Birmingham and Solihull Mental Health NHS Foundation Trust

QUALITY ACCOUNT REPORT

2020/2021

Contents

Quality Report

Part One

Statement on Quality from the Chief Executive

I am delighted to present our Quality Account for 2020/21. As I write this report, we are working hard to restore our services following the Covid 19 pandemic. 2020-2021 was one of the most difficult years in the history of the NHS with the outbreak of the COVID-19 virus. Firstly, I want to pay tribute to all our NHS, Care and key worker colleagues who have lost their lives, both here at Team BSMHFT and across the country, to this terrible virus. All of our staff, carers and volunteers have worked tirelessly since the outbreak and their amazing compassion, commitment and resolve has been focused on making sure that we keep everyone as safe as possible whilst maintaining the care and safety of all patients and staff. The unprecedented challenges posed by COVID-19 saw gigantic efforts made by all at Team BSMHFT and phenomenal collaborative focus of so many giving so much, above and beyond their day to day roles. I am grateful to our 4,200 strong workforce who, regardless of the challenge, strive to provide ongoing care for our patients and support to families, carers and each other as staff. The environments and context that we work within in ordinary circumstances are complex and challenging and we hugely proud of all of our staff for the valuable work that they have done in these unprecedented circumstances.

Despite the challenges of the pandemic we continued to deliver a range of quality improvements during the year to support our quality aims of:-

- Improving Patient Safety by Reducing Harm
- Focussing on a Positive Patient Experience
- Focussing on a Positive Patient Safety Culture
- Focussing on Quality Assurance
- Using our Time More Effectively

This account details the progress that we have made in delivering the above fundamentals that are the basis of our new five year Quality Strategy. It is an opportunity to reflect on the achievements that we have made and also the challenges we have encountered.

Our story of improvement whilst not without challenges is a positive one, and our commitment to further improvements is strong. During the year we had to change the way in which we worked to enable us to develop more skills and capability in our approach to quality improvement by conducting virtual training sessions with colleagues, stakeholders and with experts by experience. Many of our quality improvement projects were led virtually to ensure continued engagement, motivation and focus.

We have made good progress in delivering our goals linked to reducing harm with an average of 83% of all incidents resulting in no harm to patients compared to a national average of 62% according to the National Reporting and Learning System (NRLS).

We did experience an increase in the use of restraint in our inpatient units particularly during the first wave of Covid 19 however we have seen levels reduce again as the pandemic has eased. In March 2021 we launched our Reducing Restrictive Practice Quality Improvement Collaborative with more than 15 different projects operating in teams across the Trust to reduce restraint, seclusion and the use of rapid tranquilisation. We equally saw an increase in the number of physical assaults by patients on our staff during wave 1 and this often coincided with incidents of restraint. Since the late Summer however, we have seen levels of physical assault reduce significantly across the organisation and we are now reporting some of our lowest levels ever.

Sadly during the year three of our inpatients 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 improve the safety of our inpatient ward environments.

Our national benchmarking position for death by suicide was published in May 2021 by the University of Manchester National Confidential Inquiry into Suicide and Homicide. Latest published data tells us that 9.5 suicides per 100,000 people take place across the overall population of Birmingham and Solihull. Birmingham and Solihull has the joint 14th lowest suicide rate in England at the time of writing this report. When looking more closely at the number of suicides per 10,000 patients under our care, the latest National Patient Safety Scorecard shows that fewer patients under the care of our Trust die by suicide, compared to those seen on average in other mental health trusts across the country. Every suicide is a tragedy and we still have much improvement to make in this important area. We are working towards a zero ambition for suicide levels - and this forms a central part of aim to improve patient safety by reducing the harm to patients.

During the year, the Care Quality Commission took enforcement action against the Trust due to its concerns about ligature anchor point risks in our acute inpatient wards and also due to concerns about the quality of our care planning documentation. We have developed an improvement plan around these two areas which includes considerable investment in door alarm systems in our acute inpatient wards. Such alarms will trigger if any weight is applied to the door enabling immediate responses to be made by the clinical team. We have also revisited the way in which we develop our care plans and have developed and implemented minimum standards for multi-disciplinary team meetings. During the year we started to pilot some new approaches in some of our wards such as increased arts activities and this has proved to be a helpful aspect of therapeutic engagement for many patients. We also introduced daily safety huddles in our acute inpatient wards ensuring that teams come together regularly to review the safety of their environment and their patients in a multi professional way, enabling timely decisions to be taken in response to risk. As I write

this report, we continue to explore all other opportunities to strengthen the safety of our inpatient wards.

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

- Quality
- Clinical Services
- People
- Sustainability

Experts by Experience awarded us the co-production kite mark in recognition of the joint approach that we took to our strategy development.

Ensuring quality for all service users is fundamentally important and this year we will take learning from a range of national reports on health inequalities in mental health so that we can ensure that we truly understand inequalities by race, gender and disability. This will enable us to work with experts by experience to co-produce improvements to their care. We would like to thank our Healthwatch Birmingham and Solihull Partners for reminding us in their stakeholder statement of the critical importance of understanding and responding to health inequalities.

As I close this introduction, I reiterate my thanks and that of the Board of Directors, to our compassionate and committed staff, our service users, families and carers, our stakeholders and our Council of Governors and look forward to continuing to tackle our challenges, build on our successes and make progress in 2021/22.

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

Roisin Fallon-Williams
Chief Executive

Background

Once a year, every NHS Trust is required to produce a Quality Account Report. This report includes information about the services the Trust delivers, how well we deliver them and our plans for the following year.

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

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

What the Quality Report includes

- What we plan to do next year (2021/22), what our priorities are, and how we intend to address them.
- How we performed last year (2020/21), 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 have 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 2021/22
- Progress made since publication of our 2020/21 quality report including performance against each of the 2020/21 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 2020/21
    - 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 2021/22. In creating our quality priorities and goals, we have considered the aspirations in the NHS Long Term Plan; NHS England's Five Year Forward View for Mental Health and NHS Improvement Planning Guidance. We have also engaged widely with our workforce and our service users and Experts by Experience to ensure that these goals will support the delivery of our Quality Strategic Priority which reflects the local needs of our service users and staff as well as national needs.

Priority for Improvement 1: Improve Patient Safety by Reducing Harm

What this means: We will reduce unwarranted variations and reduce harm across our services. We want to reduce the level of harm and suicide rate amongst our most vulnerable patients ensuring appropriate and consistent application of the Mental Health Act, good access to crisis care and effective community care pathways. We want to 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.

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

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

During 2021/22 we will:

Preventing Harm	
Reduce levels of restrictive interventions in our inpatient units by completing year 1 of our QI Collaborative for Reducing Restrictive Practice	Measures of success:- Reduction in incidents of prone restraint Reduction in incidents of bedroom seclusion Reduction in incidents of assault on our inpatient wards
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 utlising an anchor point which result in moderate, severe or catastrophic harm to patients
Scale up and spread Safety Huddles across all wards in the Trust	Measure of Success:- Reduced level of harm attributable to patients and staff through incidents
To improve the physical health monitoring of patients in our care	Measures of Success:- ensure relevant blood tests and ECGs

	are performed prior to initiation of anti-psychotic 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 reduce the number of deaths of patients due to alcohol and substance misuse who are in our care	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

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 will:-

Improving Patient Experience	
Improve the involvement of service users in MDT meetings and ensure that	Measures of success:-

all service users have a copy of their care plan	% of service users attending their weekly MDT % of service users in receipt of their care plan Qualitative measure to be established through EBE group and reporting to commence against this measure from January 2022
Improve the involvement of carers in service user care and recovery	Measures of success:- % of carers registered on RIO % of carers with a completed carer engagement tool
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 2020/21 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:- Number 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:- Improvement in safety culture metrics in the national staff survey relating to incident reporting and learning 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.

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

During 2021/22 we will:

Improving Quality Assurance	
Pilot, evaluate and 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 Improvement in national staff survey metrics relating to the 'Ability to Contribute to Improvements'

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 2021/22 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:- Clinical outcomes associated with service user satisfaction levels with life domains and treatment aspects of their care

2.1.2 Monitoring, Measuring and Reporting Progress on the Priorities

Monitoring measuring and reporting progress on the above priorities will take place through a quarterly report to the Integrated Quality Committee at Birmingham and Solihull Mental Health NHS Foundation Trust. Such reporting will include reference to relevant outcome measures reported through the National Mental Health Community Patient Survey which is published annually and also the Annual NHS Staff Survey. In addition, we will monitor our performance against a range of key indicators such as restraint levels, suicide levels, incidents of self harm and incidents of physical assault through a monthly integrated performance dashboard that is presented to our Trust Board meeting in public each month. In addition, we will develop our reporting around health inequalities in the delivery of health care by including quantitative and qualitative information about the clinical outcomes and the experience of different racial communities, those with disabilities and differing sexual orientations.

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:-

- Incident reporting levels (an increased level of incident reporting demonstrates a positive safety awareness culture)
- The level of harm that came to patients from incidents that happened whilst they were in our care (a lower level of harm is good)
- The level of restrictive practice that occurred in our inpatient wards, particularly prone restraint and physical restraint (a lower level is good)
- The level of physical assault that took place on our inpatient wards (a lower level is good)
- The number of suspected and confirmed suicide levels and our nationally benchmarked position according to the National Confidential Inquiry Annual Report (a lower level is good)

We routinely report and review the levels of harm that come to patients from incidents that can occur during their care. We report these levels on a monthly basis to a range of forums within our governance structure including our Patient Safety Advisory Group, Our Integrated Quality Committee and our Trust Board.

During 20201-2021 incident reporting levels increased. This was in part influenced by Covid 19 and the associated level of Covid19 patients we were caring for and the risk of transmission of Covid19 in our working environment. Whilst we saw levels of harm increase in the stages of wave 1, these dramatically reduced from September 2020 and have remained at circa 17% since this time. This means that in 83% of incidents reported no harm came to our patients. National benchmarking levels published by the National Reporting and Learning System known as NRLS demonstrate that we have lower levels of harm arising from incidents than the national average of 39%. Levels of incident reporting and associated levels of harm are shown below in figures 1 and 2:-

Figure 1 – General Incident Reporting Levels

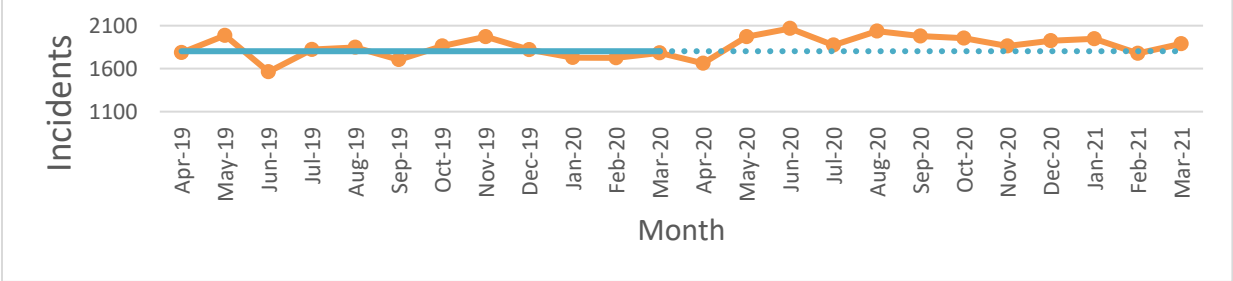
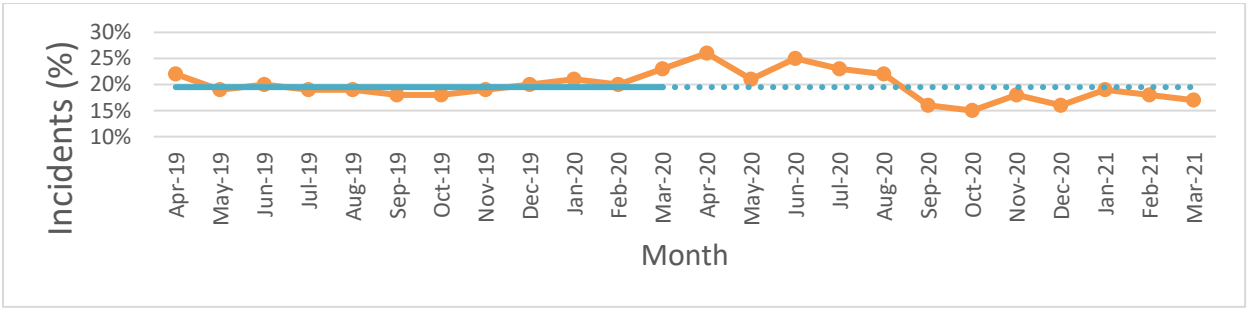


Figure 2 - %of incidents resulting in harm to patients

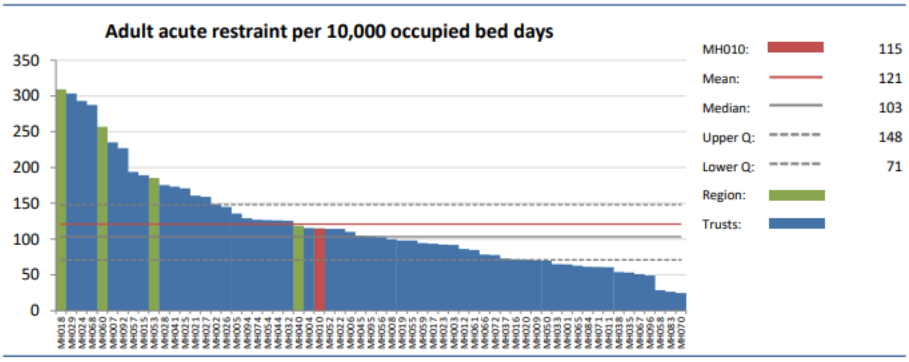


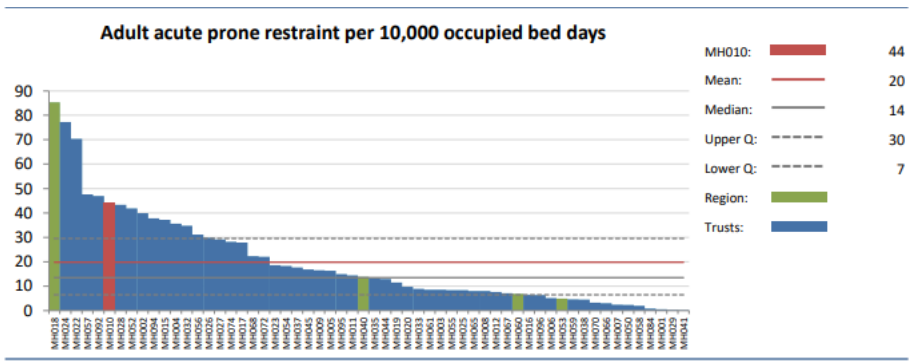
The level of restrictive practice that occurred in our inpatient wards, particularly prone restraint and physical restraint (a lower level is good)

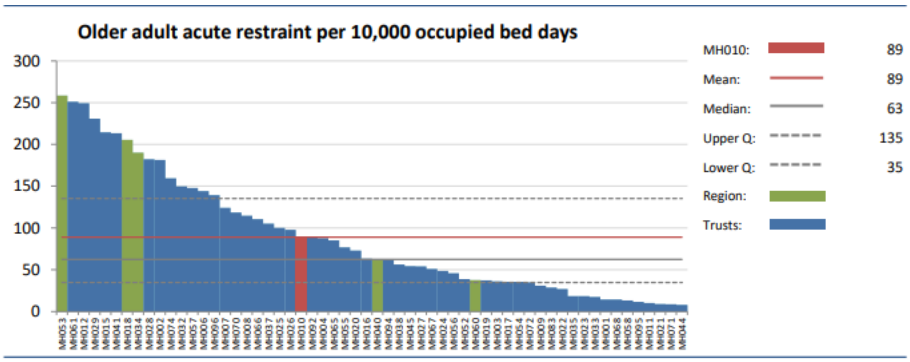
During 2020/21 we:

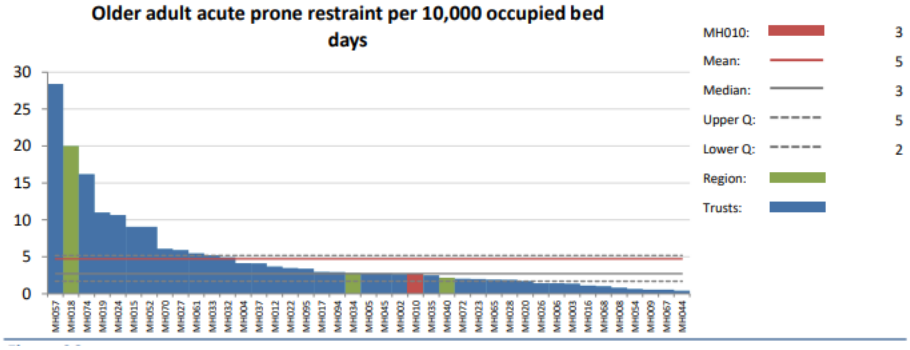
- Established our Quality Improvement Collaborative aimed at reducing levels of restraint and reducing levels of violence and aggression within on our inpatient wards. The programme has been designed in collaboration with experts and experts by experience, with the aim to support wards to carry out quality improvement through regular learning days and dedicated support from the BSMHFT Quality Improvement Team. This is being achieved by providing the tools and resources for selected teams to develop their own quality improvement plans. There are currently 18 projects registered as part of the Collaborative which launched in March 2021. Experts by Experience form a core part of the Collaborative. We had planned to launch the collaborative earlier in the year however this had to be re-planned due to the focus we needed to give to managing the Covid 19 pandemic.

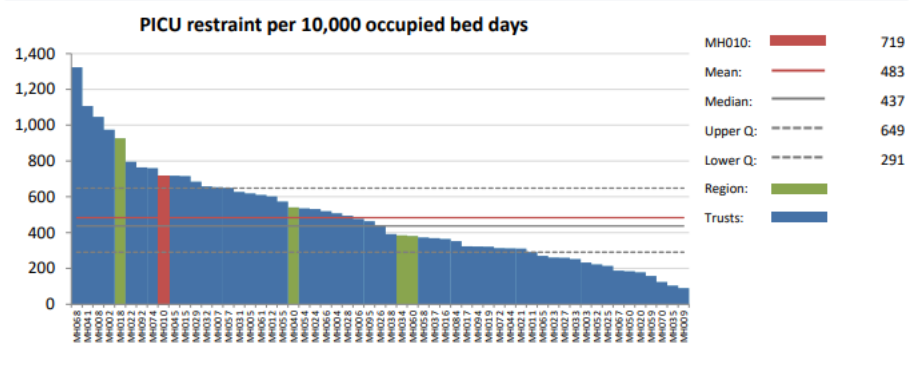
  During the year we did receive national benchmarking data telling us how our restraint levels compared to those seen in other mental health trusts during 2019/20. We are the Trust marked by the red bar below:-

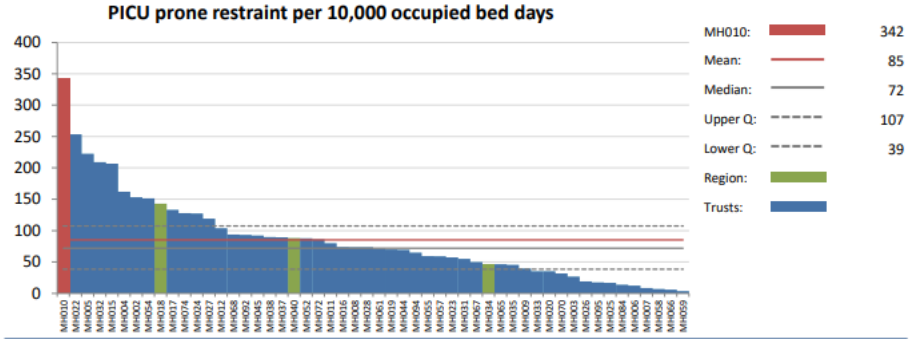










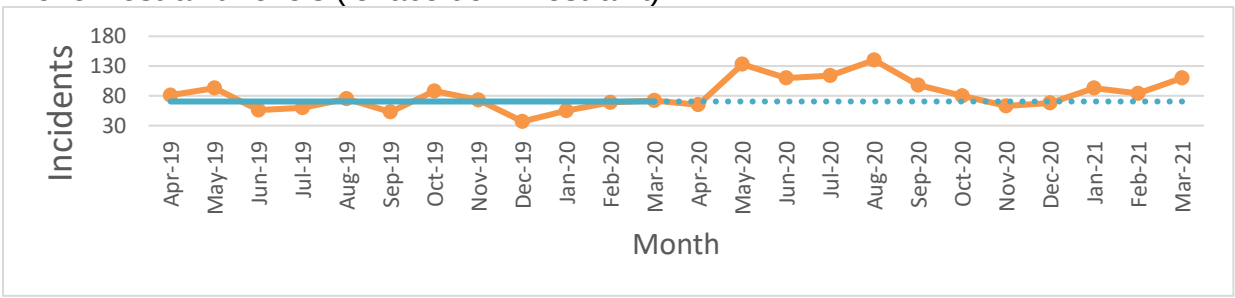


We did note that whilst we generally have an improved position nationally in comparison to previous years, we have more improvements to make, particularly within our Psychiatric Intensive Care Units (PICU), hence the important work of the collaborative that we have established. During wave one

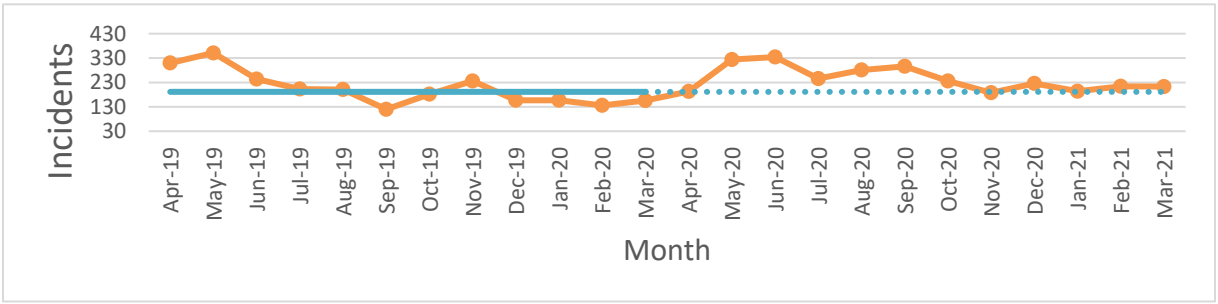
of Covid we saw levels of both prone and non-prone restraint increase. This was in part influenced by the increased acuity of patients on our wards and also the impact of some additional controls that we had to put in place to manage the spread of Covid 19 such as limited arrangements for visiting and more enhanced risk assessments for periods of absence from the ward environment.

Our prone and non-prone (physical) restraint levels are shown below and we can see that as restrictions have eased the levels of restraint have started to reduce.

Prone Restraint Levels (ie face down restraint)

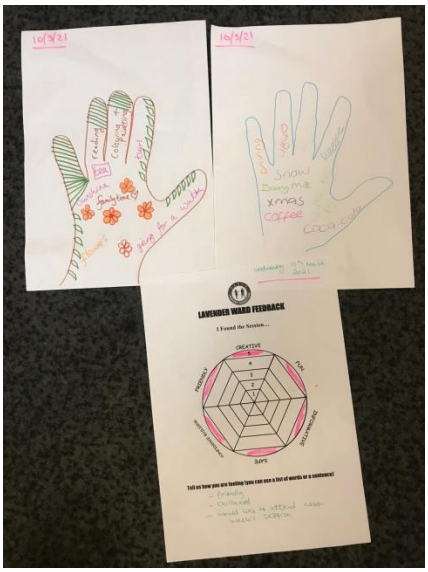


Non-prone Restraint Levels



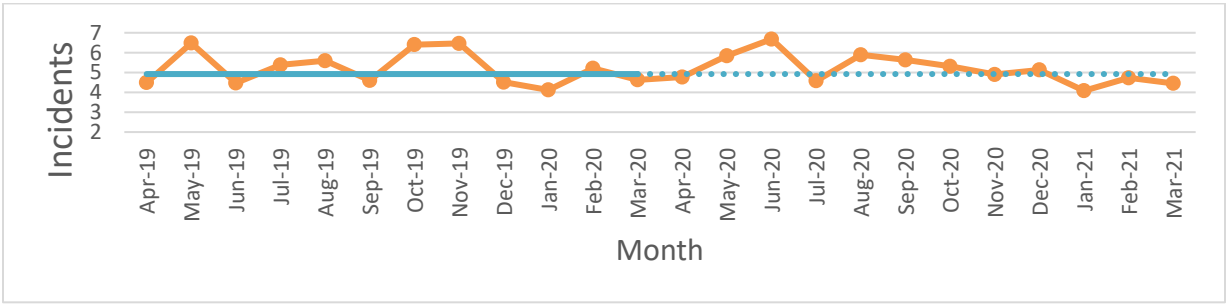
The level of physical assault that took place on our inpatient wards (a lower level is good)

We set ourselves a goal to pilot enhanced therapeutic activity models on 4 acute inpatient wards and 3 secure care inpatient wards with the aim of improving recovery, reducing incidents of physical assault, reducing incidents of restraint, reducing incidents of self harm. We did have to suspend some of the activity on our secure care wards during periods of very high acuity in the pandemic and it was in January 2021 that we began to introduce additional therapeutic activities to our four pilot wards in acute care. Our results from the 4 pilot wards in acute care have demonstrated some success with one of our pilot wards telling us '*Service users have engaged very positively with the therapeutic activities on offer on the ward and we have received some very positive service user feedback. 'Women in Theatre had their last session on Lavender last Friday and the sessions have been going really well and there has been a real positivity around the Drama sessions on the ward. Both staff and service users have approached me to ask for further information regarding these sessions. The have found both the facilitators and the content of the session fun and enjoyable. Several women were planning to only sit and observe however managed to stay throughout the sessions and actively engage in them also. Although the numbers attending the sessions are not large in quantity they have certainly had a positive impact on the service users and they have felt listened to and relaxed'.* Some examples of outputs of the sessions and a piece of service user feedback are shown pictorially below:

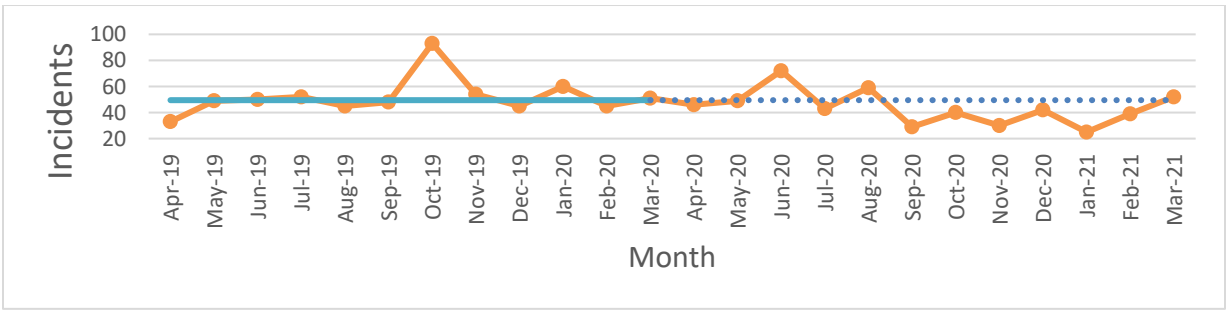


Levels of physical assault on staff and on patients are reviewed and reported on every month to a range of governance forums including our Patient Safety Advisory Group, our Integrated Quality Committee and our Trust Board. During the initial phase of Covid we saw an increase in assaults but as the wards stabilised and routines became more established we saw a reduction in such incidents.

Physical Assaults on Staff



Physical Assaults Patient on Patient

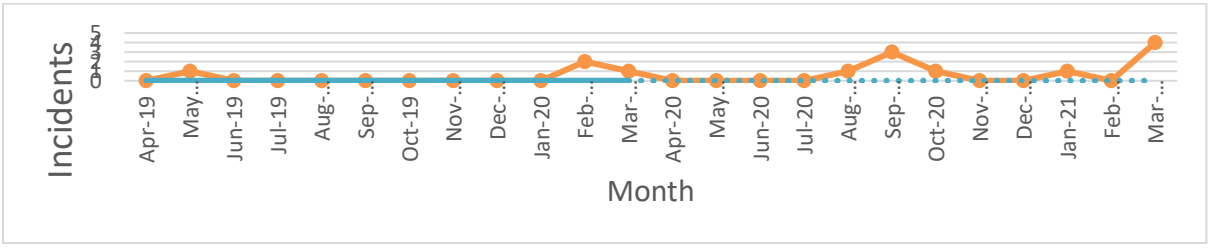


Suspected and Confirmed Suicide Levels

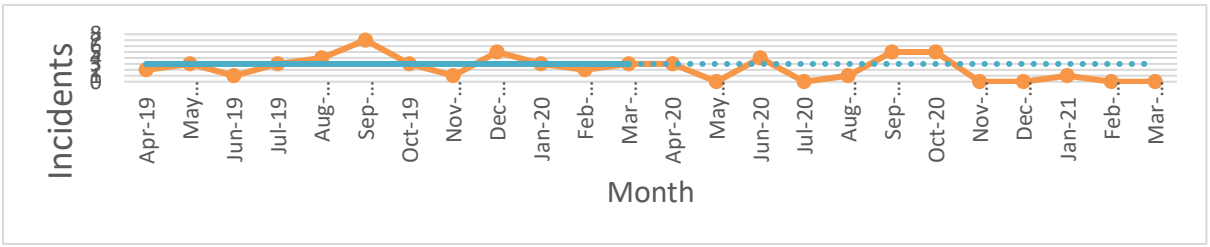
When we initially receive an incident report that suggests a service user may have died by suicide, we call this a ‘suspected suicide’. All suspected suicides are subject to a Coronial Inquest and it is at the closure of the inquest that the Coroner determines whether the cause of death was a ‘confirmed suicide’ or another cause. During the

Covid pandemic the Coroner saw a surge of deaths reported nationally which meant that it has taken longer than usual for some inquests to take place. We saw an increase in suspected suicide levels in patients that we were caring for in the community when the Covid wave 1 restrictions started to ease over the Summer months and again in March 2021 as wave 2 restrictions started to slowly be lifted. We undertake a root cause analysis investigation for every suspected suicide case of a patient in our care. Through this process we were able to see that lockdown restrictions had an impact on the mental health wellbeing of some of our patients, particularly the loss of social networks and supportive family networks.

Suspected Suicides in the Community

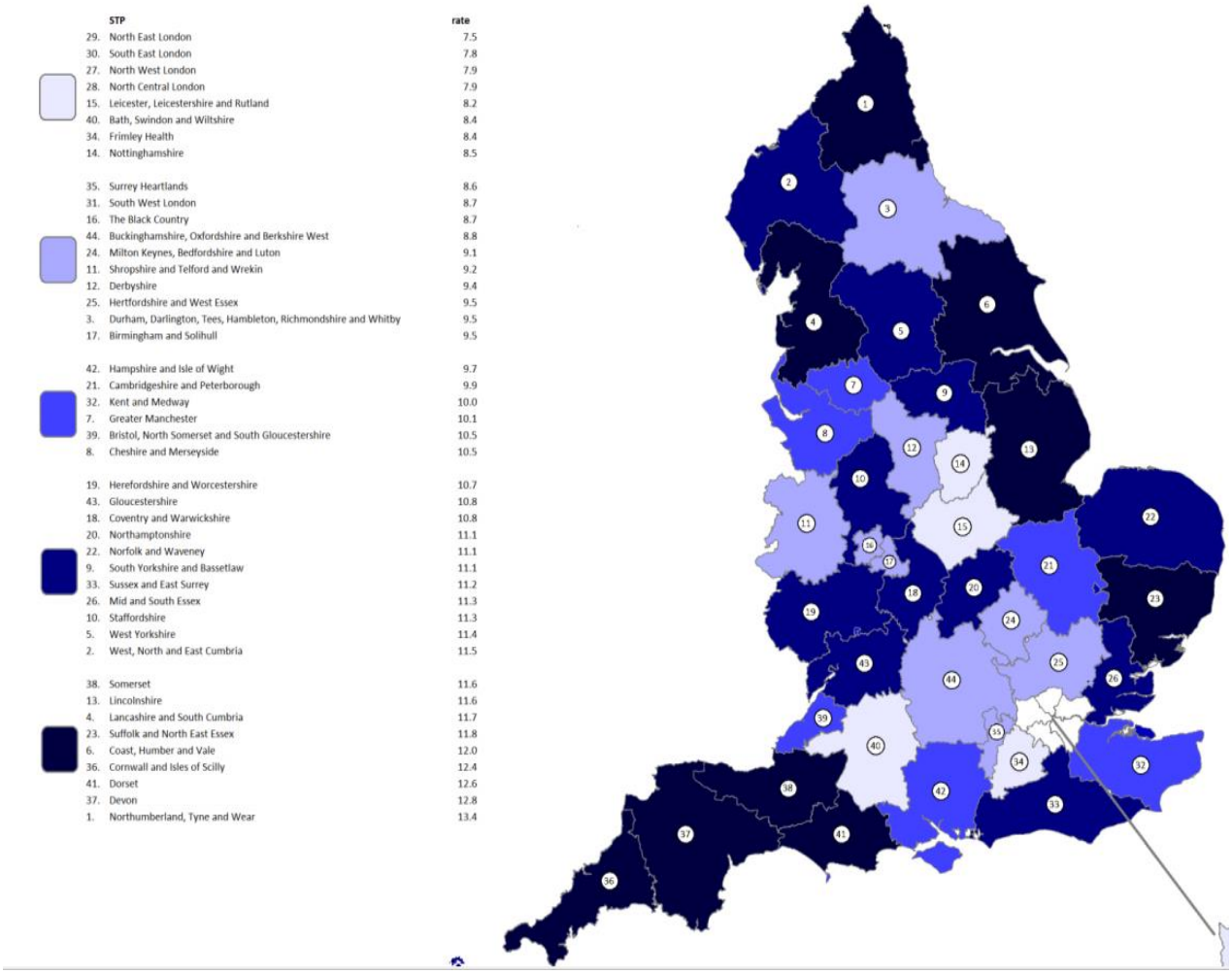


Confirmed Suicides in the Community



Each year the University of Manchester publishes a report called the National Confidential Inquiry into Suicide and Homicide. This report considers levels of suicide and homicide across varying geographical areas of England, Scotland, Ireland and Wales. The report is based on levels of suicide per 100,000 population and is not specific to patients in receipt of mental health care. The rate for Birmingham and Solihull is 9.5 per 100,000 population. The lowest rate is 7.5 in North East London and the highest rate is 13.4 in Northumberland Tyne and Wear. Out of 44 different geographical areas, we have the joint 14th lowest level of suicide in our population.

Figure 1: Rates of suicide per 100,000 population, by STP 'footprint' area of residence (average rate 2016-2018)



	STP	rate
29.	North East London	7.5
30.	South East London	7.8
27.	North West London	7.9
28.	North Central London	7.9
15.	Leicester, Leicestershire and Rutland	8.2
40.	Bath, Swindon and Wiltshire	8.4
34.	Frimley Health	8.4
14.	Nottinghamshire	8.5
35.	Surrey Heartlands	8.6
31.	South West London	8.7
16.	The Black Country	8.7
44.	Buckinghamshire, Oxfordshire and Berkshire West	8.8
24.	Milton Keynes, Bedfordshire and Luton	9.1
11.	Shropshire and Telford and Wrekin	9.2
12.	Derbyshire	9.4
25.	Hertfordshire and West Essex	9.5
3.	Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	9.5
17.	Birmingham and Solihull	9.5
42.	Hampshire and Isle of Wight	9.7
21.	Cambridgeshire and Peterborough	9.9
32.	Kent and Medway	10.0
7.	Greater Manchester	10.1
39.	Bristol, North Somerset and South Gloucestershire	10.5
8.	Cheshire and Merseyside	10.5
19.	Herefordshire and Worcestershire	10.7
43.	Gloucestershire	10.8
18.	Coventry and Warwickshire	10.8
20.	Northamptonshire	11.1
22.	Norfolk and Waveney	11.1
9.	South Yorkshire and Bassetlaw	11.1
33.	Sussex and East Surrey	11.2
26.	Mid and South Essex	11.3
10.	Staffordshire	11.3
5.	West Yorkshire	11.4
2.	West, North and East Cumbria	11.5
38.	Somerset	11.6
13.	Lincolnshire	11.6
4.	Lancashire and South Cumbria	11.7
23.	Suffolk and North East Essex	11.8
6.	Coast, Humber and Vale	12.0
36.	Cornwall and Isles of Scilly	12.4
41.	Dorset	12.6
37.	Devon	12.8
1.	Northumberland, Tyne and Wear	13.4

Deaths by Suicide in Mental Health Inpatient Wards

National statistics reported by the National Confidential Inquiry into Suicide and Homicide demonstrate that whilst the number of deaths by suicide in mental health inpatient units is reducing, there is still opportunity to reduce these further. Evidence demonstrates that the majority of deaths by suicide in mental health wards were by hanging/strangulation from ligature points. Ensuring that our physical estate is as safe as possible is very important to us – particularly our inpatient wards where we know we care for patients who are at high risk of harm due to their mental illness.
During 2020-2021 we sadly reported 3 confirmed inpatient suicides occurring on our acute inpatient wards. I would like at this stage of this report to reiterate my sincere apologies and condolences to the families and friends of these patients. In all of these cases the service user utilised their en-suite bathroom door or bedroom door as a ligature anchor point. We had been piloting the use of continuous door alarm systems on some doors in our acute inpatient wards, however we had not made a final decision on which alarm system was the most suitable for our inpatient units until the Summer of 2020. Since making this decision we have:-

- Implemented door alarm systems on all en-suite bathroom doors at Mary Seacole House Ward 2 as part of our Physical Estate Ligature Risk Reduction Programme

- Established our roll out plan for en-suite door alarm systems across all acute inpatient wards and Psychiatric Intensive Care Units aligned to our capital investment programme. We anticipate that this will be complete by March 2022.
- Established a plan to place continuous door alarm systems on some of the bedroom doors of our highest risk wards during 2021-22
- Agreed to develop a 3-5 year ligature risk removal programme across our entire inpatient Estate to remove all ligature anchor points

During 2020/21 we also took forward a number of other initiatives to improve the safety of our services. These included:

- Participation in the National Sexual Safety Collaborative
- The establishment of our Safeguarding Partner roles in each of our service areas
- The appointment of a Patient Safety Specialist in line with the requirements of the National Patient Safety Strategy
- Strengthening our approach to the monitoring and management of haematological and other physical health investigations
- Reviewing the infrastructure of our electronic patient records to ensure that they are streamlined and minimise the risk of duplication of information
- Scoping the use of 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 Implementation of year one of our Personality Disorder Guidelines
- The piloting, evaluation and roll out a quality improvement project to establish minimum standards for multi-disciplinary Team (MDT) working across our Acute Inpatient Wards and Psychiatric Intensive Care Units
- The establishment of Safety Huddles on all of our acute inpatient wards and psychiatric intensive care units

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

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

During 2020/21 we set the following goals and I detail our achievement below:-

- Finalise a vision and a set of principles of Expert by Experience (EBE) participation, to work in conjunction with the Family and Carer strategy and Recovery for All Strategy. This will include a review and development of an experts by experience reward and recognition policy – we commenced the co-production of vision and principles of Expert by Experience (EBE) participation

including a review of our reward and recognition policy for Experts by Experience.

- Increase EBE participation in Level 1 Quality Improvement projects to 30% by March 2021 – we delivered dedicated Expert by Experience training sessions in Quality Improvement in a virtual manner due to Covid. These proved to be very successful and we now have experts by experience involved in core Quality Improvement work such as the therapeutic activities work on our wards & our Least Restrictive Practice QI Collaborative
- Develop the role of the Patient Safety Partner in accordance with the National Patient Safety Strategy and pilot this approach before scale up and spread – We started to scope the role of the Patient Safety Partner ensuring that our Experts by Experience have a stronger and equal voice within the governance of patient safety and patient experience – we are introducing this role in 2021/22
- Increase the number of Personal Health Budgets for service users who are eligible for section 117 after care as they are discharged from inpatient wards - . During 20/21 there has been a continued focus on personalised care and personal health budgets . These are continuing to be offered to service users with a particular focus on people leaving hospital as part of their Sec 117 after care arrangements. The impact of covid (in both the Trust and the CCG) has reduced the number offered this year although more sustainable mechanisms have been developed to ensure that this offer is available to all eligible people as we move forward. QI will be important in embedding this work across the Trust.

  Undertake baseline assessment, work with Family and Carer Pathway Group to determine key aims and deliverables to improve the Patient, Family and Carer experience of Serious Incidents and Complaints – we commenced recruitment of EBEs within a new Quality Improvement Project to improve the patient, family and carer experience of our complaints process

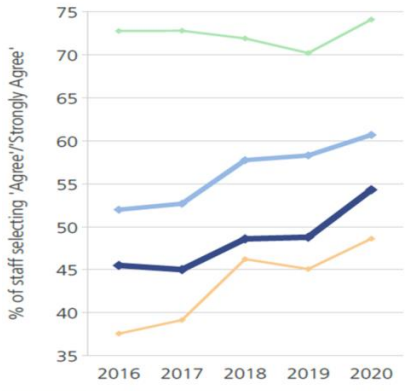
In addition, we engaged with experts by experience to develop a template for a care plan that can be shared with patients, families and carers. We also undertook work with some key experts to strengthen the patient, family and carer voice in care planning.

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. When incidents do occur in our services we want to ensure that we use the principles of a Just Culture when understanding any care or service delivery problems, any contributory factors to the incident and the root cause of the incident. It is critical that we treat staff involved in

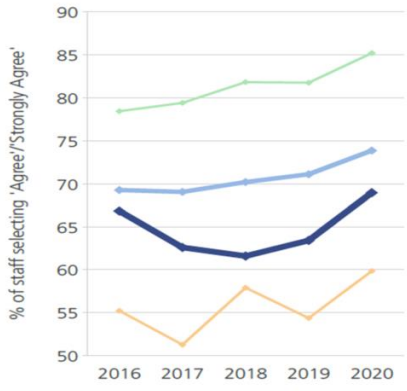
incidents fairly and that we make changes to improve care in response to incidents to try to ensure that they do not happen again. Each year there is a national NHS Staff Survey which takes a sample view of staff across the NHS to understand their experience of working in the NHS. As part of this annual review there are a number of safety culture metrics which give a view on how confident staff are in our incident reporting, investigation and feedback processes. Our results from the latest survey are shown below:-

Q16a
My organisation treats staff who are involved in an error, near miss or incident fairly



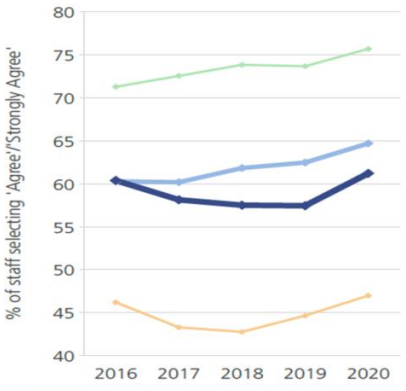
	2016	2017	2018	2019	2020
Best	72.8%	72.8%	71.9%	70.2%	74.1%
Your org	45.5%	45.0%	48.6%	48.8%	54.3%
Average	52.0%	52.7%	57.8%	58.3%	60.7%
Worst	37.6%	39.1%	46.2%	45.1%	48.6%

Q16c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



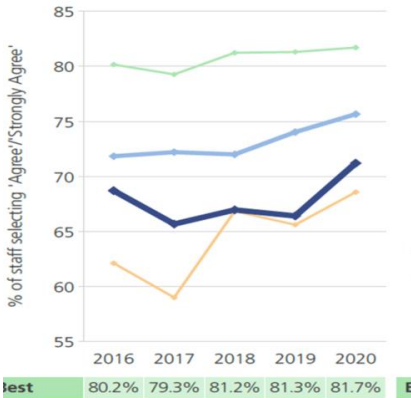
	2016	2017	2018	2019	2020
Best	78.4%	79.4%	81.8%	81.8%	85.2%
Your org	66.8%	62.6%	61.6%	63.4%	69.0%
Average	69.3%	69.1%	70.2%	71.1%	73.9%
Worst	55.2%	51.3%	57.9%	54.4%	59.9%

Q16d
We are given feedback about changes made in response to reported errors, near misses and incidents



	2016	2017	2018	2019	2020
Best	71.3%	72.6%	73.8%	73.7%	75.7%
Your org	60.4%	58.1%	57.5%	57.4%	61.2%
Average	60.3%	60.2%	61.8%	62.5%	64.7%
Worst	46.2%	43.3%	42.8%	44.7%	47.0%

Q17b
I would feel secure raising concerns about unsafe clinical practice



	2016	2017	2018	2019	2020
Best	80.2%	79.3%	81.2%	81.3%	81.7%
Your org	68.7%	65.7%	67.0%	66.4%	71.2%
Average	71.8%	72.2%	72.0%	74.0%	75.7%
Worst	62.1%	59.0%	66.8%	65.6%	68.6%

Q17c
I am confident that my organisation would address my concern

	2016	2017	2018	2019	2020
Best	69.6%	69.4%	74.9%	75.5%	76.5%
Your org	54.5%	49.0%	48.5%	50.7%	55.8%
Average	58.7%	59.4%	59.2%	60.5%	63.1%
Worst	43.6%	41.7%	46.2%	46.1%	46.8%

Q18b
My organisation acts on concerns raised by patients / service users

	2016	2017	2018	2019	2020
Best	83.5%	86.2%	84.2%	85.8%	85.2%
Your org	73.1%	70.7%	70.6%	71.6%	74.1%
Average	74.8%	74.8%	74.0%	75.5%	77.0%
Worst	57.9%	57.6%	59.5%	54.7%	59.7%

We can see from the results above that we have improved in all of the metrics in the latest survey which is a positive development. We still have much work to do to create a strong patient safety culture and during 2020 we took part in a new peer review scheme hosted by the Royal College of Psychiatrists which looks at the effectiveness of serious incident review processes. Colleagues who had been involved in serious incident reviews told the Peer Review Team that:-

- I feel that the support offered was of benefit and the guidance of the learning was clear. this enabled the team to understand the learning points.
- Much improvement happened in recent year regarding approach and sensitivity during the SI process.

- Very supportive process
- My experiences of being involved in SI reviews have been positive and feel that this is due to the professionalism of the individuals completing the review.
- I have always had a positive experience with the SI team who are always very clear, calm and compassionate
- An inclusive process with a nice feel of support
- Investigator was very compassionate to myself and the staff involved. Was also extremely flexible with arranging times to meet staff (i.e. early morning for night staff).
- During the recent SI review we were provided with a lot of support as a whole team due to the nature of the incident. Things were managed sensitively and recommendations were taken on board.

Some of the things that we have done during 2020-2021 to support our safety culture include:

- Included TRIM support as part of our support package to staff following traumatic incidents by developing a number of TRIM practitioners in the Trust who can support staff effectively. TRIM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event. TRIM practitioners are clinical and non-clinical members of staff who have undergone specific training allowing them to understand the effects that traumatic events can have upon people. They are not counsellors or therapists, but understand confidentially and are able to listen and offer practical advice and assistance. During the year we have developed 25 TRIM practitioners across our Trust who have undertaken approximately 30 TRIM interventions to support staff
- Introduced the concept of civility saves lives as part of our safety culture. When incivility occurs in the workplace through poor behaviours such as rudeness, this impacts not only on the recipient but also on wider staff and patients, families and carers. National research shows that rudeness has a direct impact on reduced staff performance, a reduced commitment to work, increased staff absence, a reduced quality of work and an impact on the patient experience. When patients observe or experience incivility it can leave them feeling anxious and reduce their confidence and view of our Trust and the care they receive.
- Piloted Learning from Excellence in our Dementia and Frailty Services and issued 30 thank you letters of recognition of individual moments of excellence. We evaluated the success of the pilot and developed a scale up and spread plan so that we have a process to report, recognise and learn from excellent practice amongst our staff. Safety in healthcare has traditionally focused on avoiding harm by learning from error and whilst it is important that we continue to learn from error, this approach alone may miss opportunities to learn from excellent practice. We believe that developing and implementing a system to capture, celebrate and learn from excellent practice can create new opportunities for learning and improving resilience and staff morale.
- Developed and consulted on a service area level dashboard pulling together information on the quality of services delivered, workforce information, financial

information and information on access to services – we will implement this as part of our business as usual approach in early 2021/22

- Considered Human Factors as part of our incident processes ensuring that we understand any system issues that need attention
- Increase the level of clinical supervision training reported through our portal by at least 10% to ensure continued learning, reflection and support to our staff – we achieved our aim of a 10% increase with a an average rate for the year of circa 45% compared to 39%
- Our training in Appreciative Inquiry was stalled during Covid. We are now in active discussion with the Midlands Academic Health Science Network so that we can reintroduce this training in April 2021 to aid our development of a Just Culture.

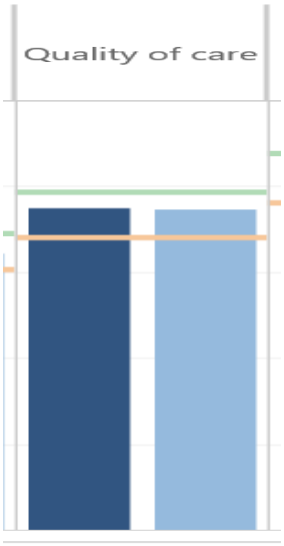
Priority for Improvement 4: A Focus on Quality Assurance

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

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

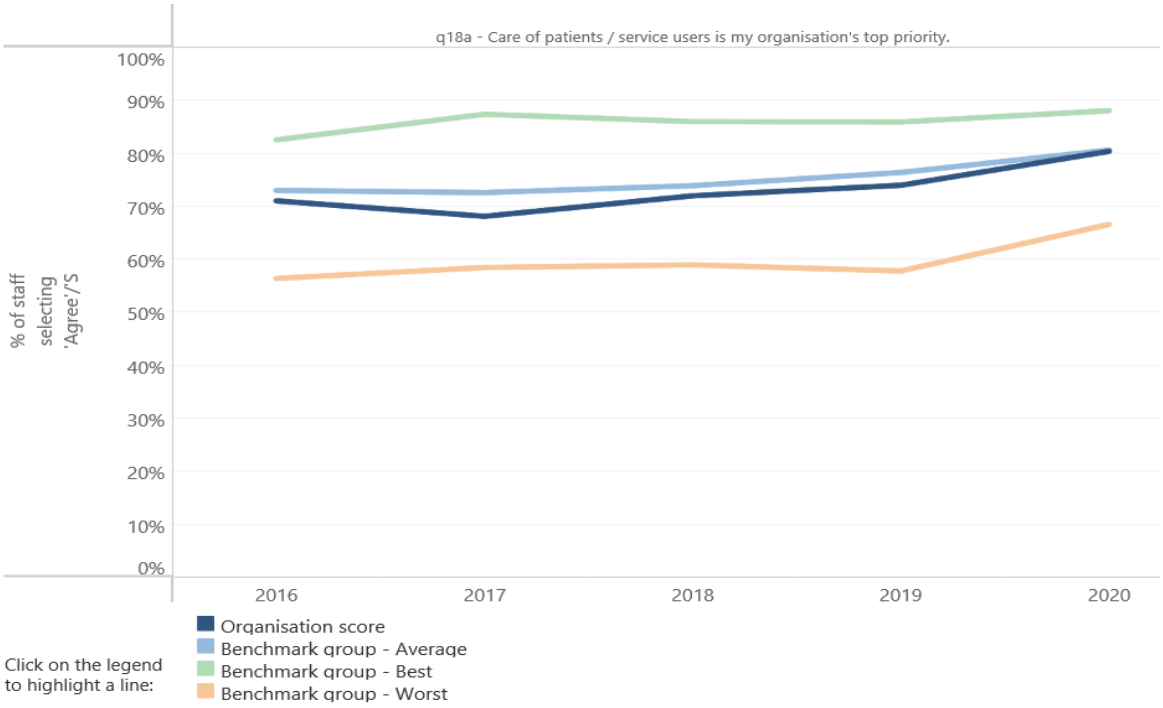
We will measure our success through improvements in the National Staff Survey metrics relating to the ‘Care of Patients/Service Users in my organisations top priority’ metric; the ‘Quality of Care’ metric and improvement in ratings awarded by the CQC.

Our quality of care domain in the national staff survey for 2020 was as follows:-



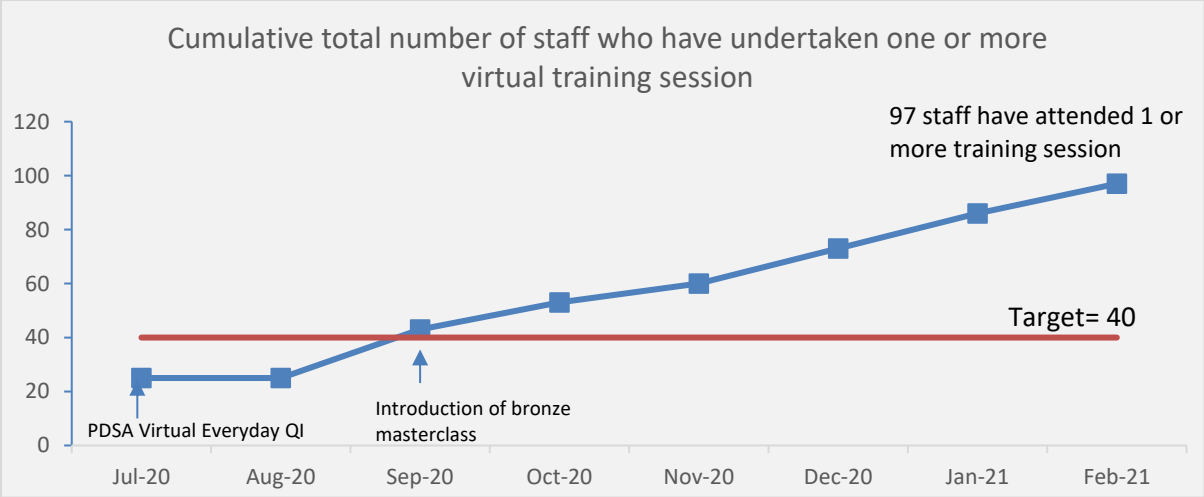
The green line shows the best and highest performing results in the Country. The orange line shows the lowest scores in the Country. We are the dark blue box which demonstrates that our staff results for quality of care reflect that seen on average across the Country (national average shown in light blue box).

Our result for the metric relating to the 'Care of Patients/Service Users is my organisations top priority' is shown in the graph below. Whilst we still have further improvements to make, it is positive to see a continual improvement in this metric over the past 3 years.



During 2020/21 we have taken forward the following developments to support an improved approach to quality assurance:

- Exceeded our 10% target of increasing the number of our staff who are trained in Quality Improvement methodology by over 100%



- We have standardised the way we present all of our quality data into 'run charts' enabling a better understanding of our performance and how changes we are making are successfully improving care or are encountering challenges. Run charts are now being used as our business as usual way of reporting on all quality improvement projects and quality and safety metrics. Run charts are graphs of data over time and are one of the most important tools for assessing the effectiveness of change. Run charts have a variety of benefits: They help improvement teams formulate aims by depicting how well (or poorly) a process is performing. They help in determining when changes are truly improvements by displaying a pattern of data that you can observe as you make changes. They give direction as you work on improvement and information about the value of particular changes.
- Developed process, outcome and balancing measures for all of our quality improvement projects. Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making actually lead to improvement.
- Developed a peer review process to continually review our compliance levels with CQC regulations and encourage shared learning. We will implement this process in 2021/22.

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

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

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

During 2020/21 we:

- Procured and commenced implementation of continuous door alarms on all en-suite doors in our acute inpatient units. Such alarms will activate if any weight is applied to any aspect of the door enabling immediate staff response
- Explored the use of digital technology to enable the selection and future implementation of a digital 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

- We had also intended to develop the 'triple aim' approach to our quality improvement programmes and monitor and report efficiency impacts of the programmes, however due to the Covid pandemic we did have to put a number of our projects into 'hibernation' to enable staff to be able to directly respond to the rising demands that they were facing due to increased mental health and physical health acuity of our patients.

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 2020/21 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 2020/21 represents 90 % of the total income generated from the provision of relevant health services by BSMHFT for 2020/21

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 2020/2021, 7 national clinical audits and 2 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 2020/21 are as follows • POMH 20a: Prescribing Valproate • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • POMH 18b: Use of clozapine • National Confidential Enquiry - 'Transitions' Child Health Clinical Outcome Review Programme - Adolescent Mental Health • National Audit of Care at End of Life. • National Audit of dementia • NCEPOD- Physical Health in Mental Health Hospitals • Falls and Fragility Fracture Audit Programme (FFFAP) • 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 2020/2021, are listed below : - • POMH 20a: Prescribing Valproate

		• National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • POMH 18b: Use of clozapine • Falls and Fragility Fracture Audit Programme (FFFAP) • 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 2020 to March 2021 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:-

Title of National Clinical Audit	Eligible	Participated	% *
POMH 20a: Prescribing Valproate	Yes	Yes	117[1]
National Clinical Audit of Psychosis (Early Intervention Services) (NCAP)	Yes	Yes	49%
POMH 18b: Use of clozapine	Yes	Yes	119[1]
Falls and Fragility Fracture Audit Programme (FFFAP)	Yes	Yes	N/A -Organisational questionnaire only [2]
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	Yes	Yes	

** Percentage of required number of cases submitted*

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

[2] There were no inpatient Falls reported by Acute Hospitals for us to participate in the Case note Audit.

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 2 national clinical audits were reviewed by the provider in 2021/21 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	

POMH 17b: Use of depot/LA antipsychotic injections for relapse prevention

Whilst the data collection for the audit of the use of depot and long-acting antipsychotic injections for relapse prevention took place in November 2019. The results were received in March 2020. At this time, the Clinical Effectiveness Committee (Now Clinical Effectiveness Advisory Group), which would usually have received the results, had paused due to urgent Covid19 work. The committee resumed its responsibilities in July 2020 and received the report.

This was the first re-audit for the Prescribing Observatory for Mental Health (POMH) Quality Improvement Programme 17b: The use of depot/long-acting injectable antipsychotic medication for relapse prevention.
The clinical standards for this audit were derived from national guidelines for the treatment of schizophrenia.
Patients eligible for inclusion in this audit were all those under the care of adult mental health services (with no age restrictions) including forensic services, who are prescribed depot/long-acting injectable antipsychotic medication. This did not include patients under the care of CAMHS, learning disability and older people's services.
This produced a population of 2108 eligible patients, of which we sampled 118 due to capacity constraints.

Key Success points:
99% of patients had a care plan which is better than the total national sample (TNS) of 92%.
In 97% of cases the care plan included a crisis plan which is significantly better than 77% of the TNS.
Areas of Improvement:
The areas in which BSMHFT were below the 2017 results and the TNS were the recording in the care plan for the clinical plan in response to default from treatment (16%).

BSMHFT scored 70% for the documentation of signs and symptoms in care plans. This had previously been 83%, although still higher than the TNS of 68%. This is part of the trust wide workstream looking at care plans and crisis plans.

Trust Response/Key actions:

Standard 1e: Care plans should include a clinical plan for response to default from treatment, i.e., if a patient fails to attend an appointment for administration of their depot/LAI antipsychotic medication injection or declines their injection:

- BSMHFT only scored 16% of the top criteria due to the clinical plan not being a part of the patient care plan, all patients had a clinical plan but for 84% this was not contained within the care plan. As it was this specific distinction POMH was looking for, we scored quite low for this particular standard.
- Whilst the compliance rate against the specifics (Clinical plan being in the care plan) of this standard were quite low, this represents the way in which our Trust uses care planning. Other Trusts use "template Care Plans" which are likely to involve this sort of information. Our Care Plans are more service user led and reflect other areas, as advised by CQC. It was noted that the Trust performed well in having clear statements in the patients notes regarding this area (actions to be taken in case of default from treatment), and in fact we were one of the best performing teams in this regard.

In response to this, inpatient settings and community clinical planning is also being explored.
However, over the past year care planning has been undergoing a complete re-design trust wide.

For inpatients:

- A new care planning process has been designed based on a MDT model
- Significant reduction in administrative burden
- Promotes patient engagement and MDT working
- New printed version developed in conjunction with Experts By Experience.
- Live on 16 acute wards with plans in place to extend to all other inpatient services over next 6 – 9 months

For outpatients:

- New care planning process designed linked to DIALOG outcome measure
- Significant reduction in administrative burden
- Care planning driven by needs identified by the patient
- Scope to include all community services beginning with CMHTs to be completed over next 9 – 12 months

NCAP EIS spotlight

In October 2020, the Trust participated in the 2020/21 National Clinical Audit of Psychosis. This audit focused on Service users with first episode psychosis receiving treatment from our early intervention in psychosis service (EIS). The audit included a review of Cognitive Behavioral 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. The age ranges the audit explored were 14-35years.

There were also two physical health related domains which were

1. Physical health annual review, which included: smoking status, alcohol intake, substance misuse, BMI, blood pressure, glucose and cholesterol.
2. Physical health interventions, such as smoking cessation, substance misuse, weight gain/obesity, harmful alcohol use, Dyslipidemia, Diabetes/high risk of diabetes and Hypertension.

The report is due in Summer 2021 and will be reviewed by the Early Interventions Team, who will decide the actions we need to take and areas of focus, and then return to the Clinical Effectiveness Advisory group, where the actions will be overseen.

National Confidential inquiry (NCI) into suicide and homicide

The Trust as a matter of course, continually contributes to the University of Manchester National Confidential Inquiry into Suicide and Homicide. The latest National Confidential Inquiry Annual Report into Suicide and Homicide was published in May 2021. This report considers levels of suicide and homicide across varying geographical areas of England, Scotland, Ireland and Wales. The report is based on levels of suicide per 100,000 population and is not specific to patients in receipt of mental health care. The rate for Birmingham and Solihull is 9.5 per 100,000 population. The lowest rate is 7.5 in North East London and the highest rate is 13.4 in Northumberland Tyne and Wear. Out of 44 different geographical areas, we have the joint 14th lowest level of suicide in our population. We are currently considering our position against these findings, but can already see that some alignment between national findings and the local position relating to deaths by alcohol and substance misuse. We have therefore included a quality goal for 2021-22 around this matter within the earlier section of this report. With regard to inpatient suicides, the most common method was by ligature and in 2021-2022 we will complete the roll out of ligature door alarm systems to all en-suite bathroom doors in our acute inpatient wards and to bedroom doors in our highest risk areas. We will also develop a 3-5year rolling programme to removal all ligature anchor points in our inpatient estate.

2.7	The number of local clinical audit (a)	The reports of 37 local clinical audits were

	reports that were reviewed by the provider during the reporting period.	reviewed by the provider in 2020/2021 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	

Rapid tranquilisation Audit	Background: Previous Trust audits have demonstrated improvements are needed in adherence to the Trusts' Rapid Tranquilisation (RT) policy, highlighting this as one of the major clinical risks within the organisation. These audits have demonstrated the importance of monitoring physical health following administration of medicine for RT, formal assessment of adverse effects in majority of RT episodes, and service user involvement to state their future treatment preference after being administered RT. This audit sought to elucidate compliance with BSMHFT RT policy with respect to the factors outlined above when RT is administered to a service user via the intramuscular (IM) route. Some of the results fell short of the policy expectations, and therefore the audit appeared to be the next plausible step to gain assurance on the organisations adherence to the policy. The aim of the audit was to determine whether the BSMHFT policy for RT is being adhered to when RT is administered to service users via the IM route. We felt this audit will benefit patient care by providing an opportunity to compare and improve standards of practice in RT with respect to efficacy and patient safety, with a consequent improvement in patient experience. The audit had a sample size of 131 patients from inpatient wards (52). These Included forensic units, intensive care units, acute units, and non-acute units. Episode Results: There were 131 separate administrations recorded in this 2-week period, however 22 of these administrations were either a duplicate record of administration or subsequently recorded as being over-ridden. This was either because the dose was not administered or because an oral dose was actually administered. Of the 109 separate administrations in fact given, there were 13 occasions when two medications were administered simultaneously, meaning that there were actually 96 episodes of RT in the two-week period reviewed to 37 service users across 16 wards. Eden Female Psychiatric Intensive Care Unit (PICU) had 26 episodes of RT, the highest number of episodes across the directorates reviewed. One service user on the unit received 18 episodes (18%) of RT. There were 46 episodes (47%) which took place on acute Adults of Working Age (AWA) inpatient wards. 46 (47%) RT episodes took place on Intensive Care Units (ICU), 5 (5%) episodes within secure care services and one RT episode took place on an Older Adults ward. Results against Standards: - Advance statements and directives: These are statements that would document the patients wishes and instructions, they should be

	used when patients are unable to articulate themselves and their wishes. - In 24% of instances of RT the patient had an advanced statement (n=23), 49% did not, in 8% of RT episodes the patient had been given the opportunity to record an advanced statement, but had declined to do so, and a further 19% had been unable to record an advance statement as they did not have capacity to do so. - Document of Physical health check prior to RT being prescribed and administered: In the majority of RT episodes, the physical health assessment (n = 86, 90%) was available prior to administration of the RT. On a few occasions these had been refused and documented on RiO. In just over ¾ of the RT episodes, an ECG had been performed prior to administration of RT medication (n = 76, 79%) with 4 documented refusals. 50% of these ECG's had been performed and results recorded with the 3 months prior to IM administration, 26% between 3 to 12 months prior, and 3% over 12 months prior. This is a significant increase in recording from the previous 2016 audit, where 55% of service users had an ECG preformed prior to an RT episode. Of the 20 episodes of RT which took place without baseline ECG, the majority utilised IM Lorazepam (n = 16, 80%), followed by IM Aripiprazole (n = 2, 10%) and IM Promethazine (n=2, 10%). - Other strategies and de-escalation: The policy gives reference to non-pharmacological interventions as being: '…de-escalation, distraction techniques, consideration of placement, physical restraint and seclusion.' - In just over half of the RT episodes (n=53,5%), there was documented evidence that a non-pharmacological intervention had been attempted to de-escalate the violence and aggression prior to using RT. - Patient Assessed for any adverse effects as a results of RT (and these were treated where relevant): This was documented in 31% (n=30) of administered RT, of those, there were no adverse effects recorded. Whilst this an improvement from the 2016, there remains significant opportunity for improvement. - Post RT monitoring (Physical health): 21% of patients had a post RT physical health check, whilst in 79% no record was found. - Post RT NEWS Score and Mental Health assessment: It was found that 34% of the sample received a mental state examination following RT (n=33), 31% received a NEWS Score (n=30) and 10% received a full physical health examination (n=10). This means that the majority of patients within the Trust do not receive these assessments following RT. Recommendations: - Our trust Reducing Restrictive Practice Quality Improvement Collaborative workstream have a change package to address debrief and care planning following RT. - Physical Health Committee to develop actions to address

	physical health monitoring and ECG monitoring. • RT policy to be re-written: Specific areas to be strengthened: prescribing practice, rationale, monitoring, risk. • RT messages to be strengthened in ILS training across the trust. • The trust will also explore ways to ensure medics are trained in RT standards This report gathered actions from various committees and returned to the Clinical Effectiveness Advisory Group for actions to be logged and overseen.
Clozapine Audit	Following the death of a patient on clozapine earlier this year the Coroner's office issued a Prevention of Future Death (PFD) notice. The notice raised several concerns around the management of clozapine patients including the management of clozapine plasma level assays. The main concern was the management of patients with clozapine levels identified as high (over 600mcg/L) and the subsequent management and review of the medication. At the time of the inquest, the patient had had a level done post mortem and this had come back as almost four times the normal top of the range. The patient had an assay completed about 9 months before his death, but there was no evidence that this was reviewed by the consultant and although it is likely that no changes would have been made at the time, it may have indicated a need for closer monitoring. The assay was not requested by the consultant and so they did not know to follow it up - this highlighted the fact that a large majority of requests have no basis in clinical management and are in fact errors by the person taking the sample. The lack of understanding at all levels as to the clinical significance of the normal full blood count for monitoring purposes and the need for a clinical plasma assay was also criticised. This audit was designed to capture a baseline level of compliance with the standards in place at the time in the BSMHFT guidelines, in order to ascertain gaps and possible future recommendations for clinical practice relating to the monitoring of clozapine. Results: 1. While not specifically collected during the audit, it was noted that of the 110 results, 22 (20%) were classed as high (above 600mcg/L) and 18 (16.4%) were low (below 350mcg/L). This means that 64% were within the specified therapeutic range. This provides a degree of reassurance that most patients are being managed satisfactorily. 2.When we look at the audit criteria, it is apparent that 80 samples (73%) were not taken as trough values and therefore have no clinical value; this indicates a very large waste of resources with the testing. This is a cost to service users, as well as a financial and time cost to our organisation and the Pathology service. 3. Of the samples, 29% were documented as having a valid reason for the sample in line with the 2018 BSMHFT guidance. While some of these will have been indicated and not documented, the majority are ordered either in error, or simply as a matter of incorrect practice. This highlights the concern raised by the coroner about the poor understanding by most staff as to why monitoring is needed and about clozapine processes in general. 4. There was a lack of documentation following the result being reported. 29% have such an entry and this may be in those cases where levels are within the normal range. Reading through the comments

	from auditors who looked at more entries than just those directly related to the sample, it seems as though most were ordered in error and therefore the clinicians had no expectation that they needed to review them. 5. The final question does not have a specific audit target as a repeat sample is not always warranted, especially if the care plan clearly outlines what the intention is and that the patient or their representative is involved in the discussion. A small number (12.7%) resulted in documented changes to the dose, though it is likely a small additional number were altered. This Audit was reported directly to our Trust Clinical Governance Committee and the following recommendation were made. Recommendations 1. For all clozapine blood level tests, the following must take place: a. the date and time of the sample must be recorded on the blood sample form. b. The sample must be taken 12 hours after the last dose of clozapine is taken by the service user c. The result must be reviewed by a clinician (ideally, the clinician who has requested the test) as soon as possible and a progress note made regarding the result and any required actions 2. All clinical staff will continue to be made aware of the difference between a full blood count (weekly, fortnightly or monthly) for monitoring the rare side effect of agranulocytosis, and a clozapine plasma level assay (checking the amount of clozapine in the blood stream) and how to request each test This learning from the above two points has been disseminated to all teams and discussed in Multi-Disciplinary Meetings. Assurance has been sought from Clinical Directors for this. 3. Consideration should be given by the Clozapine Monitoring Group of ways to identify when a clozapine plasma level assay has been requested but not taken – A QI project with ANP's, looking at the process of requesting clozapine levels, reasons, and actions is underway. (This includes the use of a checklist) 4. We will repeat this audit in June 2021 and consider the results at Trust Clinical Governance Committee. 5. An Insight report of high clozapine levels and the interim process of reporting these manually within the Pharmacy team, including the resource requirements for this has been developed, this is now being tested. 6. A Rio form for Services Suers with clozapine levels over 600 has also been built and is currently being tested. 7. Our trust Pharmacological Therapies committee are overseeing a review of all clozapine guideline to ensure clarity and consistency across.
	Across the course of the past year, we carried out several pharmacy and medicines related audits to assess various topics from inpatient controlled drugs, our inpatient medicines code, compliance with Mental Health Act forms and Antimicrobial prescribing. <u>Key finding and actions</u> • Antimicrobial prescribing had returned to normal levels compared to past audits in our June 2020 audit, but was a little higher than expected in the re-audit in September 2020.

Pharmacy/Medicines (Inpatient controlled drugs, Inpatient Medicines Code Audit, Prescribing compliance with MHA forms and Antimicrobial prescribing)	• The number of topical treatments remains comparatively high in both. • Compliance with antimicrobial guidance was just above the commissioner's target in our June 2020 audit, but just below in September 2020. • Clinical pharmacists will continue to work with medical staff to ensure that antimicrobial prescribing is appropriate, and the outcomes are documented. • Pharmacy staff have conducted an audit of controlled drugs across almost all of the Inpatient wards within the trust. Findings have been discussed with senior ward staff and each ward has a specific ward action plan for improving compliance with standards. • A key focus will be on the management of controlled drug registers and where necessary some brief training provided to existing or new staff on the management of controlled drugs. • Pharmacy Services, working with Inpatient wards will continue to support staff including training on key medicines safe and secure handling issues. • Pharmacy staff will work intensively with those wards showing the greatest non-compliance with standards. • Pharmacy staff will work with Estates to scope and develop the business case for procurement and installation of air conditioning units and/or temperature-controlled medicines cabinets to ensure ambient temperatures within the clinic rooms or medicines cabinets are maintained. • Pharmacy will work with wards and Estates to ensure that when medicines cabinets are non-compliant with BS2881 and are being replaced then suitable alternative cabinets that comply with the standard are sourced.
<u>Physical Health</u> *(Weight Management on Inpatient units, NEWS2)*	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. <u>Key finding and Actions from NEWS2 Audit</u> • 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. • We have more methods for training 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. • Clinical Guideline awareness is to be promoted and understanding supported. The impact of medication and other factors has been a longstanding concern both in the wider MH community and in the Trust. A number of audits looking at BMI, or weight gain have been carried out over the last 5- 10 years. Collectively the results have shown an increasing problem with weight gain and high BMI in service users, particularly if they have had an inpatient admission. The impact of obesity is a contributory factor in reduced life expectancy in SMI, and as part of the Physical Health Strategy, the Physical Health Committee agreed it should be a leading priority.

	Key findings from Weight Management Audit: • As a Trust we are doing well with measuring and recording physical health data, this most recent data was enabled by a large set of data, collected during an admission. • The audit had two standards, to reduce weight gain during admission, and to support weight loss for those in an overweight or obese BMI category. • Although there have been differences in methodology, the 2020 audit showed some improvement in the numbers of service users who were able to maintain body weight during their admission. The action plan for each service area highlights where we can make further impacts by offering targeted programmes (in longer admissions) and increase the opportunities for physical activity. This has two main resource implications, firstly we need to support our clinical teams to have informed, confident, and supportive conversations in relation to weight management, and secondly, we need to carefully consider how we use our specialist resources such as Dietitians and health instructors for maximum impact.
<u>Safeguarding</u> *(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 priorities this year centred on the areas of exploitation and neglect. The case audits help the LSCP with information about the quality of work being undertaken by professionals to safeguard children and young people. The Case Audit process identifies areas of good practice as well as identifying areas of improvement that can improve the lives of children and young people in Solihull. Due to the impact of the Covid pandemic on agencies the audit was scaled down. A reduced number of cases were selected for audit. The case selection is provided by the LSCP with suggestions for cases to audit made by agencies including BSMHFT. A number of cases are also taken through a deep dive process in preparation for a Joint Area Targeted Inspection audit. This year's case selection had a small number of cases open to BSMHFT (8 cases in total) which reduced the scale of the audit. In addition some of these cases had brief episodes of care. Of the case audit list provided there were 4 children and young people known to CAMHS and EIS and 4 parents open to adult services (CMHT, perinatal, Assertive Outreach Team) The LSCP made some recommendations for the partnership from this audit and this will feature in the Response and Delivery Groups work plan for the coming year. Good practice case: • An audited case was open to CAMHS and Early Intervention Service demonstrated good practice. Safeguarding concerns about criminal exploitation of the young person were picked up at the point of assessment and a prompt safeguarding referral was made to the Local Authority. At this stage, the mental health assessment found no needs requiring a CAMHS service but the service kept the referral open until the outcome of the MASH referral was known. There was good liaison when a social worker was allocated. Attendance at the local exploitation panel helped raise the understanding of risk and ensured subsequent consideration of exploitation risks and safeguarding needs as part of any future formulations. Having a BSMHFT CPN linked to the Youth Offending Service helped with information sharing and facilitated his mental health needs being assessed again. This facilitated the early identification of the onset of first episode psychosis and his route into Early Intervention. The Early Intervention Service kept his case open when he was moved to an out of area placement by the Local Authority and this helped maintain a continuity of care. There was good multi-agency working throughout.

	Key findings and Actions from the audit specific to BSMHFT: • Family composition details were not being consistently recorded on the electronic case recording system via the Children and Siblings form. A QI project was completed by the safeguarding lead to review this, from which a training video was recorded, which aims to support staff in improving recording of these details. We have also sent out communications to support staff in completing the Children and Siblings form, which will be periodically repeated to ensure all staff are aware of this and why consistent recording is important. LSCP Key findings and actions from multi-agency findings that we will be contributing to: • Agencies have been asked to "Audit whether the VOC/lived experience of children (including those who are non-verbal or have additional communication needs) influences interventions and decision making within their own organisations". We are waiting for the audit to come through to us (VOC = 'voice of the child') to complete. • Agencies have also been asked to "Define what early help looks like where there are concerns about exploitation to include clarity about the role of partner agencies in early intervention." - We are currently completing an all-age exploitation self-assessment for Solihull Local Safeguarding Children Partnership (LSCP) for BSMHFT. After obtaining the baseline from this self-assessment we will be implementing a work plan to help improve the response to exploitation across all BSMHFT Birmingham/Solihull services.

Quality Risk Assessment & Care Planning audits	Our CPA team carried out various Risk assessment and Care planning audits and developed reports which were sent out and, in most cases, discussed at local clinical areas.
	
	• Actions taken by the CPA team covered:
	  ○ Reviewing and updating the audit tools to better capture qualitative information
	  ○ Delivering an ongoing blended training package of focused team/service sessions and a rolling ½ day personalised care planning session,
	  ○ A review of clinical risk assessment and management training (CRAM), incorporating level 2 suicide prevention training, was completed, piloted, and implemented. Unfortunately, during COVID CRM training was suspended for a period of time and then in line with safety measures training is now delivered by e-learning and webinars.
	
	Care planning is undergoing a complete re-design trust wide.
	For inpatients:
	• New care planning process designed based on a MDT model
	• Significant reduction in administrative burden
	• Promotes patient engagement and MDT working
	• New printed version developed in conjunction with Experts By Experience.
	• Live on 16 acute wards with plans in place to extend to all other inpatient services over next 6 – 9 months
	For outpatients:
	• New care planning process designed linked to DIALOG outcome measure
	• Significant reduction in administrative burden
	• Care planning driven by needs identified by the patient

	• Scope to include all community services beginning with CMHTs to be completed over next 9 – 12 months

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 2020-2021 that were recruited during that period to participate in research approved by a research ethics committee 916.

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 2020/21 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.	

	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.	BSMHFT has the following conditions on registration for all of its acute inpatient wards and one Dementia and Frailty Ward known as Reservoir Court:- 1. The registered provider must take steps to address the ligature risks across all wards by 18 June 2021 2. By 29 January 2021 the Registered provider must implement an effective system to improve risk assessments and care planning. The Registered Provider must report to the Commission on the steps it has taken in connection with this by 5 February 2021. 3. By 4 January 2021, the registered provider must inform the Commission of the order of priority in terms of addressing the ligature risks and timescales for addressing the ligature risks across each ward. 4. Commencing from 5 February 2021 the registered provider must report to the Commission on a monthly basis setting out progress being made in respect of including mitigating measures being put in place until all ligature risks are addressed. 5. Commencing from 1 March 2021, the Registered Provider must report to the Commission on a monthly basis the results of any monitoring data and audits undertaken that provide assurance that the system implemented is effective. The Care Quality Commission has taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2020 to 31 March 2021 under section 31 of the Health and Social Care Act 2008.

	Prescribed Information	**Form of statement**
7	Whether or not the provider has taken part in any	

	special reviews or investigations by CQC under Section 48 of the Health and Social Care Act 2008 during the reporting period.	Birmingham and Solihull Mental Health NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission under section 48 during the reporting period.
7.1	If the provider has participated in a special review or investigation by CQC: (a) the subject matter of any review or investigation (b) the conclusions or requirements reported by CQC following any review or investigation (c) the action the provider intends to take to address the conclusions or requirements reported by CQC and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period.	

	Prescribed Information	**Form of statement**
8	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider	Birmingham and Solihull Mental Health NHS Foundation Trust did not submit records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's: (i) valid NHS number (ii) General Medical Practice Code (b) the percentage of records relating to outpatient care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code (c) the percentage of records relating to accident and emergency care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code.	

	Prescribed Information	**Form of statement**
9	The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.5	Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Assessment Report for 2020 / 2021 is not due to be submitted until the 30th June 2021 following national agreement to extend the submission deadline for the Data Security and Protection Toolkit for all NHS organisations, recognising the unprecedented demand placed on NHS Trust's during the COVID-19

		pandemic. A baseline update was submitted as required in February 2021, and the final outcome for 2019 / 2020 was standards not fully met – plan agreed.

	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 2020/21 by the Audit Commission.
10.1	If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	

	Prescribed Information	**Form of statement**
11	The action taken by the provider to improve data quality.	Birmingham and Solihull Mental Health NHS Foundation Trust will be taking the following actions to improve data quality: Maintaining regular assessment of the quality of data underlying all key performance measures so that any issues can be addressed. Continuing detailed audit and review of the accuracy of clinical case classification, activity monitoring and clinical outcome measurement information. On-going comparison of service user contact and GP registration details with the national NHS Summary Care Record database to ensure information in our clinical systems stays up-to-date. Close monitoring and continuous quality improvement work on a range of data quality performance indicators, with clinical and administrative staff using

		monitoring reports to identify and correct data errors. A range of data quality audits covering all key reporting data sets, with special in-depth audits and corrective work if significant data quality problems are identified. Maintaining work on completeness and validity of MHSDS submissions in relation to the 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

27 Learning from deaths

	Prescribed information	**Form of statement**
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During April 2020 and March 2021 1473 of BSMHFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 433 in the first quarter; 228 in the second quarter; 384 in the third quarter; 428 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 14th May 2021 18 case record reviews and 21 serious incident investigations have been carried out in relation to 1473 of the deaths included in item 27.1. In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was completed was: 22 in the first quarter; 14 in the second quarter; 2 in the third quarter; 1 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	3 representing 0.20% 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 0.23% for the first quarter; 2 representing 0.88% for the second quarter; 0

	a quarterly breakdown), with an explanation of the methods used to assess this.	representing 0% for the third quarter; 0 representing 0% for the fourth quarter. These numbers have been estimated using the serious incident root cause analysis approach and supplemented with a mortality scoring methodology as specified below: 1 Definitely avoidable 2 Strong evidence of avoidability 3 Probably avoidable (more than 50:50) 4 Possibly avoidable, but not very likely (less than 50:50) 5 Slight evidence of avoidability 6 Definitely not avoidable
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	There is a need to improve the recording and monitoring of blood tests and ECGs – this is now being taken forward as a quality goal to improve physical health for 2021-22 There is a need to improve the recording of physical health checks of patients – this is now being taken forward as a quality goal to improve physical health for 2021-22 Anchor ligature points in acute inpatient wards remain a risk to patients and a planned approach to anchor ligature point reduction is required – this is now being actively addressed with significant capital investment made in continuous ligature door alarm systems for all acute ensuite doors and also for bedroom doors on high risk acute inpatient wards. A rolling capital programme to remove all anchor points from all aspects of the inpatient Estate over the next 3-5 years is now in development.
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 has since been an update to phlebotomy training to ensure electronic forms are being used to avoid risk of confusion Continuous door alarms have been fitted to all ensuite bathroom doors on two acute inpatient wards and a programme to complete these on all

		acute ensuite doors will conclude by March 2022 A holistic clinically risk based review of all physical, procedural and relational controls on our inpatient wards has commenced to identify further opportunities to improve patient safety
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Due to the Covid pandemic we have been unable to fully evaluate the impact of these actions, however in regard to safety of inpatients on acute wards, we do know that incidents of actual self harm have reduced by 50% since January 2021
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 39 serious incident investigations completed after 23rd March 2020 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.	3 representing 4.55% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the serious incident root cause analysis approach and supplemented with a mortality scoring methodology as specified below: 1 Definitely avoidable 2 Strong evidence of avoidability 3 Probably avoidable (more than 50:50) 4 Possibly avoidable, but not very likely (less than 50:50) 5 Slight evidence of avoidability 6 Definitely not avoidable
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item	9 representing 1.08% of the patient deaths during April 2019 to March 2020 are judged to be more likely than not to have been due to problems in the care provided to the patient.

	27.8.	

27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	Three representing 0.48% of the patient deaths during April 2018 - March 2019 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting Against Core Indicators

The NHS Outcomes Framework sets out a series of care outcomes services should strive for in relation to clinical quality, patient safety and patient experience. It defines measures related to those outcomes and we report regularly to the Department of Health on our performance against those measures. The Department of Health identified 15 of those measures that should be included in Trust Quality Accounts where relevant. Six are relevant to Birmingham and Solihull Mental Health NHS Foundation Trust services. These are:

- The percentage of patients on Care Programme Approach who were followed up within 7 days 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
2020-21	91.8%			
2019-20*	95.8% (94.7%)	95.0%	100%	85.9%
2018-19	96.1%	95.7%	100%	82.8%
2017-18	96.1%	96.1%	99.4%	79.9%

Data Source: RiO - our internal clinical information system
**Please note that national comparator figures for 2019-20 relate to the period Apr-Dec 2019 only as there was no national collection of this data for the last quarter of the financial year. No national comparator figures were collected or published for 2020-21.*

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, 2020/1 compliance was significantly impacted by Covid -19 on the ability to carry out direct face to face contacts, particularly for older adults discharged to nursing and residential care homes. During this period an increased level of contacts were by telephone directly with service users or with care home staff where it was not possible to visit or talk to them 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
2020-21	97.5%			
2019-20*	96.3% (96.0%)	97.9%	100%	91.9%
2018-19	97.1%	98.1%	100%	88.5%
2017-18	96.2%	98.6%	100%	93.8%

Data Source: RiO - our internal clinical information system

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

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+
2020-21	0.0%	6.2%
2019-20	0.0%	5.8%
2018-19	0.0%	5.8%
2017-18	0.0%	5.6%

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 2020 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
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 2019

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

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

2.3.5 Patient Safety Incidents

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

Figures released by the National Reporting and Learning System (NRLS) are reported on a 6 monthly basis and are a reflection of harm levels caused by incidents reported during that data period. The quoted national figures are for all mental health trusts.

Reported Patient Safety Incidents	Percentage of Patient Safety Incidents

	per 1000 bed days				resulting in Severe Harm or Death			
	Trust	National Median	Highest National	Lowest National	Trust	National	Highest National	Lowest National
Oct 20 – Mar 21*	58				0.4%			
Apr 20 – Sept 20*	58				0.3%			
Oct 19 – Mar 20	49	53	146	18	0.4%	1.0%	4.2%	0.0%
Apr 19 – Sep 19	51	56	131	17	0.5%	0.9%	3.3%	0.0%
Oct 18 – Mar 19	44	53	119	15	0.6%	1.0%	4.3%	0.0%
Apr 18 – Sep 18	44	49	114	25	0.4%	1.1%	3.7%	0.09%
Oct 17 – Mar 18	41	45	97	15	0.4%	1.1%	4.38%	0.1%
Apr 17 – Sep 17	35	44	126	16	0.6%	1%	3.7%	0.0%
Oct 16 – Mar 17	36	46	88	11	0.6%	1.1%	4.7%	0.1%
Apr 16 – Sep 16	40	42	89	10	0.5%	1.1%	6.1%	0.3%
Oct 15 – Mar 16	40	38	85	14	0.5%	1.1%	6%	0.1%
Apr 15 – Sep 15	42	39	84	6	0.6%	1%	3.7%	0
Oct 14 – Mar 15	47	31	93	5	0.5%	1.1%	5.1%	0%
Apr 14 – Sep 14	43	33	90	9	0.8%	1.0%	5.9%	0%

*Please note that this national data is not due to be published until September 2021

	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%
Oct 17 – Mar 18	4788	41	21	0.4%
Apr 17 – Sep 17	4013	35	24	0.6%
Oct 16 – Mar 17	4279	36	26	0.6%
Apr 16 – Sep 16	4681	40	21	0.4%
Oct 15 – Mar 16	4856	40	22	0.5%
Apr 15 – Sep 15	5040	42	29	0.6%
Oct 14 – Mar 15	5550	47	31	0.5%
Apr 14 – Sep 14	5086	43	39	0.8%

Data source: National Reporting and Learning System (NRLS)

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

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

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

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

Part three – Other Information

In this section of the report we share other information relevant to the quality of the services we have provided during 2020/21 which together with sections 1 and 2 of this report, provide an overview of the quality of care offered by our Trust during this period.

3.1.1 Safety

The three indicators selected for patient safety are:

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

3.1.1.1 Serious Incidents

During 2020/21 much work took place to improve our system for reviewing serious incidents with an added focus on thematic reviews and learning. We developed a centralised team of patient safety managers to lead reviews within our Trust working along clinicians and subject matter experts. We also undertook thematic reviews to understand any commonalities of findings between serious incidents so that we could be confident that we were addressing these through key programmes of improvement. This included a cluster review of all inpatient suicides that had occurred during the period 2013 to 2020 which resulted in a range of improvements being taken forward including adjustments to our physical environment, our relational controls and our procedural controls. In addition, we worked 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 enabled us to

take a system wide view on opportunities to improve how agencies can work together for the benefit of patients.

	2017/18	2018/29	2019/20	2020/21
Number of Serious Incidents Reported	100	91	78	96

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 2020/21.

	2017/18	2018/29	2019/20	2020/21
Number of Never Events Reported	0	0	0	0

3.1.1.3 Clostridium Difficile

C.difficile is a primary drug-resistant infection. Clostridium difficile is a bug that causes diarrhoea of varying severity, most usually after a course of antibiotics.
People who are already weak or frail can sometimes become seriously ill as a result of contracting it. We are pleased to confirm that there were no cases of Clostridium Difficile reported in the Trust during 2020/21.

3.1.2 Effectiveness

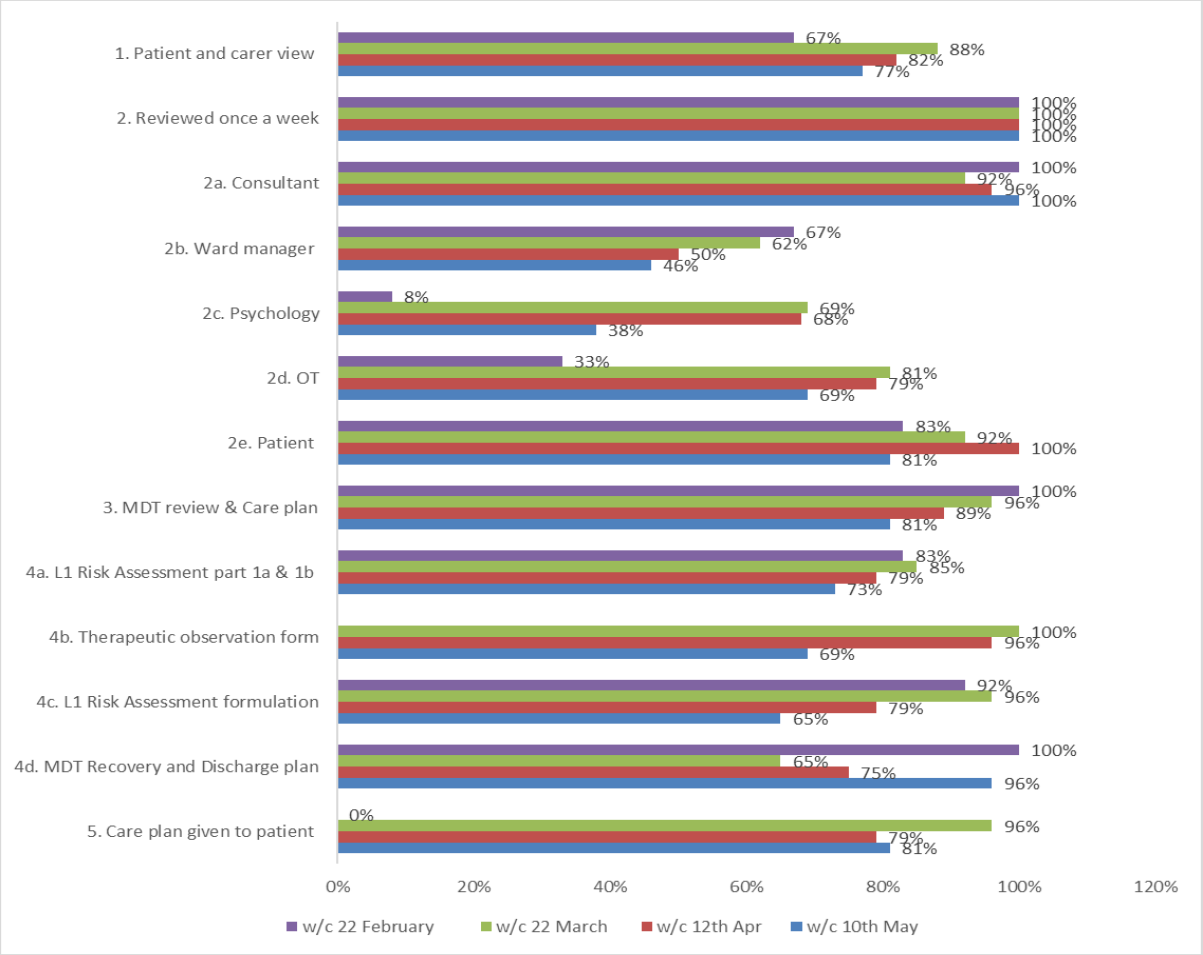
We identified the following key indicators for monitoring effectiveness. These are:-

- Multi Disciplinary Team Standards in our Acute Inpatient Wards
- PLACE Assessments*

3.1.2.1 Multi Disciplinary Team Standards in our Acute Inpatient Wards

We recognised from a range of serious incidents that occurred in 2019-2020 that we needed to develop some consistency and minimum standards for the quality of multi disciplinary team meetings. This included the range of attendees that should be present, ensuring the carer and patient voice was central and that relevant risk and actions translated into the patients care plan. This need was also reiterated when the CQC placed conditions on the registration of activities in our acute inpatient units citing the need for improved care planning. In the late Summer of 2020 we piloted a revised approach to such standards in one of our acute inpatient wards using Quality Improvement methodology. This was clinically led and subsequently evaluated and modified for use across all of our acute inpatient units. We commenced roll out of these standards to our acute inpatient wards at the beginning of the 2021 calendar year and started reporting against compliance with the standards in March 2021. For the

purpose of the quality account, we have included data covering end February 2021 to mid May 2021:-



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

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

Due to a national review of PLACE assessments, there were no assessments during 2020. We have therefore for the purpose of this account included our results for 2019.

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

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

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

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

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

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

See table overleaf.

BSMHFT's 2019 PLACE Scores

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

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

3.1.3 Patient Experience

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

	2017/18	2018/19	2019/20	2020/21
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	60% (71%)	73% (71%)	68%	59%
Number of complaints	164	152	85	81
Timeliness of complaints	100%	100%	100%	100%
% of dissatisfied complainants	11 returned - 6%	7 returned – 4%	18 returned – 15%	9 returned – 7%
Number of referrals to the Ombudsman	5	8	2	2
FFT score	87%	88%	91%	94%*

(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 is crucial for the organisation to ensure we are continually improving service user experience from complaints received, we encourage feedback from service users, carers and families in order to achieve this from the services we provide. During 2020/2021 we have seen a further decrease in formal complaints, 85 in total, which is -4 from the previous financial year. We have also seen a reduction in returned complaints, 9 in total, which is -9 from the previous financial year. Preparatory works commenced during 2019/2020 to receive direct feedback and inclusion from families and carers, this work has continued during 2020/2021 where a process group has been devised with plans for completion by Q3.

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 – 2020/21	National Threshold	2020/21
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%	92.0%
2	Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. within 18 weeks of referral	50% 75% 95%	52.1% 80.4% 99.9%
3	Inappropriate out-of-area placements for adult mental health services (average bed days per month) *	n/a*	1026
4	Admissions to adult facilities of patients under 16 years old	n/a	0%

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 2021 would not be possible.

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 2020/21 dated 21 June 2021

Mental health is one of the NHS services that has been heavily impacted by the Covid-19 pandemic and is likely to face increased demand. Indeed, in Healthwatch Birmingham's report on *'what care and support did Birmingham citizens need during the Covid-19 lockdown?'*[1] mental health and emotional support was selected by the majority of respondents. People told us about increased stress, anxiety and depression; and that they were suffering from loneliness, a loss of a sense of identity and some were suffering emotionally.

Alongside the challenges and difficulties that the pandemic presented, has been the commitment and hard work of the Trust and its staff to support service users, their families and carers. We make our comments, to this Quality Accounts, cognizant of the important role that staff have played as well the impact Covid-19 has had on their health and wellbeing. Throughout the past year service users and their families have told us about the amazing work the trust and staff have carried out during this difficult time:

> *I finished my psychotherapy treatment several months ago and I am so glad that I was able to work with such a compassionate, highly-skilled, experienced professional. It took over a year to feel that his holding of boundaries, me & the therapy space was safe, allowing me to experience myself, him & then others in a different, much less defensive way. The therapist made every effort to hold this safe space during lockdown via telephone & online sessions. Psychotherapy is mysterious in that I know it's helped me but I'm not sure how! I will be forever grateful to him & the Specialist Psychotherapies Service (Callum Lodge Specialist Psychotherapies Service)*
>
> *Do they always get everything right, no, who does, but they show they really care every single day and that's all I ask (Solihull)*
>
> *I stayed alive because my nurse was an Angel (Parkview Clinic)*
>
> *Even though things are very different at the moment with lockdown, mental health services have gone out of their way to ensure that my daughter still receives the help and support that she needs (Solihull)*
>
> *I had home treatment with Ladywood Home treatment team, they are good at their job.*

Performance 2020/21 and Quality Priorities for 2021/22

Healthwatch Birmingham and Healthwatch Solihull are pleased see a continued focus on improving patient safety by reducing harm, positive patient experience, a positive patient safety culture, quality assurance, and using the Trusts time more effectively. Although there has been some improvement in some measures (e.g. 83% of incidents resulted in no harm), other measures, such as the use of restraints in inpatient units saw an increase during the pandemic.

[1] https://www.healthwatch.co.uk/reports-library/what-care-and-support-did-birmingham-citizens-need-during-covid-19-lockdown

It was of concern for Healthwatch Birmingham and Healthwatch Solihull to read about increase on incidents of patient assaults on staff that coincided with incidents of restraints, the 3 inpatient suicides, the number of patients (1473) who have died during the reporting period and the enforcement action taken by the CQC. As these areas form part of the Trusts 2021/22 priorities, we would like to read in the 2021/22 Quality Account the improvements made.

Improve patient safety by reducing harm
We welcome the Trusts recognition that restrictive practice including restraint and seclusion can increase stigma, isolation and risk of harm. We would like to read how the Trust has arrived at the interventions outlined in the Quality Account. We believe that it is important that service users are involved in developing these and that the Trust is collecting feedback from patients/their families to understand what works best. We suggest that one of the measures of success should be the extent to which Trust has engaged with patients/families and staff to understand the causes of restrictive practice, impact on service users and/or staff and an understanding of what would work for them in terms of interventions.

We note plans to improve the physical health monitoring of patients and the goal to ensure physical monitoring for 100% of the Trusts over the next three years. We would like to read, in the 2021/22 Quality Accounts progress made towards this and the percentage of patients having a physical health assessment. In particular, the percentage of episodes of Rapid Tranquilization (RT) that have had an appropriate physical health recording. We would also like to read the percentage of inpatients that have had a physical health assessment and systemic enquiry checks completed within 24 hours of admission.

Healthwatch Birmingham and Healthwatch Solihull agree with the establishment of the Quality Improvement Collaborative and plans to ensure quality improvement through learning days. We are pleased that experts by experience are at the core of this collaborative. We would like to see in the 2021/22 Quality Account examples of learning that has taken place during learning days, how learning is shared across the Trust and how the Trust communicates what learning has taken place with patients/families. Key to the success of this collaborative, will be how inclusive it is. We know through the feedback we hear that some groups face poorer mental health and barriers to accessing mental health services. We would like to see the involvement of patients by experience from diverse communities including disability and age. To what extent is the Trust using data (on who or which groups of service users are more likely to be restrained) to inform who gets involved in the collaborative? The Trusts response to Healthwatch Birmingham's recent report into health inequalities, the Trust outlined the work it has done with various ethnic group, in particular the Somali people. We would like to see how this work is informing the priorities the Trust has set out and the goal to reduce variability in the service.

We note the number of inpatient deaths that occurred in the past year and welcome the plans that have been put in place to make the inpatient environment safe. We would like to read in the 2021/22 QA the impact these actions have had on improving patient safety.

A focus on a positive patient experience
The actions set out by the Trust to ensure that patients have a powerful and equal voice in their care is welcome. We are pleased that the Trust has increased the level of participation of experts by experience in various quality improvement projects. We particularly welcome the introduction of the role of the patient safety partner to ensure that experts by experience have a stronger voice. We would like more information on how this will work in practice. We would like to read in the 2021/22 Quality Account how successful this has been in giving experts by experience an equal voice and examples of actions taken based on their views.

Involvement of service users in MDT meetings is important, more so ensuring that that they have a copy of their care plan. Feedback from service users has demonstrated the importance of care plans on the quality of care and outcomes for service users. We look

forward to reading in the 2021/22 Quality Accounts progress on the percentage of servicers users attending weekly MDT meetings and the percentage of those in receipt of care plan. We would also like to read in the 2021/22 Quality Account the number of care plans that include a clinical plan for response to default from treatment (use of deport/LA antipsychotic injections for relapse prevention.

We agree that it is important to include a qualitative measure as this will help the Trust to understand the experiences of using the care plans and how well they are being implemented including impact on outcomes. We look forward to reading in the 2021/22 Quality Account how the Trust has involved service users and their families in developing the qualitative measure.

In our conversations with carers we note that not feeling heard and involved is an important issue for them. We suggest that the Trust includes in the measure for involving carer something around communicating carers views in care planning and demonstrating the impact of their insight in the care planning process. We believe that continuous carer involvement would improve consensus on future decisions around actions to be taken, especially understanding of why decisions are taken and increase confidence in why decisions are being taken.

We note that the Trust is engaging with experts by experience to develop a template for a care plan that can be shared with patients, families and carers. We would like to read in the 2021/22 examples of the use of these templates and how many families are involved in care planning.

A focus on a positive patient safety culture
We note that there has been improvement in staff views in the survey about their ability to raise concerns and be assured that action has been taken (q16a, c, d; and Q17b, c; and Q18b). However, the Trusts performance remains below the Best Trust and below average. We welcome the Trusts involvement in the peer review scheme hosted by the Royal College of Psychiatrist. We note the positive experiences outlined by those involved in serious incident reviews. We would like to read in the 2021/22 Quality Account how these positive experiences are informing practice across the Trust. We would also like to read about how the Trust is acting and ensuring learning on things that did not work well.

A focus on Quality Assurance
Healthwatch Birmingham and Healthwatch Solihull welcome a focus on this priority and look forward to reading in the 2021/22 Quality Account how service users and staff have been involved in the development of the Quality Assurance framework. In particular, how the Trust has used this involvement to understand what good care looks like to service users and their families. We note the work that the Trust has planned to pilot, evaluate and roll out an internal quality assurance peer scheme across the trust. We would like to know how representative the experts by experience both in terms of conditions and ethnicity are. We look forward to reading in the 2021/22 Quality Account not only about the number of peer review visits but also about the people involved, their diversity and how is the Trust is using the information gathered through these peer review visits.

A focus on using our time more effectively
We welcome the Trusts aim to reduce unwarranted variations in care and support through the implementation of a Community Care Planning tool to improve the therapeutic effectiveness of service user interactions. We note the measures of success outlined, however, it is not clear how the clinical measures will be complemented by patient related measures.

CQC registration

Whilst we recognise the challenges the Trust has faced over the past year, we are concerned that the CQC has taken enforcement action against the Trust. We note that the Trusts registration with the CQC has the following conditions: – take steps to address ligature risks across all wards by June, implement an effective system to improve risk assessment and care

planning among others. We would like to read in this Quality Account progress made towards these conditions.

Reporting against core indicators

We note that the percentage of patients on the Care Programme Approach followed up within 7 days after discharge from psychiatric inpatient care is lower than in the past three years. We also note that Covid-19 impacted direct face-to-face contact following discharge, with contact mainly through telephone. Experiences shared with us show that the use of phone appointments and technology was appropriate during lockdown circumstances but as services are restored varied ways for engaging with the Trust are required. For some service users, the use of technology may enhance their use of mental health services, for other it may serve as a barrier. In our response to the Trust Strategy 2020-2025, we asked that the following be considered:

- 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 new 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 different ways of engaging using digital technology alongside the relevance of these for different service users.

Equality and Diversity

The unequal impact of Covid-19 on people with a disability and Black, Asian and Ethnic Minority groups has further highlighted the important role of health and social care organisations in promoting equality for everyone. As the Nuffield Trust highlighted in their report inequalities persisted during the Covid-19 pandemic with some groups facing poorer mental health and barriers to accessing services. It is disappointing not to see no commitment from the Trust to inclusion and equality in the 2020/21 Quality Account. We believe that a focus on inequality is ever more important as the Trust works to restore services if it is to reduce variability. It will be important for the Trust to understand the various experiences of discrimination that lead to health inequality and use this to inform restoration of services. We believe that Covid-19 has changed how health and social care collects and uses feedback, and public health data to understand the community it serves. We believe that this should be a critical focus of the Trusts priorities. Healthwatch Birmingham recently shared our *'Health Inequalities: Somali people's experiences of health and social care services in Birmingham'* with the Trust. We would like to know how the findings of this report are continuing to informing the Trusts health inequalities work; how the Trust is improving its knowledge about the issues facing minority ethnic groups, improving engagement with ethnic minority groups, and how it is designing and delivering services in a manner that addresses issues of discrimination and stigma.

Andy Cave
CEO
Healthwatch Birmingham

1.2 Birmingham Health and Social Care Overview and Scrutiny Committee

The Birmingham Health and Social Care O&S Committee would like to take the opportunity to thank the Trust staff for their tireless commitment to support patients and families in the most challenging of circumstances during the Covid-19 pandemic.

The committee acknowledges the 5 priority areas for improvement in the forthcoming year, the associated goals and how success will be measured building on initiatives implemented in 2020/21. In particular, taking into account lessons learnt from deaths in 2020/21 and including these as goals for 2021/22 i.e. improving the recording and monitoring of blood tests and ECGs; improving the physical health checks of patients and improving patient safety by installing ligature alarm systems on ensuite bathroom doors by March 2022. Also, the aim to develop a quality assurance framework in coproduction with staff, service users, families and carers to assure quality of services and care.

Looking at performance against priorities during 2020/21 it is apparent that the Covid-19 pandemic did impact on performance against some of the priorities. Notably, levels of prone and non-prone patient restraint and physical assault on staff and patients which, in part, was due to restrictions put in place to manage the spread of Covid-19. Also, the reduction in personalised care and health budgets offered to service users leaving hospital as part of their after-care arrangement but note that, going forward, mechanisms have now been put in place to make the offer available to all eligible people.

On a positive note, the committee is pleased to see an improvement in the results from the NHS Staff Survey; the development of the support package to staff following traumatic incidents and the improvements made in standardising the way quality data is presented to enable a better understanding of performance.

It is also pleasing to see there were no Never Events or cases of Clostridium Difficile reported in the Trust in 2020/21, as was the further decrease in formal complaints from the previous financial year.

Finally, it is very encouraging to see that the Trust has performed above average against all of the reported national mental health indicators and note that NHSE/I recognised that, due to the impact of Covid-19, the national target to achieve no out of area placements by end March 2021 would not be possible

Councillor Rob Pocock

Chair Birmingham Health and Social Care O&S Committee

1.3 Birmingham and Solihull Clinical Commissioning Group Statement

Birmingham and Solihull Mental Health NHS Foundation Trust
Quality Account 2020/21

Statement of Assurance from NHS Birmingham and Solihull CCG

June 2021

1.1 NHS Birmingham and Solihull Clinical Commissioning Group, as co-ordinating commissioner for Birmingham and Solihull Mental Health NHS Foundation Trust welcomes the opportunity to provide this statement for inclusion in the Trust's 2020/21 Quality Account.

1.2 A draft copy of the Quality Account was received by the CCG on 7th June 2021 and the review has been undertaken in accordance with the Department of Health and Social Care guidance. This statement of assurance has been developed from the information provided to date.

1.3 We acknowledge the significant ongoing challenges the Covid19 pandemic has presented throughout 2020/21 and the part the Trust has played in the mental health system response to these challenges.

1.4 We note the Trust's five quality priorities for 2021/22 and will continue to work with the Trust to maintain oversight of progress in delivery against these priorities.

1.5 The 3 inpatient suicides during the past year are tragic events. The Care Quality Commission has taken enforcement action against the Trust due to concerns around the management of environmental risks and care planning processes. We have worked closely with the Trust to seek assurance that appropriate actions are being taken in response to the concerns identified by CQC. This has included jointly undertaking a longitudinal review of past inpatient suicides to inform future actions.

1.6 The report contains a commitment to ensure that the Trust's physical estate is maintained as safely as possible and that ligature risks are minimised. This action is clearly vital in inpatient wards where patients who are at high risk of harm due to their mental illness are cared for, and where environmental risks must be mitigated as effectively as possible. We are aware that a very significant amount of work has been undertaken by the Trust to review options and plan for the necessary environmental work to be undertaken in a way that takes full account of risk, logistical and financial factors.

1.7 Alongside the environmental measures described in the report, there is a recognition that steps need to be taken to ensure that new and revised approaches to care planning, risk management and MDT working are as robust and effective as possible. We agree that this area needs to be a key quality priority for the Trust. To that end we are also pleased to see a focus on increased activity on a number of units. Relational and procedural controls are as important as environmental ones. Inpatient units have to be demonstrably therapeutic and supportive of a recovery journey, rather than simply environmentally safe and containing spaces.

1.8 We note the commitment to increase the involvement of families and carers in service user care and recovery. Taking steps to ensure that families and carers are consistently viewed as active and genuine partners in care across all Trust services is integral to developing new approaches to risk management and care planning.

1.9 We note the ongoing work to ensure quality metrics and quality data is being collated andpresented in ways that are meaningful to all parties and informs change.

1.10 We welcome the recognition that attention to physical health needs, particularly of personswith severe mental illness, is a continuing area of focus for the Trust moving forward.

1.11 We agree that reviewing the deaths of patients due to alcohol and substance misuse who are in Trust care is an appropriate area for quality focus. There are number of complex factors at play and a seeking an improved understanding of these factors, and how a rangeof services across our local system can work together to better support patients with this presentation, is important.

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

1.13 As we move at pace toward the formation of an Integrated Care System in Birmingham andSolihull, the importance of driving new collaborative and partnership based approaches to quality assurance and quality improvement is paramount. To this end the CCG has undertaken a number of joint themed reviews with the Trust, based on themes identified from serious incident reports and other quality indicators. The Trust has been open and supportive to this process.

1.14 We will continue to build on existing relationships and new ways of working as we move forward into an ICS. We seek to ensure, as a local mental health system, that our approachto quality oversight demonstrably informs our local transformation work and has a clear focus on improved outcomes for the people who use our services.

Paul Jennings
Chief Executive Officer
Birmingham and Solihull
CCG

1.4 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 years 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 have contributed to an increased level of serious incidents which places 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 is a strong priority for 2021/22.

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 about levels of restrictive practice in our Psychiatric Intensive Care Units (PICUs). As Governors, a number of us have taken part in Quality Improvement Training this year and we are represented on our Reducing Restrictive Practice Quality Improvement Collaborative ensuring that the 'expert by experience' voice is heard in any improvement ideas for change. We will be inviting the Collaborative to present on their work to us this year so that we can understand more of the barriers to improvement and contribute to small tests of change. We are pleased to see that since we have moved from wave one to wave two of Covid levels of restrictive practice generally appear to be sustainably reducing along with reduced levels of physical assault on our inpatient wards.

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 2020-2021 have been delivered. We have seen some great examples of co-production and a number of governors contributed to the development of the Trust Quality Strategy and goals. In recognition of this approach, we have awarded the co-production kitemark to our Quality Strategy.

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 heard and addressed. We are pleased to see the improvements that we have made in the Annual Staff Survey on all of our safety culture metrics. We recognise that we still have a journey of improvement ahead of us, however it is pleasing to see that we are moving in the right direction. We can also see that more staff agree that quality and safety of care is a top priority for our organisation which again is pleasing.

We are supportive of the priorities laid out for 2021/22 and believe that these are the right priorities for 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.

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 millions of pounds in a safer physical inpatient environment through the installation of continuous pressure door sensors on all ensuite bathrooms in our acute inpatient wards during 2021/22. 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 3-5year 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 2021-2022.

Council of Governors of BSMHFT

June 2021

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

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

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

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

- *The content of the Quality Report is not inconsistent with internal and external sources of information including:*

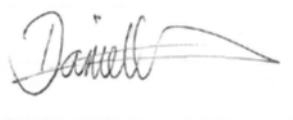
    - *Board minutes and papers for the period April 2020 to March 2021*
    - *Papers relating to quality reported to the Board over the period April 2020 to March 2021*
    - *Feedback from commissioners dated 21 June 2021*
    - *Feedback from Governors dated 15 June 2021*
    - *Feedback from local Healthwatch organisations dated 21 June 2021*
    - *Feedback from the local Health and Social Care Overview and Scrutiny Committee dated 21 June 2021*
    - *The Trust's complaints report published in February 2021 under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009*
    - *The 2020 national patient survey*
    - *The 2020 national staff survey*
    - *The Head of Internal Audit's annual opinion of the Trust's control environment dated XXXXXXXX*
    - *CQC inspection report dated 1 April 2019 and subsequent enforcement notice dated December 2020*

- *The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered*
- *The performance information reported in the Quality Report is reliable and accurate*
- *There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice*
- *The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and*

- *The Quality Report has been prepared in accordance with NHS Improvement's Annual Reporting Manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.*

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

By order of the Board



Roisin Fallon Williams
Chief Executive

Danielle Oum
Trust Chair