NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Birmingham and Solihull Mental Health NHS Foundation Trust

Quality Account Report 2021/2022

compassionate inclusive committed

Contents

Quality Account Report

Part 1 – Statement on Quality from our Chief Executive

Background

Part 2 – Priorities for Improvement and Statement of Assurance from our Board

2.1 Priorities for Quality Improvement for 2022/23
2.1.2 Progress Made against Priorities for Quality Improvement in 2021/22
2.1.3 Measuring and Reporting Progress

2.2 Statements of Assurance from the Board

2.3 Reporting Against Core Indicators

Part 3 – Other information

Annexe 1 – Statements from Partners

Annexe 2 – Statement of Directors' Responsibilities for the Quality Report

Quality Report

Part One

Statement on Quality from the Chief Executive

I am delighted to present our Quality Account for 2021/22.

I want to begin by stating how immensely proud I am of all my colleagues who have continued to demonstrate their extraordinary resilience, compassion and flexibility to providing high quality care throughout such a hugely challenging time in their work and home lives. A time when we are deeply saddened to have lost patients/ service users, colleagues, loved ones and friends.

This Quality Account recognises the incredible work that has been delivered as well as setting out our commitment to continually improving the safety and quality of our services for our patients/ service users, their carers, their families and our community.

The impact of the pandemic has exposed the fragility of our society and we all know that this has had an uneven impact upon our own local communities and staff. Looking ahead it raises the question of how we ensure that a new geography of disadvantage does not emerge in the areas and communities served by our Trust as services are restored to pre pandemic levels and we respond appropriately to the challenges posed by different facets of vulnerability and inequality.

However, despite the challenges over the last year we have continued to drive change to address our unwavering priority to improve the mental health wellbeing for our populations and our colleagues. We are leading the way and encouraging collaborative working across systems building stronger alignment to improve care pathways and enhance socio economic strategies across Birmingham and Solihull to address the wider determinants of ill health. In doing this we are taking every opportunity to engage with our communities, to listen to them and work with them in more meaningful and different ways.

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

We continue to drive continuous improvement. Our quality improvement framework outlines our commitment to learning, including from families and from the best nationally and globally, to continually improve patients/ service users'

outcomes. Despite the challenges we have faced we have seen progress to support our quality aims of:

· Improving patient safety by reducing harm

· Focussing on a positive patient experience

· Focusing on a positive patient culture

· Focussing on Quality Assurance

· Using our time more effectively.

Part of our Quality Improvement Programme involved a Reducing Restrictive Practices QI collaborative. This multi-disciplinary approach targeted inpatient services across our Trust and was supported by experts by experience. We have shown clear results in reducing rates of prone restraint (and restraint in general) and there has been a reduction in bedroom seclusion.

We have also seen reductions in other measures such as the use of rapid tranquilisation, where medication is used to reduce violent behaviour. However, we have not seen a significant reduction in the number of assaults reported and this continues to form one of our quality priorities into 2022-23.

Sadly, during the year 17 of our community service users died by suicide. This was tragic for the patients, their families and carers, our staff and fellow service users on the wards. I would like to take this opportunity to extend our sincere condolences to all who were affected by these most serious of incidents. Later in this report I speak about the learning that has arisen from these sad deaths and our ongoing commitment to preventing suicides in the communities that we serve, and in our inpatient wards.

We are continuing to drive improvements across all services and taking every opportunity available to embed a culture where we learn lessons from our practices and behaviours. Collectively working with all partners that use and work in our services we are identifying opportunities where we can improve our systems and processes. We are already seeing results with improved care. e.g., Throughout 2021-2022, we have seen the harm rate of patient safety incidents reported remaining low with the % of incidents resulting in harm remaining below the mean value and compared to other benchmarked mental health trusts.

Our aim is to embed a learning lessons approach as we introduce the new Patient Safety Incident Response Framework.

As I close this introduction, I reiterate my thanks and that of my fellow Board members, to our compassionate and committed staff, our service users, families

and carers, our stakeholders, our partners in the Integrated Care System and our Council of Governors and look forward to continuing to tackle our challenges, build on our successes and make progress in 2022/23.

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

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 (2022/23), what our priorities are, and how we intend to address them.
- How we performed last year (2021/22), 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 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.

One vision

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

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

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

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

Our ambition
Delivering the highest quality services in a safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve.
Our aims • A focus on a positive service user experience • A focus on preventing harm • A focus on a positive safety culture • A focus on quality assurance • A focus on using our time more effectively

Part 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 2022/23

- Progress made since publication of our 2020/21 quality report including performance against each of the 2021/22 quality priorities
- The monitoring, reporting and measurement approach to progressing achievement of our priorities
- A series of statements of assurance from the Board of Directors including:

- Participation in National and Local Clinical Audit Programmes
- Research
- Commissioning for Quality and Innovation 2022/22
- Registration with the Care Quality Commission
- Improving Data Quality
- Learning from Deaths
- Reporting against Core Indicators

2.1 Priorities for improvement during 2021/22

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 2022/23. 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 with our workforce and our service users and Experts by Experience to ensure that these goals will support the delivery of our Quality Strategic Priority which reflects the local needs of our service users and staff as well as national needs.

Our overall priorities remain the same for 2022-23 in reflection of our multi-year journey to embed positive practice across these themes. The specific actions that support each of these have changed since last year, with some actions dropping to business as usual approaches where we have demonstrated success and others have remained with some slight adjustment to reflect the progressive journey we are taking.

Priority for Improvement 1: Improve Patient Safety by Reducing Harm

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

During 2022/23 we will:

Preventing Harm	
Improve the safety of our acute inpatient wards by installing ligature alarm systems on the ensuite doors and bedrooms doors of our highest risk acute inpatient wards	Measure of success: - Reduced level of ligature incidents utilising an anchor point which result in moderate, severe or catastrophic harm to patients
To improve the physical health monitoring of patients in our care	Measures of Success: - To ensure that all inpatients have the physical health assessment and systemic enquiry checks completed within 24 hours of admission

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

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

During 2022/23 we will:

Improving Patient Experience	
Improve the involvement of service users in MDT meetings and ensure that all service users have a copy of their care plan	Measures of success: - % of service users in receipt of their care plan

	Qualitative measure to be established through EBE group and reporting commenced
Improve the involvement of carers in service user care and recovery	Measures of success: - % of carer details on RIO
Pilot the role of Patient Safety Partner in patient safety and patient experience aspects of governance meetings to ensure that service users have equal voice around the table	Measures of success: Number of patient safety partner roles established Feedback from patient safety partners on their experience

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

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

During 2022/23 we will:

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

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

Priority for Improvement 4: A Focus on Quality Assurance

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

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

During 2022/23 we will:

Improving Quality Assurance	
Roll out an internal quality assurance peer review scheme across the Trust involving staff and experts by experience	Measures of success:- Number of peer review visits completed

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

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

By 2025:

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

During 2022/23 we will:

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

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 Quality Patient Experience and Safety Committee at Birmingham and Solihull Mental Health NHS Foundation Trust.

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

Priority for Improvement 1: Improve Patient Safety by Reducing Harm

Our measures of success relating to this priority were defined as:-

- Reduction in incidents of prone restraint
- Reduction in incidents of bedroom seclusion
- Reduction in incidents of assault on our inpatient wards
- Reduced level of ligature incidents utilising an anchor point which result in moderate, severe or catastrophic harm to patients
- Reduced level of harm attributable to patients and staff through incidents
- Ensure relevant blood tests and ECGs are performed prior to initiation of antipsychotic medication in all inpatient settings (to increase this by 100% over a three-year period)
- Ensure relevant blood tests and ECGS are performed for outpatients prior to the initiation of antipsychotic medication and annually thereafter for outpatients prescribed clozapine or depot antipsychotic medication (including Home Treatment Teams), increasing to 100% service users being offered this by the end of three years
- To ensure all episodes of Rapid Tranquilisation (RT) have appropriate physical health recording (as set out in the RT policy) by the end of the first year
- To ensure that all inpatients have the physical health assessment and systemic enquiry checks completed within 24 hours of admission by the end of the first year
- To increase the completion of the alcohol screening tool in our Home Treatment Teams with evidence of appropriate intervention against the March 2021 baseline level

Reducing Restrictive Practices

Part of our Quality Improvement Programme was the inclusion of a Reducing Restrictive Practices QI collaborative. This involved a multi-disciplinary approach to focused quality improvement activity in targeted inpatient services across Birmingham and Solihull Mental Health Foundation Trust including support from experts by experience. The collaborative has met regularly throughout 2021-22 to develop and implement a number of improvement cycles. The activity of the collaborative has shown clear results in reducing rates of prone restraint (and restraint in general) and considering normal variation there has been a reduction in bedroom seclusion also.

Figure 1 - rate of restraint (all types) per 1000 bed days

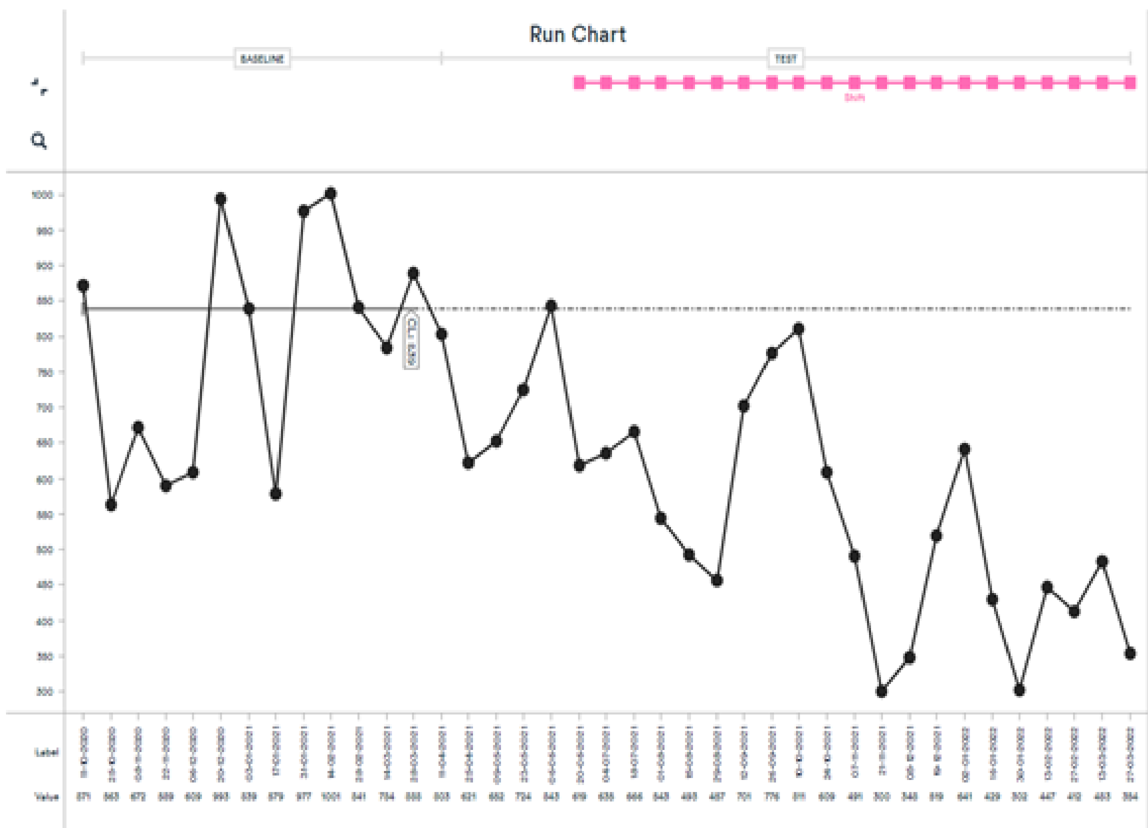


Figure 2 - rate of prone restraint per 1000 bed days

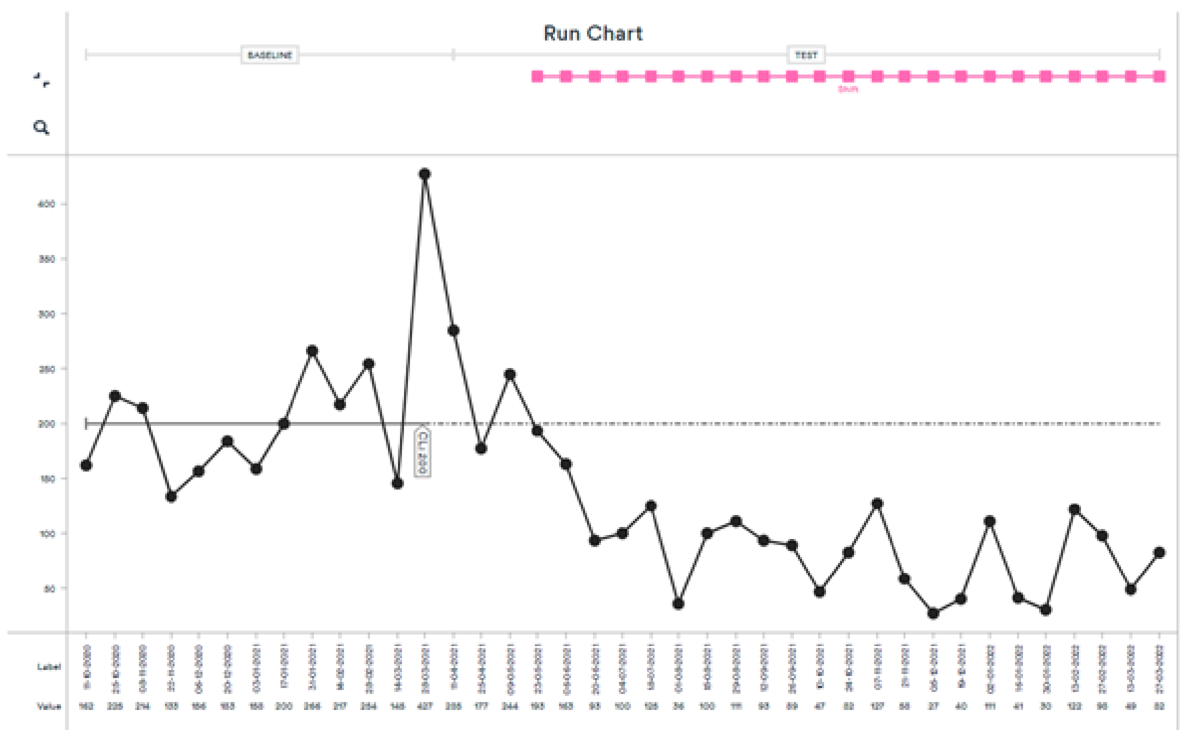
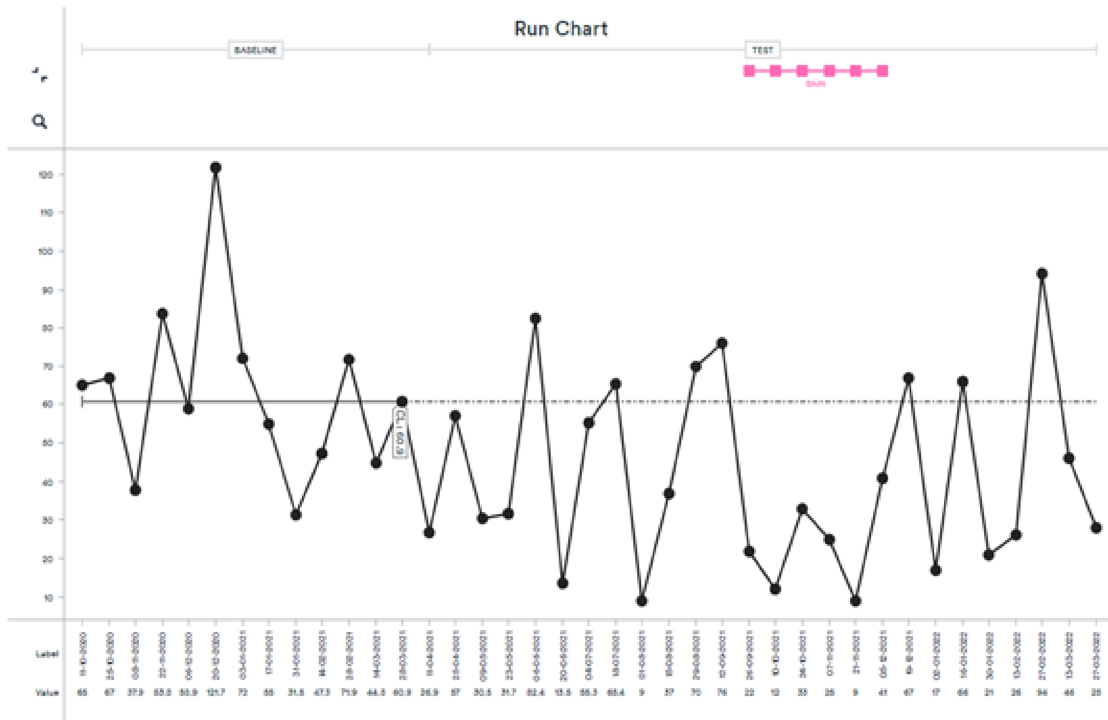
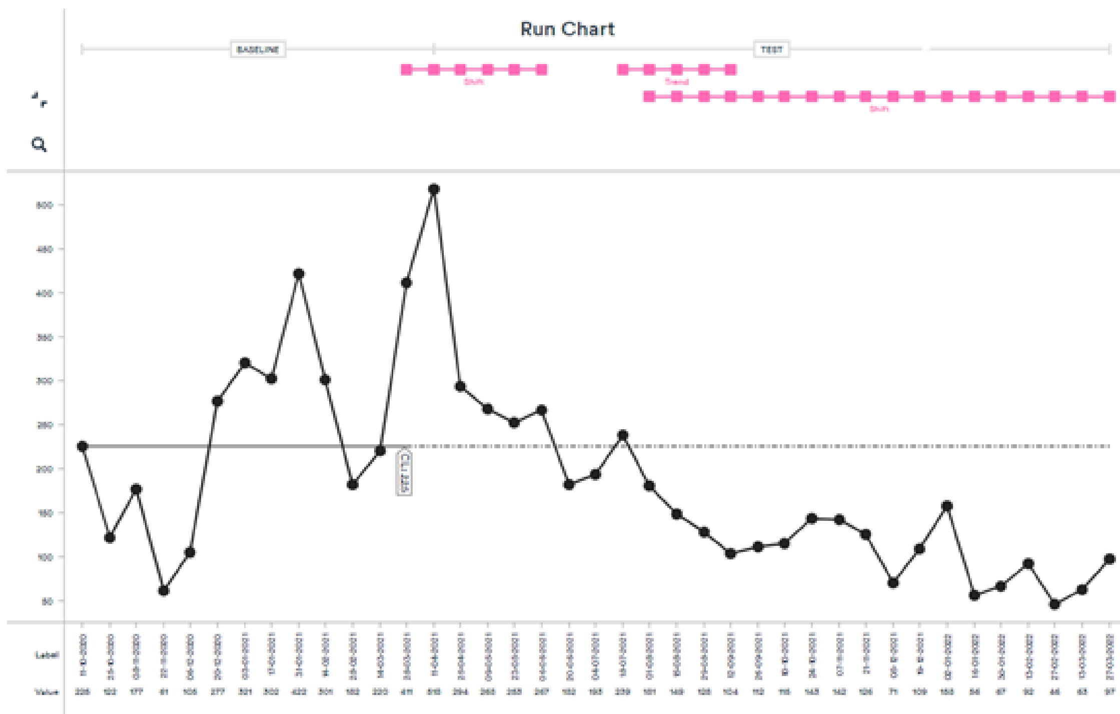


Figure 3 - rate of bedroom seclusion per 1000 bed days



During the work of the collaborative, we have also seen reductions in other measures such as the use of rapid tranquilisation, where medication is used to reduce violent behaviour.

Figure 4 - rate of rapid tranquilisation per 1000 bed days



The collaborative continues its work to ensure that the gains delivered so far in reducing restraint, seclusion and rapid tranquilisation continue to offer benefits to patient care and experience.

During the year 2021-22 we have not seen a significant reduction in the number of assaults reported and this continues to form one of our quality priorities into 2022-23.

Reducing Harm from Anchor Point Ligatures

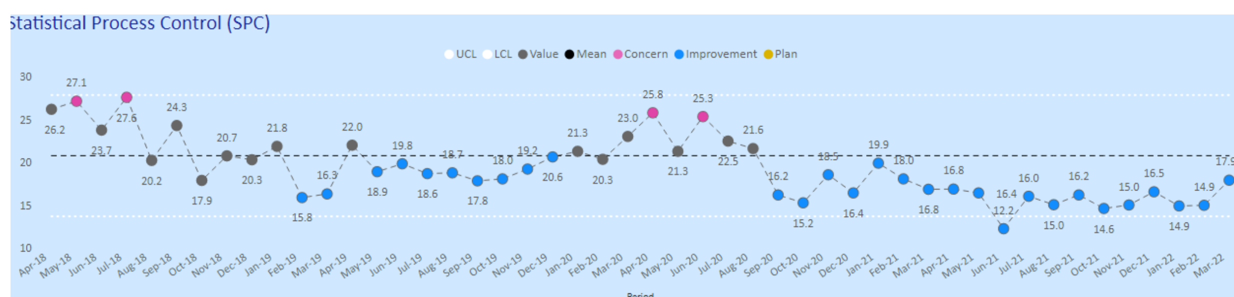
We have focused on a range of activity to reduce the frequency and impact of anchor point ligatures within our inpatient services. Activity has included the strengthening of risk assessment and care planning processes and regular monitoring of this to not only ensure that this is taking place but that service users are engaged with this and understand their care plan.

Alongside these relational measures we have also embarked on a multi-year capital investment programme to improve the safety of our clinical environments. This has included the fitting of en-suite door alarms and anti-barricade systems to reduce the risk of utilising doors as anchor points and increase the response time to emergency situations. The works completed in 2021-22 form part of a 3-5 year programme of works designed to improve the environmental safety of our inpatient settings. This means that this will continue to be a quality priority for us into 2022-23.

Reducing Harm

We have seen the harm rate of patient safety incidents reported remain low throughout 2021-22 with the % of incidents resulting in harm remaining below the mean value and compared to other benchmarked mental health trusts.

Figure 5 - % of incidents resulting in harm to patients



Monitoring of Physical Health

The Trust takes part in a range of National Audits and delivers local clinical audits in order to test compliance against a range of clinical and practice standards. This has included for 2021-22 the following:

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Physical Health in Mental Health Hospitals audit. We are awaiting the final published report from this audit and will review the outcome within our

Clinical Effectiveness Assurance Group, which will oversee the development and monitoring of any actions required.

- Risk to patient's physical health and monitoring the National Early Warning Score 2 (NEWS2) trigger system audit. We have demonstrated an improvement in compliance with physical checks within 24 hours of admission, the audit has shown:
    - 80.6% of the sample had the first set of observations completed within the first 24 hours of admission (as per policy). This is an improvement from last two audits which were 77% and 71.3%.
    - An additional 16.9% taken at soon as the service users mental health allowed, however this was after the 24 hours guideline.
    - 2.7% did not have a recorded physical health observation on the digital ward system. However, after reviewing these service users, most had been discharged within the 48 hours; therefore, not allowing the staff time within the admission period.
- Prescribing Observatory for Mental Health (POMH) 18b: Use of Clozapine audit. Actions we are taking to improve are:
    - Update our Clozapine initiation guidance
    - Develop Clozapine initiation checklist for clinicians
- National Clinical Audit of Psychosis (NCAP): Early Intervention Services audit. We scored 100% within the Clozapine treatment domain, with a physical health assessment rate of 96%.
- Rapid Tranquilisation audit: this forms part of our annual audit programme with the current audit cycle data collection complete awaiting the final analysis and report development. The outcome of this audit will be reviewed within our Clinical Effectiveness Assurance Group, which will oversee the development and monitoring of any actions required.
- The Home Treatment Service has included the routine screening for alcohol use within its assessment document within the electronic patient record (RIO) for all service users entering the service.

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 2021/22 we set the following goals and detail our achievement below:-

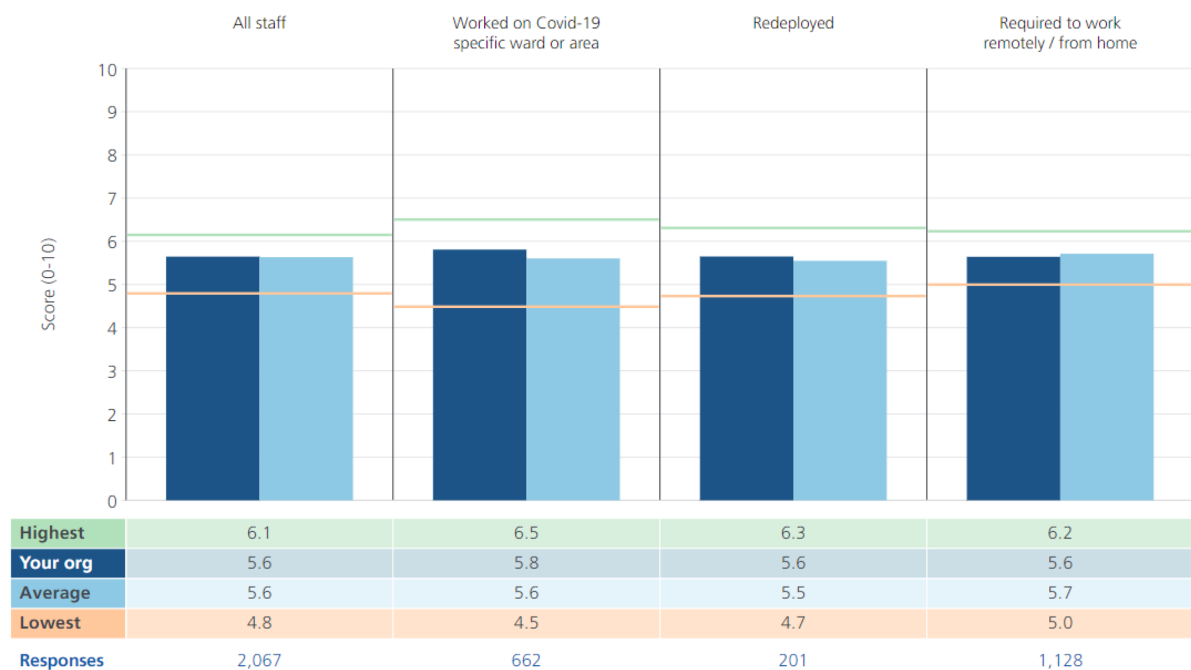
- % of service users attending their weekly MDT

    - Our monthly multi-disciplinary review audits have identified that in 2021-22 97% of service users in our inpatient services attended their weekly review meeting
- % of service users in receipt of their care plan
    - On average 68% of service users confirmed that they received a copy of their care plan in 2021-22.
    - We have a function on our electronic patient record system (RIO) that prints a summary of the key care plan information for service users. We recognise that measuring whether a service user has been given a copy of their care plan is only one measure of engagement and does not indicate whether the service user has been involved in its development and feels engaged with the plan itself. We therefore will introduce additional qualitative measures into our monthly MDT review audit to test this.
- Qualitative measure to be established through Experts by Experience group and reporting to commence against this measure from January 2022
    - The development of qualitative measures was delayed by our urgent response to the Covid-19 Omicron variant which required us to focus on covid outbreak management. The development of qualitative measures is now underway and will be completed in quarter 1 of 2022-23.
- % of carers registered on RIO
    - We have an established Family and Carer Pathway Collaborative Group which works to improve the way services engage families and carers in supporting the service user journey. The first step in this journey is to record the details of those carers that service users wish us to involve in their support. The proportion of carers recorded on our electronic patient record has remained static at 34% this year. The collaborative will continue to work to improve this position.
- % of carers with a completed carer engagement tool
    - The carer engagement tool is designed to work with carers to understand their role and support needs in caring for their loved one who is receiving services. Around a quarter of carers registered on our system have a carer engagement tool available on the system and of those who accepted the offer of this 89% have completed this. The collaborative will continue to roll this process out to more service users and their carers in 2022-23.
- Number of patient safety partner roles established and gain feedback from patient safety partners on their experience
    - The role of the patient safety partner has been a developing one over 2021-22 with role descriptors now in place and plans to recruit to this in quarter 1 of 2022-23. Once established and evaluation of their impact will be made.

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

Our measures of success relating to this priority were defined as:-

- Number of LFE submissions made in recognition of excellent practice
  - We have developed a mechanism for staff to record excellence in practice electronically. This is available through a simple electronic form for all staff. During the second half of the year this has gathered momentum with nearly 400 submissions being made. Excellence submissions are shared with the staff nominated and their line managers to recognise their actions. We are currently developing the mechanism to report excellence within quality reports so that in addition to learning from the times things go wrong we can learn from our successes also.
- Improvement in safety culture metrics in the national staff survey relating to incident reporting and learning from incidents



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	6.1	6.5	6.3	6.2
Your org	5.6	5.8	5.6	5.6
Average	5.6	5.6	5.5	5.7
Lowest	4.8	4.5	4.7	5.0
Responses	2,067	662	201	1,128

We scored the same as the national average for learning in this year's staff survey. We recognise we have more work to do to ensure that staff feel truly engaged in developing a learning culture.

Interestingly staff who worked in covid specific areas or were redeployed were more likely to offer a positive score than those who worked from home.

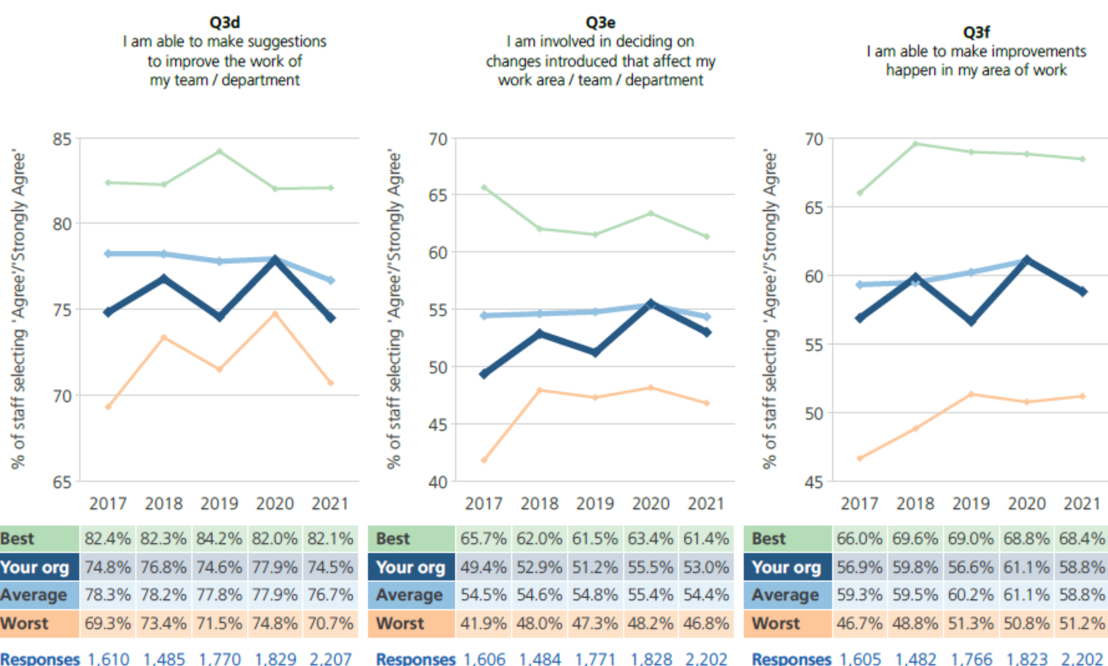
Priority for Improvement 4: A Focus on Quality Assurance

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.

Our measures of success relating to this priority were defined as:-

- Number of peer review visits completed
- Improvement in national staff survey metrics relating to the 'Ability to Contribute to Improvements'
    - We recognise we have work to do to improve on staff reporting they are engaged in making changes; two of the three staff survey question responses have fallen below the national average this year:



Q3d	2017	2018	2019	2020	2021
Best	82.4%	82.3%	84.2%	82.0%	82.1%
Your org	74.8%	76.8%	74.6%	77.9%	74.5%
Average	78.3%	78.2%	77.8%	77.9%	76.7%
Worst	69.3%	73.4%	71.5%	74.8%	70.7%
Responses	1,610	1,485	1,770	1,829	2,207

Q3e	2017	2018	2019	2020	2021
Best	65.7%	62.0%	61.5%	63.4%	61.4%
Your org	49.4%	52.9%	51.2%	55.5%	53.0%
Average	54.5%	54.6%	54.8%	55.4%	54.4%
Worst	41.9%	48.0%	47.3%	48.2%	46.8%
Responses	1,606	1,484	1,771	1,828	2,202

Q3f	2017	2018	2019	2020	2021
Best	66.0%	69.6%	69.0%	68.8%	68.4%
Your org	56.9%	59.8%	56.6%	61.1%	58.8%
Average	59.3%	59.5%	60.2%	61.1%	58.8%
Worst	46.7%	48.8%	51.3%	50.8%	51.2%
Responses	1,605	1,482	1,766	1,823	2,202

We will work with staff to understand how we can improve their engagement in making positive changes in their work areas.

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

Our measure of success relating to this priority was defined as:-

- Clinical outcomes associated with service user satisfaction levels with life domains and treatment aspects of their care
    - We recognise that delivering care through the pandemic period has been difficult and has affected outcomes for some of our service users. We have taken the results of the 2021 NHS community mental health survey and developed an action plan of improvement based on what it tells us. Some of the results from the survey are set out below:

Section	Focus	Score (of 10)	Benchmark to other MH Trusts
1	Health and Social Care Workers	6.5	About the same (as expected)
2	Organising Care	8.1	About the same
3	Planning Care	6.2	Somewhat worse than expected
4	Reviewing Care	6.7	About the same
5	Crisis Care	6.3	Worse than expected
6	Medicines	6.6	Somewhat worse than expected

7	NHS talking Therapies	7.4	About the same
8	Support and wellbeing	4.0	Worse than expected
9	Feedback	1.3	About the same
10	Overall View of Care & Services	6.7	About the same
11	Overall Experience	6.3	Somewhat worse than expected
12	Care During the Covid-19 Pandemic	6.3	About the same

Key:

■ Much worse than expected ■ Worse than expected ■ Somewhat worse than expected ■ About the same
■ Somewhat better than expected ■ Better than expected ■ Much better than expected ■ Your trust

2.2 Statements of Assurance from the Board

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

	Prescribed information	Form of statement
1.	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	During 2021/22 BSMHFT provided the following mental health services: A&E Liaison Adult Acute Ward Adult CMHT Adult Day Care AOT CAMHS Deaf Community Deaf Inpatient Eating Disorders Community Eating Disorders Inpatient Early Intervention
		Forensic CAMHS Community Forensic CAMHS LOW SEC Forensic CAMHS MED SEC Forensic Outreach High Dependency Wards Home Treatment IAPT Justice Liaison Low Secure Perinatal Community Perinatal Inpatient Medium Secure Wards Neuropsychiatry Older Adult Acute Ward Older Adult Community

		Memory Services OPIP (Older Adult Day Care) PICU Primary Care Prison Mental Health Care Rehab Ward Substance Misuse Services
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	BSMHFT has reviewed all the data available to them on the quality of care in these services.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2021/22 represents 90 % of the total income generated from the provision of relevant health services by BSMHFT for 2021/22

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 2021/2022, 7 national clinical audits and 3 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 2021/22 are as follows: • National Clinical Audit of Psychosis (NCAP) Spotlight Audit in Physical health • POMH19b: Prescribing for depression in adult mental health services • POMH 14C: Alcohol Detoxification • POMH 1h & 3e: Prescribing high dose and combined antipsychotics • National audit of care at end of life (NACEL) • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • National Audit of Dementia (NAD)- spotlight on Memory Assessment Services • National Confidential Enquiry into Patient Outcomes and Death (NCEPOD): Physical Health in Mental Health Hospitals • National Confidential Enquiry - 'Transitions' Child Health Clinical Outcome Review Programme - Adolescent Mental Health • National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH).
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 2021/2022, are listed below: • National Clinical Audit of Psychosis (NCAP) Spotlight Audit in Physical health • POMH19b: Prescribing for depression in adult mental health services • POMH 14C: Alcohol Detoxification • POMH 1h & 3e: Prescribing high dose and combined antipsychotics

		• National audit of care at end of life (NACEL) • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • National Audit of Dementia (NAD)- spotlight on Memory Assessment Services • National Confidential Enquiry into Patient Outcomes and Death (NCEPOD): Physical Health in Mental Health Hospitals • National Confidential Enquiry - 'Transitions' Child Health Clinical Outcome Review Programme - Adolescent Mental Health • National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH).

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 2021 to March 2022 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 Clinical Audit of Psychosis (NCAP) Spotlight Audit in Physical health	Yes	Yes	100%
POMH19b: Prescribing for Depression in Adult Mental Health Services	Yes	Yes	100%
POMH 14C: Alcohol Detoxification	Yes	Yes	100%
POMH 1h & 3e: Prescribing High Dose and Combined antipsychotics	Yes	Underway- Delayed by provider	N/A
National audit of care at end of life (NACEL)	Yes	Yes	2- low numbers were expected
National Clinical Audit of Psychosis (Early Intervention Services) (NCAP)	Yes	Yes	100%
National Audit of Dementia (NAD)- spotlight on Memory Assessment Services	Yes	Yes	100%

National Confidential Enquiry into Patient Outcomes and Death (NCEPOD): Physical Health in Mental Health Hospitals	Yes	Yes	8 case notes
National Confidential Enquiry - 'Transitions' Child Health Clinical Outcome Review Programme - Adolescent Mental Health	Yes	Yes	Facilities questionnaire only
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	Yes	Yes	100%

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 17 national clinical audits were reviewed by the provider in 2021/22 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.	

National Clinical Audit of Psychosis (Early Intervention Services) (NCAP)
In September 2021, the Trust reviewed the findings of the 2020/21 National Clinical Audit of Psychosis re-audit. This audit focused on Service users with first episode psychosis receiving treatment from the Solihull Early Intervention in Psychosis service (EIS). The audit included a review of cognitive behavioural therapy (CBT) up take, family intervention uptake, education and employment programme up take and whether service users who had not responded adequately to or tolerated treatment with at least two antipsychotic drugs are offered clozapine. There were also two physical health related domains which were: Physical health annual review (smoking status, alcohol intake, substance misuse, BMI, blood pressure, glucose and cholesterol) and Physical health interventions (smoking cessation, substance misuse, weight gain/obesity, harmful alcohol use, Dyslipidaemia, Diabetes/high risk of diabetes and Hypertension).

Key success

- It is recognised that data was collected during a time of demand to move to digital interventions due to the COVID-19 restrictions. Despite this Solihull EIS were still able to maintain service delivery at a high level.
- EIS Solihull scored top performing in the CBTp, family interventions and supported employment programmes domains and has showed improvement across all of these domains since the previous audit.
- EIS Solihull scored 100% for the domain relating to clozapine treatment- this is an improvement from 88% in the previous audit.
- EIS Solihull has also improved significantly in the physical health assessment and interventions domain. They achieved ‘Top Performing’ compared to ‘Needs Improvement’ in the previous audit. Solihull EIS was the highest scoring team in the country achieve 96% in physical health assessments. A presentation around how we achieved this was given at the EIS conference in August and has been shared with the Trusts physical health committee.

- EIS scored above the national average for offered and accepted interventions for substance use, harmful alcohol use, weight/obesity and hypertension.

Key areas for improvement

- Overall Solihull EIS was scored as needs improvement by NCAP. This is due to scoring 'Needs Improvement' in the access and waiting time's domain and the outcome measures domain. Unfortunately, data for the access and waiting time domain was commissioning level data pulled from NHS digital. This data is combined with Forward Thinking Birmingham (FTB) which EIS Solihull has no control over.
- EIS Solihull scored needs improvement for not having an over 35's or ARMS service. However, since data was collected the over 35's aspect is now established and has been since the 4th Jan 2021 with the ARMs aspect being in development phase but is being hindered by recruitment issues and the identification of an organisation to deliver the CAARMS assessment training. This is being explored by NHSE as this is not just a local issue but a national one.

Key actions

- Share success of physical health instructor with the wider trust
- Escalate issue of using combined access and waiting times data to the NCAP network

POMH 18b: Use of clozapine

This is a re-audit of the use of Clozapine. Clozapine is a universally recommended treatment for the treatment of schizophrenia that has failed to respond to at least two standard antipsychotic medications. However, this antipsychotic medication is also associated with several potentially serious side effects. Therefore, it is essential that service users and/or carers are informed of both the potential benefits, and potential risks of Clozapine, prior to the initiation of treatment. The audit reviewed pre-treatment screening, off-label prescribing, monitoring in the first two weeks, assessment of side effects, impact of discharge from hospital and annual medication reviews. The outcome of this audit was reviewed by the Pharmacological Therapies Committee (PTC) in November 2021.

Key success

- The prevalence of off-label prescribing was very low
- There has been some improvement in documenting the early on-treatment monitoring of vital signs in patients prescribed clozapine.

Key areas for improvement

- 30% of sample as a documented discussion of potential benefits and side effects of clozapine prior to initiation.
- Clozapine treatment is associated with weight gain, an adverse lipid profile and the development of diabetes, but the relevant baseline measures were not documented for 50% of the sample.

Key actions

- The trust has updated the clozapine initiation guideline
- The trust has looked at developing a clozapine initiation checklist that is easily accessible to support clozapine initiation
- Ensure that the side-effect checklist which is already available, is available on RIO, and will form a part of the patient's clinical record, to ensure that each side effect is considered and the presence or absence is recorded

POMH Topic 20a: Improving the quality of valproate prescribing in adult mental health services

Reviewed by the Pharmacological Therapies Committee (PTC) in December 2021, this baseline audit looked at recording reasons for initiating valproate treatment, off label prescribing, pre-treatment physical health assessments, 3-month reviews, annual review and women of childbearing potential.

Key success

- Fewer women of childbearing potential now on valproate in our Trust
- Improved identification of eligibility for women of childbearing potential / completion of Prevent
- Improved performance in completing risk acknowledgement forms

Key areas for improvement

- Reason for prescription not consistently documented
- Where use was off-label, this was not consistently acknowledged in records
- Physical health checks within 3 months of commencing valproate not consistently recorded

Key actions

- Raise awareness with prescribers of the GMC duties of a doctor requirement when prescribing off label.
- Raise awareness with clinicians, that where they rely upon YCC results to inform prescribing, they should acknowledge this in progress notes

National Audit of Inpatient Falls (NAIF)

The National Audit of Inpatient Falls (NAIF) is a national clinical audit run by the Falls and Fragility Fracture Audit Programme (FFFAP) at the Royal College of Physicians. This audit measures compliance against national standards of best practice in reducing the risk of falls within acute care.

Key areas for improvement

- The full range of audit requirements are triggered by acute hospitals populating the hip fracture database. Once populated any BSMHFT patients who sustained a hip fracture in our care would be subject to this audit programme. During the audit period, we did not receive any requests for patient-based audits of care associated with BSMHFT.

Key actions

- There are internal learning processes for falls and hip fractures within the Trust. Due to this and the limited participation in this audit, the trust has agreed that we will no longer take part in this audit.

National Clinical Audit of Psychosis (NCAP) Spotlight Audit- Physical health

It is recognised that Life expectancy for adults with psychosis or schizophrenia could be between 15 and 20 years less than for people in the general population. This may be because people with psychosis or schizophrenia often have physical health problems, including cardiovascular and metabolic disorders, such as type 2 diabetes, that can be exacerbated by the use of antipsychotics.

This spotlight audit focused on two physical health related domains which were: Physical health annual review (smoking status, alcohol intake, substance misuse, BMI, blood pressure, glucose and cholesterol) and Physical health interventions (smoking cessation, substance misuse, weight gain/obesity, harmful alcohol use, Dyslipidaemia, Diabetes/high risk of diabetes and Hypertension) offered to people with psychosis seen by adult community mental health services.

Key success

- The trust performed above the national average when providing interventions for referring people to specialist alcohol and drugs services

Key areas for improvement

- There were issues identified during data cleaning with the data collection platform provider. Data were found to be missing from the majority of site's BMI (Q12), Glucose (Q14) and Cholesterol (Q15) screening responses, such that where sites had entered values, the data was not received by the server and was irretrievable.
- Physical health monitoring does not appear to be consistently recorded

Key actions

- Although it not always the trusts responsibility to conduct physical health assessments, it is within our remit to encourage service users to have them.

POMH 14C: Alcohol Detoxification

Many service users admitted to acute adult psychiatric wards have significant alcohol dependence and many may require medically assisted alcohol withdrawal. This re-audit reviews practice for alcohol detoxification conducted in acute psychiatric inpatient settings. The key indicators for this audit included: Alcohol detoxification of an inpatient should be informed by a documented assessment of drinking history, current daily alcohol intake, a physical examination, carried out on admission, blood tests relevant to the identification of alcohol related physical health problems, pharmacotherapy to treat withdrawal should be limited to a benzodiazepine, carbamazepine or clomethiazole and thiamine should be prescribed in acute alcohol withdrawal.

Key success

- Most of the sample received a liver function and renal function blood test.
- Most of the sample were referred to a more specialist alcohol service for support once they had alcohol detox as an inpatient.

Key areas for improvement

- The number of service users eligible to take part in this audit were low (n=11) as the trust does not record how many of our inpatients require alcohol detox.
- A detailed alcohol history is required to ensure the prescribed detoxification regimen adequately protects against potentially serious complications of acute alcohol withdrawal. The trust had a documented full alcohol drinking history for 60% of the sample.
- 65% had a physical exam- dropped from 80% in the previous audit
- The administration of thiamine during alcohol detoxification protects against the development of Wernicke's encephalopathy and permanent neurological damage in the form of Korsakoff's psychosis. There was no improvement on the assessment and treatment of symptoms of Wernicke's encephalopathy.
- Only 45% of the sample were prescribed only one benzodiazepine. This may partly reflect the use of different benzodiazepines for different indications, for example chlordiazepoxide to manage withdrawal symptoms and lorazepam to manage acute behavioural disturbance. It was also established that lorazepam is regularly prescribed on admission as PRN.

Key actions

- The trust has established a working group to review and promote the alcohol detox inpatient guideline which has been updated based on the finding of this audit.
- The working group will also review local alcohol detoxification prescribing protocols to ensure advice is given/safeguards are in place to reduce inadvertent co-prescribing/administration of multiple benzodiazepines to patients identified as drinkers on admission to hospital and will explore reasoning for prescribing Lorazepam on admission.
- The working group will also share benchmarked data with the local Commissioners, as a basis for constructive discussion regarding commissioned services for alcohol abuse.

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

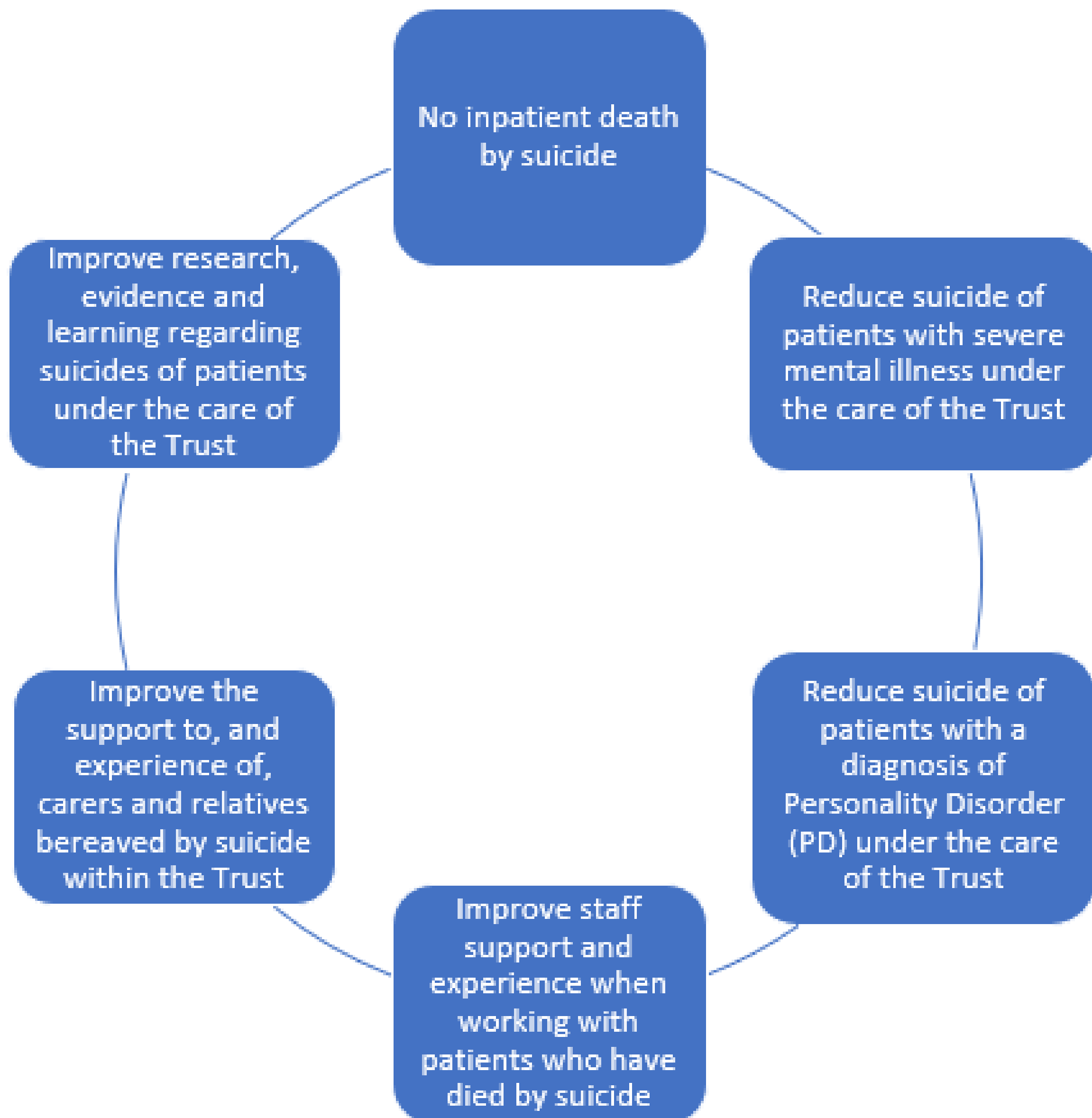
We have reviewed the 2019 NCISH report alongside a refresh of our suicide prevention strategy and will incorporate the learning from the national review and a review of local incidents to continue to improve the safety of our service users.

NCISH key messages are:

- Focus on established risk factors for suicide
- Increase in risk during leave and immediately post discharge from mental health hospitals (3 days)
- An increase in suicide amongst under 18s
- Economic adversity increases the risk of suicide

- Increase in suicide for people with physical health conditions, particularly involving chronic pain
- Understanding the risk factors for domestic violence
- Effects of the pandemic on isolation, anxiety and disruption to care may have contributed to suicides by mental health service users.

Our suicide prevention strategy has 6 strategic aims:



We are utilising the NCISH 10 ways to improve safety:

And work with Service Users to develop a Suicide Safety Plan:

Suicide safety plan

Activities I can do to get through right now

Things to make my situation safer

Things to lift or calm my mood

Things to distract me

Supportive family and friends

Voluntary support organisations

Emergency professional support

2.7	The number of local under entry 2.5. clinical audit (a) reports that were reviewed by the provider during the reporting period.	The reports of 17 local clinical audits were reviewed by the provider in 2021/22 and Birmingham and Solihull Mental Health Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	

Clozapine assay re-audit

Last reviewed in September 2021, this audit is considered a key priority by the trust following the death of a patient on clozapine to prevent this ever happening again. The baseline audit assessed lower and higher clozapine assays. After the first audit there were less concerns with lower clozapine assays. This time round the focus was on assays that were above 600mg. The aim of the re-audit was to determine if we had made any improvement from the first audit.

There were 50 patients included in the re-audit.

Key success

- The reaudit indicated there has been improvement in trough levels, clinical indication, documentation on RIO and dose change due to assay

Key areas for improvement

- Further work to ensure the appropriate ordering of trough value assay samples
- Ensure assays are only requested when clinically indicated
- Results from assays are notified to the consultant as soon as possible and are acted on
- Documentation of any considerations or plans following an assay result
- Clear indications as to any changes made with doses following an assay
- Repeat bloods should be ordered after an appropriate period of stable dosing if needed

Key actions

- Pharmacy staff will review and report back on levels above 600mcg/L
- Update the Clozapine guideline based on the findings of this audit

PICU Prison Assessment Re-audit

This is an annual re-audit that looks at our compliance with the BSMHFT PICU Prison Assessment guideline.

Key successes

- Completed assessments were 71% compliant with standards which is an increase from 50% in the previous audit.

Key area for improvement

- There were slight delays between the patients referral date and their PICU assessment.
- It was unknown whether the decision was discussed during the MDT
- MDT's were not held within 2 working days of the assessment.

Key actions

- The new guideline has been ratified and is to be implanted

Staff to be trained in their roles and responsibilities

Solihull Safeguarding Children Board Multi-agency case audit

BSMHFT participates in an annual multi-agency case audit in Solihull. This audit considers cases that are directly related to any of the Solihull Local Safeguarding Children Partnership (LSCP) priorities. The focus of this audit is to explore the extent to which the voice of the child is heard by Birmingham and Solihull Mental Health NHS Foundation Trust during their work with children and families.

For this audit, BSMHFT selected cases from three tiers:

Tier 1 related to parents/carers who were known during the audit timescale to BSMHFT with either a less intense intervention level (such as 'care support' in community mental health teams) or for a brief interaction with the service (such as a single contact with liaison psychiatry in general hospital). From Tier 1, eleven service users were audited.

Tier 2 related to parents/carers who were known during the audit timescale to BSMHFT with more prolonged and regular contacts (such as 'Care Programme Approach' in community mental health teams or perinatal services) or through more intense crisis support (such as being under the care of a Home Treatment Team or receiving inpatient care on a psychiatric ward.) From Tier 2, six service users were audited.

Tier 3 related to children and young people who were known or had contact with the BSMHFT CAMHS Service in Solihull, 'SOLAR'. These individuals were known to one of the SOLAR services; either core

CAMHS, primary care, medical or crisis. It also included two service users who were referred to SOLAR and open for assessment. From Tier 3, eight service users were audited.

Key success

- There were some examples where evidence of Think Family was clear: children being considered, specific details being recorded and attempts to establish the voice of the child by observation, reflection or liaising with other professionals involved.
- SOLAR particularly displayed evidence of listening and responding to the child, adapting to their needs/wishes and advocating for their voice.

Key areas for improvement

- The main theme of the findings of this audit can be concluded as a lack of 'Think Family' consideration. 'Think Family' underpins establishing the voice of the child, especially for those professionals working with adults using mental health services as seen in the Tier 1 and 2 audits.
- There needs to be more joint up working between SOLAR and adult mental health teams where the child and parent are both open to BSMHFT.

Key actions

- Re-promote the children's and sibling's form to allow for a specific place where the identifying details of a child and family can be recorded, such as names and dates of birth.
- To add learning points into the SOLAR operational policy

Introduce the integrated safeguarding system which aims to better integrate safeguarding into clinical everyday practice and incorporate the voice of the child and think family.

Weight Management on Inpatient units

Obesity is an important cardiovascular risk factor contributing to the premature death of people with mental illness. On average, the life expectancy of those with a Serious Mental Illness is 15-20 years less than the rest of the population and this is mainly due to preventable physical illnesses. Both nationally and globally, the incidence of Obesity is increasing. BSMHFT has a comprehensive Physical Health Strategy aiming to turn the tide on the poor physical health outcomes of our service users. As part of the Strategy, we have committed to deliver a trust wide obesity action plan to ensure high quality interventions and support is accessible for Service Users.

This re-audit is part of the implementation plan laid out in the BSMHFT Weight management strategy. A total of 557 patient records were retrieved and analysed by service area.

Key success

- This audit indicated that there is some evidence of Trust improvement in supporting service users to maintain body weight during admission – during which there are a myriad of complex contributory effects including sedentary activity, medication side effects, reduced free food choices and eating as a pastime.
- A previous audit reported in 2017 in found weight gain in 80% of hospital admissions, with an average weight gain 7.06 kg. This audit shows improvement on this with just over 51% of service users gaining weight, with an average gain of 5.9kg.

Key actions

- Food services to be nutritionally balanced and offer clearly identified opportunities to choose healthier meal choices
- Staff to have access to local good quality training to feel confident and skilled at having supportive, non- judgemental conversations about weight gain.
- BMI > 30 to be documented as medical problem and regularly reviewed in the MDT meeting and care planned accordingly.

Risk to patient’s physical health and monitoring the National Early Warning Score 2 (NEWS2) trigger system

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

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

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

Key Success

- The audit identified that 80.6% of the sample had the first set of observations completed within the first 24 hours of admission (as per policy). This is an improvement from last two audits which were 77% and 71.3%.
- We then have an additional 16.9% taken at soon as the service users mental health allowed, however this was after the 24 hours guideline.

Key areas for improvement

- 2.7% did not have a recorded physical health observation on the digital ward system. However, after reviewing these service users, most had been discharged within the 48 hours; therefore, not allowing the staff time within the admission period.

Key actions

- The COVID pandemic has increased the monitoring of basic physical health observations and NEWS2 scores. We have better methods for quicker reporting and are now quicker at reviewing the service user’s observation and are acutely aware when there is deterioration.

Staff training is available for all our staff, including face to face ‘managing the deteriorating patient’ (COVID-19) training ad-hoc training, eLearning and all the presentation and links on the COVID pages of our intranet.

Pharmacy/Medicines

(Inpatient controlled drugs, Inpatient Medicines Code Audit, Prescribing compliance with MHA forms, Antimicrobial prescribing and Hypnotics prescribing)

Across the course of the past year, the trust carried out several pharmacy and medicines related audits to assess various topics from inpatient controlled drugs, inpatient medicines code, compliance with mental health act forms, hypnotics and antimicrobial prescribing.

Key findings and actions

- Pharmacy staff have conducted an audit of safe and secure handling of drugs across 50 wards covering general adults, older adults, Steps to Recovery and secure care wards. For the 50

wards, there was 91% compliance with standards which is similar to previous audits.6 wards were fully compliant with the standards.

- Twelve wards had more than 10% non-compliance with safe and secure handling of medication standards. This is slightly higher than previous audits.
- Findings of the controlled Drugs audit have been discussed with senior ward staff and each ward has a specific ward action plan for improving compliance with standards.
- 91% of service users had Mental Health Act Consent to Treatment certificate in place to authorise their prescribed treatment for mental health disorders, representing a 1% improvement in practice compliance from 2020.
- Pharmacy services will work with staff on Inpatient wards to provide training on key safe and secure handling of medicines issues.
- Pharmacy staff will work intensely with those wards showing the greatest non-compliance with standards.
- The project to look at the procurement and installation of appropriate solutions for controlling the climate for storage of medicines to be resumed.
- Pharmacy will work with wards and estates to ensure that where medicines cabinets are non-compliant with BS2881 and are due to be replaced then suitable alternative cabinets that comply with the standard are procured.
- Where needed, pharmacy staff will provide additional controlled drugs training for staff to enable them to comply with all standards.
- The BSMHFT guideline on management of insomnia audit found that not all standards for hypnotic medication prescribing within the Steps to Recovery Service, Rosemary and Bergamot wards was being followed.
- Compliance with antimicrobial guidance is above the commissioner's target and this has been sustained.
- Clinical pharmacists will continue to work with medical staff to ensure that antimicrobial prescribing is appropriate and the outcomes are documented.

3. Research

	Prescribed Information	**Form of statement**
3	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	The number of patients receiving relevant health services provided or subcontracted by **Birmingham and Solihull Mental Health NHS Foundation Trust** in **2021-2022** that were recruited during that period to participate in research approved by a research ethics committee is **507**.

4. CQUIN

	Prescribed Information	Form of statement
4	Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services.	A proportion of BSMHFT income in 2021/22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because of the Covid Pandemic. CQUINS were suspended for the financial year and funding was through block contract payments determined nationally.
4.1	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	
4.2	If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	

5. CQC

	Prescribed Information	Form of statement
5	Whether or not the provider is required to register with CQC under Section 10 of the Health and Social Care Act 2008.	Birmingham and Solihull Mental Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is conditional.
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.	Birmingham and Solihull Mental Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is conditional. BSMHFT has the following conditions on registration: **1.** The registered provider must take steps to address the ligature risks across all wards by 18 June 2021 **2.** By 29 January 2021 the Registered provider must implement an effective system to improve risk assessments and care planning. The Registered Provider must report to the Commission on the steps it has taken in connection with this by 5 February 2021. **3.** By 4 January 2021, the registered provider must inform the Commission of the order of priority in terms of addressing the ligature risks and timescales for addressing the ligature risks across each ward. **4.** Commencing from 5 February 2021 the registered provider must report to the Commission on a monthly basis setting out progress being made in respect of including mitigating measures being put in place until all ligature risks are addressed. **5.** Commencing from 1 March 2021, the Registered Provider must report to the Commission on a monthly basis the results of any monitoring data and audits undertaken that provide assurance that the system implemented is effective. Birmingham and Solihull Mental Health Foundation Trust make regular submissions and meets with the CQC to update it on progress against its actions relating to these conditions. The Care Quality Commission has not taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2021 to 31 March 2022. Birmingham and Solihull Mental Health NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission during 1 April 2021 to 31 March 2022.

	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 special reviews or investigations by the Care Quality

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.	Commission during 1 April 2021 to 31 March 2022.

8. Data Submission

	Prescribed Information	Form of statement
8	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider	Birmingham and Solihull Mental Health NHS Foundation Trust did not submit records during 2021/22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's: (i) valid NHS number (ii) General Medical Practice Code (b) the percentage of records relating to outpatient care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code (c) the percentage of records relating to accident and emergency care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code.	

9. Information Governance

	Prescribed Information	Form of statement
9	The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.5	Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Assessment Report for 2021 / 2022 is not due to be submitted until the 30th June 2022 in line with national submission timescales relating to the Data Security and Protection Toolkit. The 2020/21 Data Security and Protection Toolkit attainment level for the Trust was 'standards not fully met – plan agreed.'

10. Payment by Results

	Prescribed Information	Form of statement
10	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.	Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.
10.1	If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	

11. Data Quality

	Prescribed Information	Form of statement
11	The action taken by the provider to improve data quality.	Birmingham and Solihull Mental Health NHS Foundation Trust will be taking the following actions to improve data quality: • Maintaining regular assessment of the quality of data underlying all key performance measures so that any issues can be addressed. • Continuing detailed audit and review of the accuracy of clinical case classification, activity monitoring and clinical outcome measurement information. • On-going comparison of service user contact and GP registration details with the national NHS Summary Care Record database to ensure information in our clinical systems stays up-to-date. • Close monitoring and continuous quality improvement work on a range of data quality performance indicators, with clinical and administrative staff using monitoring reports to identify and correct data errors. • 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 Data Quality Maturity Index • Maintaining work on completeness and validity of the IAPT submissions and assessing the new experimental data set items added to the Data Quality Maturity Index • Active data quality support to operational services by service-aligned data analysts, bringing any data issues

		forward for attention and supporting and monitoring improvement actions

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 2021-22 1503 of BSMHFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 374 in the first quarter; 445 in the second quarter; 407 in the third quarter; 277 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 31/03/2022, 13 case record reviews and 45 investigations have been carried out in relation to 1503 of the deaths included in item 27.1. In 1 case 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: 18 in the first quarter; 15 in the second quarter; 11 in the third quarter; 14 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.	1 representing 0.07% 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: 1 representing 0.27% for the first quarter; 0 representing 0% for the second, third & fourth quarters. These numbers have been estimated using the [name, and brief explanation of the methods used in the case record review or investigation]

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.	The death was investigated under our serious incident framework and improvements were identified in the regularity and quality of face to face named nurse time in order to understand the changes in their risk presentation, particularly in relation to the expression of suicidal thoughts.
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).	- There have been changes to the structure of the weekly multi-disciplinary reviews and ward rounds to make them more collaborative. Within the review; care plans, risk assessments, observation levels and leave prescriptions are all reviewed and updated on our electronic patient record (Rio) live in the meeting - Safety huddles have been incorporated into the normal daily routine of our inpatient wards; this is where a discussion is held focusing on the patients most at risk to develop a plan of action to manage and reduce any risks identified. These discussions and any relevant plans are formally recorded on shift coordination sheets. - Our Inpatient guidance is currently under review and should outline that when new expressions of suicidal ideation are made this should be escalated via a multi-disciplinary meeting, safety huddle discussion or to the on-call doctor for review

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.	We monitor the delivery of multi-disciplinary reviews and safety huddles each month and have confirmed that these are now established and take place weekly and daily respectively. We are currently beginning a qualitative evaluation of these with the support of service users.
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.	27 case record reviews and 26 investigations completed after 31-03-2021 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.	6 representing 0.4 % of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the final avoidability score of 3 or less.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item	7 representing 0.47 % of the patient deaths during 2020-21 & 2021-22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting Against Core Indicators

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

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

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

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

This indicator identifies whether people with a mental illness discharged from our inpatient wards have a direct face-to-face or telephone follow-up contact with a

member of clinical staff on at least one of the seven days following discharge. The measure aims to ensure that service users are protected at a time of significant vulnerability and appropriately supported through their transition back into day-to-day life outside hospital. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health NHS Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2021-22	92.5%	*	*	*
2020-21	91.8%	*	*	*
2019-20*	94.7%	95.0%	100%	85.9%
2018-19	96.1%	95.7%	100%	82.8%

Data Source: Rio - our internal clinical information system

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

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

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

- Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:
- A process audit of the Trust's methodology has confirmed that our processes and calculations adhere to national reporting definitions.
- Regular samples of records are compared with clinical progress notes to ensure that they are being correctly included or excluded from indicator calculations.

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

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

Whilst the trust has taken these actions to improve the percentage completion, 2021/22 compliance was significantly impacted by Covid -19 in terms of the ability to make direct contact with service users, particularly for older adults discharged to nursing and residential care homes. During this period there was an increased level of contact by telephone instead of face-to-face visits and in some cases, contacts had to be made indirectly with care home staff where it was not possible to visit or talk to service users directly in this setting.

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

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

	Birmingham and Solihull Mental Health Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2021-22	95.4%	*	*	*
2020-21	97.5%	*	*	*
2019-20**	96.0%	97.9%	100%	91.9%
2018-19	97.1%	98.1%	100%	88.5%

Data Source: Rio - our internal clinical information system

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

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

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

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

2.3.3 Readmissions to hospital within 28 days of discharge

The percentage of admissions to Trust hospitals of patients aged:

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

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

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

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

	Age 0-15	Age 16+
2021-22	0.0%	5.3%
2020-21	0.0%	6.2%
2019-20	0.0%	5.8%
2018-19	0.0%	5.8%

Data source: Rio – our internal clinical information system

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

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

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

2.3.4 Patient Experience of Community Mental Health Services

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

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

Data source: National Community Mental Health Service User Survey 2021

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
Apr 20 – Mar 21*	58	64	236	21	0.3%	1.0%	58.8%	0.0%
Oct 19 – Mar 20	49	53	146	18	0.4%	1.0%	4.2%	0.0%
Apr 19 – Sep 19	51	56	131	17	0.5%	0.9%	3.3%	0.0%
Oct 18 – Mar 19	44	53	119	15	0.6%	1.0%	4.3%	0.0%

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

	Patient Safety Incidents – Total Reported	Patient Safety Incidents per 1000 Bed days	Patient Safety Incidents resulting in Severe Harm or Death	% Patient Safety Incidents resulting in Severe Harm or Death
Oct 20 – Mar 21	6427	58	24	0.4%
Apr 20 – Sept 20	6588	58	23	0.3%
Oct 19 – Mar 20	5823	49	22	0.4%
Apr 19 – Sep 19	6188	51	31	0.5%
Oct 18 – Mar 19	5330	44	31	0.6%
Apr 18 – Sep 18	5233	44	22	0.4%

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 doctor's marketplace, preceptorship training and at Student Experiential Learning Pathway sessions.

- Constantly evolve incident types to be reflective of incidents occurring in the Trust.
- Continuing to develop and promote the utilisation of the 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 2021/22 which together with sections 1 and 2 of this report, provide an overview of the quality of care offered by our Trust during this period.

3.1.1 Safety

The three indicators selected for patient safety are:

- Serious Incidents
- Never Events

3.1.1.1 Serious Incidents

During 2021/22 we have completed much of the groundwork to move the investigation of our serious incidents in line with the NHS Patient Safety Incident Response Framework in preparation for the national roll out of this programme. We continue to work closely with partners across various agencies which support health and social care in Birmingham and Solihull to complete multi-agency reviews where it was evident that a patient involved in a serious incident was receiving care, support or advice from more than one agency. This enables us to take a system wide view on opportunities to improve how agencies can work together for the benefit of patients.

	2018/29	2019/20	2020/21	2021/22
Number of Serious Incidents Reported	91	78	96	82

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 2021/22.

	2018/29	2019/20	2020/21	2021/22
Number of Never Events Reported	0	0	0	0

3.1.2 Patient Experience

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

	2019/20	2020/21	2021/22
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	68%	59%	67%
Number of complaints	85	81	109
Timeliness of complaints	100%	100%	99.1%
% of dissatisfied complainants	18 returned (20%)	9 returned (11%)	9 returned (8%)
Number of referrals to the Ombudsman	2 0 accepted for re-investigation	2 0 accepted for re-investigation	2 0 accepted for re-investigation
FFT score	91%	94%*	79%

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

It has been a challenging year as we seek to learn from service user experience in the midst of high system pressures. This is reflected in a sharp rise in complaints in 2021/2022 to 109 cases, an increase of 34% from the previous year. Despite this our dissatisfied complainants have remained at 9 cases, which is a reduction of 3% from the previous year. For the third year running, the PHSO have received 2 complaints from service users, neither of which they have accepted for reinvestigation. We failed to meet the agreed timescale for a single complaint which was shared with the complainant a day

late. We feel that our performance during 2021-22 demonstrates a positive record and improving picture of the way that we work with service users and their families to investigate their concerns and support their resolution. Work begun in 2020/21 on reviewing the carer experience of complaints was completed and will feed into the planned work for 2022/23 of a review of the Complaints Policy, including the establishment of an advisory panel of service users, carers, families, stakeholders and staff.

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

	NHSE/I Oversight Framework updated in November 2017: National Indicators – 2021/22	National Threshold	2021/22
1	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	60%	93.8%
2	Improving access to psychological therapies (IAPT): * a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. ii. within 18 weeks of referral	50% 75% 95%	52.1% 30.9% 84.2%
3	Inappropriate out-of-area placements for adult mental health services (average bed days per month) **	n/a*	551*
4	Admissions to adult facilities of patients under 16 years old	n/a	0%

* The waiting times for IAPT have reduced below the national targets primarily due to factors outside the Trust's immediate control. Covid 19 has significantly impacted on the Trust's ability to maintain face to face appointments and contacts with service users, due to a significant reduction in the availability of physical space in primary care facilities where people were being seen for their appointments. Nationally a recognised shortage

in the availability of appropriately qualified staff has added a further challenge along with staff sickness due to Covid. A system wide forum has been established with the Birmingham and Solihull Clinical Commissioning Group and other partners to jointly develop plans to improve the position going forwards.

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

In addition, please note that the average bed days per month for 2021/22 are based on the Standard Operating Protocol agreed with NHSE/1 to include 10 local acute private beds to be classified as 'appropriate placements' from the 1st of October 2022 and admissions to local PICU private beds from the 1st of January 2022. However as recognised by NHSE/I, these changes are not reflected in national MHSDS reporting and will continue to show as being ‘inappropriate’ placements due to MHSDS data constructs).

Annex 1: Stakeholder Statements

1.1 Healthwatch Birmingham and Healthwatch Solihull Statement

Statement from Healthwatch Birmingham and Healthwatch Solihull on Birmingham and Solihull Mental Health NHS Foundation Trust Quality Account 2021/22

Healthwatch Birmingham and Healthwatch Solihull welcome the opportunity to provide our statement on the 2021/22 Quality Account for Birmingham and Solihull Mental Health NHS Foundation Trust. We welcome that the Trust has been clear in its assessment of its position, in particular the areas where it has performed well and areas needing further improvement. We acknowledge that Covid-19 continues to have a significant impact on the Trusts activities and on how the Trust delivers its services. We are however pleased to see that the Trust is using the learning from this period to design facilities which can be used flexibly.

We welcome plans to reshape the Trusts environment over the next year including taking full advantage of the opportunities that technology offers, both for the Trust and patients. The pandemic necessitated a change in how the Trust delivers its services. However, the pace of change was so fast so much so that in many cases patients, carers and the public were not taken along on the journey of change. We are pleased to see the Trust commit to continued engagement with service users, carers, and the public. We would like to read in the 2022/23 Quality Account how the Trust has engaged with service users, carers, and the public in reshaping how care is delivered. Including how engagement has informed and shaped the Trusts plans.

As noted in our statement to the 2020/21 Quality Account, Healthwatch Birmingham and Healthwatch Solihull would like to see varied methods of engaging and enabling access to health care. In theory, the use of technology for citizens to enhance their use of health and care services is a good thing, however, technology can be both an enabler and a barrier to accessing services. Thereby leading to variability in access and care, and health inequality. We would like to read in the 2022/23 Quality Account how the Trusts engagement strategy and inequalities work has informed the adoption of technology in the delivery of care.

We also ask that the Trust reconsiders the issues we raised in our statement to the 2020/21 Quality Account:

- Existing barriers such as language should not be ignored. It is therefore important that guides on how to access mental health services using digital technology are developed in various languages and accessible formats.
- The digital divide that exists among socio-economic classes in Birmingham and Solihull should be taken to account. People from lower socio-economic status often have reduced accessibility to digital technologies. In addition, due to lower household income, people from lower socio-economic status are likely not to have broadband, own a computer or smart phone or indeed afford credit for internet use on their phones.
- According to NHS Digital, one in ten people in England lacks basic digital skills and nearly six million people have never used the internet. Therefore, the number of people

digitally excluded is significant and needs to be taken to account when considering transforming with digital. For instance, familiarity with modern technology for the elderly and those with language barriers is difficult. It is important that the Trust engages with various groups to ensure that their needs are met.
- It is important that the trust considers developing a digital communication strategy that identifies the diverse ways of engaging and delivering care using technology alongside the relevance of these for different service users.

Healthwatch Birmingham and Healthwatch Solihull agree with the priority goals for the Trust for 2022/23. We recognise many of the issues from our own engagement with the public. In particular improving access to crisis and community care in order to reduce unwarranted variations and harm across the service. We are also pleased to see a focus on understanding health inequalities or aspects of discrimination in the delivery of mental health care. We look forward to reading in the 2022-2023 Quality Accounts how the Trust has involved various stakeholders (including service users and carers) in developing and implementing this aspect of the patient safety priority.

We are pleased to also see continued focus on patient experience, especially on plans to improve the involvement of service users in MDT meetings; involvement of carers in service user care and recovery and ensuring an equal voice for service users at governance level. We look forward to reading in the 2022/23 Quality Accounts how insights from these involvement activities have informed care delivery and improved patient experience. Over the past year, Healthwatch Birmingham and Healthwatch Solihull have seen an increasing number of contacts from service users and carers concerned about access to mental health services. We have seen over the year a greater level of negative feedback for mental health services in the city, with no one leaving us a positive review in the last two quarters of the year. Of the experiences people told us about mental health services:
- For Quarter 4 (January – March 2022) - 94% were negative, and 6% neutral experiences.
- For Quarter 3 (October – December 2021) - 96% were negative with 4% were neutral.
- For Quarter 2 (July – October 2021) - 95% were negative, 3% positive, and 2% neutral: and
- For Quarter 1 (April – June 2021) - 73% were negative, 22% positive experiences, and 5% neutral.

Issues people have told us about have included:
- staff attitudes
- delays accessing the support they need from mental health services.
- lack of support or services from mental health teams
- lack of mental health support for people with a gender identity different from what they were assigned to at birth, either when accessing mental health services, or waiting for an appointment at a gender identity clinic
- being treated as an inpatient out of area, or difficulties visiting their relatives who are receiving inpatient care
- length of time it has taken to receive care following a crisis event such as a suicide attempt
- poor care from home treatment teams.

People have also told us about the effect on their mental health from delays to care and treatment. During the two quarters where we received some positive feedback, people told us about the following:

- mental health help for older people
- access to longer term treatment
- home visits
- supportive staff

Throughout the year, Healthwatch Birmingham and Healthwatch Solihull collect experiences and insights from the Trust's service users, carers, and members of the public. We believe that this is a valuable resource for the Trust that can complement the Trusts engagement activities and help inform or shape the delivery of the priority areas for 2022/23. We look forward to engaging with the Trust through our 'right to respond' program.

1.2 Birmingham and Solihull Clinical Commissioning Group Statement

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 2021/22 Quality Account.

A draft copy of the Quality Account was received by the CCG on 17th May 2022 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.

We acknowledge the significant ongoing challenges the Covid19 pandemic has presented throughout 2021/22 and the part the Trust has played in the mental health system response to these challenges. We recognise the impact of the sad loss of staff, service users, families and carers during the pandemic.

We note the Trust's ongoing work around five quality priorities and the Trust's continuing focus on improving outcomes and standards in these areas.

The Trust has kept the CCG regularly updated throughout 2021/22 on its ongoing programme of investment in buildings and equipment aimed at ensuring safer environments across the Trust. This is important work. Equally important is the development work around relational and procedural controls that the Trust has been undertaking, including a focus on multi-disciplinary team working, care planning, risk assessment, safety huddles, engagement with families, increased opportunity for meaningful activity, and the creation of therapeutic rather containing spaces.

The Trust has continued to report on a monthly basis to the Care Quality Commission in response to conditions placed on its registration. The CCG has been kept fully sighted on the response each month.

The work of the Reducing Restrictive Practices collaborative in reducing incidents of prone restraint is to be commended and it is good to see the harm rate of patient safety incidents remaining low compared to other benchmarked mental health trusts

The significant number of community suicides during 2021-22 is saddening. We recognise there will be several wider societal and economic factors behind this picture, all of

which have significant potential to impact on the mental health and wellbeing of our citizens. As a CCG we have continued to work with the Trust to ensure the completed reviews undertaken after each case have had a robust level of joint scrutiny.

The CCG has continued to work with the Trust in undertaking a series of joint themed reviews on areas identified from serious reported incidents. This work has continued to highlight that in a number of areas we require an integrated and consistent mental health system response, rather than single agency response, in order to improve outcomes for our citizens.

The move to an Integrated Care System will allow for a greater focus on mental health system issues. It is a time of tremendous opportunity for local partners to work closely together in order to deliver better outcomes for our citizens. Throughout 2021-22 the Trust has worked with the CCG to help shape and form the emerging systems for quality oversight and governance of mental health programme work. As these arrangements become embedded the Trust will maintain a key role both in service delivery but also in providing assurance to Birmingham and Solihull's Integrated Care Board on the effectiveness of our local mental health system.

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

In opening this statement, we as the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust would like to formally give our thanks and pay tribute to all staff who have supported our service users, families, carers and each other throughout one of the most challenging periods in the history of the NHS. Their ongoing commitment to provide care in this most challenging period has been remarkable. The covid pandemic has enabled an element of parity of esteem to be given to mental health due to the enormous impact that Covid 19 has had on the mental wellbeing of our population and as such we have seen demand for our services continue to increase due to economic climate changes, financial implications of loss/impact on employment, relationship breakdowns and pressures and bereavement. The pandemic has displayed and helped us all recognise the importance that our family, carer and social networks have on our ability to live our lives well.

We have recognised that the removal of some of these networks during heightened Covid restrictions may have contributed to an increased level of acuity and consequent serious incidents within the community of people we care for. This has placed more and more importance of the need for strong clinical risk assessments to be undertaken on an individualised basis. We are pleased to see that we recognise the importance of service user, family, and carer engagement when we are discussing the care needs of individual patients in mental health care and the concerted efforts being made to ensure that improved engagement and 'voice' of patients, families and carers continues as a high priority. In relation to safety measures and reducing harm, we are pleased to see that our nationally benchmarked position for restrictive practice is largely improving, however we remain concerned that improvement is not trust wide. We hope that as the

Reducing Restrictive Practice Quality Improvement Collaborative comes to an end change idea which are showing promising signs of delivering will be embedded across the organisation.

Despite the challenges that Covid has presented, we are pleased to see that the majority of the quality goals that we set for ourselves in 2021-2022 have been delivered. We would like to see a stronger focus on measures that demonstrated delivery of the Trust Quality Strategy and goals during 2022/23 inclusive of waiting times and out of area placements. We recognise the importance of ensuring a 'Just Culture' within the organisation so that staff feel safe to speak up about concerns relating to patient safety and feel confident that such concerns are constructively heard and addressed fairly and with a focus on positive change.

We recognise that we still have a journey of improvement ahead of us, it is, however, pleasing to see that we are moving in the right direction. We are supportive of the priorities laid out for 2022/23 and believe they provide an appropriate focus for the next 12 months. We would however in future years like to see more focus on transition points within care as we know that when our service users move from team to team this can result in increased risk and would like a greater focus on understanding if Covid has impacted on community suicides.

As the Council of Governors, we would like to extend our apologies and condolences to all families affected by the suicide of loved ones this year. This must be an incredibly tragic time for all. We are supportive of the measures that the Trust is taking to invest in a safer physical inpatient environment through the installation of continuous pressure door sensors on all ensuite bathrooms in our acute inpatient wards. We are equally supportive of the measures to apply such alarms to bedroom doors of high-risk wards. We are pleased to see that we are also developing a 3-5 year capital investment programme to remove anchor points from our entire inpatient estate. We recognise that improving the physical safety of our wards is only one part of managing safety and are pleased to see that we are increasing the level of therapeutic activities in our inpatient wards to aid the recovery of our service users and that teams are also engaging in daily safety huddles to ensure improved communication of safety issues and management plans. During the year, we have increased our involvement in research and were proud to present both nationally and internationally on the work of our LEAR group which focussed on the experience of lived experience practitioners. We hope that this will further aid the development and importance of coproduction across the organisation. 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 2020/21 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 2022-2023.

Council of Governors of BSMHFT

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

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

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

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

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

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

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

By order of the Board

Roisin Fallon Williams	**Danielle Oum**
Chief Executive	**Trust Chair**