

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

National mental health indicators

	NHSE/I Oversight Framework updated in November 2017: National Indicators – 2022/23	National Threshold	2022/23
1	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	60%	100%
2	Improving access to psychological therapies (IAPT): ** a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. within 18 weeks of referral	50% 75% 95%	49.9% 35.2% 67.9%
3	Inappropriate out-of-area placements for adult mental health services (average bed days per month) *	n/a *	846
4	Admissions to adult facilities of patients under 16 years old	n/a	0%

* The waiting times for IAPT have reduced below the national targets primarily due to factors outside the Trust's immediate control. Covid 19 has significantly impacted on the Trust's ability to maintain face to face appointments and contacts with service users, due to a significant reduction in the availability of physical space in primary care facilities where people were being seen for their appointments. Nationally a recognised shortage in the availability of appropriately qualified staff has added a further challenge along with staff sickness due to Covid. A system wide forum has been established with the Birmingham and Solihull Clinical Commissioning Group and other partners to jointly develop plans to improve the position going forwards.

** Due to the impact of COVID-19 on the need for acute and urgent mental health services, it was recognised by NHSE/I that the national target to achieve 0 out of area placements by end March 2022 would not be possible.

In addition, please note that the quoted figures for average bed days per month for 2022/23 take into account a Standard Operating Protocol agreed with NHS England whereby admissions to ten local acute private beds have been classified as 'appropriate placements' from 1st October 2022 and admissions to local PICU private beds from 1st January 2022. NHS England recognise that this protocol is not reflected in national MHSDS reporting figures, which will continue to show admissions to these beds as being 'inappropriate' placements due to MHSDS data constructs. A trajectory was in place in 2022-23 agreed with commissioners to reduce out of area bed days to 561 bed days by March 2023. This has

remained challenging for the Trust and a project group is in place to identify and implement a range of actions, which include a dedicated bed manager whose focus is to manage the needs of out of area patients with a view to supporting transfers back to their home localities where possible and exploring the use of additional beds locally. Further actions are being planned in partnership with Forward Thinking Birmingham which address patient flow challenges, including delayed transfers of care, across the Integrated Care System as a whole.

3.3 Other information

Quality Awards

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

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

Infection Prevention and Control

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

- Surveillance of alert organisms and conditions.
- IPC, decontamination and mattress compliance audits.
- Annual mattress/ Sharps/ Food safety audits.
- Regular IPC compliance visits.
- Monthly hand hygiene audits/ training.
- IPC Champions study days/ training (3 per year)
- Monthly cleaning scores/ PLACES scores.
    - ➢ We ensure standards of environmental cleanliness are maintained with the recent role out of the National Standards of Cleaning which was implemented within the trust.

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

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

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

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

Quality Management System and QI Strategy

As outlined above in our 2023-4 quality goals, we are developing our approach to quality planning, assurance, improvement and control, as part of a quality management framework. We have identified staff who can support this journey, in addition to our QI team, and they have accessed specific Chief Quality Officer training with the Institute of Healthcare Improvement. It is envisaged that this approach, over a 3 to 5 year period, will allow us to integrate our data, making it accessible by all staff, from ward to Board, to encourage staff to understand and use the data to develop improvements and to support all staff to engage in local accountability for changes. Year 1 will include developing the infrastructure, such as our data systems, integrating clinical governance and clinical effectiveness processes with patient safety learning processes and linking this with a continuous cycle of improvement at ward and team level.

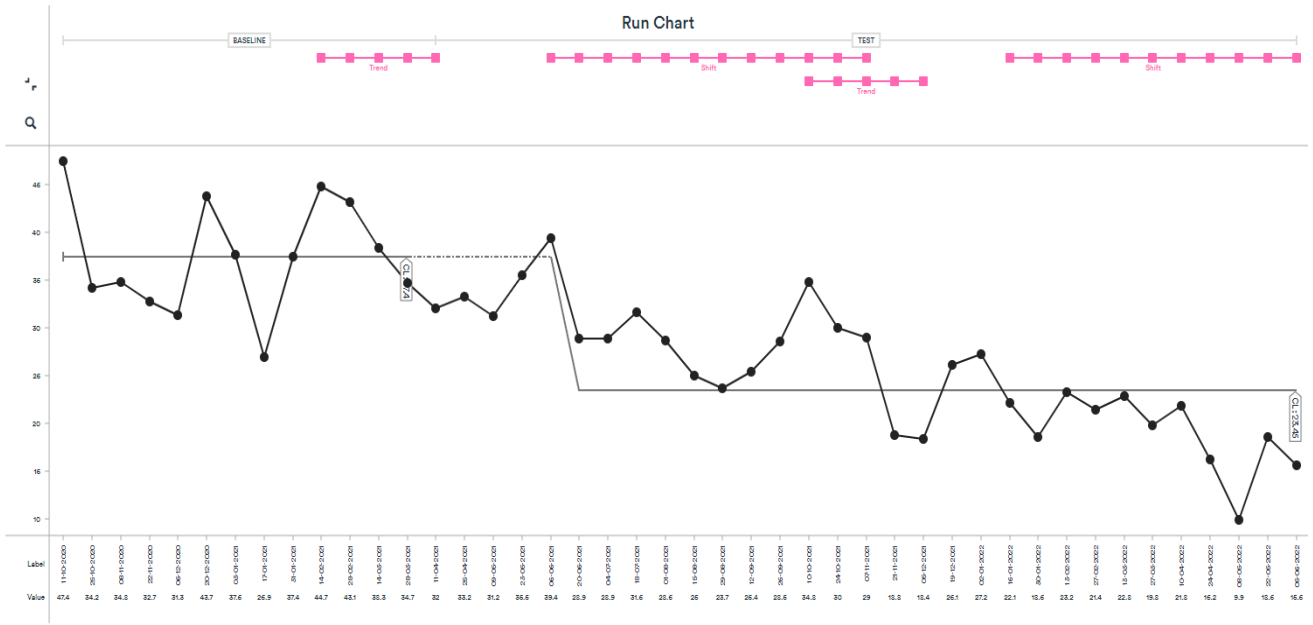
To support this, we have developed a 3-5 year Quality Improvement Framework, which outlines our plans to continue to embed QI methodology and expertise within the organisation. This will build on the success we have already built, with our QI training programmes, QI projects open across the organisation and development of further posts such as a data analyst to support clinical areas in this work.

Reducing Restrictive Practice

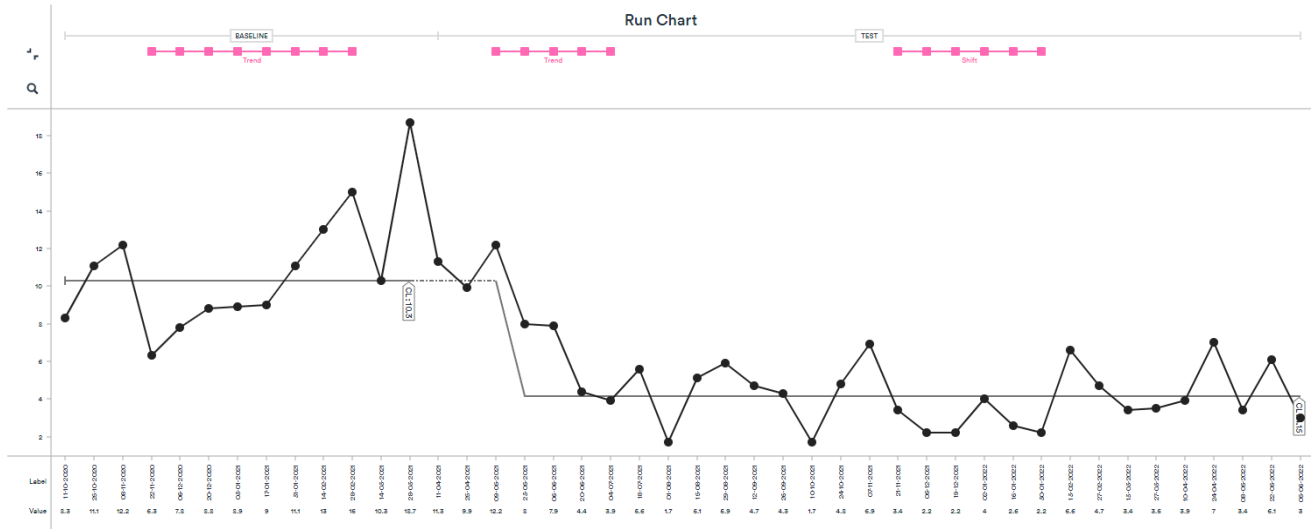
Following our successful Quality Improvement Collaborative that we completed across the organisation in 2021 and 2022, we held a celebration event in July 2022. This brought together all the teams across the services across the organisation, in person, to share the success of the Collaborative and to plan how we would embed

the improvements in Business as Usual. Key achievements of the Collaborative included:

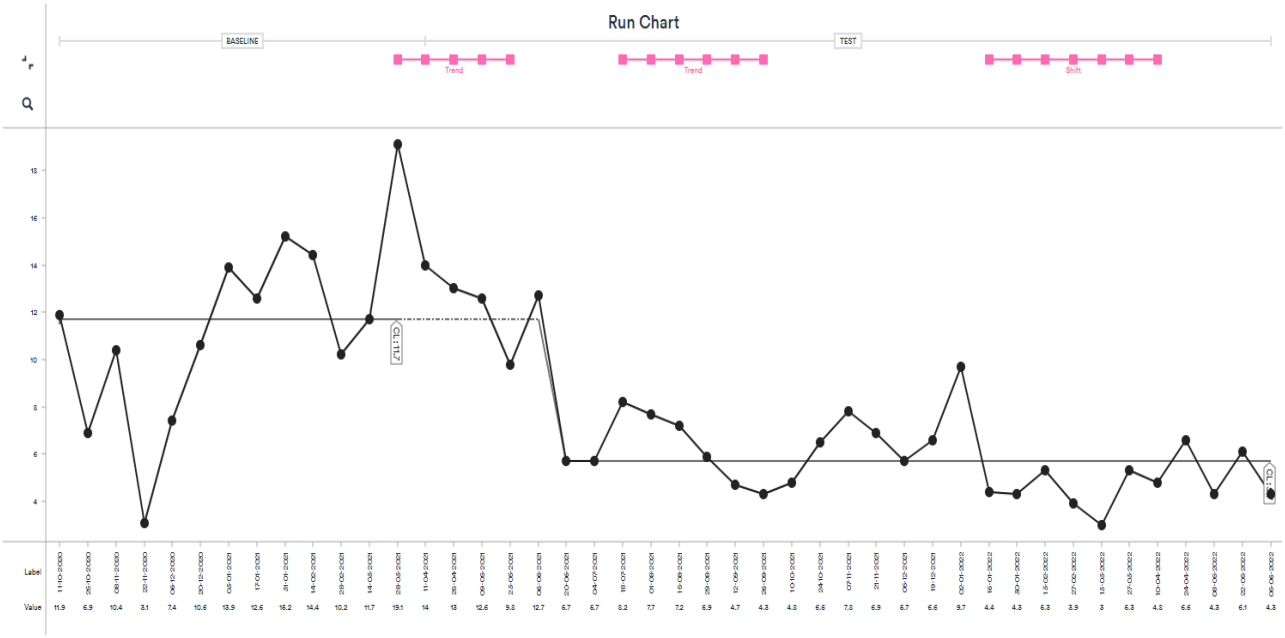
Rate of restraint per 1000 Occupied bed days (OBD) – a 37% reduction



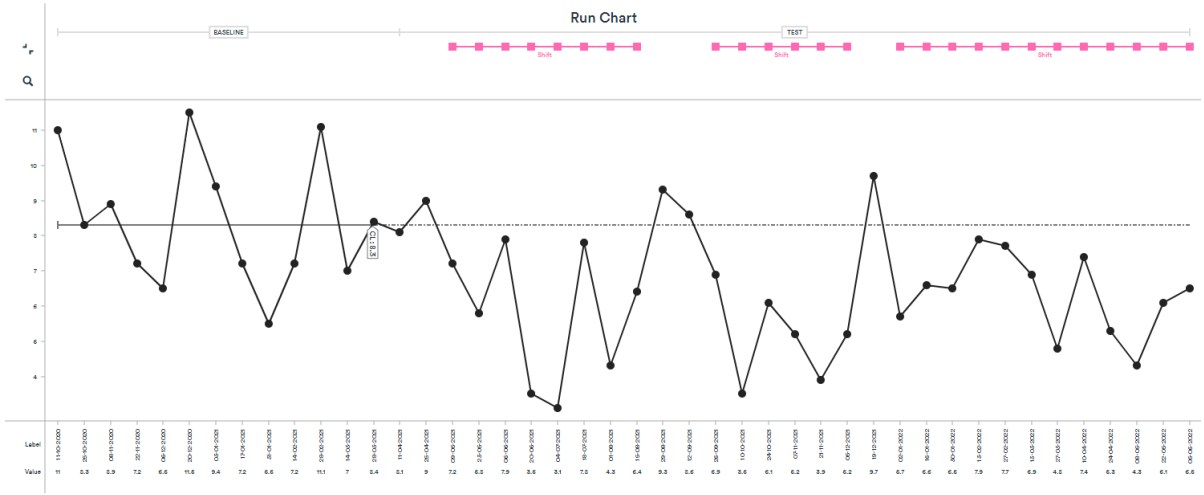
Rate of prone restraint per 1000 OBD- a 60% reduction



Rate of rapid tranquilisation per 100 OBD- a 51% reduction



Rate of seclusion per 1000 OBD



The charts demonstrate that through the Collaborative, and using a QI approach, we were able to reduce restrictive practices across the organisation. Following the Celebration event, we then had a transition period, where the four local clinical areas worked together to identify their own priorities in relation to restrictive practices, and to be able to embed this into business as usual.

We gained other valuable learning in a variety of ways, including using positive behavioural support plans, offering other , more trauma informed routes of administration for rapid tranquilisation (the deltoid route) and other ways to

support service users in distress, such as self soothe boxes or sensory rooms, leading to a reduction in the need for restrictive practices. We also incorporated the LD and autism work supported by NHSE regarding the sensory aware changes to ward environments, which again has led to much better experiences for service users, not only those with a diagnosis of LD or autism, but also the other service users as well. We also gained a lot of learning in running a QI Collaborative and staff gained a lot of experience in using QI methodology. Finally, it offered a great opportunity to really listen to those with lived experience of restrictive interventions and to work collaboratively to make real change.

We now have a Restrictive Practice steering group, which oversees local progress, and also is a forum to share good practice across clinical areas. Infrastructure is also being developed to enable a continuous improvement approach, for example developing our data formats so they are easily accessible from ward to Board, supporting staff to develop skills in QI methodology and involving service users and Experts by Experience in a variety of ways to ensure that learning from those with lived experience really makes a difference to clinical practice.

3.4 Workforce

3.4.1 Guardian of Safe Working Hours

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

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

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

- Acts as a champion pf safe working hours.
- Receives exception reports and records and monitors compliance against terms and conditions.
- Escalates issues to the relevant executive director, or equivalent for decision and action.
- Intervenes to reduce any identified risks to doctors or to patient safety.

- Undertakes work schedule reviews where there are regular or persistent breaches in safe working hours; and
- Distributes monies received as a consequence of financial penalties, to improve training and service experience.
- Meets with the Deputy Medical Director for Medical Workforce, Associate Medical Director for Medical Education and Senior Human Resource Business Partner for medical staffing, as well as with all of the postgraduate doctors in training to receive direct information about the rotas and working conditions.

3.4.2 Freedom to Speak Up Guardian

The Trust refreshed it's speaking up arrangements in November 2020 and currently employs one full time Lead Guardian and another full time Guardian reporting to the Lead Guardian. Both are registered on the National Guardians Directory. There is also an evolving network of eight Freedom to Speak Up Champions based in local teams, from different professional backgrounds with a further four from the second Cohort pending their national training. Unlike the Guardians, Champions do not hold cases but are based across the Trust in their local areas providing advice and support to their colleagues. They signpost and role model a positive speaking up culture.
Freedom to Speak up Guardians are responsible for taking action to promote the following:

- Colleagues throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up
- Speaking up policies and processes are effective and constantly improved
- Senior leaders role model effective speaking up
- All colleagues are encouraged to speak up
- Individuals are supported when they speak up
- Barriers to speaking up are identified and tackled
- Information provided by speaking up is used to learn and improve
- Freedom to speak up (FTSU) is consistent throughout the health and care system, and ever improving

Staff are encouraged to raise concerns and suggestions for improvement through existing channels such as line managers and supervisors, via incident reporting mechanisms, through informal/formal HR processes such as the Dignity at Work and Grievance and Disputes policy. Other avenues are the four staff networks, Staff side representatives and the Spiritual Care Team. The Trust has also launched the Enough is Enough campaign which supports individuals raise concerns about bullying, harassment and discrimination. Periodically, colleagues are invited to report their health and wellbeing at work through the NHS People Pulse Survey alongside the annual NHS Staff Survey. Staff can also raise concerns which may meet the threshold of the Public Interest Disclosure Act (PIDA, 1998) with senior managers and or the Freedom to Speak Up Guardians.

Freedom to Speak Up Guardians operate independently and impartially providing an alternative route if any of these routes are blocked or if barriers exist. Reporting directly to the Board they can escalate concerns to anyone internally or external to the organisation. They are also responsible for monitoring and reporting detriment

as a result of speaking up, with allegations reported to the Lead Executive for FTSU with oversight from the FTSU Non-Executive Director.

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

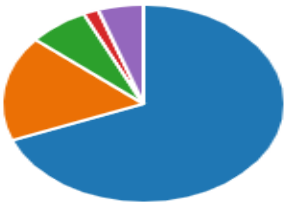
The tables below show a selection of qualitative feedback that is used for learning and improvement:

	anonymous	Excellent listening Assurance of Confidentiality - I felt safe telling my story Excellent advice given on how to, where to next Extremely approachable
	anonymous	I was treated with respect and listened too I was really upset when I called the team and they were patient, kind and emphathic the support i received was very helpful
	anonymous	Some of my concerns have been addressed however others have not been.
	anonymous	Happy with being listened to and confident it would remain confidential

5. Given your experience are you likely to speak up again?

More Details

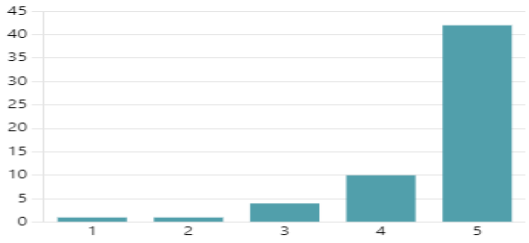
Very likely	40
Somewhat likely	10
Neither likely nor unlikely	4
Somewhat unlikely	1
Very unlikely	3



8. How likely are you to recommend the Guardians to your colleagues ?

More Details

4.57
Average Rating



Guardians are required to collect and report anonymised data on the cases raised with them by workers reporting this quarterly to the National Guardians Office. This data is categorised as follows: cases raised including an element of patient safety

and quality; worker safety and wellbeing; bullying and harassment; detriment for speaking up and cases raised anonymously.

They report to the Board in person twice yearly and in the interim to the People Committee (a sub-committee of the Board) reflecting trends and themes and recommendations for improving the organisations' speaking up arrangements. In the 2022/23 period, there were a total of 341 enquiries to the Guardians. Copies of previous FTSU Board reports which provide further detail and activity over the last financial year can be viewed here: 2023 - Birmingham and Solihull Mental Health NHS Foundation Trust - BSMHFT

Together with the Executive and non-Executive Directors for FTSU the Guardians are currently reviewing and reflecting on the organisation's existing speaking up arrangements identifying strengths and areas for improvement NHS England » The guide for the NHS on freedom to speak up Development objectives will be presented to the Board in 2023 setting out the high level actions to be taken over the next 6-24 months.

3.4.3 Staffing surveys

Employee Experience and Engagement Surveys

We continue to monitor and respond to staff concerns through both the NHS People Pulse survey and the NHS National Staff Survey. We use the People Pulse Survey on a quarterly basis to understand any changes to staff experience and engagement with a particular emphasis on wellbeing. The Annual Survey is used extensively in the Trust as an annual assessment of progress towards our People Goals. The total number of responses this year for the staff survey was almost exactly the same as last year with 2230 permanent colleagues sharing their view. Our approach to the staff survey includes a substantial engagement exercise with teams across the trust. Teams are assisted to understand and examine their local team or directorate results and to make changes in response to enhance employee experience. This year 92 frontline teams received a team result. In addition we use anonymous surveys regularly as part of policy development and problem solving in our wider approach to Organisational Development.

3.4.4 International Nursing Recruitment

International Recruitment

We are continuing to use International Recruitment as an additional source for our future workforce pipeline for nurses. We currently have funding in place to for 40 Internationally Educated Nurses (IEN) and recently requested an additional 20 nurses as part of the IEN Winter pressures monies.
Our interviews are now planned till end of August 2023.

OSCE and Pastoral Support.

The OSCE programme is run at the Atwood Centre and the support from the Bureau has been extremely helpful. We currently have one of our clinical educators involved in the delivery of the MH OSCE full time. We have 2 candidates who have passed the OSCE and have 2 who are due to take this in June 2023.

We are now looking at resources to support with pastoral and transitional aspects of the role of a B5 nurse. This will also support with development into future roles. Lead for the project and Lead Clinical Educator are developing a bespoke IEN pathway with clinical learning labs to support with the transition from completing OSCE to working on the wards.

OET Pilot

We are part of a bid to support candidates with OET support. This is a pilot funded by NHSE and we have been allocated 10 places and provided with £12,000. This additional support will provide our IEN's with additional package to help pass the OET.

Annex 1: Stakeholder Statements

1.1 Healthwatch Birmingham and Healthwatch Solihull Statement

Healthwatch were contacted for their contribution, however they have given apologies as unable to send contribution due to capacity issues with the team

1.2 NHS Birmingham and Solihull Integrated Care Board Statement

See statement below on page 67

Birmingham and Solihull Integrated Care System
Caring about healthier lives

NHS
Birmingham and Solihull

NHS Birmingham and Solihull Integrated Care Board
First Floor Wesleyan
Colmore Circus
Birmingham
B4 6AR

Telephone: 0121 203 3300
www.birminghamandsolihullicb.nhs.uk

Birmingham and Solihull Mental Health Foundation Trust
Quality Account 2022/23

Statement of Assurance from NHS Birmingham and Solihull Integrated Care Board

June 2023

1.1 Birmingham and Solihull Integrated Care Board (ICB) as coordinating commissioner for Birmingham and Solihull Mental Health Foundation Trust, welcomes the opportunity to provide this statement for inclusion in the Trusts 2022/23 Quality Account.

1.2 A draft copy of the Quality Account was received by the ICB on 7th June 2023 and the review has been undertaken in accordance with th e Department of Health and Social Care Guidance. This statement of assurance has been developed from the information provided to date.

1.3 The information provided within this account presents a balanced report of the healthcare services that Birmingham and Solihull Mental Health Foundation Trust, provides. The report demonstrates the progress made by the Trust against the 202223 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and the priorities set for 2023/24.

1.4 We have worked closely with Birmingham and Solihull Mental Health Foundation Trust, over the course of 2022/23, working collaboratively to review the organisations' progress in implementing its quality improvement initiatives. We are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2023/24.

Yours Sincerely

Lisa Stalley-Green

NHS Birmingham and Solihull Integrated Care Board Deputy Chief Executive and Chief Nursing Officer

1.3 Birmingham and Solihull Mental Health NHS Foundation Trust Council of Governors Statement

The Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust would like to formally express its thanks to all staff who have supported our service users, families, carers and each other throughout 2022/23.

We are pleased to note that this quality accounts report recognises the importance of service user, family, and carer engagement when we are discussing the care needs of individual patients in our care. It is also important to document the concerted efforts being made to ensure that improved engagement of service users, families and carers continues as a high priority.

In relation to safety measures and reducing harm, we are pleased to see that our nationally benchmarked position for restrictive practice is largely improving, however we remain concerned that improvement is not trust wide.

We have seen a stronger focus on measures that demonstrate delivery of the Trust Quality Strategy and goals during 2022/23 inclusive of waiting times and out of area placements. We particularly recognise the importance of ensuring a 'Just Culture' within the organisation so that every colleague feels empowered to speak up safely about concerns relating to patient safety.

In developing that culture, it is essential that colleagues feel confident that such concerns are constructively heard and addressed fairly and with a focus on positive changes in improving our care.

We recognise that we still have a journey of improvement ahead of us, it is, however, pleasing to see that we are moving in the right direction. We are supportive of the quality priorities laid out for 2023/24 and believe they provide an appropriate focus for the next 12 months.

This includes measures on making a safer physical environment and the embedding of coproduction as a key aspect of inclusively improving quality in partnership with service users and families in a way that highlights and tackles health inequalities.

The Council of Governors welcomes the Trust's Quality Improvement agenda and goals for 2023/24 and will continue to play a key role in ensuring that the Board is continuously improving the services provided to patients, alongside the experience of Trust employees and volunteers.

In concluding this statement, I would like to take the opportunity on behalf of the Council of Governors to thank the Trust for their proactive approach to seeking the views of Council in developing this approach to quality improvement.

As a whole Council of Governors, we have a wide pool of lived experience and expertise to share, and we will continue to play our part in aiding service improvement, enhanced safety and quality of care for our patients. We look forward to making more progress in 2023-2024.

John Travers
Lead Governor

Annex 2: Statement of directors' responsibilities for the quality report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- *The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance Detailed Requirements for Quality Reports 2019/20*

- *The content of the Quality Report is not inconsistent with internal and external sources of information including:*
  - *Board minutes and papers for the period April 2021 to March 2022*
  - *Papers relating to quality reported to the Board over the period April 2021 to March 2022*
  - *Feedback from commissioners dated 17 June 2022*
  - *Feedback from Governors dated 17 June 2022*
  - *Feedback from local Healthwatch organisations dated* 15 June 2022
  - *The 2020 national patient survey*
  - *The 2020 national staff survey*
  - *CQC inspection report dated 1 April 2019 and subsequent enforcement notice dated December 2020*

- *The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered*
- *The performance information reported in the Quality Report is reliable and accurate*
- *There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice*
- *The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and*
- *The Quality Report has been prepared in accordance with NHS Improvement's Annual Reporting Manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.*

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Roisin Fallon Williams
Chief Executive

Phil Gayle
Trust Chair