Birmingham and Solihull Mental Health NHS Foundation Trust

QUALITY ACCOUNT REPORT

2019/20

Contents

Quality Report

Part One

Statement on Quality from the Chief Executive

I am delighted to present our Quality Account for 2019/20. As I write this report, we find ourselves in one of the most difficult years in the history of the NHS with the outbreak of the COVID-19 virus. Firstly, I want to pay tribute to all our NHS, Care and key worker colleagues who have lost their lives, both here at Team BSMHFT and across the country, to this terrible disease. All of our staff, carers and volunteers have worked tirelessly since the outbreak and their amazing compassion, commitment and resolve has been focused on making sure that we keep everyone as safe as possible whilst maintaining the care and safety of all patients and staff. The unprecedented challenges posed by COVID-19 at the latter end of 2019/20 saw gigantic efforts made by all at Team BSMHFT and phenomenal collaborative focus of so many giving so much, above and beyond their day to day roles. I am grateful to our 4,200 strong workforce who, regardless of the challenge, strive to provide ongoing care for our patients and support to families, carers and each other as staff. The environments and context that we work within in ordinary circumstances are complex and challenging and we hugely proud of all of our staff for the valuable work that they have done in these unprecedented circumstances.

This account details the progress that we have made in delivering our three year Quality Strategy, 2017-2020. It is an opportunity to reflect on the achievements that we have made and also the challenges we have encountered.

Our story of improvement whilst not without challenges is a positive one, and our commitment to further improvements is strong. Our Quality Strategy, which was approved by the Board in March 2017, detailed the following Quality Ambitions:

Safety – Preventing suicides, deaths in care and reducing harm

Safety – Embed a culture of least restrictive practice with reduced incidents of restraint, seclusion and physical assault

Safety – Ensure that robust and dynamic clinical risk management is embedded in day to day practice to support the safety and recovery of our patients

Effectiveness – Ensure that all patients receive care that is predicated on evidence based guidance from NICE

Effectiveness – Promote recovery, good mental and physical health

Responsiveness – Ensure that people have a positive experience of care by listening to service users, families, carers, staff and stakeholders to continuously learn and improve our quality of care

Caring – Ensure that patients, carers and families are able to contribute to developments aimed to enhance the patient experience

Well Led – Ensure that quality governance is strong and consistent across services

We have made good progress in delivering our goals linked to suicide prevention and our national benchmarking position has improved as per the National Confidential Inquiry, from 9.2 suicides per 100,000 people in the first year of our strategy to 8.4 suicides per 100,000 people in the third year of our strategy. Birmingham and the Black Country has the joint 9th lowest suicide rate in England at the time of writing this report. When looking more closely at the number of suicides per 10,000 patients under our care, the latest National Patient Safety Scorecard shows that fewer patients under the care of our Trust die by suicide, compared to those seen on average in other mental health trusts across the country. Every suicide is a tragedy and we still have much improvement to make in this important area. We are working towards a zero ambition for suicide levels - and this forms a central part of our new Quality Strategy for 2020-2025.

Our journey of least restrictive practice continues and we now have safewards in place across all of our inpatient units. We exceeded our 15% reduction target for prone restraint – achieving a 28% reduction since 2016/17. At the start of this strategy, NHS Improvement benchmarking showed that the Trust had some of the highest levels of restraint in the country. Three years into our strategy, and with the expert guidance and support of our clinicians, our Positive and Proactive Care Expert Panel and quality improvement approach, we have moved out of the upper quartile for these incidents, and in some areas such as older people's services are now below the median line. Levels of violence within our inpatient wards have fluctuated throughout the last 3 years. During 2019/20 there were 1,257 incidents of assault on our staff by patients. This is an increase in incidents of 9% compared to 2016/17. There were also more incidents of physical assault between patients representing 625 incidents (an increase in incidents of 15% compared to 2016/17). This is a critical area for our continued focus and in January 2021 we will be launching a range of new evidence based approaches which are aimed at minimising incidents of violence and assault in our acute inpatient wards.

Our Positive and Proactive Care Expert Panel have undertaken much work to understand the experience of individuals cared for in seclusion within the Trust and have engaged the views of patients and staff to help identify improvements that we can make to the seclusion experience. A number of quality improvement projects are now being undertaken in the Trust to improve the experience of seclusion and to reduce the level of time that patients may spend in seclusion facilities.

Our approach to physical health has also improved in some areas. We know from national mortality research that the life expectancy of those with a serious mental illness can reduce by approximately 15%. Over the last three years, we have increased our recording of cardio metabolic indicators such as blood glucose levels, alcohol use, tobacco use and BMI from 38% to 67% of inpatients and from 6% to 17% to individuals supported by our community services. Understanding these indicators means that we are able to help provide advice and support to patients under our care in relation to diabetes, smoking cessation, alcohol and drug misuse and weight loss.

One of our commitments in our strategy was to 'provide an enhanced range of physical health opportunities and activities for patients in our inpatient services'. During the three years we have funded outdoor gyms in a number of our inpatient units and for example at Hillis Lodge, all patients are encouraged to use a pedometer to measure the steps that they are walking daily. Activities more generally across the Trust do however need to increase and we are currently working alongside our Allied Health Professionals to develop an increased range of physical activities and therapeutic activities for our patients. Reference is made to specific priorities to increase therapeutic activities in some of our acute inpatient wards during 2021.

In our Dementia and Frailty Services we have seen a reduction in the number of falls that result in serious harm to our patients - with one incident of this nature reported in 2019/20 compared to eight per year at the start of our three year strategy. Falls more generally have been variable and reported incidents show us that, despite some significant improvement in 2018-19, we did not sustain this level in 2019/20 with 496 falls taking place during the year.

Our journey of recovery has moved at a great pace with the commitment and involvement of staff, patients, families, carers, governors and experts by experience. We have extended the Recovery College model to Solihull and to the North of Birmingham. 'Recovery for All' training now features on our mandatory training programme with good participation levels. The Recovery College has achieved IMPROC (Implementing Recovery through Organisational Change) accreditation and our co-production agenda is developing positively. We have established a Family and Carer Pathway Group who have overseen a number of positive developments - including the carer assessment tool, wording to be included in our complaint letters and serious incident investigation letters to families and the development of our Carers Strategy.

Our strategy sets out an aim for us to achieve a score of 90% from the Friends and Family Test for patients recommending our Trust as a place to receive care. Our score is published monthly on the NHS England website and the latest publication demonstrated that we had achieved this goal. Acting on feedback from the Friends

and Family Test and learning from incidents, complaints and audit has been a real focus of our strategy.

We have developed new approaches such as the ‘Kitchen Table’ safety approach, commenced an early pilot of ‘Learning from Excellence’, established our video library of ‘It Takes Three’ videos (3 key lessons in 3 minutes) and we have developed our integrated learning lessons bulletin to all staff.

During the year we have worked hard across the Trust to establish skill and competency in quality improvement approaches, which will now be a cornerstone of our improvement approach to quality, safety, effectiveness and experience for patients, families, carers and our hardworking colleagues. At the start of our strategy we did not have an established approach to quality improvement. Three years on we have a skilled team of experts and have trained over 295 staff in quality improvement methodology. We have established a range of quality improvement programmes which will now help us to deliver our new Quality Strategy for 2020-2025.

Working alongside our HR colleagues, we have established a compassion at work group and have commenced Schwartz Rounds and Balint Groups to provide staff with support at challenging times. Schwartz Rounds are a multidisciplinary forum bringing staff together to reflect on the emotional challenges associated with their jobs. The focus is not on the clinical aspects of the patient, but on staff experience. We know that the compassion shown by staff can make all the difference to a patient’s experience of care and that our staff must therefore, in turn, feel supported in their work. We have also commenced an approach known as TRIM (Trauma Risk Management Approach) which has been proven to demonstrate that its application can psychologically help and support staff who have witnessed or been party to a traumatic incident. Our staff are our most valuable asset and it is increasingly important that we support and care for them, so that they can care for our patients in the best way possible.

Whilst we were not inspected by the Care Quality Commission during this period, on 1 April 2019, they published their report on findings from an inspection that had taken place the previous year. Our report confirmed a rating of Good for the domains of Caring and Responsiveness and a rating of Requires Improvement for Safety, Effectiveness and Well Led. This meant that our overall rating as a Trust was Requires Improvement. Whilst we continue on our journey towards ‘Good’ we should recognise some of the great comments and outstanding aspects of care that were cited by the CQC in their report.

These include:

- ‘Staff treated patients with compassion and kindness. Staff were caring and passionate about their roles’.
- The trust had improved collective leadership and the board and senior leaders were confident about plans to improve the quality of care. The trust was working with a number of organisations and stakeholders to improve services. They had learnt from other organisations to develop a culture of quality improvement and we saw signs of achievement.
- The ‘See Me’ user involvement project promoted patient involvement in planning and delivering mental health services across Birmingham and Solihull. The trust customer relations team assisted patients and carers to stay actively involved with the trust.
- Hillis Lodge had developed a range of outstanding practice related to healthy lifestyles and patient engagement. New outdoor exercise equipment had been installed in the communal garden area and there had been a very high uptake from patients at sessions using these. Pedometers had been purchased and patients were encouraged to wear these out when going into the community. Information about steps taken communally was then being used to create events and sessions for patients.

It is clear however, that we need to make improvements in some core areas –the quality and content of clinical documentation - particularly clinical risk assessments and care plans, safe storage and transportation of medications, supervision arrangements for staff, and the availability of personal alarms for patients in our inpatient units. We have taken forward a number of improvements associated with these areas this year, including the purchase and provision of new locked medication bags in which our community staff can safely transport medications, the installation of a drug fridge temperature alarm system to ensure drugs are always stored with safe temperature ranges and the purchase of personal alarms for inpatients where these are deemed appropriate

The fact that health inequalities prevail is clearly evident in our health services and communities across the country including here in Birmingham and Solihull. We have much to do both as a mental service provider and as part of the health care system to develop meaningful and focused actions to begin to address health inequalities. We have made a commitment to champion equality, diversity and inclusion, we have pledged to support an ambition to become an anti-racist, anti-discriminatory organisation and to ensure that not just the majority but all our colleagues and citizens have a strong voice that is heard, respected and acted upon in all aspects of our work and interactions.

As I close this introduction, I reiterate my thanks and that of the Board of Directors, to our compassionate and committed staff, our service users, families and carers, our stakeholders and our Council of Governors and look forward to continuing to tackle our challenges, build on our successes and make progress in 2020/21.

I declare that to the best of my knowledge the information in this document is accurate.

Roisin Fallon-Williams
Chief Executive

Background

Once a year, every NHS Trust is required to produce a Quality Account Report. This report includes information about the services the Trust delivers, 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.

What is NHS Choices?
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 (2020/21), what our priorities are, and how we intend to address them.
- How we performed last year (2019/20), 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

We have a simple and clear purpose: 'To provide excellent, compassionate, high quality mental health services that are innovative and involve service users, carers, and staff'. We aim to promote and ensure the following values in every element of our work. We put service users at the centre of everything we do by displaying:

- Honesty and openness – We will keep each other well informed through regular communication. We will have honest conversations and explain our decisions.

- Compassion – we will bring compassion to all our dealings with service users and carers and expect it in our colleagues.

- Dignity and respect – We will respect all those whom we deal with at work, especially our service users and staff and take action to address those who do not.

- Commitment – We commit to help our colleagues provide the best care services that we can. We will do what we say we will.

We provide comprehensive mental healthcare services for the residents of Birmingham and Solihull and to communities in the West Midlands and beyond. We operate out of more than 40 sites and 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 form the most affected areas.

Part two: 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 2020/21
- Progress made since publication of our 2018/19 quality report including performance against each of the 2019/20 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 2019/20
    - Registration with the Care Quality Commission
    - Improving Data Quality
    - Learning from Deaths
    - Reporting against Core Indicators

2.1 Priorities for improvement during 2020/21

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is committed to continuous quality improvement. This section of the report describes areas for improvement in the quality of our health service provision during 2020/21. 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 Guidance. We have also engaged widely with our workforce and our service users and Experts by Experience to ensure that these goals will support the delivery of our Quality Strategy which reflects the local needs of our service users and staff as well as national needs.

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 ensure that our inpatients receive care in a 'safe and least restrictive environment'. Restrictive practice, including restraint and seclusion, can increase stigma, isolation and the risk of harm; it can adversely affect patients with a trauma background and it reduces the potential to 'share risk' between mental health practitioners and patients by reducing the opportunity to build trust and work collaboratively on safety planning that supports a patient's autonomy and development of coping strategies. Social isolation may actually serve to increase risk, as may having a staff member alongside a patient for a prolonged period of time when this is continually non-interactive. Increased or improved therapeutic intervention and activity may effectively reduce the need for restrictions on activity.

Evidence suggests that when incidents of violence are followed by containment measures, this can escalate to further violence. Preventative de-escalation measures are recommended here, including reducing the potential for conflict on wards, facilitating a calm, less rigid ward environment, and anticipating patients' needs and responding early to them.

During 2020/21 we will:

- Establish our Quality Improvement Collaborative aimed at reducing levels of restraint and reducing levels of violence and aggression within on our inpatient wards
- Pilot enhanced therapeutic activity models on 4 acute inpatient wards and 3 secure care inpatient wards with the aim of improving recovery, reducing incidents of physical assault, reducing incidents of restraint, reducing incidents of self harm
- Ensure that staff and service users have access to appropriate, evidence based advice, guidance and support regarding the reduction of restrictive practices and restraint, embedding existing processes into the overall Trust culture.

National statistics reported by the National Confidential Inquiry into Suicide and Homicide demonstrate that whilst the number of deaths by suicide in mental health inpatient units is reducing, there is still opportunity to reduce these further. Evidence demonstrates that the majority of deaths by suicide in mental health wards were by hanging/strangulation from ligature points. Ensuring that our physical estate is as safe as possible is very important to us – particularly our inpatient wards where we know we care for patients who are at high risk of harm due to their mental illness. This year we will further implement our ligature risk reduction strategy with a particular focus on reducing the risk of utilising bathroom en-suite doors as a ligature anchor point.

During 2020/21 we will:

- Implement door alarm systems on all en-suite bathroom doors at Mary Seacole House Ward 2 as part of our Physical Estate Ligature Risk Reduction Programme
- Establish our roll out plan for door alarm systems across all acute inpatient wards and Psychiatric Intensive Care Units aligned to our capital investment programme

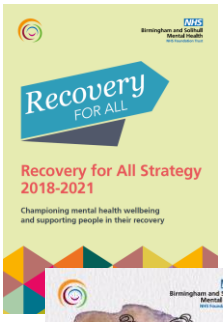
During 2020/21 we will also take forward a number of other initiatives to improve the safety of our services. We will:

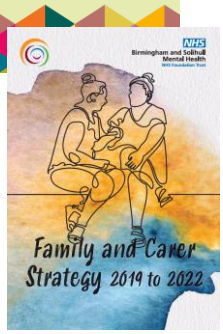
- Be part of at least one national patient safety collaborative
- Report on year one of our participation in the National Sexual Safety Collaborative
- Establish our Safeguarding Partner roles in each of our service areas
- Appoint a Patient Safety Specialist in line with the requirements of the National Patient Safety Strategy
- Strengthen our approach to the monitoring and management of haematological and other physical health investigations
- Review the infrastructure of our electronic patient records to ensure that they are streamlined and minimise the risk of duplication of information
- Scope the use of DIALOG as a replacement for CPA and Care Support with inbuilt outcome measures
- Implement year one of our Personality Disorder Guidelines
- Pilot, evaluate and roll out a quality improvement project to establish minimum standards for multi-disciplinary Team (MDT) working across our Acute Inpatient Wards and Psychiatric Intensive Care Units
- Establish Safety Huddles on all of our acute inpatient wards and psychiatric intensive care units with a view to then extending this approach across all other inpatient wards
- Increase the completion of Think Family children and siblings forms in early adopter sites by 50%

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 2020/21 we will:





- Finalise a vision and a set of principles of Expert by Experience (EBE) participation, to work in conjunction with the Family and Carer strategy and Recovery for All Strategy. This will include a review and development of an experts by experience reward and recognition policy
- Increase EBE participation in Level 1 Quality Improvement projects to 30% by March 2021
- Develop the role of the Patient Safety Partner in accordance with the National Patient Safety Strategy and pilot this approach before scale up and spread
- Increase the number of Personal Health Budgets for service users who are eligible for section 117 after care as they are discharged from inpatient wards.
- Undertake baseline assessment, work with Family and Carer Pathway Group to determine key aims and deliverables to improve the Patient, Family and Carer experience of Serious Incidents and Complaints.

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 2020/21 we will:

- Include TRIM support as part of our support package to staff following traumatic incidents by developing a number of TRIM practitioners in the Trust who can support staff effectively. TRIM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event. TRIM practitioners are clinical and non-clinical members of staff who have undergone specific training allowing them to understand the effects that traumatic events can have upon people. They are not counsellors or therapists, but understand confidentially and are able to listen and offer practical advice and assistance

- Introduce the concept of civility saves lives as part of our safety culture. When incivility occurs in the workplace through poor behaviours such as rudeness, this impacts not only on the recipient but also on wider staff and patients, families and carers. National research shows that rudeness has a direct impact on reduced staff performance, a reduced commitment to work, increased staff absence, a reduced quality of work and an impact on the patient experience. When patients observe or experience incivility it can leave them feeling anxious and reduce their confidence and view of our Trust and the care they receive.
- Pilot Learning from Excellence in our Dementia and Frailty Services, evaluate and devise scale up and spread plan so that we have a process to report, recognise and learn from excellent practice amongst our staff. Safety in healthcare has traditionally focused on avoiding harm by learning from error and whilst it is important that we continue to learn from error, this approach alone may miss opportunities to learn from excellent practice. We believe that developing and implementing a system to capture, celebrate and learn from excellent practice can create new opportunities for learning and improving resilience and staff morale.
- Commence training in the use of Appreciative Inquiry as an approach to support a positive safety culture. Appreciative Inquiry focusses on strengths and areas that staff and teams are good at, rather than weaknesses, to create sustainable change and development.
- Increase the level of clinical supervision training reported through our portal by at least 10% to ensure continued learning, reflection and support to our staff
- Pilot a service area level integrated dashboard offering easy access to data relating to workforce, quality and safety, performance and finance to assist with local decision making and leadership

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.

We will measure our success through improvements in the National Staff Survey metrics relating to the 'Ability to Contribute to Improvements' metric; the 'Quality of Care' metric and improvement in ratings awarded by the CQC.

During 2020/21 we will:

- Increase the number of staff receiving training in quality improvement by at least 10% compared to the number in receipt of training as at 31 March 2019
- Utilise run charts as our business as usual way of reporting on all quality improvement projects and quality and safety metrics. Run charts are graphs of data over time and are one of the most important tools for assessing the effectiveness of change. Run charts have a variety of benefits: They help improvement teams formulate aims by depicting how well (or poorly) a process is performing. They help in determining when changes are truly improvements by displaying a pattern of data that you can observe as you make changes. They give direction as you work on improvement and information about the value of particular changes.
- Develop process, outcome and balancing measures for all of our quality improvement projects. Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making actually lead to improvement.
- Develop a peer review process to continually review our compliance levels with CQC regulations and encourage shared learning

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 2020/21 we will:

- Develop the ‘triple aim’ approach to our quality improvement programmes and monitor and report efficiency impacts of the programmes
- Explore the use of digital technology to enable service user safety to be sustained and improved whilst also maximising time for clinicians to deliver direct service user care
- Explore other digital developments which can support patient safety whilst reducing the burden of paperwork on our frontline clinical staff

2.1.2 Monitoring, Measuring and Reporting Progress on the Priorities

Monitoring measuring and reporting progress on the above priorities will take place through a quarterly report to the Integrated Quality Committee at Birmingham and Solihull Mental Health NHS Foundation Trust. Such reporting will include reference to relevant outcome measures reported through the National Mental Health Community Patient Survey which is published annually and also the Annual NHS Staff Survey. In addition, we will monitor our performance against a range of key indicators such as restraint levels, suicide levels, incidents of self harm and incidents of physical assault through a monthly integrated performance dashboard that is presented to our Trust Board meeting in public each month.

2.1.3 Progress Made since Publication of the 2018/19 Quality Report

Goal 1: Develop and implement a clinically driven and consistent approach to quality improvement across the organisation

Measures of success

- Broader workforce capacity and capability will be in place in quality improvement methodologies and delivery.
- We will see further improvement in our achievement of quality goals during 2019/20

Enablers

- Engagement, training and skills development of staff in quality improvement.
- Identification and agreement of priorities and focus through a diagnostic process
- Implementation of a range of quality improvement projects

2019/20 Progress

	2017	2018	2019
Appointment of centralised QI Experts	0	1	6
Broader workforce capacity and capability will be in place in quality improvement methodologies and delivery.	1	58	295
Formal quality improvement projects will be in place for a number of our quality goals during 2019-2020	0	0	80

How did we perform and what did we do?

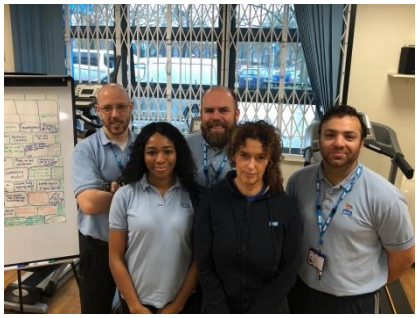
We fully achieved the goals that we set ourselves for this important area of work. We worked in partnership with the Institute for Healthcare Improvement to train almost 300 of our staff in quality improvement methodologies, encouraging them to speak up and contribute their ideas for improvement. We also developed our own highly skilled team of experts to lead and support us on our journey of quality improvement on a continual basis. Our staff came forward with over 80 ideas on how we can improve care and experience and we worked with them to test out their ideas for implementation.

Goal 2: Provide services which ensure that mental health and physical healthcare needs are assessed and given equality of consideration when developing, planning and delivering care

Measures of success

- To reduce falls that result in significant harm by 50 per cent compared to 2017/18.

How did we perform and what did we do?



We have seen significant improvement in the management and prevention of falls resulting in serious harm over the past 12 months. The dedication, commitment and hard work of our multi-disciplinary teams within our Dementia and Frailty Services has meant there have been a range of new interventions with the aim of preventing falls across the organisation. This includes the implementation of fall huddles, changes in care planning dependent upon presenting risks, changes to the physical environment to enable extended day facilities to enable better line of sight and observation, and promotion of the anti-slip socks. A Falls Steering Group and quality improvement project was also established to govern improvement. The outcomes of these approaches have seen falls resulting in serious harm reduce to the lowest level since 2016/17.

2016/17	2017/18	2018/19	2019/20
5	**2**	7	1

- Reduce falls across our inpatient services by 15 per cent compared to 2016/17 outturn.

2016/17	2017/18	2018/19	2019/20
358	**548**	478	507

How did we perform and what did we do?

Whilst we made significant strides in reducing the number of falls resulting in serious harm to patients, we did not achieve our target of reducing the overall number of falls occurring in our inpatient units. Since 2016/17 we have seen the number of falls increasing despite the range of new interventions that have been implemented. Such interventions include the implementation of fall huddles, changes in care planning dependent upon presenting risks, changes to the physical environment to enable extended day facilities to enable better line of sight and observation and promotion of the anti-slip socks. A deep dive into falls across the organisation is in the process of development to aid the development of further interventions to aid improvement and we will report on the number of, and severity of, falls in our Trust to our Integrated Quality Committee and Trust Board via the monthly integrated performance dashboard.

Measure of Success: Increase cardio-metabolic assessment of inpatients and community patients with a diagnosis of psychoses to achieve the 90 per cent of inpatients and Early Intervention patients and 75 per cent for community patients on the Care Programme Approach (CPA).

How did we perform and what did we do?
We have seen an ongoing increase in the percentage of patients within our inpatient care and those in early intervention who have recorded cardio-metabolic indicators although these did not reach the target levels that we had hoped for. However, we have been able to develop new reports to drill down to team level, in order to understand the challenges in achieving this quality goal, and we have worked hard with staff to start to remove the blocks, for example modifying processes in phlebotomy and prioritising service users in a different way. We have also used quality improvement methodology in some teams as an alternative way to start to improve or monitor.

	2017/18	**2018/19**	**2019/20**
Inpatients	**61.5%**	**63.5%**	67.1%
Early Intervention	**N/A**	**26.9%**	45%
Community	**27.5%**	**25.5%**	17%

Goal 3: Service users have reduced mortality through co-produced crisis plans, learning from mortality case note reviews and we will reduce the number of suicides

Measures of success

- Reduce number of confirmed suicides of patients on our caseload representing a 30 per cent reduction compared to 2016/17.
- No inpatient suicides on inpatients wards.
- No never events.
- Improvement in crisis plan measurement in patient survey (Q21 and Q23) ‘Do you know who to contact out of hours if you have a crisis?’ and ‘When you tried to contact them did you get the help you needed?’

Enablers

- Themes and learning points from Learning from Deaths.
- Improved family and carer engagement in care planning, crisis planning and learning from serious incidents and mortality.
- Ensure all clinical staff have received suicide prevention training.

- Implement three day post discharge follow up and ensure a care plan is in place at the point of inpatient discharge
- Approval and implementation of our new Suicide Prevention Strategy.

How did we perform and what did we do?

We are pleased to confirm that there were no Never Events during the year, however we did sadly have one case of an inpatient suicide. Such incidents are always very traumatic for families, fellow ward patients and staff and we reiterate our condolences to all who were affected by this tragic event. We are taking a number of steps to improve safety on our wards including more therapeutic activities, better care planning, the introduction of safety huddles and improved multi-disciplinary team working arrangements.

Ensuring that we provide good and easy access to crisis support for our patients and their families and carers is essential and in the National Patient Survey for 2019 we were able to see that patients felt that we had improved our arrangements for crisis contact. We need to continue with this improvement moving forward. We care for thousands of patients in the Birmingham and Solihull community and sadly there are times when some patients die outside a hospital by suicide. At the time of writing this report, Her Majesty's Coroner has given a verdict of suicide to 36 cases of death relating to patients who were on our community caseload during 2019/20. In response to this increase, during the year we have invested money to increase the number of staff in our Home Treatment Teams including psychologists, medics and nursing staff. We have also worked in partnership with our Commissioners and Birmingham Mind as part of a new mental health crisis telephone service and in 2020/21 we will start the development of a new mental health urgent care centre which will have more urgent care facilities in which we can care for and assess patients. We have also been working in partnership with other agencies across Birmingham and Solihull to understand how by working together we can improve the experience of our patients when they are being cared for outside hospital.

To work towards our zero suicide ambition we will:-	2016/17	2017/18	2018/19	2019/20
Reduce the number of confirmed suicides by at least 30% compared to the 16/17 figures	26	23	34	36
No inpatient suicides	2	1	0	1
No Never events	0	0	0	0
Improvement in crisis plan measurement in patient survey **S5 Section score of the Patient Survey**	6.0	5.7	5.8	6.9
• **Q21 Do you know who to contact out of office hours if you have a crisis?**	5.3	5.8	7.2	6.8
• **Q23 When you tried to**	6.7	5.5	6.8	7.1

contact them, did you get the help you needed				

Goal 4 - Embed a culture of least restrictive practice with reduced incidents of prone restraint, seclusion and physical assault

Measures of success

- Improve patient and staff safety by reducing the number of assaults in inpatient areas in comparison to the 2018/19 outturn position
- Reduce the use of prone restraint in comparison to the 2018/19 outturn position, as another measure of improving safety
- Eliminate seclusion outside a dedicated seclusion facility
- Improve patient experience of restrictive interventions when they need to occur
- Improve consistency of processes relating to restrictive practices

Enablers

- Further embed Safewards in all inpatient areas in conjunction with Positive Behavioural Support principles.
- Review of seclusion policy and increase in training for all staff including medical staff.
- Learn from service user feedback to improve the seclusion environment.
- Environmental works to take place to ensure all seclusion suites meet national standards.
- Review by Estates and Facilities department of all seclusion suites and long term segregation facilities to ensure all equipment is fully functioning.
- Systemise the use of Advanced Statements on all Psychiatric Intensive Care Units (PICUs).

How did we perform and what did we do?

	2016/17 Numbers	2017/18 Numbers	18/19 Numbers	19/20 Numbers	19/20 Target
Reduce inpatient physical assaults on staff by 20% compared to 16/17 outturn	1141	975	1057	1257	913
Reduce inpatient physical assaults on patients by 12% compared to 16/17	488	544	501	574	429
Reduce incidents of prone restraint by 15% compared to	1127	1092	1055	814	958

During the time period of 2017-2020, the Positive and Proactive Care Expert Panel (PPCEP) has overseen a strategic approach to reducing restrictive practices, such as seclusion, restraint and rapid tranquilisation, but has also looked at broader approaches to this task, such as introducing other interventions, eg Positive Behavioural Support (PBS) Plans and Safewards. We have also used quality improvement methodology to introduce PBS to some areas, and to try innovative approaches to reducing restraint, for example alternative administration for rapid tranquilisation which reduces the need for restraint. We have been able to reduce levels of prone restraint during the three year period, using these approaches.

In relation to seclusion, we have not been able to eliminate this, either within a purpose built facility or outside, but we have now reliable reports that we share with clinical staff on a regular basis, to monitor antecedents and to support staff to be able to avoid this in future (as part of our planned Quality Improvement Collaborative, starting in early 2021). There has also been some progress in improving consistency of practices across the organisation, sharing learning and good practice, with regular attendance from all inpatient services at the Positive and Proactive Care Panel.

In terms of service user involvement in reducing restrictive practice, we have been able to talk to a variety of service users about their experiences, which has directly led to changes in practice (for example, service user experience of seclusion). We have also had a number of service users attend the PPCEP to share their experiences.

Finally, in relation to staff assaults, we have found it difficult to reduce levels across all areas, although there have been some improvements in a few inpatient areas during the three year period. Nevertheless, our strategic approach to this goal has led to us developing a post–incident support tool for staff, to continue to promote the use of Operation Stonethwaite (a joint project with West Midlands Police to support staff who have been assaulted) and to understand the underlying reasons for ongoing staff assaults, in our wide variety of service areas. The forthcoming Quality Improvement Collaborative has staff and service user assaults in a central position, and we are committed to reducing these levels in the next period.

Goal 5: Promoting recovery, co-production and family, carer and service user involvement

Measures of success
Improvement in Q37 of the National Community Mental Health Service Users Survey Results: 'Have mental health services involved a member of your family or someone else close to you as much as you would like?'

Enablers
- Scope all opportunities (existing and future) for co-production and family, carer and service user involvement from ward to board.
- Roll out of the family and carer pathway pilot programme including signposting for carers and carers' assessments.
- Evaluate the learning from the employment experience of peer support workers and establish next steps for sustainability.

How did we perform and what did we do?
During the year we held 2 co-production workshops which resulted in a number of Expert by Experience opportunities being developed. We also held workshops with peer support workers to explore possible models of working, building on the evaluation undertaken by the Institute of Mental Health. These have fed into our transformation of community service funding bid, to create more and sustainable roles. The roll out of the family and carer pathway programme took place which included the development of a carers' assessment tool for use within all aspects of our services. The aim of this tool is to enable a joint understanding of the needs of carers to enable appropriate signposting to support services. The results of our patient survey score are detailed below:

	2017	2018	2019
Q35 Community Patient Survey score	6.0	6.6	6.1

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.

Reference is made to ‘relevant health services’. For the purposes of clarity the relevant health services provided by the Trust are in the following areas:

- Acute Mental Health
- Adult Community Mental Health
- Offender Health
- Older Adults Mental Health services
- Psychiatric Intensive Care
- Psychological Services (IAPT)
- Secure Mental Health Services (Men’s Low and Medium secure, Women’s Medium secure & FCAMHS)
- Specialty Mental Health Services (Perinatal, Deaf services, Eating Disorders, Inpatient CAMHS & Neuropsychiatry)
- Substance Misuse Services
- Urgent Care/Crisis Care
- Youth Community Mental Health Services

	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 2019/20, BSMHFT provided and/or subcontracted 11 relevant health 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 11 of these relevant health 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,	The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by

	relevant health services.	BSMHFT for 2019/20.

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 2019/2020, 5 national clinical audits and 1 national confidential enquiries 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% 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 Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in during 2019/20 are as follows National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight Audit National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight Audit 2 (Thematic Review) National Clinical Audit of Psychosis – Early Intervention in Psychosis Spotlight Re-audit Prescribing Observatory for Mental Health (POMH) - Topic 19a: Prescribing for Depression in Adult Mental Health Teams - Topic 17b: Use of Depot/LA antipsychotic injections for relapse

		prevention National Confidential Enquiry into Homicide and Suicide
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 2019/2020, are listed below : - National Confidential Enquiry into Homicide and Suicide National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight Audit National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight Audit 2 (Thematic Review) National Clinical Audit of Psychosis – Early Intervention in Psychosis Spotlight Re-audit POMH Topic 19a: Prescribing for Depression in Adult Mental Health Teams POMH Topic 17b: Use of Depot/LA antipsychotic injections for relapse prevention
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 2019 to March 2020 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:-

Title of National Clinical Audit	Eligible	Participated	% *
National Confidential Enquiry into Homicide and Suicide	Yes	Yes	100 (26)
National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight Audit	Yes	Yes	99% (201/204)
National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight Audit 2 (Thematic Review)	Yes	Yes	N/A[2]
National Clinical Audit of Psychosis – Early Intervention in Psychosis Spotlight Re-audit	Yes	Yes	100% (88)
POMH Topic 19a: Prescribing for Depression in Adult Mental Health Teams	Yes	Yes	93[1]
POMH Topic 17b: Use of Depot/LA antipsychotic injections for relapse prevention	Yes	Yes	119[1]

** Percentage of required number of cases submitted*

[1] POMH do not provide ascertainment rates. The figures provided are the number of cases submitted by Birmingham and Solihull Mental Health NHS Foundation Trust

[2]This is a thematic analysis of qualitative data collected in the first NCAAD Spotlight audit, so separate sample was not required

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 2019/20 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 6d: assessment of side effects of depot/LAI

In October 2018 the Trust took part in the 4th iteration of this audit designed by the Prescribing Observatory for Mental Health (POMH) around the assessment of side-effects of depot / LAI antipsychotics. This iteration focused on patients who were prescribed continuing treatment with depot/long-acting injectable (LAI) antipsychotic medication and who were not under the care of acute wards or home treatment/crisis intervention teams. The Trust submitted data for 139 patients encompassing patients from our CMHT/AOTs, Forensic Inpatients, Forensic Community and prison services. The report for this audit was received in April 2019.

In the 2018 audit we performed poorly for some standards relating to physical health monitoring of side effects associated with continuing treatment with depot/LAI medication. Our performance was below that of the total national average for 2018 and had decreased from our previous scores in 2017.

However, we performed nearly twice as well comparative to the total national sample (TNS) for the standard which looked at the 'proportion of women younger than 50 years of age with

documented assessment of menstruation in the last year'.

Trust Response/Key actions:

The Pharmacological Therapies Committee agreed that the action point for this audit would address the low levels of blood tests undertaken to check for side effects:

This would be addressed through a piece of work reviewing depot clinics to identify areas of good practice in terms of side effect assessments and management and disseminate details of this good practice.

It was also agreed this would be considered by the Physical Health Committee going forward and was subsequently confirmed that it is in their work plan and forms part of their strategy.

- There is a current QI project that is looking at addressing issues with consistent physical health monitoring. One of the investigation points for this QI project is around the use of blood tests in physical health monitoring.

NACEL (June 2019)

In September 2018 we participated in the 2018/19 National Audit for Care at End of Life, the report for which was received in June 2019. This audit had three components; an Organisational Level Audit, a Case Note Review and a Quality Survey, however, mental health trusts were only expected to participate in the organisational audit. The main basis for this decision was due to relatively small number of deaths occurring in inpatient units, which would mean the sample would be too small to enable effective benchmarking, and could create a potential risk that patients sampled would be easily identifiable.

Participation in the Organisational Level Audit gave us opportunity to review our governance and training arrangements around end of life care and the specialist palliative care available to patients within our Trust, compared to other Trusts.

This audit found that the majority of Mental Health Trusts, including BSMHFT, have reported the presence of, and good compliance with, appropriate policies relating to End of Life Care. We also offer a range of support measures to bereaved friends, families and carers, including comfort care packs, which are not currently offered by the majority of mental health Trusts. However, it was noted that there is a generalised lack of available training relating to End of Life Care in BSMHFT and most Mental Health Trusts.

Since this time we have taken forward extensive work to improve end of life care arrangements in accordance with best practice. For example, an End of Life Strategy Group has been assembled to look at how we care for patients on their End of life Care pathway. This group has met several times throughout 2019/2020 and it is felt to be a positive step at improving culture within the Trust.

In response to the lack of induction or mandatory training around end of life care, our Clinical Effectiveness Committee discussed the future possibility of having an acute care group that is

readily available to provide training and support to staff who will directly be involved in end of life care for a patient, when this need arises. It was raised that we have specialist psychologists within our Trust who are based in palliative care settings who would be logical candidates to assist with training. The topic of having a clear person or team across the trust whom staff can go to for training, awareness and support, in a similar way to the current approach to tissue viability was agreed and is now under consideration by the End of Life Care Group.

Following the publication of a new piece of NICE guidance at the end of 2019, it was agreed that the End of Life Strategy Group would be an appropriate governance home for the 4 guidelines relating to end of life care applicable to our Trust. This is a new approach to reviewing NICE guidelines, so regular feedback will be sought from the strategy group about how they are incorporating these guidelines into their strategy. It is thought this change will help improve our practice around end of life care and increase our performance in the next iteration of the audit.

At the point of discussing the audit results, it was noted that a 'Death Café' had been trailed in 2019 and may be useful to continue as another way of improving compliance with the next iteration of this audit. These cafés were designed to be a relaxed and supportive environment for staff to ask questions about death and general feedback for the sessions was really positive. Subsequently, it has been confirmed that the Death Café will continue running throughout 2020 at various locations across the Trust.

NCAP EIP spotlight

In October 2018 our Early Intervention Service (EI) participated in the 2018/19 National Clinical Audit of Psychosis Spotlight audit. This spotlight audit focused on 3 main domains of timely access, effective treatment and the recording of outcome measures. It and also collected data relating to physical health for the CQUIN Indicator 3a Cardio metabolic assessment and treatment for patients with psychoses.

We submitted data for 65 patients who were between the ages of 14-65. These patients were, experiencing first episode psychosis (FEP) and had been on the case load of an EI team for 6 months or more at the census date (01/02/2018) and were still on the caseload in September 2018. The report for this audit was received in June 2019.

NCAP provided overall scores for each domain depending on how each Trust performed against the goals set by NCAD. We were considered "Top performing" in the Timely Access domain as 65% of our patients with suspected FEP commenced treatment within 2 weeks because we exceed the NCAP target of 53%. We were also considered "Top performing" for the majority of the Effective Care domain as we were able to evidence that patients had access to a sufficient range of interventions such as cognitive behavioural therapy (CBT) and family interventions. One particularly good result was that 100% of patients with carers had carers who were offered carer focused education and support programmes.

The main measurement of the 'Outcome Measures' domain was how many patients had at least two outcome measures recorded at least twice. We were scored as 'Greatest Need For Improvement' for this domain as we scored 0% compared to the target of 75%. We also scored

"Greatest Need For Improvement" for the CQUIN physical health monitoring standards, which measured the percentage of people with FEP who have been on the caseload for 6 months or more, who had received a full physical health assessment and any relevant interventions in the last year, as we scored 58% compared to the target of 80%.

In response to these results, it was quickly clarified that in the lead up to this audit the EI team were routinely using the Recovery Star outcome measure. This was not recognised as an appropriate outcome measure by NCAP, which is why we scored 0%. Since this audit the EI team have changed practice and are now routinely using the DIALOG outcome measure which is recognized by NCAP.

This report also highlighted an issue with physical health monitoring and interventions. It is recognised that poor physical health monitoring requires improvement in our Trust and there are currently multiple pieces of work already in process on going to address this theme. It was agreed these results would be passed to the Physical Health Committee who will be able to consider them in line with the physical health strategy and any Quality Improvement projects that are hoping to address gaps in physical health monitoring.

POMH 7f Lithium

In March 2019 we took part in the 6th iteration of this POMH audit which focused on the physical health monitoring of patients recently initiated on lithium treatment (i.e. on lithium for less than a year) versus those who have been on maintenance lithium treatment (i.e. on lithium for more than a year). We submitted data for 109 patients, which included patients from our Forensic inpatients, Forensic community, acute inpatient, PICUs, CMHTs, HTT and AOT services.

The audit found that the monitoring of weight/BMI for both patients initiating lithium treatment and on maintenance lithium treatment had increased from our results in the 2016 audit and was equal to or better than the national average results. We had also increased our monitoring of serum calcium levels for patients on maintenance lithium treatment from 2016, however, it was still below the national average results for 2019.

One area of concern highlighted by this audit was that our completion of Thyroid Function Tests has decreased from our 2016 audit result for both initiation treatment and maintenance treatment and is below the national average result. Our monitoring of serum lithium levels every 6 months during maintenance treatment had also dropped since the last audit.

In response to these results it was agreed that the findings would be taken to the Physical Health Committee to inform the Physical Health Strategy going forward.

During discussions in our Clinical Effectiveness Committee it was acknowledged that patients stabilised on maintenance lithium treatment had the prescribing responsibility handed over to GPs, who should then do the physical health monitoring. It was felt this may largely explain why our results for physical health monitoring in maintenance treatment are generally lower than results for initiation of lithium treatment. In light of this, a conversation was held between Clinical Governance and Information Governance to establish if information held on Your Care Connected

(YCC) (the shared clinical records that GPs and BSMHFT can access) can be considered as part of future national audits. This established that, depending on the wording of the question, we will be able to use data on YCC to account for instances where our clinicians have considered the results from physical health monitoring completed by GPs. This should make future audit results more reflective of practice and enable us to account for more instances of good practice.

Our Pharmacological Therapies Committee noted that other national audits and local anecdotal information had identified that clinicians are hesitant to prescribe lithium as an augmentation treatment. It was agreed that a piece of work will be completed to remind clinicians of the usefulness of lithium and promote its use where appropriate. This should ultimately result in more effective patient care.

POMH 19a Depression

In June 2019 we took part in this baseline POMH audit which investigated the care we provide for patients who have depression and are under the care of short-term CMHTs or longer-term CMHTs. The audit aimed to investigate if patients on the caseload were appropriately under mental health services and if patients have received care for depression in line with best practice guidelines.

We submitted data for 140 service users (SU) who were aged 18 and over. The sample was split into two sub-samples by POMH sample A – SU who had been discharged with a diagnosis of depression within the last 6 months having had an episode of care with short-term CMHTS (i.e. CMHTs and HTTS) not lasting longer than 6 months. S, and sample B – SU who had a current diagnosis of depression and remain under the care of a long-term adult CMHT.

This audit found that 68% of service users referred to our CMHTs with a diagnosis of depression would meet NICE guidelines for secondary care input. Others were lacking the complexity that warrants specialist treatment.

Only 17% of service users under longer term care of CMHTs had potential triggers or stressors for their illness identified in their care/crisis plan and appropriate strategies to manage those triggers documented, this is compared to 66% of the total national sample.

The audit found that when a service user was not showing sufficient response to treatment we did not consistently document evidence of considering switching to another antidepressant or augmenting treatment with lithium.

We also only documented a comprehensive treatment history for 13% of our patients under the care of a longer-term CMHT compared to 48% nationally.

Another area for improvement was around the content of reviews. When reviews had been completed within the last year they were found to have consistently recorded less information than the national average in the following fields: Therapeutic response to medication, adherence to medication, medication side effects, the role of alcohol use and/or use of other substances in precipitating/maintaining depression.

However, we had more instances of recording symptoms and severity of depression and the role of co-morbid mental illness in precipitating/maintaining depression than other Trusts.

A key point of discussion has been around how to address the issue of inappropriate CMHT referrals being received. We are working closely with primary care services to gain an understanding about why they are making referrals and which referrals are appropriate. However, it was also identified that we need to raise awareness in our liaison psychiatry, liaison and diversion, street triage and home treatment teams about which cases would meet the criteria for a CMHT referral.

These results also have shown showed that a very small proportion of SU had a comprehensive treatment history documented. It was noted that the majority of assessments are now undertaken by nursing staff, who may not have had specific training that emphasises the need to take a detailed history of previous treatments including dose, response and side effects. Therefore, it is felt that a key action to address with this audit result is to raise awareness with nursing staff who undertake assessments.

As the results identified that care and crisis plans did not always include details of triggers for relapse, or strategies to address these triggers and relapse factors, it was agreed these findings should be shared with the CPA Team as part of an ongoing piece of work to improve the processes of care planning and crisis planning.

Similarly care support plans are also being reviewed, so it has been suggested that we investigate adding automated prompts to the care records system that will remind clinicians to record responses to treatment, adherence to treatments and side effects when completing annual reviews.

A further piece of work is currently being undertaken done to explore the routine use of outcome measures to help provide assurance that the content of annual reviews are sufficient to effectively monitor patient response to treatment.

NCAAD Psychological therapies spotlight -(Report released Feb 2020

This publication presented the findings of the National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies spotlight Audit, which specifically looked at the delivery of psychological therapies in secondary care adult mental health services following on from the core NCAAD audit. • BSMHFT performed well for standard 1 which looked at our recording of data relating to equity of access. Results for all sub-standards in this standard measured were better than the national average, with us performing particularly well for recording accommodation status, employment status and sexual orientation. We submitted a sample of 201 cases as part of this audit.

- This audit found 76% of our patients are receiving psychological therapies in line with NICE guidance, compared to 65% nationally.
- We performed better than the national average for use of outcome measures. 80% of our

patients had an outcome measure recorded at least once, with 69% having evidence of outcome measures being used more than once. This compares to the national average of 50% used once and 34% used more than once.

- 91% of therapists agreed that the continuing professional development support they receive is sufficient for the requirements of their professional body, compared to only 67% of therapists nationally.

- An area of poor performance in this audit was around length of time to access services. 32% of our patients started therapy within the recommended 18 weeks, compared to 59% nationally. Art Therapy appeared to be a positive outlier as 80% of their patients started treatment within 18 weeks.

National Confidential inquiry (NCI) into suicide and homicide

The National Confidential Inquiry Annual Report into Suicide and Homicide was published in October 2019. Benchmark levels are per 100,000 population. The rates vary from geographic population ranging nationally from 7.2 in Bedfordshire to 13.4 in Cornwall and the Isles of Scilly. Our benchmarked rate is 8.4 per 100,000 population. The NCI have published a number of common findings associated with death by suicide and homicide. We have considered our local position against these findings and have developed a new Suicide Prevention Strategy for our Trust which we have now implemented. Key quality goals for 2020-2021 have also been developed in response to findings including the need for improvements in individualised care planning and the development of enhanced mental health crisis offers. With regard to inpatient suicides, the most common method was by ligature and in 2019-20 we will complete the roll out of ligature door alarm systems in one of our acute female inpatient wards and establish our future roll out plan to all acute inpatient wards and PICUs.

2.7	The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.	The reports of 46 local clinical audits were reviewed by the provider in 2019/2020 and Birmingham and Solihull Mental Health NHS 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.	
PICU Prison Assessment re-	This audit looked at our compliance with the BSMHFT PICU Prison Assessment guideline. The audit demonstrated a need for the guideline to be refreshed to reflect training needs and staffing roles and responsibilities. This is now being refreshed and will be ratified in 2020.	

audit	
Therapeutic Observations re-audit	This audit is designed to indicate staff understanding of observation levels, our communication with patients about the observation process and how clear and consistent our documentation of observation levels is. This is the first time this audit has been completed following the roll-out of the therapeutic observations app as part of digital wards. For this reason the methodology has changed slightly compared to previous iterations to allow for us to capture information around areas of concern with using the observation app. A sample of 61 cases were used in this audit. *RESULTS* Of our sample, 100% of patients visible on the Therapeutic Observations App had a completed Observation Prescription within RiO. 100% of patients had their observation levels recorded upon admission. All but one patient had the free text purpose for observations recorded, the patient who had this information missing was in seclusion. All patients had the reason for observations recorded on the app. Of the 61 records audited, 38 utilised the 'Service User View' field to capture the service user's thoughts on their observation levels at the point of admission.
Adult safeguarding	This audit was designed to monitor practice against the Adult Safeguarding Policy by identifying how BSMHFT's clinical staff members have identified and responded to adult safeguarding concerns. The audit found that BSMHFT staff are able to recognise indicators for multiple types of abuse. There was evidence to show that doctors and nurses were talking to their patients' "significant others" where safeguarding concerns had been highlighted, which appears to be a positive step to following the "Think Family" approach. However, the results did indicate that we were not consistently following the guidance to 'Make Safeguarding Personal'. The Trust Safeguarding team have agreed on multiple actions to improve compliance with the next iteration with this audit: - Continue to promote the advice line – via distribution of the Team Charter leaflet and through training so staff can be supported when they need it. - Continue to promote the concept of 'Make Safeguarding Personal' through training, advice line and booklets. - Use methods of mandatory training, advice line and practice guides to reiterate the importance of recording indicators and other key information in care records as per the 'Think Family' approach.

Annual Adherence to Mental Health Act Consent to Treatment Paperwork within BSMHFT	This annual audit looks at the extent and nature of adherence of Consent To Treatment (CTT) paperwork to the requirements of the Mental Health Act and Care Quality Commission (CQC) guidelines, when prescribing medication. The audit considered prescribing for 346 service users from 52 teams within out trust. A total of 374 CTT forms were audited. 91% of service users had MHA CTT certificate in place to authorise their prescribed treatment of their mental health disorder, representing a sustained improvements in practice from previous year (2018: 92%, 2017: 87%). Across the Trust, 9% of service users had one or more medication prescribed unlawfully at the time of audit. This has improved over the last three years. However, only 69% of issues were reported through the incident reporting system as per guidelines, which is a substantial decline from 2018 (82%). In response to these findings, the following recommendations were made to improve compliance: - Repeat the audit on those wards with the most significant non-compliance (around seven wards) and report back in April 2019 - Think through a QI project to address ongoing issues following completion of the April re-audit - Pharmacy to lead on an 'It takes three' video in early 2020 to help raise awareness of the correct process to follow to ensure prescribing is in line with Consent to Treatment paperwork. This should also promote the role of nursing staff in ensuring medication is only administered in line with CTT.
Inpatient controlled drugs	In 2019 the ninth and tenth iterations of this audit were carried out in line with recommendations from the Duthie Report and RPSGB/DH report on 'Safe and Secure Handling of Medicines: A Team Approach'. The most recent audit measured compliance with controlled drugs standards on 46 of our 51 inpatient wards. Across the 46 wards, there was 88% compliance which is slightly higher than the results for the 3 previous iterations of the audit. In the most recent audit (November 2019) one ward achieved 100% compliance in the tenth iteration. For each ward that achieved below 90% compliance, action plans have been agreed with the senior ward manager and are being followed up by pharmacy staff with oversight from senior pharmacy staff. The main issue with compliance was around maintaining accurate records in the controlled drugs order book according to guidelines.

	The Pharmacy team have agreed to reissue advice and highlight these issues in discussions with ward staff. Pharmacy staff, working with senior nurse managers on each ward are endeavouring to improve standards overall.
Inpatient safe and secure handling	In 2019 two iterations of this re-audit were completed to assess compliance with standards around storage and handling of medication as described in the BSMHFT Medicines Code. In the most recent iteration (November 2019) 49 wards were audited. Overall the most recent audit showed 93.5% compliance with the guidelines around safe and secure handling of medicines in inpatient settings. This is slightly higher than the previous 3 audits. The main areas of non-compliance in the most recent iteration of the audit include documenting checks of deliveries, having medication cupboards that are compliant with guidelines, recording temperatures of rooms storing medication, calibration of temperature devices and application of appropriate expiry dates. Pharmacy and Estates continue to work together to develop a suitable and cost effective solution to improve in the temperature control of general ward medicine stocks. During 2019-20 we implemented an automated alarm system that triggers when fridge temperatures go 'out of safe range' levels. All wards have been left an action plan through which they can improve compliance with standards. These will be followed up by pharmacy staff on a regular basis during early 2020. Ward staff will be reminded that they should continue to make every effort to check that the medicines they receive from pharmacy are checked before they are locked away. This is not only good practice but ensures there is no inappropriate diversion of medicines from the internal supply chain.
Antimicrobial prescribing	Three iterations of this re-audit were completed in 2019. The audit is designed to look at the overall use of antibiotics in comparison to good prescribing practice and antimicrobial prescribing guidelines. The most recent audit reviewed all antimicrobial prescriptions within all inpatient services during the week of 2nd December 2019 (34 prescriptions). After the initial scoping, 18 prescriptions (62%) were entirely consistent with guidance. Following review by Pharmacy of the prescriptions initially felt to be non-compliance, this compliance score was raised to 85%. Overall the results from the most recent audit show a sustained improvement from the previous iteration. Clinical pharmacists will continue to work with medical staff to

	ensure that antimicrobial prescribing is appropriate and the outcomes documented.
Quality Risk Assessment & Care Planning audits	In 2019/20 the CPA team completed audits for the following services: Adult Community Mental Health Teams, Older Adult Inpatient services and Secure Care Inpatient services. This series of audits forms part of an ongoing piece of work to address the inconsistent quality of information recorded on care planning documentation and risk assessments. 139 records were looked at for Adult CMHT services. The results for this part of the audit programme showed a decrease in quality of care plans from the 2017 iteration of the audit. Although compliance is an issue across all community teams this does not appear systemic. In response to this decrease, the CPA team have delivered care planning training to individuals and teams at their team base and plan to remain clearly visible to ensure they are approachable whenever issues with care planning and risk assessments arise. In total 103 records were looked at for Secure care services. Overall there were a few consistent issues that were highlighted across the different sites, these were: limited evidence of personalisation of care plans, care plans including the use of professional jargon and abbreviations rather than accessible language, a lack of evidence that planned interventions and goals had been evaluated/updated in line with service review standards, lack of clear evidence that care plans were being routinely evaluated and a lack of clear evidence that patients had their needs clearly identified and described within care plans. In response to these results, the CPA team will meet with matrons and service managers to discuss the findings and develop specific action plans to address poor compliance. The findings will also be used to help update CRAM training. The CPA team will also raise awareness that it is good practice to update care plans rather than deleting them and starting again. For the older adult inpatient services 20 records were reviewed. This audit found that 100% of the care plans were relevant to the current episode of care. However there were several areas we performed poorly in: review of risk assessments within 7 days of admission, documenting evidence that needs were clearly identified and described, documenting full evidence of service users being involved in the development of their care plan and evidencing that an advance statement had been completed and considered as part of the care plan. The CPA team are currently focusing resources on addressing actions to improve quality care planning in Secure Services. After this piece of work has been completed they will address specific actions for these findings. In the meantime the CPA team will produce and circulate '3 key messages' to improve learning and good practice.

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 Trust between 1st April 2019 to 31st March 2020 that were recruited during that period to participate in research approved by a research ethics committee was 480.

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) A proportion of BSMHFT income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between BSMHFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at https://www.bsmhft.nhs.uk/about-us/trust-documents/statutorystatements-and-declarations/cquins-2017-19/
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.	

The monetary total for income in 2019/20 conditional on achieving quality improvement and innovation goals was £1,900,580.The monetary total for the associated payment in 2018/19 was £4,228,796.

	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 unconditional. BSMHFT has the following conditions on registration – none. The Care Quality Commission has not taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2019 to 31 March 2020.
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.	

	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 not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.
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.	

	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 2019/20 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.	

	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 NHS Digital's Data Security and Protection Toolkit status for 2019/20 was Standards not met; Action plan in place.

	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. 6	Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 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.	

	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. • A range of data quality audits covering all key reporting data sets, with special in-depth audits and corrective work if significant data quality problems are identified. • Maintaining work on completeness and validity of MHSDS submissions in relation to the national Data Quality maturity Index.

27 Learning from deaths

	Prescribed Information	Form of statement
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During April 2019 – March 2020 636 of BSMHFT patients died. This represents patients who died whilst receiving care from the Trust and those who died within six months of discharge from care within the Trust. This comprised of the following deaths during each quarter of that reporting period • 185 in the first quarter • 174 in the second quarter • 176 in the third quarter • 113 in the fourth quarter
27.2	The number of deaths included in item 27.1 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.	By March 23rd 2020 46 case record reviews and 55 investigations have been carried out in relation to 648 deaths included above (item 27.1) In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:- • 24 in the first quarter • 26 in the second quarter • 14 in the third quarter • 37 in the fourth quarter
27.3	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.	6 representing 0.92% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 2 representing 0.30% for the first quarter; 1 representing 0.15% for the second quarter; 1 representing 0.30% for the third

		quarter; 2 representing 0.15% for the fourth quarter. These numbers have been estimated using the serious incident root cause analysis approach and supplemented with a mortality scoring methodology as specified below: • 1 Definitely avoidable • 2 Strong evidence of avoidability • 3 Probably avoidable (more than 50:50) • 4 Possibly avoidable, but not very likely (less than 50:50) • 5 Slight evidence of avoidability • 6 Definitely not avoidable
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.	Given the small sample size it was more pertinent to learn from each of the individual cases rather conducting a thematic approach to the 0.92% identified in figure 27.3. Case 1 - In relation to the first case Issues in relation to escalation when patients do not attend ECG appointments was highlighted as a concern. The lack of discharge to an out of area placement was also highlighted as an issue. The physical health committee reviewed the issues raised with ECG's and non-attendance and a more robust system of informing teams when patients did not attend for ECG was implemented, referrals for ECG are recorded on RIO and teams can see when the patient has not been seen as they remain active on the referrals system until the until the procedure is completed.

		As part of the discharge pathway all patients have a discharge summary sent on to the follow on team (even if it is out of area), this has been integrated into the review of the CPA policy. Case 2 - In relation to the second case issues in relation to attendance at physical health clinics were raised as an issue and the need for a review of the duty system to ensure care coordinators respond to crisis calls from families and carers. Issues with care coordinator allocation were also highlighted. Following on from the second case the lessons learnt were disseminated locally to the team to ensure they developed a more robust process for discussing missed physical health appointments in multi-disciplinary team meetings (MDTs) as well as how duty ensure care coordinators are made aware of crisis calls for their caseload. Using QI methodology there is an ongoing project to review how care coordinator waiting lists are managed as well how care coordinate allocation is implemented within CMHTs. The issues highlighted from the third review highlighted poor monitoring of physical health in relation to a patient prescribed Clozapine and a lack of encouraging the patient to seek advice in relation to obesity and cardio metabolic comorbidities. Case 3 - In relation to the third case the physical health committee reviewed the way in which physical health history is reviewed and documented on the trust patient

		information system (RIO) and a new form developed which is easier to navigate and access for clinical staff. A working group has been developed to improve links with primary care providers to encourage more collaborative working in relation to patient's physical health and wellbeing. The physical health committee also developed a library of training in relation to physical health for clinical staff to access via the learning and development portfolio to promote better awareness for the need for monitoring our patient's physical health. Case 4 - In relation to the fourth case issues in relation to supervision and the need for reflection Following, a serious incident were highlighted for both nursing and medical staff. The lack of clarity in relation to the role of home treatment teams (HTT) for patients was highlighted as an issue. Support in relation to junior/ inexperienced staff conducting visits alone was also an issue in this case. Developments following this case saw additional support and supervision for psychiatrists through medical workforce directorate and the medical appraisal system. Additional supervision and improvement in regular management supervision for nursing staff in HTT. Newly appointed staff in HTT, are to shadow experienced staff during induction period and not care lone visits. HTT leaflets were developed to provide a better understanding for patients, families and carers in

		relation to the role of HTTs. Case 5 - The fifth case related to a lack of engagement with family/carers and a limited 'think around the family approach' to the patients care. Issues with the approach to managing patients awaiting beds whilst under the care of the home treatment team (HTT). The case was linked to a Prevention of future deaths notice (PFD) issued by Birmingham coroner relating to issues with bed availability. In relation to the fifth case the trust has recruited more staff into the HTT has helped staff capacity issues. Better documentation in relation to liaison between bed management and the HTT has now been implemented. Clinical service managers have been working with the HTTs in relation to better engagement with families and carers and a family liaison officer role has been introduced to help support this engagement within the HTTs. The service transformation teams continue to work in relation to bed capacity and demand which aims to introduce a crisis house and an urgent care centre which should impact upon the prioritisation of beds. Case 6 – In relation to the sixth case issues with not gaining NOK details were highlighted showing a lack of think around family approach, issues with a lack of professional curiosity and minimal psychiatric assessment and exploration of depressive symptoms were highlighted. Issues with recorded keeping noted. The trust have developed a family and carer pathway which actively

		encourages all clinicians to document next of kin or significant others details on the electronic patient recording system(RIO), as well as promoting better working with families and carers. The PDU manager and divisional management team arrange and encourage regular staff supervision and team supervision to ensure staff are learning lessons and providing adequate support and training if needed by staff. The trust have revamped clinical risk management training (CRAM) to incorporate lessons from investigations to highlight the need for professional curiosity and accurate record keeping. The trust's CPA team are reviewing the quality of care planning and documentation as part of further improvement in clinical documentation
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).	Following last year's quality account a thematic review of all medical case record reviews using a human factor analysis methodology was conducted. This review highlighted various lessons which needed action to improve care and service delivery; • Limited liaison with primary care • Reduced physical health monitoring in patients prescribed antipsychotics • Limited physical health screening and promotion • Minimal medic oversight • Gaps in documentation • Limited Risk formulation completion The themes were taken to various

		committees within the trust and a variety of work streams were developed to address key themes. A working group are addressing Primary care and liaison with GPs Physical health monitoring has been addressed via the physical health committee and up to date physical health training is now available for front line staff via the trusts learning and development prospectus. The physical health monitoring form used by the trust has been remodelled to make it easier and more accessible for clinical staff, further work on making a physical health 'tab' which will make physical health information more prominent is due later the year. Obesity management within Inpatient settings steering group was developed Prescribing and management of antipsychotic prescribing is under review by the Pharmacological Therapies Committee (PTC) Communication and documentation has been reviewed as part of the CPA policy. The CPA policy has been reviewed and updated and the Clinical risk assessment and management (CRAM) training has been remodelled to include specific lessons learnt from case reviews and serious incident reviews, as well as being facilitated by individuals who have current relevant experience in the clinical field. An audit of care planning and the quality of care planning is also in progress with further development in progress to improve the quality

		of care planning for patients. A further thematic review is scheduled for 2020 to review themes which allow us to highlight 'hot spots' and further develop ways to manage those 'hot spots' as well as further developing the lessons already highlighted in previous reviews
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 areas listed it would be premature to evaluate the outcomes. However the initial impact in relation to physical health reporting has been noted to have improved in relation to the trusts current CQUIN reporting. Feedback in relation to the revised CRAM training model has been very positive, but the impacts of this training will take some time to be evaluated and in relation to its impact upon care and care delivery.
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.	23 case record reviews and 43 investigations completed after March 2018 which related to deaths which took place 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.	4 representing 0.61% 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 [serious incident root cause analysis approach and supplemented with a mortality scoring methodology as specified below: 1 Definitely avoidable 2 Strong evidence of avoidability 3 Probably avoidable (more than 50:50)

		4 Possibly avoidable, but not very likely (less than 50:50) 5 Slight evidence of avoidability 6 Definitely not avoidable
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 27.8.	Three representing 0.48% of the patient deaths during April 2018 - March 2019 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 NHS Outcomes Framework sets out a series of care outcomes services should strive for in relation to clinical quality, patient safety and patient experience. It defines measures related to those outcomes and we report regularly to the Department of Health on our performance against those measures. The Department of Health identified 15 of those measures that should be included in Trust Quality Accounts where relevant. Six are relevant to Birmingham and Solihull Mental Health NHS Foundation Trust services. These are:

- 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 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.

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
2019-20*	95.8% (94.7%)	95.0%	100%	85.9%
2018-19	96.1%	95.7%	100%	82.8%
2017-18	96.1%	96.1%	99.4%	79.9%
2016-17	97.0%	96.6%	99.4%	59.5%

Data Source: Rio - our internal clinical information system

** 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*

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

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
2019-20*	96.3% (96.0%)	97.9%	100%	91.9%
2018-19	97.1%	98.1%	100%	88.5%
2017-18	96.2%	98.6%	100%	93.8%
2016-17	97.3%	98.5%	100%	89.8%

Data Source: Rio - our internal clinical information system
** 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+
2019-20	0.0%	5.8%
2018-19	0.0%	5.8%
2017-18	0.0%	5.6%
2016-17	0.0%	5.0%

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 'Patient experience of community mental health services' indicator score (out of 10) with regard to a patient's experience of contact with a health or social care worker as reported through the 2019 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
2019-20	6.9	Not available	7.7	5.8
2018-19	7.1	6.8	7.7	5.9
2017-18	7.4	7.3	8.1	6.4
2016-17	7.5	7.5	8.1	6.9
2015-16	7.3	7.5	8.2	6.8

Data source: National Community Mental Health Service User Survey 2019

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 a 6 monthly 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
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%
Apr 18 – Sep 18	44	49	114	25	0.4%	1.1%	3.7%	0.09%
Oct 17 – Mar 18	41	45	97	15	0.4%	1.1%	4.38%	0.1%
Apr 17 – Sep 17	35	44	126	16	0.6%	1%	3.7%	0.0%
Oct 16 – Mar 17	36	46	88	11	0.6%	1.1%	4.7%	0.1%
Apr 16 – Sep 16	40	42	89	10	0.5%	1.1%	6.1%	0.3%
Oct 15 – Mar 16	40	38	85	14	0.5%	1.1%	6%	0.1%
Apr 15 – Sep 15	42	39	84	6	0.6%	1%	3.7%	0
Oct 14 – Mar 15	47	31	93	5	0.5%	1.1%	5.1%	0%
Apr 14 – Sep 14	43	33	90	9	0.8%	1.0%	5.9%	0%

	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
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%
Apr 18 – Sep 18	5233	44	22	0.4%
Oct 17 – Mar 18	4788	41	21	0.4%
Apr 17 – Sep 17	4013	35	24	0.6%
Oct 16 – Mar 17	4279	36	26	0.6%

Apr 16 – Sep 16	4681	40	21	0.4%
Oct 15 – Mar 16	4856	40	22	0.5%
Apr 15 – Sep 15	5040	42	29	0.6%
Oct 14 – Mar 15	5550	47	31	0.5%
Apr 14 – Sep 14	5086	43	39	0.8%

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:

- 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 doctors 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 Black Hole, 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 2019/20 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.

3.1.1 Safety

The three indicators selected for patient safety are:

- Serious Incidents
- Never Events
- Incidents of MRSA and Clostridium Difficile

3.1.1.1 Serious Incidents

During 2019/20 much work took place to improve our system for reviewing serious incidents with an added focus on thematic reviews and learning. We developed a centralised team of patient safety managers to lead reviews within our Trust working along clinicians and subject matter experts. We also undertook thematic reviews to understand any commonalities of findings between serious incidents so that we could be confident that we were addressing these through key programmes of improvement. In addition, we worked closely with partners across various agencies which support health and social care in Birmingham and Solihull to establish a process for 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 enabled us to take a system wide view on opportunities to improve how agencies can work together for the benefit of patients.

	2017/18	**2018/29**	**2019/20**
Number of Serious Incidents Reported	100	91	78

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 2019/20.

	2017/18	**2018/29**	**2019/20**
Number of Never Events Reported	0	0	0

3.1.1.3 Clostridium Difficile

C.difficile is a primary drug-resistant infection. Clostridium difficile is a bug that causes diarrhoea of varying severity, most usually after a course of antibiotics. People who are already weak or frail can sometimes become seriously ill as a result of contracting it. We are pleased to confirm that there were no cases of Clostridium Difficile reported in the Trust during 2019/20.

3.1.2 Effectiveness

We identified the following key indicators for monitoring effectiveness. These were identified in the previous report and following review, they were still deemed to be a priority.

- Care Programme Approach (CPA)
- Care Support
- PLACE Assessments

3.1.2.1 Care Programme Approach and Care Support

Our Care Management and CPA/Care Support Policy requires all service users receiving treatment and care from Birmingham and Solihull Mental Health NHS Foundation Trust to be provided with a care plan, developed in partnership with them, which is clear and accessible. The care plan should include an agreed plan of the steps to take in a crisis. Overall during the course of the year we have seen a decline in the audit results associated with good care planning. We have therefore set out a plan for improvement in this area which will start with a thorough diagnostic exercise with frontline staff to understand the barriers to good care planning. This will enable us to develop an improvement plan which removes those barriers. In addition, we will review the infrastructure of our electronic patient record to remove any areas of duplication ensuring that the record is clear, streamlined and easily accessible.

For people on CPA	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Completion of CPA care plan	88.3%	82.4%	83.4%	81%
Completion of level 1 risk screening tool	86.3%	81.9%	81.9%	79%
Completion of Assessment Summary (previously known as the Health and social care assessment)	86.9%	81.5%	80.2%	78.0%
CPA review in the previous 12 months	92%	97%	95.8%	95%
For people on Care Support	**2016/17**	**2017/18**	**2018/19**	
Care Support Care plan	61.3%	63.5%	66.6%	70%
Level 1 Risk Screening Tool	50.5%	52.3%	51.6%	46%

Assessment Summary	67.3%	69.9%	73.3%	73%

There is no national data that we have benchmarked this data with.
There have been no changes in the way the data has been calculated.
Data source is the ICR report on INSIGHT, our internal reporting system, there are no national standard definitions for this data.

3.1.2.2 PLACE Results 2018 (Patient Led Assessments of the Care Environment)

The aim of PLACE assessments is to provide a snapshot (on the day) of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care (cleanliness; the condition, appearance and maintenance of healthcare premises; the extent to which the environment supports the delivery of care with privacy and dignity; and the quality and availability of food and drink). The current PLACE assessment also covers criteria on how well healthcare providers' premises are equipped to meet the needs of caring for patients with dementia (introduced from the 2015 assessments) and how well equipped the premises are to meet the needs of people with disabilities (introduced from the 2016 assessments). It should be noted that these do not represent a comprehensive assessment relating to dementia or disability; rather these focus on limited ranges of aspects with strong environmental or building associated components.

As with the previous PLACE programmes, service user representatives must make up at least 50 per cent of each assessment team and where possible one should be appointed as the PLACE Assessment Team Lead. BSMHFT's PLACE programme again had excellent support from a highly motivated team of service user representatives and from the patient and public involvement team. It should also be noted that best practice suggests that an independent reviewer (who does not form part of the assessment team) is present at the assessments; this is not mandatory but is recommended.

For all of BSMHFT's 21 assessments service user representatives made up at least 50 per cent of the team and 100% of the assessments had an independent reviewer present.

The 2019 assessment demonstrated that BSMHFT's overall organisational scores exceeded the national average scores in all 6 categories.

For cleanliness BSMHFT scored 100% and is one of 20 NHS trusts who have scored 100% and are joint top scoring nationally.

BSMHFT's overall organisational scores are an increase on its 2018 scores for all of the other 5 categories (Food and Hydration, Privacy, Dignity and Wellbeing, Condition, Appearance and Maintenance, Dementia and Disability).

- BSMHFT is joint top scoring nationally of NHS trusts for Cleanliness.
- BSMHFT is in the top scoring 9% of NHS Trusts for Food and Hydration.
- BSMHFT is in the top scoring 4% of NHS Trusts for Privacy, Dignity and Wellbeing.
- BSMHFT is in the top scoring 6% of NHS Trusts for Condition, Appearance and Maintenance.
- BSMHFT is in the top scoring 3% of NHS Trusts for Dementia (Environment).
- BSMHFT is in the top scoring 6% of NHS Trusts for Disability (Environment.

See table overleaf.

BSMHFT's 2019 PLACE Scores											
Cleanliness		**Food & Hydration**		**Privacy, Dignity & Wellbeing**		**Condition, Appearance & Maintenance**		**Dementia (Environment) (introduced 2015)**		**Disability (Environment) (introduced 2016)**	
BSMHFT Overall Score	**National Average Score**	**BSMHFT Overall Score**	**National Average Score**	**BSMHFT Overall Score**	**National Average Score**	**BSMHFT Overall Score**	**National Average Score**	**BSMHFT Overall Score**	**National Average Score**	**BSMHFT Overall Score**	**National Average Score**
100%	98.62%	97.97%	92.51%	97.43%	87.52%	99.96%	96.38%	99.48%	81.20%	95.96%	83.92%
BSMHFT's score is joint top score nationally of all NHS Trusts		**BSMHFT's score is in the top 9% of all NHS Trusts**		**BSMHFT's score is in the top 4% of all NHS Trusts**		**BSMHFT's score is in the top 6% of all NHS Trusts**		**BSMHFT's score is in the top 3% of all NHS Trusts**		**BSMHFT's score is in the top 6% of all NHS Trusts**	

BSMHFT's 2018 PLACE Scores					
100%	96. 21%	96.87%	99.13%	95.58%	95.94%
BSMHFT's 2017 PLACE Scores					
100%	96.06%	94.12%	97.71%	93.64%	89.86%
BSMHFT's 2016 PLACE Scores					
99.60%	96.87%	93.90%	96.69%	84.83%	89.01%
BSMHFT's 2015 PLACE Scores					
100%	96.70%	94.25%	95.62%	94.65%	
BSMHFT's 2014 PLACE Scores					
99.67%	96.09%	91.82%	97.74%		
BSMHFT's 2013 PLACE Scores					
98.77%	92.34%	91.83%	91.43%		

3.1.3 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.

	2016/17	2017/18	2018/19	2019/20
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	57% (69%)	60% (71%)	73% (71%)	68%
Number of complaints	157	164	152	85
Timeliness of complaints	100%	100%	100%	100%
% of dissatisfied complainants	24 returned - 15.28%	11 returned - 6%	7 returned – 4%	18 returned – 15%
Number of referrals to the Ombudsman	5	5	8	2
FFT score	86%	87%	88%	91% (89%)

(National benchmark figure)
There have been no changes in the way the data has been calculated.
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 is important to ensure that the experience of individuals making contact with our complaints process feel listened to and are satisfied with the level of response made by the Trust to their concerns. In 2019/20 whilst we saw overall levels of complaints reduce, we did see the level of dissatisfied complainants increase. We have therefore committed to undertaking a co-produced piece of work alongside complainants to understand how we can improve our processes moving forward. This is referred to in section 2 of this report.

3.2. 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

	NHS Improvement Single Oversight Framework (SOF) updated in November 2017: National Indicators – 2019/20	National Threshold	2019/20
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.	56%	93.8%
3	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	50% 75%	50.4% 94.9%

	ii. within 18 weeks of referral	95%	99.9%
4	Admissions to adult facilities of patients under 16 years old	n/a	0
5	Inappropriate out-of-area placements for adult mental health services (average bed days per month)	n/a	1050

Annex 1: Statements from commissioners and local Healthwatch organisations

1.1 Healthwatch Statement

Dated 29 April 2020

During the Covid-19 pandemic Healthwatch Birmingham, along with partners across the city, has reviewed our services to ensure we are utilising our resources to meet the needs of local populations. Working with our commissioners and by following Healthwatch England guidelines, we have recently made the difficult decision not to respond to our Birmingham Trusts Quality Accounts this year.

We appreciate the amount of work that has gone into producing the annual Quality Accounts and thank you for continuing to send them through to us for comment. We hope you understand that during this difficult time we are unable to provide you with a response. We are a small team and it is vital that we deploy our capacity to hearing the experiences and needs of our local communities during this time. We are working with partners to support services to meet current needs and supporting the recovery of the city following this pandemic.

Thank you for your continued hard work and we look forward working with you in the year ahead.

Kind Regards,

Chipiliro Kalebe-Nyamongo PhD
Research and Policy Manager/ Data Protection Officer
healthwatch Birmingham

We can make a difference
but we can't without your feedback
Please visit our Feedback Centre and share your views

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

Throughout 2019/20, we (the Council of Governors) have continued our work as outlined in previous Accounts, providing input and advice to the Trust Board individually and through the Council of Governors meetings.

We recognise the challenging environment in which the Trust has found itself this year. We have again seen increased demand on services which at times has impacted on our ability to ensure that patients are always able to access the care that they need at the point of clinical decision making. In response to this, we are pleased and supportive of the investment that the Trust made into our Home Treatment Teams during the year including more doctors, nurses and psychologists. We have been engaged in the development of the Birmingham and Solihull Crisis Care Offer and are fully supportive of the impending development of a new urgent care centre at our Oleaster Site which will provide purpose built facilities for patients in need of urgent assessment and care, including a place of safety.

A number of Governors have worked as part of the Family and Carer Pathway Group to contribute thoughts and ideas to ways in which we can improve the experience of the families and carers of our service users. This has included Governors supporting the establishment of a lead Carer role at the Tamarind Centre and the roll out of a carers engagement tool across the Trust. During the year we have continued to support recovery focussed care and have been active participants in our Recovery College. In the Summer of 2019 we also played a strong part in the development and launch of our new Family and Carer Strategy demonstrating our full commitment to supporting the empowerment of families and carers. We are pleased to see the developments achieved in relation to this agenda within section 2 of this report.

During 2019, the Council of Governors received a report from the Institute of Healthcare Improvement, our Quality Improvement (QI) Partners. We were very pleased to see the progress that has been made during the last year to develop skill and competency in quality improvement in the Trust and are excited about the training of experts by experience in QI that will take place in 2020-21. This is another example of how we can support true coproduction in the improvement of our services.

During the year, the Governors also played a critical part in contributing to the Quality Strategy for the Trust for the period 2020-2025. Governors helped to develop the key aims of this strategy and the underpinning goals. We are pleased to see that this report details the first year of our journey of implementing this strategy within section 2.

We commend the improved performance for prone restraint during 2019-20. This is a significant achievement which has exceeded the target that we set ourselves for the year. Our thanks go to frontline clinicians, our Positive and Proactive Care Panel and our Quality Improvement/Clinical Governance Teams for all of their hard work in this regard.

We note that we regrettably did not achieve a reduction in physical assaults in the Trust. We are hopeful that by using our new Quality Improvement approach in 2020-2021 we will start to see the number of physical assaults reducing, particularly as we will be fully engaging experts by experience in this work. We support the increase in therapeutic activities on our acute inpatient wards and see this as one way in which we can keep our service users engaged in their recovery.

During the year we received the Staff Survey and discussed the findings. We are pleased to see the quality priority relating to a positive safety culture in the Trust and the goals which will help us recognise and learn from excellent practice as well as from incidents. We are also very pleased to see the level of support that is being developed in 2020-21 to support the emotional wellbeing of our staff, particularly following traumatic events.

On the matter of traumatic events, the Council of Governors extends it condolences to all families and carers of service users who died from suicide during 2019-20. We are disappointed to see that despite the work that has taken place to improve crisis care and improve our physical estate, suicide levels did increase. Governors have reviewed our new Suicide Prevention Strategy which will be launched in 2020-2021 and are active members of our suicide prevention task and finish group which is working hard to make our strategy a reality.

Governors were disappointed with the increase of incidents of falls this year but recognise the increased acuity and complexity of the service users presenting in our Dementia and Frailty services. We are however very pleased to see that the number of falls resulting in serious harm to patients has significantly reduced. On the broader aspect of physical health, we can see overall improvements in the recording of cardio metabolic and cardio vascular indicators however we note that these are not to the level we need them to be. We can see from our learning from deaths (part 25 of section 2) that physical health is a theme arising from Mortality Case Note Reviews and Governors would like to understand more about the work that we are doing in 2020-2021 to address these issues.

During the year, Governors have recruited to a range of posts including a new Non-Executive Director who sits on the Integrated Quality Committee of the Trust. We were delighted to present a number of awards to staff at our Quality Excellence Awards Ceremony in 2019 and to take part in the shortlisting for such awards. We have seen some excellent examples of innovation and improvement.

In concluding this statement, the Council of Governors would like to take the opportunity of thanking the Trust for their proactive approach to seeking the views of Council throughout the course of 2019/20 and the opportunities that this has brought about for service improvement, enhanced safety and quality of care. We look forward to making even more progress in 2020-2021.

Faheem Uddin, Lead Governor on behalf of the Council of Governors of BSMHFT
January 2021

1.3 Birmingham and Solihull Clinical Commissioning Group Statement

1.1 NHS Birmingham and Solihull Clinical Commissioning Group, as co-ordinating commissioner for Birmingham and Solihull Mental Health NHS Foundation Trust welcomes the opportunity to provide this statement for inclusion in the Trust's 2019/20 Quality Account.

1.2 A draft copy of the Quality Account was received by the CCG on 15th January 2021 and the review has been undertaken in accordance with the Department of Health and Social Care guidance. This statement of assurance has been developed from the information provided to date.

1.3 We acknowledge the significant challenges the Covid19 pandemic presented at the latter end of 2019/20 and the part the Trust has played in the mental health system response to these challenges.

1.4 As we move toward the formation of an Integrated Care System in Birmingham and Solihull, we thank the Trust for its openness in working with the CCG to explore new collaborative and partnership based approaches to quality assurance and quality improvement going forward.

1.5 It is good to see the actions taken to train and develop staff knowledge and competency in quality improvement approaches. Training over 295 Trust staff in quality improvement methodology is a positive and commendable step.

1.6 We note the areas of progress made against the Trust's three year quality strategy for 2017-2020. Not all quality targets have been met however we note the development of the Trust's new Quality Strategy for 2020-2025 with its associated range of quality improvement programmes.

1.7 The report contains a firm commitment to ensuring that the Trust's physical estate is maintained as safely as possible. This is particularly important in inpatient wards where patients who are at high risk of harm due to their mental illness are cared for, and where environmental risks must be mitigated as effectively as possible.

1.8 We acknowledge and fully support the Trust's recognition that systems for ensuring care planning, care documentation and risk management are as robust and effective as possible. This needs to be a key quality priority.

1.9 We note the importance of ensuring that a focus on the reduction of suicide risk in the community services is maintained; this work will be integral to delivery of a local suicide prevention strategy and will require a system wide and collective effort, supported by the development of local multi agency learning review processes for all suicides, alongside systems for real time surveillance.

1.10 We welcome the recognition that attention to physical health needs, particularly of persons with severe mental illness, is a continuing area of focus for the Trust moving forward. This is an area where we will need to work more effectively as a local health system.

1.11 We are pleased to see in the report the commitment to develop meaningful and focused actions to begin to address health inequalities and the Trust's commitment to championing equality, diversity and inclusion.

1.12 It is positive to see that the Trust has participated in the full range of national clinical audits and national confidential enquiries it was eligible to participate in, and that actions, learning and further work were identified as a result of these programmes.

1.13 The CCG is pleased to note the ongoing work of the Learning from Deaths Group and the Trust's openness to maintaining CCG representation at this group. We support this work in order to aim at providing the safest services possible.

1.14 We recognise the progress the Trust has made progress in the formation of a patient safety team for investigations of serious incidents. The CCG remains committed to working with the Trust to maintain improvement in this area, and we thank the Trust for its engagement in the CCG incident review panels. This joint work has allowed us to identify some key areas for focussed quality reviews.

1.15 As Commissioners we look forward to working collaboratively with the Trust and to further building on existing relationships and new ways of working as we move forward into an ICS.

Paul Jennings
Chief Executive Officer
Birmingham and Solihull
CCG

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 2019/20 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:*

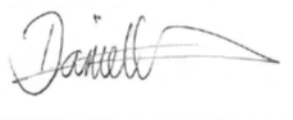
    - *Board minutes and papers for the period April 2019 to March 2020*
    - *Papers relating to quality reported to the Board over the period April 2019 to March 2020*
    - *Feedback from commissioners dated January 2021*
    - *Feedback from Governors dated January 2021*
    - *Feedback from local Healthwatch organisations dated 29 April 2020*
    - *The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 (please note that due to Covid 19 this report is not scheduled for publication until February 2021, however assurance can be given that complaints information has been shared throughout governance structures on a quarterly basis throughout the reporting period)*
    - *The 2019 national patient survey*
    - *The 2019 national staff survey*
    - *The Head of Internal Audit's annual opinion of the Trust's control environment dated May 2020*
    - *CQC inspection report dated 1 April 2019*

- *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

Danielle Oum
Trust Chair