Quality Governance Committee Agenda Item 14 Enc 12

Document Title:	Quality Account 2020/2021
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Date of Meeting:	Thursday, 13 May 2021

Purpose of the Report

Approval ☐ Assurance ☐ Information ☒

Executive Summary

The Trust 2020/2021 draft Quality Account has now been finalised.

NHS Trusts are not mandated to consult with external stakeholders on the Quality Account as detailed within the NHS Foundation Trust Annual Reporting Manual 2020/2021 published and re-issued on the 31st March 2021. This is due to the ongoing COVID-19 national response to the pandemic. We value our stakeholders and partners and whilst we are not required to undertake formal consultation as we would normally under the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/2021, we still wanted to share and any statements received will be included within this Quality Account in preparation for Trust Board and subsequent national publication.

The final document has been sent to CCG's, Local Healthwatch, and Health Overview and Scrutiny Committees will be presented for sign off to the Trust Board and Audit Committee to be published as a standalone Quality Account document on NHS Choices by 30th June 2021.

The Quality Account comprise of three parts:

Part 1: Statement on Quality from the Chief Executive
This is a signed statement that summarises the Trust's view on quality of the NHS services that it provided or sub-contracted during 2020/2021. The summary must include a statement that the information contained within the quality account is accurate. In addition within this section the Trust has included information about the Trust and some of our quality achievements, including our quality improvement awards.

Part 2: Priorities for Improvement and Statements of Assurance from the Board
This section of the report provides a summary of progress against the three quality improvement indicators the Trust identified in its 2019/2020 Quality Accounts, which were:

- Improve the reporting of medication related patient safety incidents – this is a 2 year quality priority and therefore continuing with this in 2021/2022.
- Improve the Assessment, Diagnosis and Treatment of Lower Leg Wounds – we achieved this quality priority.

- To improve patient experience/feedback response rates across all services – we have not achieved this priority of improvement. We will be carrying this priority over into next year Quality Account – revised to focus on digital solutions (quick and easy feedback).

In this section of the Quality Account the Trust also sets out its three improvement priorities for 2021/2021. This year the three indicators chosen are:

- To improve the reporting of medication related patient safety incidents – this priority area is aligned to the key quality measures within the NHS Improvement established a Medicines Safety Programme and locally building on the reduction of harm related medication incidents in 2019/2020 and same priority in 2020/2021.
- Supporting patients to manage a healthy weight in adult secure settings through interventions that culminate in having a physical health passport - building on 2020/2021 Quality Indicator to further embed quality improvement across Forensic Services to reduce obesity.
- To improve the way we receive feedback by focusing on the implementation of a 'barometer' digital based system for collecting and using patient feedback with full engagement of patients and staff to enable a greater uptake, to complement our current variety of feedback options (revised quality priority as detailed above).

Part 2 of the Quality Account also provides a number of mandated statements of assurance from the Trust Board. The form of words for these statements have been mandated by NHS Improvement and cover information on: review of services, clinical audit and national confidential enquiries, clinical research, CQUINs (no CQUINs for 2021/2022 at the present time), CQC registration and reviews, data quality and information governance number of deaths and learning from deaths. Finally in Part 2 of the Quality Account the Trust is required to report on a set of core indicators that are benchmarked against national data as published by the Health and Social Care Information Centre.

Part 3: Other Information
This section of the report provides a review of quality of care offered by the Trust in 2020/2021 against a number of locally determined indicators as agreed by the Trust Board within the 2019/2020 Quality Account. The indicators selected must span the three domains of quality; patient safety, clinical effectiveness and patient experience and should refer to historical data as well as benchmark against nationally available data. This year we have not achieved our predicted compliance for all of these indicators and therefore we will continue to monitor progress and report back in our 2020/2021 accounts. Part 3 of the report also provides an overview of performance against key nationally mandated (as set out in The Single Oversight Framework).

Annex 1: Statements from Stakeholders
Please see above in terms of there being no mandated requirement. If statements are received they will be included within the Quality Account in time for sign off by the Trust Board.

Annex 2: Statement of Directors' Responsibilities
The Chairman and Chief Executive on behalf of the Board of Directors are required to sign a statement confirming that the Trust has complied with a number of requirements in preparing the Quality Account.

Glossary:

Following feedback received in a previous year about the number of acronyms used within the accounts a glossary is provided to help describe the terms.

Recommendations

The Quality Governance Committee is asked to;

- Receive the Quality Account for consultation and provide any comments and/or feedback to Katie Montgomery Head of Quality Governance and Engagement by 20th May 2021.

Monitoring/Compliance

Which strategic priorities does this paper address	• To provide high quality health and social care services • To make our Trust a fantastic place to work • Building partnerships to benefit the health and wellbeing of our local population
Regulatory compliance (tick all that apply)	CQC: Safe ☒ Caring ☒ Responsive ☒ Effective ☒ Well Led ☒ NHS Improvement Licence ☐ Other ☐ (add details below)
Other	
Committees / meetings where this paper has been considered	Health Overview and Scrutiny Committees Quality Governance Committee

Inter-dependencies (tick all that apply and add details where relevant)

Legal ☒	The Quality Account are a look back across all domains of quality during the year 2020/2021 and also set out intentions for the year ahead (2021/2022). The indicators and data presented within the accounts therefore link to those fields identified opposite and represent data that has been presented to the Trust Board and associated Committees.
Clinical ☒	
Risk Register ☒	
Financial ☒	
HR ☒	
Staff Side involvement actions undertaken/planned ☐	
Social Care ☒	
Involvement and Experience ☒	
Equality Impact ☐	
Information exempt from Disclosure ☐	
Requirement for further review ☐	

NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

Quality Accounts 2020-2021

Contents

PART 1
About our Quality Accounts 2020/2021

Our Quality Account is our annual report to the public about the quality of health and social care services we deliver and is an opportunity for the Trust to offer its approach to quality up for scrutiny, debate and reflection by the public.

The Quality Account publication this year reflects the Coronavirus pandemic impact on our Trust in terms of where services and key priorities were affected by being stood-down to deal with the pandemic crisis. Whilst there were elements of our priorities that were impacted, there were many where the Trust continued to deliver and drive forward improvements.

Each year our Quality Account are both retrospective and forward looking. We look back at the year just passed and present a summary of our key quality improvement achievements and challenges. We look forward and set out our quality priorities for the year ahead, ensuring that we maintain a balanced focus on the three key domains of quality:

- **Patient Safety**
- **Clinical Effectiveness**
- **Patient Experience**

Our quality priorities are chosen following a process of review of current services, consultation with our key stakeholders and most importantly through listening to the feedback from our service users and carers.

Some of the content of the Quality Account is mandated by NHS Improvement and /or by The NHS (Quality Account) Amendment Regulations 2012, however other parts are determined locally and shaped by the feedback we receive.

The Quality Account are split into three main parts:

Part 1

Provides a statement summarizing the Trust's view of the quality of healthcare services provided or sub-contracted during 2020/2021.

Part 2

Provides a review of performance against the priorities for improvement as identified in our 2020/2021 Quality Account.
Sets out our quality priorities for this year (2021/2022)
Provides a series of prescribed statements of assurance from our Trust Board
Provides a report on performance against a set of core indicators using data made available by the NHS Digital Indicator Portal

Part 3

This section is used to present an overview of the quality of care delivered by the Trust against a number of local indicators as well as performance against relevant indicators set out in NHS Improvement Single Oversight Framework.

Statement on Quality from our Chief Executive

Welcome to the Quality Account for Midlands Partnership Foundation Trust for 2020/2021. We are now just over one year on from the first wave of Coronavirus which has not been an easy time on which to provide a reflective account on 2020/2021.

During the year, we have re-imagined and restored services and at the same time, we continued to deliver services and care for all our patients whilst transforming where appropriate to do so, our face to face consultations into telephone and video consultations. It has been a year unlike any other and we have witnessed the impossible become possible due to the dedication, commitment and resilience of our people within the Trust and across our local healthcare systems in collaboration with partners. Some of our staff were redeployed into new roles from where there was a less of an impact of Coronavirus and we have seen hundreds of staff learn new skills, and change their daily clinical practice to treat and provide safe care.

Despite the challenges we and the rest of the world have faced, I hope our Quality Account demonstrates good progress in improving our services for our patients and local communities and where we still have improvements to make. I am extremely proud of just how much our staff have achieved and in doing so we have shared throughout this document our achievements, challenges and successes as well as identifying those key quality improvement priority areas to dedicate our focus during 2021/2022.

We continue to recognise the important role listening and responding to the views of our service users, carers, staff and regulators plays in driving up quality and in delivering outstanding services. Key to this is the work of our Involvement and Experience Team and Freedom to Speak up Guardians who ensure these views shape our quality improvement agenda.

We have continued our commitment to quality improvement methodologies during 2020/2021 and since last year we have trained 947 (total 2329) of our staff in First Steps training and a further 44 (total 183) in Leading Quality Improvement. We have seen an increase in the number of our staff who have engaged in quality improvement training as we have moved from face to face to virtual platforms.

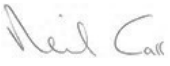
An initiative central to creating a way of working which includes coming together, sharing best practice, creating a community network through social collaboration and together realising the art of the possible has been our 'In Our Gift' Programme. We have received good news that we have recently been shortlisted for a Health Service Journal Value Award in the category of People and Organisational Development Initiative of the Year.

In 2020/2021 we identified and introduced the Patient Safety Specialist to support and develop the patient safety culture and safety systems within the Trust in conjunction with the NHS Patient Safety Strategy. I am pleased to report there are 9 key work programmes that will be developed and implemented during 2021/2022 to further improve the safety culture.

Another one of the main areas where we need to continue to improve in the coming year is improving incident reporting relating to medication errors and associated potential harm. Our rate of reporting in variable across, we want to improve in this area to ensure we can focus on learning.

I look forward to sharing with you our achievements against our three key priorities and our local indicators for 2021/2022 in our next Quality Account. I would like to thank everyone who has helped us put this Quality Account together, to our people who continue to provide our patients, service users and families with the highest quality of care and for taking the time to read our 2020/2021 Quality Account.

Neil Carr, Chief Executive



About our Trust

Our Trust Services

Midlands Partnership NHS Foundation Trust provides physical and mental health, learning disability and adult social care services across Staffordshire, Stoke-on-Trent and Shropshire. We provide a vast range of community services for adults and children and specialised services such as rheumatology and rehabilitation, which are delivered in venues ranging from health centres, GP practices, community hospitals and people's own homes.

The Trust also provides services on a wider regional or national basis including perinatal, eating disorder and forensic services. We deliver out of area sexual health services and our Inclusion service offers psychological and drug and alcohol services, in the community and in prisons, and has contracts across the country. We also provide genitourinary medicine services.

As an organisation we serve a population of 1.5 million, over a core geography of 2,400 square miles, and employ around 8,500 members of staff.

We have close links with local universities including Keele and Staffordshire.

Our Trust Strategy

Our mission, values and behaviours

The Trust's strategy revolves around our mission that 'together we are making life better for our communities' and our core values and behaviours which are centred on a culture of high-quality, sustainable care. This is supported by our strategic framework which sets out our strategic aims and objectives.

Our strategic framework

Our strategic framework is underpinned by a number of supporting strategies aligned to each objective; this includes a strategy for quality, finance, estates, IM&T, workforce & development and commercial services.

Our Quality Framework

Our Quality Framework enables us to translate the Trust's strategic aim 'to deliver high quality health & social care services' into a framework of priorities. Our framework is not simply concerned with regulatory and contract compliance, but is about building on strategic quality priorities identified by the Trust Board.

Our five key priorities for delivering our strategic quality objective are:

- People who use our services will be happy about the way they are treated and will have genuine opportunities to make an impact on service improvements
- Teams will be supported to make continuous quality improvements the norm
- We will learn from mistakes and take steps to reduce future errors
- Our CQC rating will not fall below an overall rating of 'Good' and the CQC will see evidence of outstanding practice in an increasing number of services
- We will engage in a comprehensive programme of research to enable practice to be built on the best available evidence

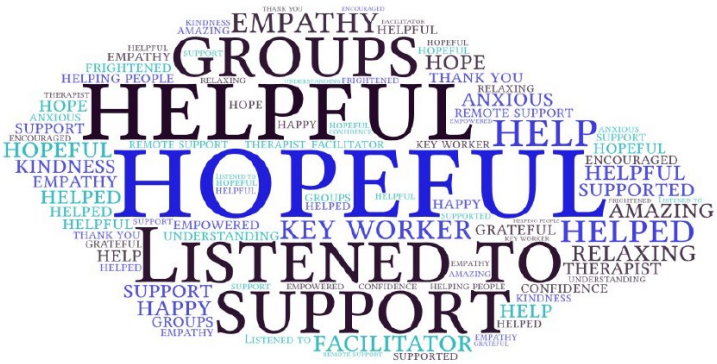
Service User and Carer Experience and Involvement

Experience and feedback

People's experiences of our services are important to us as they provide us with key measures of quality. We employ a range of tools to help us understand people's experiences so that our teams can use feedback to make local changes quickly. Some of the methods we currently employ include:

- **Surveys** - surveys have been developed locally either with a particular service or for a piece of focused improvement work. During 2020/2021, surveys were developed to explore the experiences of people who use our services with a focus on experience of using digital solutions for consultation and preferences for future engagement and consultation, such as how people wish to engage with clinical teams (face-to-face/video consultation/telephone etc) as we identified in last year Quality Account as next steps.
- Nationally set, the Trust uses the Friends and Family Test and the CQC Community Mental Health Survey to enable us to benchmark ourselves and also help us to improve our services.
- We have maintained over 90% satisfaction for Friends and Family Test.
- **Mystery shoppers** –people who use our services are asked to be 'mystery shoppers'. This can help us gain real insights into the experience of peoples using our services. The mystery shopper programme was temporarily suspended due to the pandemic but until December 2020 when regular meetings were established with the Quality Standard Assurance Visit (QSAV) Team have integrated the mystery shopper questions into the visits to ensure their voice is incorporated into the subsequent action plans.
- **Patient-Led Assessments of the Care Environment (PLACE) –** people who use our services are trained to carry out PLACE assessments annually, feeding back on their observation and working with our Facilities and Estates Teams to facilitate improvements to the services. PLACE assessments did not take place in 2020 due to the pandemic – guidance on plans for 2021/2022 are awaited.
- **Focus Groups** – these were set up by the Trust for specific purposes when, for example, services are planning changes or to support research into better care. They are also sometimes set up by external organisations such as the CQC or Healthwatch to provide us with independent feedback.
- **Forums –** Both forums and focus groups/workshops/task and finish groups have continued using a variety of methods including virtual platforms, such as Microsoft Teams and Zoom in addition to engagement by telephone/e-mail – the involvement method is always informed by the preferences/needs of our lived experience representatives.
- We launched a new virtual Trust-wide service user and carer forum in November 2020. Forums focus on reviewing consistent themes from feedback and co-producing solutions, for example improvements to discharge planning and sharing involvement opportunities, with speakers attending to gain specific feedback on a new initiative, involving service users and carers in the process.
- **Community meetings** – regular community meetings take place in in-patient areas including adult acute mental health and forensic services. Peer Support Workers facilitate these meetings for service users and carers to raise issues that are then addressed directly by the clinical teams. Face to face meetings have continued during the pandemic for some areas and have been held using Microsoft Teams/Zoom in others.
- **Concerns, Suggestions, Information Requests and Compliments** – people contact the Patient Advice and Liaison Service to request support or information, to raise any concerns they may

have to praise the staff that have cared for them. Surveys were amended in 2020 to include questions on whether people who use our services have any suggestions for improvement and also to raise a compliment. We review every contact to see if there are any emerging themes anywhere in the Trust that we need to learn from, working alongside care groups to highlight these themes and trends and involving service users and carers in improvement initiatives.



- **Patient Stories** – people who use our services are sometimes asked to share their experiences of our services at meetings of the Trust Board of Directors, the Council of Governors and Mental Health Legislation Committee.

Although many of these lead to real impact in local services, we also want to ensure we can use people's experiences and ideas in the shaping of our services to create wider sustainable impact, through our service user and carer involvement programme of activities.

Involvement for Impact

The Trust intention and value is that any engagement and involvement with service users and carers is meaningful and makes a difference, by improving services and the health, wellbeing and recovery of service users and carers.

Involvement is key to developing and delivering responsive services. For effective involvement, people need to feel supported and for their contribution to be respected, valued and have an impact. It is really important to us that the people who use our services have the opportunity to get involved in shaping services.

The Trust is signed up to the 4Pi National Involvement Standards which is a framework developed with service users and carers. This is a framework on which we base our standards for good practice and is what we use to monitor and evaluate involvement.

Despite the restrictions of the pandemic, service users and carers continued to engage in activities using virtual solutions such as Microsoft Office 'Teams' and Zoom. This opened up opportunities for lived experience representatives (service users and carers who are 'signed up' to involvement) to engage in a breadth of activities which brought representatives from physical health and social care services together with people who are using mental health and specialist services.

During 2020/2021, 5 service user and carer co-production sessions have taken place on Microsoft Teams to prepare for the submission and vision for the future of Community Mental Health Services in Staffordshire and Stoke-on-Trent during the transformation and redesign of pathways. The sessions have included service users and carers from MPFT and North Staffordshire Combined Healthcare and staff from the Voluntary Sector and Community Enterprise sector, commissioning colleagues, the local authority, MPFT and North Staffordshire Combined Healthcare. Service users and carers have been integral to the planning of pathways and vision for the future. Their feedback was used to support a successful bid for funding. Lived experience representative will continue to be involved with the project to transform and redesign pathways.

For anyone interested in being involved our contact details are involvement@mpft.nhs.uk

Involvement Activity 2020/2021

To support robust application of Involvement methodology, below is a table of examples where we have used the 4Pi National Involvement Standards Framework against the 5 key headings.

4Pi National Involvement Standards	MPFT Involvement			
	Involvement training for service users, carers and staff	**Forensic and Forensic Learning Disability Forums**	**Community Mental Health Transformation**	**BeeFree – Persistent Neck and Back Pain**
PRINCIPLES **Who is the lived experience and staff co-production partner?** **How will you make sure there are equal opportunities for all participants?**	Co-produced with 3 lived experience representatives - held via MS Teams and Zoom.	Service users currently using in-patient forensic Services including Learning Disability Forensics	15 lived experience representatives and staff system partners from North Staffordshire Combined Healthcare, Commissioning and Primary Care	5 Lived experience representatives and staff from Mind, Q Improvement Lab, Keele University, MPFT, Musculoskeletal (MSK) Interface Service, Haywood Foundation and North Staffordshire Combined Healthcare
PURPOSE **What is our shared goal/outcome?** **Why are we involving service users and carers?**	Co-design and co-deliver a training package for service users, carers and staff to learn about involvement – embedding this within our physical health, mental health, social care and specialist services	Identify how the Coronavirus pandemic affected service users on in-patient wards with the opportunity for service users to tell their stories and identify themes to inform practice	Experts by experience involved currently using or working as peer support workers within the pathways to gain insight through a service user/carer lens	To support better awareness, identification and management of mental health problems for patients with persistent neck and back pain accessing MSK services
PRESENCE **Identifying participants with relevant experience/representative of project** **Ensuring people are involved at all stages including decision-making and are able to give views in different ways**	Lived experience trainers identified with experience of delivering courses through the Wellbeing and Recovery College, using a variety of services as a service user and carer and being a lived experience representatives. Co-production throughout the development stages of the training package and revisions to the package following delivery	Service users/carers shaped discussion at the forums, took part in the forums and were provided with multiple opportunities to share their stories	Professionals, service users/carers and peer support workers identified with lived experience covering Community Interventions, Older Adult, Eating Disorders, Intensive Life Skills (Personality Disorders) and Psychosis Pathways.	Co-production through all decision-making stages from inception in March 2019 to launch in March 2021
PROCESS **Methodology to communicate ensuring accessibility** **Role description completed and admin support arranged including communicating information about payment of fees**	Training communicated via the Trust's Wellbeing and Recovery College prospectus Support offered regarding accessibility/communication needs and trainer plan developed to support both trainers	All of the forensic wards were directly invited to take part in the online forums, service users/carers shaped the content of the forums	Community mental health and specialist services Cross-organisational (CCGs, Primary Care, North Staffordshire Combined Healthcare and MPFT).	

4Pi National Involvement Standards	MPFT Involvement			
	Involvement training for service users, carers and staff	**Forensic and Forensic Learning Disability Forums**	**Community Mental Health Transformation**	**BeeFree – Persistent Neck and Back Pain**
Which care groups are involved				
IMPACT **Identifying what differences the involvement of service user and carers has made and whether the outcome has been achieved** **Sharing the process, assessing how everyone feels about this and providing updates to participants** **Has involvement made a difference beyond the activity itself e.g. delivery of services, recovery or wellbeing?**	20 new lived experience representatives signed up to involvement, with 10 being involved in new activities, representative of diverse communities and Trust services/geography All participants are provided with a feedback form to inform revisions to the training, with lived experience trainers involved in evaluation and re-design of the training based on feedback New representatives have been involved in a number of activities including the Community Mental Health Transformation across Staffordshire and Shropshire	Improvements based upon the themes include: **Gym sessions** – reintroduced with some restrictions **Family and friends** – Skype calls introduced allowing service users to interact with family and friends **Staff** – service users report improved relationships with staff **Ward environment** – service users reporting feeling happy and safe on the wards **Information** – information re COVID-19 and the vaccine shared due to service users being concerned about media reports	Successful submission to NHSE and funding provided to co-design new pathways with feedback from workshops and consultation informing the submission	Service user/carer input led to successful launch event with over 50 attendees on 31 March 2021 and continue to be involved in follow-up steering group sessions to evaluate

Promoting a Speak Up Culture

Our staff at Midlands Partnership Foundation Trust are encouraged to speak up about their concerns whether they are about patient safety, quality of service or behaviour of colleagues. In the first instance, we proactively encourage staff to speak up through their management structures. Where going through a management structure might not be the most appropriate route, staff have access to their Professional Leads, Heads of Nursing, Staff Side Representatives, Peers, Senior Leaders, Clinical Tutors and Freedom to Speak up Guardians (FTSU).

Our Freedom to Speak Up Policy and Standard Operating Procedure provide managers with information about how to support staff throughout the 'speaking up' process. Where staff speak up via the FTSU Guardian, the Guardian will also support staff through the process and in addition, follow-up with the member of staff to request feedback from them on their experience of speaking up. This feedback is used to strengthen the process of speaking up.

The Trust has two dedicated FTSU s, supported by a growing network of FTSU Champions who promote, encourage and cultivate a 'speak up' culture within teams, as outlined in the Trust Freedom to Speak Up Policy and Standard Operating Procedure, which is accessible to all of our staff on the Trust intranet page. The Trust's interactive handbook for new starters also gives a clear message to staff from the Chief Executive Officer that they will be supported to speak up if they are concerned about the quality of care, patient or staff safety or behaviours of colleagues.

Throughout the year the Trust has promoted Speaking Up through staff briefings and via the Trust's social media platforms. In addition, using virtual methods due to COVID restrictions, the FTSU Guardian have increased their attendance at Team meetings. Notably, feedback from Clinical and Care Directors, has indicated that the opportunity for staff to interact directly with the FTSU Guardian has improved engagement and understanding around the importance of speaking up. FTSU Guardians presence at team meetings has ensured staff know how to speak up and more importantly feel safe to do so.

The FTSU Guardian have continued to work actively with the People Directorate to foster a culture where speaking up is business as usual. However, Speaking Up has become more challenging during the pandemic where services have been stretched and staff are often working in very different circumstances. FTSU Champions are therefore crucial, in ensuring that colleagues know how to speak up and feel safe to do so. As team members working within the teams their colleagues will have their trust and confidence. FTSU Champions are also able to provide the FTSU Guardian with information and soft intelligence around team cultures.

This information can be shared with Senior Leaders and where necessary specific actions can be agreed and provided for those teams who require it. The FTSU Guardian provide supervision and support for the FTSU Champions, as well as an ongoing programme of development. Within the NHS workforce it has been

identified that there are specific staff groups who often find it more difficult to speak up, including Ethnic Minorities or LGBT+ staff, bank and agency staff, night staff and staff who work remotely or in remote and isolated roles. In response to these challenges, during 2020-2021, our FTSU Guardian have strengthened their focus on removing the barriers to speaking up for these staff groups. Within our Network of FTSU Champions there are Champions with special interests in the wider Ethnic Minorities & LGBT+ agenda. These FTSU Champions are known as 'Equality and Diversity Champions' (E&D Champions). Our E&D Champions are able to strengthen links with Equality Staff Networks as well as focussing their attention on addressing the blocks to Ethnic Minorities & LGBT+ staff speaking up.

The FTSU Guardians have also strengthened links with the Trusts Temporary Staffing Team to raise awareness within temporary staff groups, ensuring that we are nurturing a 'Speak Up and Listen Up' Culture across the whole workforce including Temporary Staffing, this work has included;

- Support for temporary staff to become Champions
- Strengthening links and opportunities with temporary staffing agencies to promote and support the 'Speak Up and Listen Up' message within MPFT.
- Review the Temporary Staffing Service Lead of FTSU information currently given as part of induction for temporary staff.
- Promoting the offer for MPFT Bank staff to volunteer to become FTSU Champions. Training will be provided by the FTSU Team.

During 2020-2021 the National Guardians Office released updated FTSU training for workers and for managers. The updated training has provided the Trust with an opportunity to ensure that all staff update their FTSU training. The FTSU Guardians have been working closely with the Training team to ensure Care Directorates are supported to promote the new training to all staff and most importantly those staff who work in remote or in isolated roles. In addition, the FTSU Guardians have increased attendance at Directorate and Team meetings highlighting the responsibility for all staff to complete the new training and to support all staff to foster a culture where staff feel safe to speak up,

It is vital that staff feel safe to speak up. Where staff report they have suffered detriment as a result of speaking up, the FTSU Guardian will immediately escalate this to the relevant manager and senior leaders for their attention and action. The FTSU Guardian have direct access with the Director of People during their monthly regular one to one meetings. If serious concerns exist this can be escalated to the Non-Executive Director responsible for FTSU and the Chief Executive Officer.

The FTSU Guardian also meets routinely with Staff Side Chair to share and triangulate information as well as agreeing action where appropriate. In addition the Trust also promotes measures to support and nurture a respectful culture throughout the organisation an example of these initiatives are;

- Trust Behavioural Framework
- Trust Leadership Programmes
- FTSU Policy and Standard Operating Procedure
- Management and Clinical Supervision
- Facilitated Conversations and Mediation

- Routine meetings with FTSU Guardian and Staff Side Chair to share intelligence and triangulate information.
- Online Freedom to Speak Up Training for Managers
- Team development & support provided via Organisational Development interventions
- Clear messages about thanking staff who speak up are promoted via Care Directorate Senior Leadership Teams

To ensure the Trust Board is appraised of the themes deriving from data, our Guardians report biannually to the People Committee and to the Trust Board Meeting. Furthermore, each quarter the Guardians present data to the National Guardian Office, for example, on the numbers of staff speaking up, the associated staff/professional groups, and any themes relating to patient safety, bullying or harassment or claims of suffering detriment.

FTSU Guardians have worked closely with the Quality Assurance and Effectiveness Team to support a programme of work to promote a positive culture within our Trust.

The 2020-2021 Staff Survey results indicate that MPFT staff feel safer to speak up about their concerns regarding practice compared to 2019-2020 results and are also reporting more positively compared to other similar Trusts. The 2020-2021 Staff Survey introduced a new question which directly refer to how safe staff feel to speak up, the Trust performed well in this question at 74.1% when compared within the Trusts benchmarking group 68.3%. This is good news and indicates that although there is more work to be done, the work the Trust has been embarking on to promote a Speaking Up Culture, is supporting staff to speak up.

The FTSU Guardians will continue the focussed areas of work detailed in this section into 2021-2022.

DUTY OF CANDOUR

The Duty of Candour requires Trusts to act in an open and transparent way with service users receiving care or treatment. The Trust believes that communicating honestly and openly with service users and their families when things go wrong is a vital component in dealing effectively with, and learning from errors and mistakes.

Following the Mid Staffordshire enquiry, Sir Robert Francis defined Duty of Candour as *"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made*."

There are two types of Duty of Candour, statutory and professional. All healthcare professionals have a Duty of Candour, which is a professional responsibility to be honest when things go wrong. This focuses not only on the duty to be open and honest with service users but also on the need to be open and honest within the Trust in reporting incidents or near misses that may have led to harm. The statutory duty also includes specific regulation requirements for certain situations where patient safety incidents are reported.

The Duty of Candour applies to patient safety incidents that occur during care provided that result in moderate harm, severe harm or death. The Duty of Candour also applies to suspected incidents which have yet to be confirmed, where the suspected result is moderate harm, severe harm or death. The Duty of Candour focuses on prompt notification, providing truthful information together with an apology, explanation and reasonable support for service users, or those acting on their behalf, who have been harmed.

We expect all staff to report any patient safety incident or near-miss immediately through our electronic incident reporting system Safeguard. When such an incident has resulted in moderate harm or greater, then staff apply the Statutory Duty of Candour as follows;

- *Notify the service user/carer within 10 working days of the incident being reported*
- *Contact the service user/carer to provide all facts known about the incident and a way that they can understand*
- *Speak to the service user/carer in a place and at a time when they are best able to understand and retain information*
- *Offer a personalised apology*
- *Ensure that the service user/carer knows who to contact to raise further questions or concerns*
- *Agree and carry out any further investigation which may need to take place*
- *Fully record the details of the apology/discussion in the service user's records*
- *Follow up with a written notification*

The Trust were 100% compliant for Duty of Candour during 2020/2021. In addition to the statutory requirements for Duty of Candour, the Trust has a dedicated Family Liaison Officer. This role is further described on Page 18.

The Family Liaison Officer

Following national guidance on Learning from Deaths: Guidance for NHS Trusts on working with bereaved families and carers (National Quality Board, 2018) the Trust has a dedicated Family Liaison Officer who engages and supports service users and families following moderate and above (serious) harm or death, whilst receiving Trust services. Primarily this will be with bereaved relatives; however the Family Liaison Officer also liaises with service users and families involved in non-fatal serious incidents and clinical review investigations.

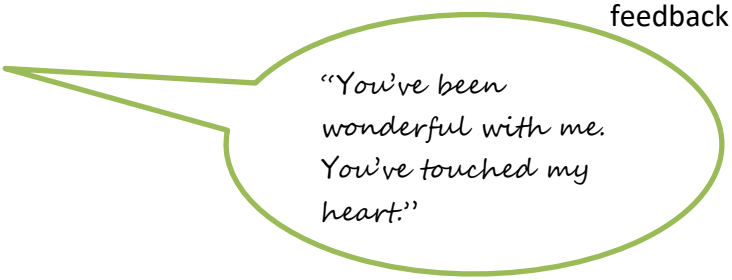
Family Liaison Officer offers a range of supportive functions including;

- Provides a strong link between the investigation process and the service user or family
- Offers service user and their family the opportunity to be involved in the Trust investigation process, to enable them to raise their own concerns and questions as a point of reference for the investigation
- Ensures a compassionate and coordinated response whilst maintaining a supportive relationship that allows an opportunity for people to share their experiences and work in partnership to improve services
- Keeps service users and their families updated on the progress and outcome of the investigation
- Provides supplementary written information to support service users and their families
- Offers initial bereavement support, signposting advice and guidance to relevant bereavement services such as CRUSE Bereavement Care and Survivors of Bereavement by Suicide
- Explains where applicable the Coroner's Inquest Process and supports the family and carer through this difficult time
- Explains the processes for raising concerns including PALS and complaints

Upon completion of the investigation, the Family Liaison Officer liaises with the service user or family to provide information on next steps. This can include providing a clinician or investigating officer to go through the investigation report with the service user, or family.

We report on the learning we have captured from service users and their families and this appears as 'Family/Service User Said' – 'We Learned' – 'We Did' within our quarterly Learning from Deaths Report that is reported through our Quality Governance Committee's and Care Group learning forums.

The Family Liaison Officer role has improved the experience of the service user, family and carer since it was introduced. Examples of the positive feedback from families about their experience, include;



During the past 12 months, our Family Liaison Officer has continued to develop the service by successfully training in 'Suicide First Aid – Understanding Suicide Intervention'. The qualification was obtained through online training and further study, and accredited by the City & Guilds of London Institute. This has enabled our Family Liaison Officer to understand and identify someone who may be thinking about suicide, and to competently intervene by signposting to services such as GP or Cruse, as a first aid approach. During this year our Family Liaison Officer has intervened which resulted in one family member receiving immediate care by their GP and subsequent bereavement counselling.

"Your Family Liaison Officer has been most kind, caring and compassionate, and has gone above and beyond in her duties and I am sure her vocation should be recognised."

The Family Liaison Officer and Head of Quality Governance and Engagement (Trust Suicide Prevention Lead) working together with Shropshire Suicide Prevention Action Group, facilitated the creation of two Bereavement Support Officer posts to provide a post-vention service within Shropshire. This was achieved by sharing the Trust learning and supportive literature with Shropshire Council. These posts have been appointed into, hosted by Shropshire and Telford MIND. Collaboratively, the Family Liaison Officer and Bereavement Support Officers have formed a peer support group which meets on a fortnightly basis to provide mutual support and supervision.

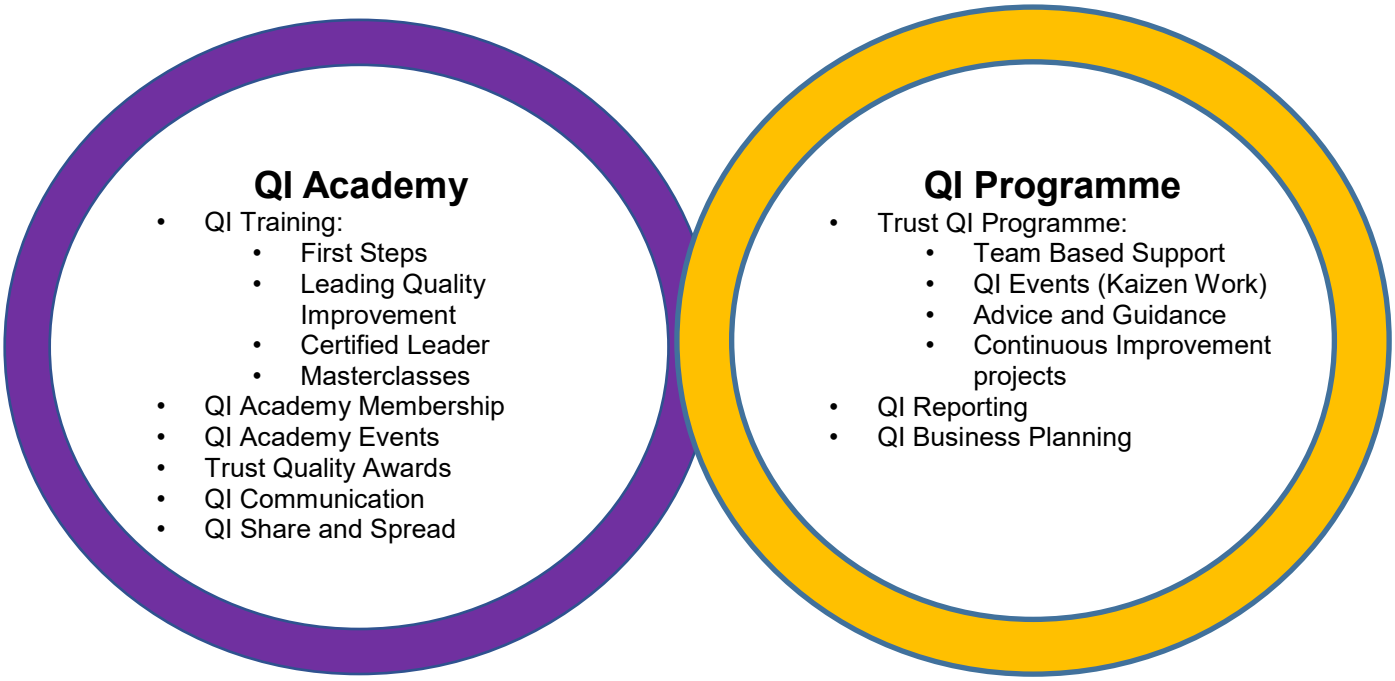
"Thank you so much for all the help that you've given me. You were the most amazing help to me when it happened."

The Family Liaison Officer has networked to promote and provide insight into the role particularly where other Trusts and partners have expressed an interest to able them to develop similar services. The Family Liaison Officer has been able to provide them with advice and information around bereavement support, post-vention training and standard work processes.

If you would like to speak to our Trust Family Liaison Officer please make contact via MPFTInvestigationsTeam@mpft.nhs.uk

Continuous Improvement (QI)

As reported in the 2019/2020 Quality Account, staff continue to embrace the ethos of the QI framework, 'In Pursuit of the Perfect Patient Experience'. They are practicing aspects of QI that enhance their working environment, improve safety, reduce time spent on wasteful activities, increase the amount of time available for service users and delivering care, and eliminate variation so that all service users and carers receive the right care, in the right way, at the right time. The Trust has delivered QI for the last eight years. The continued roll out of our practice gives everyone in the organisation a consistent approach to change. QI delivers a range of support and resources for staff, partners, service users and carers which are broadly split into two areas:



The conditions of the pandemic have expedited the move of QI to the virtual space, we have quickly responded to this and adapted all elements of the support we provide to enable QI to continue to be practiced virtually, key developments include: virtual training, virtual Kaizen/project work/facilitation and the development of virtual huddle-boards within MS Teams. In the true nature of Continuous Improvement, we have also adapted and added to the existing offer to include additional components within both the QI Academy and the QI Programme.

QI Training

Within the Academy described above, we have achieved the following to date:

	Total Staff Trained	Trained 2020 – 2021	Trained Virtually
First Steps	2329	947	657
Leading QI (LQI)	183	44	27

There are also 30 senior leaders trained as certified leaders in QI, with another 28 currently in training. 35% of total Trust staff have engaged in some type of QI Training – 7% increase from 2019-2020.

Since March 2020, First Steps Training and LQI training has been delivered virtually rather than face to face. Training has been predominately delivered by members of the QI Team with support from Certified Leaders and Certified Leaders in training.

QI Academy Membership and Events

Appointment to the QI Academy is by invitation following completion of a range of QI training/ participation, and people can become Members, Fellows and Masters of the QI Academy, with a range of expectations of them to fulfil, such as mentoring colleagues, delivering training and sponsoring events.

Through access to the breadth of opportunities within the Academy, people:

- Are more effective in their application of QI
- Develop skills, expertise and experience to support others and be confident as leaders of QI
- Ensure quality is prioritised in teams, with QI being everyone's responsibility
- Have access to effective networks to share ideas and access support from peers
- Have opportunities to engage in collective and connected projects.

This is enabled through:

- Providing a consistency of approach for all QI work
- Making people feel safe to challenge existing practice and try new ideas
- Being inclusive and seeking contributions from a wide range of people
- Creating a system of networking, collaborating, learning, adopting and spreading best practice
- Building a focused, effective coaching and mentoring system
- Ensuring opportunities exist to collectively tackle complex issues
- Looking outwards to embrace expertise and ideas developed in other sectors
- Enabling people access to innovative and current developments in QI practice
- Continually researching better ways to facilitate learning, deliver the QI programme and provide support to people.

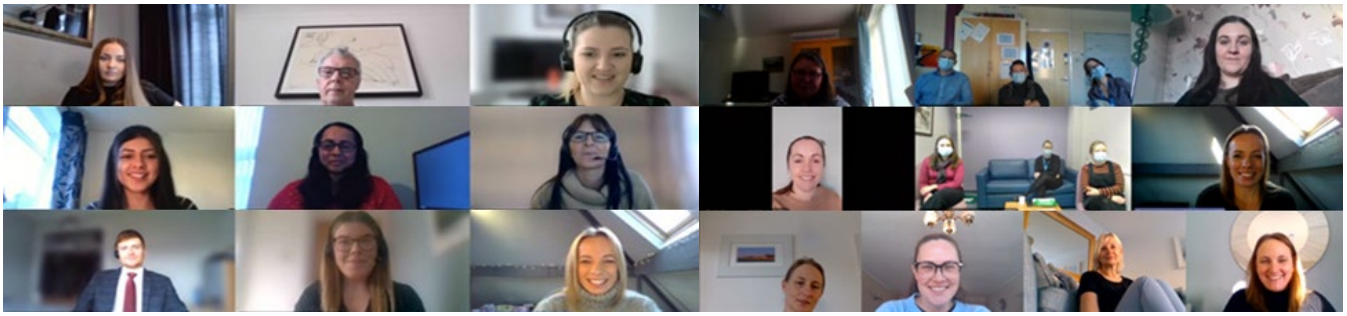
Trust Quality Awards

The QI Academy also hosts the Trust Quality Awards, which offer a local approach to rewarding teams for different types of activities that improve quality. It is specifically a reward scheme for impact, not status. Teams can be awarded a bronze, silver or gold award, depending on the level of engagement in quality activities, and the impact of those activities both within the team's own service and across the wider organisation. Points are awarded across a number of categories such as: staff 'Living our Values'; teams doing something differently; making a difference to their own or another team's processes; making improvements which can be shared and spread; growing skills to lead continuous improvement; and leading on QI across the Trust.

There have been successful applications from many different areas of the organisation. Awards are judged on impact – projects, for example, need to have been completed, and outcomes realised and sustained for 90 days. More points are awarded for efforts which have greater reach and for learning which can be shared with other teams. Points can now also be gained for a team demonstrating their environmental sustainability efforts.

Quality Awards Achieved by Care Group/Directorate

Care Group	No. of Awards	Bronze	Silver	Gold
Children and Families	6	2	3	1
Corporate	9	2	2	5
Shropshire	5	4	1	0
Specialist	1	1	0	0
Staffordshire and Stoke on Trent	7	3	3	1
Total	**28**	**12**	**9**	**7**



QI Communication & Share and Spread

Research carried out looking at the impact of QI within organisations has shown that two of the most significant indicators of how embedded QI is within organisations are how often people talk about QI and how many people they talk to about QI. On the back of this research, the QI team have focused on strengthening our approach to communication both internally and externally. Internally we have continued with our regularly updates to Academy members via Virtual Huddle-boards embedded within MS Teams, Sway, MS Teams Channels, updating our intranet and introducing the QI Café.

Both internally and externally, we have focused on developing our social media presence via Twitter, and this is a prominent element of our approach to share and spread, and is one of the main mechanisms we use to share successes and learning with the wider Trust and partners.

Externally, members of the team are part of many regional, national and international networks including the West Midlands Continuous Improvement Exchange Forum, Queen's Nurse Institute, Regional Coaching Network, National Q Forum, National QI Communication Collective and Liberating Structures local and international Groups. Involvement in these networks allow us to share our successes and also continue to

bring new learning back into the organisation, which has been invaluable in the adaptation of QI delivery into the virtual space.

QI Programme

The QI Programme consists of the following:

- QI Events (Kaizen Work) – Projects that utilise the QI methodology to make systemic process improvements
- Team Based Support – Focused on embedding the key foundational element of QI practice at a team level
- Continuous Improvement Projects – More general project support on applying change methods and QI principles
- Advice and Guidance – often discrete support that can help colleague to progress improvement independently, and can sometimes include help with problem definition, data collection, measures, testing or share and spread.

Staff Feedback on QI Support

When we asked more broadly about what impact QI has:

Managing Director – Shropshire, Telford and Wrekin said:

- *"We used QI methodology across a number of teams to illustrate unhelpful variation and waste... the teams were supported with training and clear leadership ... (and were) given time to form solutions and test them. Results included standardisation, further clarity of relative roles and responsibilities across teams, leading to a significant reduction in waits. This is staff-led change was supported ...by a service user and partners".*

Head of Operations – Children's and Families said:

- *"QI (Team) have been a great support to the Children and Families Care Group in 2020/21, they have supported the care group in moving towards its ambition of having 100% of staff QI aware and the leaders within the care group trained in leading quality improvement. Now 79% of the Care Group have received some QI training... (we have) redesigned our points of access which has been delivered using a QI approach. In doing this it has also helped enhanced awareness and appreciation of QI amongst those working on the pathway".*

Operations Director - Staffordshire and Stoke on Trent said:

- *"Within the Community Mental Health Transformation our QI and Involvement and Expirence Teams have used innovative engagement techniques to support stakeholders to contribute,share their ideas and learn from each other. They have been amazing at harnessing the assets and strengths that everyone has to bring and their support has not only been key in the successful development of a co-produced model but they have also helped to create an energy and focus that has set a positivie tone for the rest of the transformation".*

Due to the conditions and pressures of the pandemic many of the QI projects did not progress as planned, a number of projects have since restarted, however several remain on hold. Below are a selection of examples of work done in 2020.

Homefirst Referral Process Kaizen Event

exploring how errors and variation could be reduced within the referral process.

- *"The Kaizen event included several staff from different roles to ensure that we looked at different parts of the process. This was a great opportunity for staff to be involved in QI, in some cases for the first time. The outcome of the workshops was a piece of Standard Work that has been trialled, reviewed twice and continues to be used in practice now." (*D2A Central Data Team Lead)

North Falls Redesign Kaizen Workshop

identifying waste and generating ideas of improvement using Google Jamboard and Liberating Structures.

- *"The facilitated session with the team was fantastic and we got a lot out of the jamboards. These made us realise that there were key themes for redesign that we had not realised. The liberating structures exercise was particularly useful as it really stimulated conversations, was fun and set the tone for the work we want to do ... a collective approach and to see this as an opportunity rather than another work stream!" (*Operational Manager)

Children's Speech and Language Therapy

exploring how the team could standardise more elements of their work, looking at waste and ideas for improvement.

- *"The QI Team supported our admin team who work in three separate localities to think about streamlining processes. This was received well... and they were freely able to voice their opinions and ideas... the team now have a regular huddle, provide admin support when the other teams are struggling and are much more cohesive in their thinking".* (Team Lead)

Shropshire Community Interventions Pathway Kaizen Event

a range of workshops exploring the opportunities to improve the patient journey by removing waste and testing new ideas.

- *"The QI Team has enabled the teams to work together to improve the patient journey, reduce waste and increase trust between teams. It has also been great to see the professionals working together to come up with shared improvements and to see their understanding of and confidence in QI process increase."* (Clinical and Care Director – Shropshire, Telford and Wrekin)

QI Reporting and Business Planning

QI continues to report regularly to a range of committees presenting updates on events, training and progress against objectives.

The QI Team complete:

- Monthly updates to the Trust Director Delivery Forum
- Quarterly reports to Quality Governance Sub-Committees and Performance and Quality Meeting
- Bi-Annual reports to Quality Governance Committee and Trust Board.

A review of QI objectives are built into and aligned with the Annual Business Planning process and the plans are revised annually to ensure that priority areas of focus for each of the Care Groups are highlighted. This enables the QI Team to forward plan the programme and ensures that QI support is deployed in the right areas. Progress against objectives is included within the QI reports highlighted above.

QI and links to other Trust Initiatives

Within QI, there are many opportunities to link, support and signpost to other Trust-wide initiatives. Some of the areas include: In Our Gift, Digital Champions, Sustainability Champions, Freedom to Speak Up, Equality and Inclusion, Research and Innovation and Leadership Development. Several of these areas come under the umbrella of the 'Clinical & Practice Network'.

Planning for the Future

The plan for the QI for 2021/2022 is as follows:

Drivers	Objectives
Consolidating virtual training	This has been a huge success and has meant that the training is accessible to all without long journeys to get to the training venue. This is a change that we want to keep.
Strengthen the Academy membership	We will continue to develop skills, expertise and experience across the Trust. We will continue to develop new ways to reach out to members, fellows and masters of the academy e.g. on-line training resources, videos, forums and Masterclasses.
Maintaining expertise in the team and further developing networks	As a QI team we will ensure that we are continuously improving what we do and our knowledge and skills and learn from the internal networks and wider QI Network as appropriate.
Continuing the roll out and refinement of the Quality Awards	Going forward we will listen to teams to hear how they are improving quality in their areas focusing on impact, not status and ensure all efforts to make things better for the people who use our services can be taken into account towards the next award.
Supporting agile working	As a QI team we will be having conversations about what agile means to us and how else we can embrace agile working going forward.
Adapting the offer and responding to the Organisational requirements	Going forward we will continue to develop what we do to support clinical teams with their improvement efforts. Some of this will continue to be carried out virtually.
Partnership and System wide Quality Improvement	We will continue to develop and explore opportunities to undertake Partnership and System wide Quality Improvement work.
Evaluation of QI	We will be carrying out an evaluation of QI within the Trust and creating a process to undertake this annually.

Staff Survey Results

Staff Engagement Approach

In August 2020, a new 3 year major people and organisational development transformational programme was launched within MPFT called in 'In Our Gift'. In Our Gift is about inclusively and collectively re-imagining the future of MPFT and what's possible together with every one of our 8500 staff members serving a population of 1.5 million patients, service users and caregivers.

The vision for In Our Gift is about creating a way of working which includes coming together, sharing best practice, creating a community network through social collaboration and together realising the art of the possible. By its very nature 'In our Gift' is a collective ambition so owned by all staff within MPFT. The In Our Gift Approach has recently been shortlisted for a Health Service Journal Value Award in the category of People and Organisational Development Initiative of the Year.

In Our Gift is made up of 4 Quadrants, supported by Trust Values and Behaviours and Governance processes. The approach is enabled by the use of Digital Technology and a suite of facilitation tools known as Liberating Structures.

Key goals for the In Our Gift Approach were set out right from the start and included;

- The requirement for a robust and accessible wellbeing offer for all colleagues
- A collaboration engine that captures the hearts and minds of the workforce through idea generation, making the impossible possible and ideas that could be implemented without heavy governance, just happen
- A strong digital application for access and agility
- A delivery methodology to complement our existing Quality Improvement (QI) approach which is based on the Virginia Mason model
- An ongoing and never-ending resource that could be developed at the point of need
- Support for leaders to implement the 'how' and the associated aims within our gift
- A recognition scheme to compliment impact and achievement
- Quick and easy sharing of best practice.
- A new pulse check with a section that uniquely links CQC domains to trust values including a happiness index.
- Talent management pilot

Staff Survey Results

In 2020, staff were invited to take part in the annual NHS Staff Survey. 4969 staff responded representing 59% of the workforce. This is the highest number of responses we have ever had as an organisation. MPFT is now benchmarked against a bigger category of NHS organisation which include Mental Health, Learning Disability and Community Trusts, and in this bigger category MPFT achieved a joint 7th highest response rate nationally. Within this category we achieved the highest number of responses.

The 220 staff survey remained largely the same as the 2019 survey, however it did not include the section on personal development. This was replaced with a section on staff experience of working through the pandemic. Two new questions were added to the survey; "I feel safe in my work" and "I feel safe to speak up about anything that concerns me in this organisation".

Benchmarking Key Theme Results

The staff survey comprises of 78 questions, which make up 10 key themes. Each theme is scored out of ten, with increments of 0.1 noted as a significant change. These can be seen in Table 1 below. Comparing the theme scores with results from 2019 staff survey scores, we have seen statistically significant positive change in all 10 themes, with a change in score in 9 out of 10 themes.

We have been rated as the 5th most improved Trust of type by the Health Service Journal. Furthermore, MPFT is 1 of only 10 Trusts of type who have seen improvement across 9 or more benchmarking themes. Within the benchmarking category, MPFT is 1 of 2 trusts with 10 themes scoring above average.

As can be seen in Table 1 the biggest increases can be seen in the Health and Wellbeing (0.5 score increase) and Morale (0.3 score increase). The theme of Safe Environment – violence has remained the same at 9.6.

Table 1: Benchmarking Themes Comparison with the scores in 2019

Theme	Our Score 2020 ational	Comparison th our 2019
Safe Environment – Violence	9.6 (Above Average)	Same
Equality and Diversity	9.4 (Above Average)	0.1 Increase
Safe Environment – Bullying and Harassment	8.5 (Above Average)	0.2 Increase
Quality of Care	7.6 (Above Average)	0.1 Increase
Immediate Managers	7.4 (Above Average)	0.1 Increase
Staff Engagement	7.3 (Above Average)	0.2 Increase
Safety Culture	7.1 (Above Average)	0.2 Increase
Team working	7.1 (Above Average)	0.2 Increase
Morale	6.6 (Above Average)	0.3 Increase
Health and Wellbeing	6.6 (Above Average)	0.5 Increase

Table 1 below shows our bench-marking performance in 2018/2019-2020/2021

	2020/21		2019/20		2018/19	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.4	9.1	9.3	9.1	9.3	9.2
Health and wellbeing	6.6	6.4	6.1	6.1	6.1	6.1
Immediate managers	7.4	7.3	7.2	7.2	7.2	7.2
Morale	6.6	6.4	6.3	6.3	6.3	6.2
Quality of appraisals	N/A	N/A	6.0	5.7	5.8	5.5
Quality of care	7.6	7.5	7.5	7.4	7.4	7.4
Safe environment – bullying and harassment	8.5	8.3	8.3	8.2	8.4	8.2
Safe environment – violence	9.6	9.5	9.6	9.5	9.6	9.5
Safety culture	7.1	6.9	6.9	6.8	6.8	6.8
Staff engagement	7.3	7.2	7.1	7.1	7.0	7.0
Team working	7.1	7.0	6.9	6.9	N/A	N/A

Analysis of the results across the 75 questions, shows scores significantly improved on 45 questions, 30 questions had no significant difference and 0 questions were significantly worse when compared to 2019 results. The most improved questions are listed in Table 2 below.

Table 2: The 10 most improved question scores

MFPT has seen the largest increase in the Health and Wellbeing theme and is 0.2 above the national average for Trusts of the same type. In 4 out of 5 questions, health and wellbeing saw an improvement, with the most significant highlights being a 12% increase in the organisation taking positive action on this area, 7% increase in satisfaction with flexible working patterns and a 15% reduction in staff coming into work when they are not well enough to complete their duties. For staff self-describing in the survey as belonging to a Black, Asian or minority Ethnic background, there was an improvement of 17% around the organisation taking positive action on health and wellbeing and a 9% reduction in work-related stress. Additionally, staff reported a further 3% increase in reasonable adjustments being made by their employer.

These results are likely to be reflective of the increased focus on staff wellbeing through the pandemic and the launch of the new, wide-ranging and inclusive health and wellbeing offer known as SOOTHE. This approach and the interactive web-based handbook has been nationally recognised by NHSi as a best practice example and has recently been featured via video at a NHS Employers conference in March 2021. The interactive handbook can be found here https://view.pagetiger.com/soothe

Morale as a theme has seen a 0.3 increase and is 0.2 above average for Trusts of a similar type. Scores across all 9 questions which make up this theme have improved. The most significant improvements include 7-9% improvements on the questions asking staff if they are considering leaving the organisation. This means that less staff are considering looking for a job outside of MPFT.

Further significant improvements for the staff survey results were noted in the questions asking staff about their experience of senior leaders within the organisation. Of these questions, there was an 11% improvement in score on the question relating to the effectiveness of communication between senior leader and staff, 6% increase in senior leaders involving staff in important decisions and a 5% improvement in senior managers acting on staff feedback.

Staff engagement

The Trust has achieved a score for this theme of 7.3, which reflects a 0.2 increase since 2019.
The average score for the benchmarking category has seen a 0.1 increase.

This key theme is made up of 9 questions exploring 3 key areas; motivation, the ability to contribute to improvements and recommendation of the organisation as a place to work or receive treatment. Significant increases have been seen in the domain of advocacy with 9% - 7% increases across the 3 questions. With regards to the question about recommending the organisation as a place to work, MPFT has seen the second highest increase nationally within its benchmarking category. Increases are also shown across the 3 questions pertaining to involvement in decision making. The area of motivation has seen the least improvement, with only 1 of 3 questions seeing an improvement. This is perhaps not surprising given the context of the pandemic.

Table 3 Staff engagement comparison with 2019

Staff Engagement Question	2019	2020	Change since 2019
Advocacy			
Would recommend organisation as place to work	62%	71%	9% Increase
If friend/relative needed treatment would be happy with standard of care provided by organisation	71%	78%	7% Increase
Care of patients/service users is organisation's top priority	74%	82%	8% Increase
Involvement			
Able to make suggestions to improve the work of my team/dept.	75%	78%	3% Increase
Opportunities to show initiative frequently in my role	71%	73%	2% Increase
Able to make improvements happen in my area of work	56%	59%	3% Increase
Motivation			
Often/always look forward to going to work	61%	63%	2% Increase
Often/always enthusiastic about my job	77%	77%	No change
Time often/always passes quickly when I am working	81%	80%	1% Decrease

In Our Gift Next Steps

The results of the 2020 Staff survey will be used to inform our next steps within our In Our Gift approach. The following areas will be priority areas to focus upon.

Wellbeing and Experience

The health and wellbeing of our staff is fundamental to ensuring they are fit and able to provide care for others and the Trust is committed to ensuring it has the right mechanisms in place to support staff to create the culture in which they are helped to stay healthy and well and also to support staff when they are unwell. This involves having the right management structures, work environment, policies or procedures, occupational health services, and opportunities to receive care and support in relation to physical and emotional wellbeing. The Trust is committed to preventing ill health and continues to work hard to ensure that staff within the Trust recognise that their health and wellbeing is taken seriously.

Whilst we have made significant progress with our approach to health and wellbeing through our SOOTHE approach, there remains further work to progress due to the ongoing impact of working within the NHS during the Coronavirus pandemic. It is also likely that many staff have experienced difficulties, including loss within their families and social relationships. Through SOOTHE we will continue to build upon on our offer to ensure we are both recognising the impact upon wellbeing and offering support in wide ranging and inclusive ways. This includes the development of a bespoke staff offer delivered by out Wellbeing and Recovery College.

Our core Occupational Health and Wellbeing Service is provided across the Trust's geography primarily by Team Prevent UK Ltd. In addition to this core offer, our comprehensive wellbeing support package which is

based British Psychological Guidance (2020), national guidance and the evidence base includes:

- Executive briefing –to increase visibility of senior leaders, answer key questions and share key messages
- Regular updates via email – a key space for information, updated with key messages highlighted to ensure staff are informed and have clear guidance
- Dedicated intranet space and updates for wellbeing, weekly communications about wellbeing (SOOTHE). This includes Wellbeing Wednesdays where key messages and events around wellbeing are shared
- Dedicated interactive web-based handbook for our wellbeing offer https://view.pagetiger.com/soothe
- Support groups and spaces to chat to promote connection and support including Shielding Space to Chat, A Parents Place to Park and Menopause Matters
- Coaching offer for leaders to seek support, emotional defusing, time out or work through specific issues for leaders/managers
- Virtual Staff networks to connect individuals across our diverse staff groups – BAME, Disability, LT conditions, LGBT+
- Team support and listening ear service, in conjunction with F2SU, Equality lead and staff side representation
- Lead Psychologist identified to consult with hotspot areas such as District Nursing, Palliative Care, Home First, All Inpatient services
- Increased funding provided to our Specialist Staff Psychology Service to meet increased need
- Bespoke offer for staff delivered by the Wellbeing and Recovery College that includes webinars, brief sessions and team support on a range of wellbeing topics

Social Collaboration

At the heart of the In Our Gift approach is social collaboration – working in a collective and collaborative way to improve both patient/service user and staff experience. It's not just a way of working it's the way we work by coming together and sharing best practice. The aim is to create community networks through social collaboration and together realising the art of the possible. A key part of this has been the introduction of the In Our Gift Ideas Hub in August 2021, a digital platform for staff to share ideas and innovations and collaborate together.

Whilst our staff survey results evidence that staff are experiencing more involvement and opportunities to affect change within MPFT, this quadrant of In Our Gift will enable us to focus on improving these results further. This way of working together in MPFT will be key as we continue to shape both the experience of staff and patient care post pandemic.

Leadership

For the 'In Our Gift' philosophy to be realised to its full potential, leaders in MPFT must influence and develop a culture within their teams that supports a collective and compassionate approach. This means working together to create a strong team ethos where every single member of Team MPFT understands how important their contribution is to the overall success of the organisation. The continued development of a leadership offer that both supports our leaders as they support others and delivers a collective and compassionate approach will be the focus through 2021/2022.

Continuous Improvement

Our approach to continuous improvement is based on our Quality Improvement (QI) methodology, the foundations of which are constructed on Lean thinking and the aim that everybody; everywhere is working towards improving their service. By putting service users and carers right at the centre and staff in the driving seat of change, we believe that staff will develop their own effective and sustainable solutions to improving their areas of work. This works best when supported by a clearly structured and actively facilitative QI framework and leaders who will support and break down any barriers to change. Given the agenda to continue to improve patient experience and staff experience in new ways of working this methodology will be key and utilised through 2021/2022

Monitoring Progress

The monitoring of plans aligned to the In our Gift Approach and methodology to improve the experience and wellbeing of our staff sits with the People Committee and ultimately, Trust Board, with improvement being measured through the yearly National Staff Survey and the regular In Our Gift pulse check.

CQC Ratings

The Trust's core services were rated by the CQC last year as reported in the 2019/2020 Quality Account. This included nine of the Trust's 16 core services.

The reports can be accessed via https://www.cqc.org.uk/provider/RRE

The Trust has an overall rating of 'Good'.

The Trust has delivered a comprehensive action plan in response to the feedback received from the CQC. During 2020/2021 the Trust has provided assurance to CQC in relation to two core services assessed as part of their transitional regulatory approach; Acute wards for adults of working age and psychiatric intensive care units; and Specialist community mental health services for children and young people. The reviews were positive and whilst they did not result in a report or a change to ratings, assurance provided to the CQC informs future monitoring and regulatory activity.

Adult Social Care Inspections

Seven of the Trust's Home First Services were last rated by the CQC Adult Social Care Inspectorate during 2019/20 as reported in last year's Quality Account. During December 2020, the CQC undertook a focused visit of services at Home First Stafford and rated the service Good for "Is the Service Safe" and "Is the Service Well led. Overall the service is rated as 'Requires Improvement'. The current ratings for each service following their inspection visit are set out below:

The Midlands Partnership NHS Foundation Trust has delivered actions in response to the inspection of our Home First Services. The CQC will assess how well improvements have been sustained as part of future inspection activity. The reports can be accessed via https://www.cqc.org.uk/provider/RRE

PART 2

Priorities for Improvement 2020/2021

In this section of the report we review the priorities for quality improvement that we identified in last year's Quality Account. The three quality priorities we set are all important to the safe and effective delivery of care and are aligned to our Commissioning for Quality and Innovation (CQUIN) schemes.
The priorities were chosen following a process of reviewing our current services, consulting with our key stakeholders and listening to the views of our service users and carers.

Priority 1 – Improve the reporting of medication related patient safety incidents

Why did we chose this area?

While medicines are hugely important in healthcare, they also have the potential to cause problems. Unsafe medication practice and errors can cause serious harm to patients.

It is human to make mistakes so we need to continuously improve the reporting of incidents to reduce the potential for error by learning and acting when things go wrong. Nationally, NHS Improvement established a Medicines Safety Programme in February 2019 following research that identified that there were;

- An estimated 237 million 'medication errors' occur year in the NHS in England, with 66 million of these potentially clinically significant 'definitely avoidable' adverse drug reactions collectively cost £98.5 million annually, contribute to 1700, and are directly responsible for, approximately 700 deaths per year.
- Errors are made at every stage of the process, with approximately 54% made at the point of administration, 21% made at the point of prescribing and 16% made at the point of dispensing.

Currently incident reporting of medication related patient safety incidents varies across our Trust. Reporting all medication incidents whether they resulted in harm or not, is essential to improving patient safety.

What were we aiming for?

This priority area builds on the key priority areas identified last year around reducing harm caused by medication errors.

To improve the reporting of medication related patient safety incidents.

Our measures of success were?

That we will have improved our medication incident reporting culture from the current baseline figure.

We are anticipating this will be over a two year period and therefore this will also be a key priority in 2021/2022.

Progress during 2020/2021:

- We have analysed data on medication incidents over the previous 24 month period (April 2019-March 2021, to identify trends causative factors to highlight learning points to permits us to learn and improve things if they go wrong and take action to prevent similar events from re-occurring.
- The data shows an average of 152 medication incidents are reported each month. Of this, an average of 120 incidents are attributable to internal incidents and an average of 32 incidents are reported each month which are attributable to external organisations. These are our baseline figures to improve from.
- The vast majority of patient safety incidents reported are categorised as 'no harm'.
- We have also identified areas that are expected 'high' 'and 'unexpected' low level reporters of medication related patient safety incidents against activity and patient acuity data.
- We have found there is a correlation with the national data-set where Trust data also shows that 'administration error' is consistently the highest reported cause group.
- Medication lost/missing/not available is the second highest reported cause group.
- Our analysis shows that as a Trust we need to improve the reporting of 'near-misses' as a first step in preventing medication errors.

Next Steps:

- Working collaboratively with clinical services and care group medicines safety, quality and governance and operational leads we will develop an action plan focused on specific aspects identified as requiring improvement which will be monitored at our Medicines Safety Group and report outcomes to Quality Governance Committee.
- Reducing Harm from Medication Errors will be a standing item on the monthly Medicine Safety Group and Governance Group Meeting.
- Care Group Senior Leads will be nominated to become active members of the Trust Medicine Safety Group.
- Medicines Safety Champions and will work closely with clinical staff to further improve the reporting of incidents and to foster the safety culture to include strengthening learning.
- Further improve the feedback from incidents that are reported to clinical teams and individual reporters.
- Implement electronic prescribing and medication administration systems to improve all elements of medication safety and associated governance arrangements.

Priority 2 – Improve the Assessment, Diagnosis and Treatment of Lower Leg Wounds

Why did we choose this area?

It is estimated that approximately 1.5% of the adult population in the UK is affected by active lower leg ulceration (73,000 patients) and yet less than a quarter receive appropriate assessment and treatment.

What were we aiming for?

To ensure that people in our services who have lower leg ulceration receive evidence based best practice care, thus reducing unwarranted variation

Our measures of success were?

That at least 50% of patients with lower leg wounds receive assessment diagnosis and treatment in line with NICE Guidelines.

Progress during 2020/2021:

- We have achieved (and exceeded) this key priority in two of the three standards during 2020-2021. Overall compliance across the three key standards was 73%.
- 82% of leg wound assessments were completed within the 28 days of referral with evidence of assessments meeting national requirements.
- Of the patients with adequate arterial supply, 100% were treated with full compression therapy
- For patients who had a leg ulcer 50% had been referred for assessment for surgical interventions.
- We have continued to provide a full service for the assessment, diagnosis and treatment of lower legs wounds, however due to COVID-19 pandemic there were two clinical audit limitations. Firstly, the audit sample size was reduced as staff members were redeployed lessening the capacity to conduct clinical audit. Secondly, the audit was completed by accessing the patient electronic record system (RiO) and access to specific paper records/notes was limited (infection prevention and control precautions) meaning that validation of records could not be completed during the audit.
- Our Ambulatory Clinics and Tissue Viability Service have worked collaboratively to comply with national guidance associated with the assessment, diagnosis and treatment of lower leg wounds namely the Lower Limb Assessment Essential Criteria and relevant NICE Guideline.

Next Steps:

- Our audit findings suggest that we need to focus on ensuring timely referrals into secondary care for potential surgical intervention this will be achieved by developing education sessions for community nurses who complete lower leg assessments around the use of the lower leg algorithm and treatment pathway for leg ulceration during 2021-2022.
- We will re-audit in 6 months and report findings within our Tissue Viability Quarterly Report to our Quality Governance Committee.

Priority 3 – Improve patient experience and feedback response rates across all services

What were we aiming for?

To improve patient experience/ feedback response rates across all services

Our measures of success were?

That we will have improved our overall feedback response rate by 20%

Progress during 2020/2021:

- During 2020/2021 services continued to provide opportunities for service users and carers to complete a feedback survey however the number of surveys received did reduce during the onset of the pandemic as we moved towards an increased digital offer
- We started to include patient surveys as part of the service user welcome packs
- Working towards easy to use digital solutions for our patients and service users we have continued to embed QR codes and web-links to enable quick service user feedback remotely
- We moved to digital technology to support feedback following video-consultation
- We continued to develop our surveys during this period including implementing the new Friends and Family Test question
- We have also included standard questions for all surveys to include a question about service improvement's and compliments and to improve the demographic data we collect
- Our Peer Recovery Support Workers have started to carry out face-to-face patient surveys.
- Text messaging has been tested in one of our services successfully with a 46% rise in surveys completed during Quarter 4 2020/2021 (during the trial) compared to Quarter 4 2019/2020

Next Steps:

- We did not fully achieve our desired priority for improvement last year and therefore we want to continue our focus on this key quality priority for 2021-2022.
- To continue to design and provide digital offers to enable a quick and improved feedback experience.
- To develop our public social media platform to include (but not exhaustive) 'You Said – We Did' information on our Trust website to demonstrate improvements made as a result of feedback.

Priorities for Improvement 2021/2021

Our three improvement priorities for 2021/2022 link to the three domains of quality; patient safety, clinical effectiveness and experience and satisfaction. The three key priorities for improvement identified are:

- To improve the reporting of medication related patient safety incidents (continued – 2 year improvement plan)
- Supporting patients to manage a healthy weight in adult secure settings through interventions that culminate in having a physical health passport
- To improve the way we receive feedback by focusing on the implementation of a 'barometer' digital based system for collecting and using patient feedback with full engagement of patients and staff to enable a greater uptake, to complement our current variety of feedback options.

Progress against these improvement initiatives will be monitored routinely and in partnership with our Commissioners. The Trust Board will receive a quarterly report on progress and achievement and this will be published on the Trust website under the Trust Board Meeting Papers Section. This progress report is a component of a Trust wide Assurance Report which provides an update on these three priority indicators and all quality and clinical performance; alongside Trust finance, business, workforce and operational performance.

Key to the achievement of these quality priorities is the capability and capacity of our staff. Through leadership from our Care Group operational directors and clinical leads we will ensure that our staff are provided with the right information, training and clinical supervision to put these initiatives into practice with support from the Quality and Performance Directorate and Project Management Office.

The three key priorities for improvement identified are:

Quality Domain	Priority Area	Why have we chosen this area?	What are we aiming to achieve?	Our measures of success
Patient Safety – **Improve the reporting of medication related patient safety incidents**	This priority area builds on the key priority areas last year to improve the reporting of medication related patient safety incidents.	This quality priority is in the second year of improvement focus as patient safety incident reporting of medication related patient safety incidents vary across our Trust. Nationally, NHS Improvement established Medicines Safety Programme identified that there were; -there were an estimated 237 million 'medication errors' per year in the NHS in England, with 66 million of these potentially clinically significant -'definitely avoidable' adverse drug reactions collectively cost £98.5 million annually, contribute to 1700, and are directly responsible for, approximately 700 deaths per year.	Following evaluation in 2020-2021 we will; -Focus on specific areas where the recording of error is reduced to foster the safety culture with robust systems of reporting and learning from incidents. -Improve the reporting of 'near-misses' as the first step in preventing medication errors. -Develop implementation plans for electronic prescribing and medication systems to improve all elements of medication safety and associated governance arrangements.	That we will have improved our medication incident reporting culture from the baseline figure. We will strengthen our feedback from incidents to include what we did and how we learned. We will have developed an Electronic Prescribing and Medication Systems Plan ready for implementation.
Quality Domain	**Priority Area**	**Why have we chosen this area?**	**What are we aiming to achieve?**	**Our measures of success**
Clinical Effectiveness – **Supporting patients to manage a healthy weight in adult secure settings through interventions that culminate in having a physical health passport.**	We would like to build on the quality improvement work around the physical health passport to reduce obesity and improve quality of inpatient care.	Whilst we achieved our quality indicator priority last year we would like to continue our focus to improve the health and wellbeing of our inpatients within Forensics Services. Obesity is one of the most significant modifiable risk factors for premature mortality and chronic disease in people with mental illness. To align with the NHS Long Term Plan ambitions regarding obesity and evidence best practice 'Managing a Healthy Weight in Adult Secure Services'	We will continue to build on progress made by; -Further embedding the physical health passport across all adult secure settings -Increasing the number of weight management group sessions -Introducing post group support sessions	We will; -Demonstrate an increase in the number of physical health passports from the baseline figure -Increase the number of weight management group sessions -Introduced the post group support sessions.
Quality Domain	**Priority Area**	**Why have we chosen this area?**	**What are we aiming to achieve?**	**Our measures of success**
Patient Experience – **To improve the way we receive feedback by focusing on the implementation of a 'barometer' digital based system for collecting and using patient feedback with full engagement of patients and staff to enable a greater uptake.**	To improve patient experience feedback response rates across all services (greater uptake).	We would like to continue an improvement relating to patient feedback because gathering patient feedback on their experience is key to understanding whether the services we provide are meeting people's needs and are high quality, safe and clinically effective. Our feedback response rates vary across our Trust services and we want to look at the way we ask for feedback to maximize opportunities for us to learn and improve our services.	To develop digital feedback options for gathering experience and providing feedback using a variety of platforms	To have improved our overall patient and service user feedback by 20% to ensure that our patients, service users and carers voices are heard and used to improve services by using a digital platform as an enabler.

Statements of Assurance from the Board

Review of Services

During 2020/2021 the Midlands Partnership NHS Foundation Trust provided and /or subcontracted 176 relevant health services.

The Midlands Partnership NHS Foundation Trust has reviewed all the data available to them on the quality of care in 176 of these relevant health services.

The income generated by the relevant health services reviewed in 2020/2021 represents 100% of the total income generated from the provision of relevant health services by Midlands Partnership NHS Foundation Trust for 2020/2021.

Clinical Audit/Confidential Enquiries

During 2020/2021, 10 national clinical audits and 3 national confidential enquiries covered relevant health services that Midlands Partnership NHS Foundation Trust provides.
During that period Midlands Partnership NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Midlands Partnership NHS Foundation Trust was eligible to participate in during 2020/2021 are as follows:

National Audit
• The Falls and Fragility Fracture Audit Programme (FLS-DB) Clinical Audit
• National Audit of Inpatient Falls (NAIF)
• National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation (PR) audit
• National Clinical Audit of Psychosis (NCAP) - Early Intervention in Psychosis Audit
• National Diabetic Foot Care Audit (NDFA)
• National Early Inflammatory Arthritis Audit (NEIAA)
• Sentinel Stroke National Audit Programme (SSNAP)
• Vertebral Fracture Sprint Audit (VFSA)
• POMH 20a – Improving the quality of Valproate prescribing in adult Mental Health Services
• POMH 18b – The use of Clozapine
National Confidential Enquiries
• National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
• Physical Health in Mental Health
• Learning Disabilities Mortality Review Programme (LeDeR)

The national clinical audits and national confidential enquiries that Midlands Partnership NHS Foundation Trust participated in during 2020/2021 are as follows:

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• National Early Inflammatory Arthritis Audit (NEIAA)
• Sentinel Stroke National Audit Programme (SSNAP)
• Vertebral Fracture Sprint Audit (VFSA)
• POMH 20a – Improving the quality of Valproate prescribing in adult Mental Health Services
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National Confidential Enquiries
• National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
• Physical Health in Mental Health
• Learning Disabilities Mortality Review Programme (LeDeR)

The national clinical audits and national confidential enquiries that Midlands Partnership NHS Foundation Trust participated in, **and** for which data collection was completed during 2020/2021, 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.

National Audit	
Audit Title	**% cases submitted**
The Falls and Fragility Fracture Audit Programme (FLS-DB) Clinical Audit	**100%** *735/735 eligible cases*
National Audit of Inpatient Falls (NAIF)	**50%** *1/2 eligible cases*
National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation (PR) audit	**100%** *172/172 eligible cases*
National Clinical Audit of Psychosis (NCAP) - Early Intervention in Psychosis Audit	**100%** *153/153 eligible cases*
National Diabetic Foot Care Audit (NDFA)	**100%** *546/546 eligible cases*
National Early Inflammatory Arthritis Audit (NEIAA)	**0%** *Audit nationally suspended*
Sentinel Stroke National Audit Programme (SSNAP)	***100%*** *1082/1082 eligible cases*
Vertebral Fracture Sprint Audit (VFSA)	**100%** *5/5 eligible cases*
POMH 20a – Improving the quality of Valproate prescribing in adult Mental Health Services	**100%** *121/121 eligible cases*

National Confidential Enquiries	
Enquiry Title	% cases submitted
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	**0%** Nationally data collection paused *due to COVID-19*
Learning Disabilities Mortality Review Programme (LeDeR)	**100%** 43/43 *eligible cases*

The reports of 7 national clinical audits were reviewed by the provider in 2020/2021 and Midlands Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Introduce new ways of working / services

- Instigate new Fracture Liaison Service (FLS) telephone clinic for patients 75yrs and over.
- Fracture Liaison Service to liaise with the falls service and physiotherapy service to develop a pathway for a strength and balance programme.
- Introduction of flat lifting equipment for Wards at Haywood hospital.
  Implementation of digital contact mechanisms and processes, i.e. text updates to support communication with carers, across mental health inpatient wards.

Improve documentation to standardise processes and ensure best practice

- Completion of the Assessment Review Care (ARC) form across mental health inpatient services, to improve collection of information to support equity of access.
- Develop a standardised, joint initial assessment (form) incorporating the Parkinson's Therapy Service, Occupational Therapy and Speech and Language Therapy.
- To trial the use of the Abnormal Involuntary Movement Scale (AIMS) form at depot clinics, in support of medication reviews.

Multidisciplinary / Joint working

- Fracture Liaison Service to engage with the local Primary Care Nurses (PCNs) to develop methods to support optimal adherence to anti-osteoporosis treatments and to support long term follow up care.

Enhance training and support for staff

- Falls Awareness Week planned to include access to relevant information leaflets, to refresh and promote awareness and knowledge around falls reduction best practice.
- Develop an educational element to the Parkinson's service, providing advice and support for patients and carers, including developing educational fact sheets, in line with Parkinson's UK resources, that can be utilised in any clinical setting and be delivered to patients and carers.
- To incorporate training to educate staff in inpatient and community teams around the Abnormal Involuntary Movement Scale form, to support implementation.

Focussed interventions (individuals/teams) / others

- Trial use of identified outcome measures with a small cohort of Parkinson's patients, prior to full roll out.
- Following the National Care at the End of Life Audit, a task and finish group has been set up to discuss the overlap between work streams and complete an overarching action plan to cover all areas, monitored by the End of Life Steering Group.

Local Audit Actions

The reports of 35 local clinical audits were reviewed by the provider in 2020/2021. Examples of actions as a result of these audits that Midlands Partnership NHS Foundation Trust intends to take to improve the quality of healthcare provided are:

Reorganise or standardise work flow / practice / processes

- Physical Health Strategy Group to develop diabetes pathway standing operating procedure (SOP) and flowchart to support consistency in approach across all Forensic wards and teams.
- The procedure for contacting patients following a Chlamydia test has been updated and now includes a process whereby all patients with negative results receive text messages informing of the result.
- Standardise processes across Forensic inpatient services, outlining the identification of Multi-agency Public Protection Arrangements (MAPPA) eligible offenders.
- Review the current format of the Learning Disability Positive Behavioural Support (PBS) Pathway to make it more user friendly; review layout, descriptors and links to PBS tools/assessments.

Improved patient literature / access to information

- Ensure patient information is available in common languages, with Community Children's Nursing (CCN) teams sending information from a generic e-mail address.
- Develop a young person's transition work book / information pack.
- Develop and display Autism easy read leaflets on the Ellesmere ward.
- Add an easy read leaflet on Positive Behavioural Support (PBS) Pathway for people to use routinely with service users and carers as appropriate.

Multidisciplinary / Joint working

- Consider ways to address Did Not Attend (DNA) rates for Audiology services, including discussions with referrers to facilitate the engagement of families at the time of referral.
- Develop a joint process between Bee U Services, adult Mental Health Services and young people for assessment transfer preparation meetings prior to transfer. This includes the young person meeting the adult Mental Health Services case holder or representative from adult team.

Clinical Research

The number of patients receiving relevant health services provided or subcontracted by Midlands Partnership Foundation Trust in 2020/2021 that were recruited during that period to participate in research approved by a research ethics committee was 1984.

Commissioning for Quality and Innovation

A proportion of Midlands Partnership NHS Foundation Trust income in 2020/2021 was conditional on achieving quality improvement and innovation goals agreed between Midlands Partnership NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2020/2021 and for the following 12 month period are available electronically at: https://www.mpft.nhs.uk/about-us/quality/cquins

The monetary total for income in 2020/2021 conditional upon achieving quality improvement and innovation goals was £3.3m and the monetary total for the associated payment in 2019/2020 was £3m.

Bolstering Staffing in Adult and Older Adult Community Mental Health Services

During 2020/2021 we have received additional funding of 1.4m from Commissioners to progress in bolstering staffing in adult and older adult community mental health services. A further 1.1m was received for Adult Crisis Home Treatment care in the community.

Registration with the Care Quality Commission

The Midlands Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered. Midlands Partnership NHS Foundation Trust has the following conditions on registration for each of Home First Services: the registered provider must ensure that the regulated activity of personal care is managed by an individual who is registered as a manager in respect of that activity at or from all locations. The Care Quality Commission has not taken enforcement action against the Midlands Partnership NHS Foundation Trust during 2020/2021.

Midlands Partnership NHS Foundation Trust has not been asked to participate in any thematic reviews or investigations by the Care Quality Commission during 2020/2021.

Quality of Data

Midlands Partnership NHS Foundation Trust submitted records during 2020/2021 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.8% for admitted patient care;
- 100% for out-patient care.

Which included the patient's valid General Medical Practice Code was:

- 99.3% for admitted patient care;
- 100% for out-patient care.

Midlands Partnership Foundation Trust DSP Toolkit report replaces the Information Governance Assessment Report overall score and grade for 2020/2021 has been deferred to June 2021 due to the COVID-19 pandemic, mid-year submission has taken place. We will submit the DSP Toolkit and report the findings in the 2021/2022 Quality Account.

Midlands Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2020/2021.

Midlands Partnership NHS Foundation Trust will be taking the following actions to improve data quality;

- Data Quality Group in place with performance and quality member representatives from across the Trust.
- Data Quality Group exceptions are formally reported to the Digital Committee, a new Trust Board Committee, through Active Directory (AD) Information and Data Warehousing.
- The Data Quality Group has an action plan which is monitored by the Information Management and Technology Project Management Office. The Group now reports into the Digital Committee.
- Specific actions have been identified and developed, to improve the standardisation and consistency of inputting of clinical related data by our clinical and operational staff.

Learning from Deaths

During 2020/2021 596 of Midlands Partnership NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 154 in the first quarter;
- 109 in the second quarter;
- 167 in the third quarter;
- 166 in the fourth quarter.

By 31st March 2021, 131 case record reviews and 213 investigations have been carried out in relation to 596 of the deaths included in the paragraph above.

In 2 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 50 in the first quarter;
- 28 in the second quarter;
- 35 in the third quarter;
- 18 in the fourth quarter

0 representing 0% of 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:

- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the outcome from the Root Cause analysis review for unexpected deaths and the outcome of the mortality case note review for death by natural cause.

Summary of learning from case record reviews and investigations conducted in relation to the deaths identified:

Service Area	Learning
Community (Physical Health / Community Hospitals)	**Positive** Many examples were found demonstrating privacy and dignity was maintained whilst promoting safe care. We saw evidence of COVID-19 restrictions and infection prevention and control compliance the importance of completing and recording NEWS2 on admission to aid clinical decision making and adhere to the admission protocol. Positive palliative care being provided across our integrated pathways **Areas for development** We acknowledge death certificates are not always recorded correctly – 1a is the main cause of death; 1b has to cause 1a and 1c to cause 1b – MCCD training / supervision in progress.

Service Area	Learning
Mental Health Services /Community	**Positive** We have noted the importance of partner acute trusts to involve the Acute Liaison Nurse in discharge planning. We learned that the Access Team followed Trust procedures and Access Team Standard Operational Procedures relating to Referral and Assessment including guidance set out in the UK Mental Health Triage Scale Guidelines. There was appropriate referrals into Community Intervention Pathway. There was a wide range of good practice relating to recovery focussed care-planning which reflected service user's goals. Many examples of staff practicing in line with consent and GDPR guidelines. We learned there were examples of adherence to Community Dementia Memory Team Clinical Pathway. A flexible approach was taken to offer a face to face appointment as an alternative to a telephone assessment according to the patients need. We saw many examples of COVID-19 restrictions compliance. We recognised the importance of exploring feelings of hopelessness when completing a review of care. Examples of good practice in engagement with service users in Mental Health Staffordshire, particularly when they disengage. **Areas for development** We learned that we needed to follow Standard Operating Procedures to ensure effective regular communication was held with GPs. The importance of timely recording on information on the electronic record system RIO. The need to evidence assessment and re-assessment of risk following periods of change and DNA process was not followed. We recognised in some cases there was reduced family and carer involvement in key care-planning meetings. The need to ensure annual physical health reviews are completed to inform ongoing care and management plans.
Mental Health Services / Inpatient Services	**Positive** We recognised the need to implement the NEWS2 into all mental health inpatient ward areas to ensure monitoring of intake and output and also recognised early on. **Areas for development** The importance of timely recording of information on the clinical electronic record system RIO. Decision making regarding ground leave for patients who are recurrent absconders to be made more prescriptive in the revised Missing Person's Standard Operating Procedure.
Inclusion Services	**Positive** Examples seen where Inclusion Services were 'going the extra mile' in particular when service users are disengaging with services, and also the involvement of multi-agencies to provide additional support. We recognised the importance of peer to peer support for Hepatitis C. There was evidence to show that the Prescribing SOP was followed. We saw evidence of good multi-disciplinary working across primary, secondary, social care services and within inpatient and community areas. There was a wide range of evidence of good working relationships between Inclusion and Mental Health Teams. We learned there was regular evidence of harm reduction discussions in key work sessions Communication was in line with an 'Amber' Referral into Services We saw many examples of service users being offered life-saving drugs such as Naloxone as part of crisis management plans.

Service Area	Learning
	There was a plethora of good care planning and risk assessment documentation detailed within the outcomes of investigations which was evidence based and supportive of partnership working, building of family and friend relationships and signposting to support behaviour changes. We learned there was good examples of liaison with Acute Care Providers around risks and prescribing of medications. **Areas for development** We learned in some cases there was a lack of record keeping in respect of the issuing of Naloxone medication (outside of the prescription record itself). We recognised for those patients who were treatment resistant alcohol dependant users with complex SMI the need for a focussed engagement plan to work with external alcohol services to jointly formulate and plan care.
Mother and Baby Unit	**Positive** The importance of timely and accurate recording of information on the clinical electronic record system RIO. We evidence level of risk managed by use of enhancing levels of observations and engagement, in line with local and national guidance was followed. Evidence of the use of therapeutic engagement as per the Trusts Observation and Engagement Policy Consideration of physical health needs and appropriate investigations following consultation with relevant professionals. We learned the importance of good multi-disciplinary and multi-agency approach to care and treatment. We recognised in some cases there was reduced family and carer involvement in key care-planning meetings The importance of effective communication from the MBU to local community services. We saw examples of service users being involved in formulating their plan of care. A range of interventions / engagements were available which included psychological therapy, ward reviews which were multi-disciplinary in nature, pharmacological interventions, re-direction and distraction techniques and observation and engagement. **Areas for development** Effective liaison with other agencies regarding physical health investigation results.
Prison Services	**Positive** The need to ensure clinical information for Prisoner who are imminently transferring to another prison to ensure attention is drawn to potentially significant health needs **Areas for development** Need to ensure GPs summaries are received by GPs in a timely way. The need to ensure annual physical health reviews are completed to inform ongoing care and management plans.
Learning Disability Services	**Positive** We found many cases demonstrating effective MDT working and service user engagement (teams going the extra mile). **Areas for development** There is a lack of clear accountability relating to shared care agreements within Learning Disability Teams and Primary care.

Description of the actions taken in 2020/2021 as a consequence of the learning and the impact of these actions

Action Taken	Impact of Action
NEWS2 Training – Mental Health Wards	We have implemented NEWS2 across our Trust to improve the detection of and response to clinical deterioration in patients and service users with acute illness. We are continuing to audit practice next year and will pledge to report in next year Quality Account.
Implemented eObservations (eObs) within our Acute Mental Health Wards to allow for electronic recording and monitoring of observations	Hand-held devices which are fast, easy-to-use and accessible to record patient's up to date patient observations (patients whereabouts and sleep status) has significantly improved patient safety systems (up to date monitoring), enhanced the development of person-centred and evidence based interventions allowing for real-time monitoring of data to inform ward round and MDT discussions.
Implementation of Physical Health Monitoring Clinics for Service Users with Severe Mental Illness	This has been a multi-partner progress action to design and implement physical health monitoring clinics for this with severe mental illness to reduce the mortality gap. Clinics are now being provided to detect early physical health disease or mental health deterioration jointly with our Primary Care colleagues. Whilst we paused our evaluation of the new model we have pledged to provide a report of the evaluation outcomes in next year's Quality Account.
Inclusion Services Improvement Areas	Our inclusion services are revisiting clinical standards relating to the following; - GP Summaries - Mortality and Suicide Learning Forum
Carer Engagement	- We have carried out a series of virtual workshops with service users and carers. - Triangle of Care training and subsequent self-assessments developed and implemented across the Trust. We have pledged to improve the involvement of family and carers with their loved ones care from admission to discharge within specified adult community mental health services and we will detail in next year Quality Account the improvements made in respect of this.
Care Group clinical audits completed and locally owned to make the improvements in care-plan and risk assessment documentation.	We have focused on risk assessment and formulation coupled with the standardisation of where clinical teams are to document on the electronic patient record system RIO. Also to ensure all aspects of care is documented (for example Naloxone medication being issued).
Missing Persons Standard Operating Procedure	SOP updated in respect of ground leave for service users who are recurrent absconders.
Learning Disabilities Shared Care Agreements	Work in progress in respect of working with Commissioners and Primary Care colleagues (early discussions). We will detail in the Quality Account next year in respect of improvements made in respect of this.

7 case record reviews and 20 investigations completed after 31st March 2020 which related to deaths which took place before the start of the reporting period.

0 representing 0% 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.

0 representing 0% of the patient deaths during 2019/2020 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 outcome from the Root Cause analysis review for unexpected deaths and the outcome of the mortality review for death by natural cause.

Reporting Against Core Indicators

The NHS (Quality Account) Amendment Regulation 2012 sets out a core set of quality indicators, which Trusts are required to report against in their Quality Account. The inclusion of these mandated indicators enables the Trust to provide data that is benchmarked against the national average performance of other mental health trusts. We have reviewed these indicators and are pleased to provide you with our position against all relevant indicators for the last three reporting periods (years). *Please note that the CPA 7 day follow up and delayed transfer of care figures for Quarter 4 2019/2020 differ from those published in our 2019/2020 Quality Account. This is due to a refresh in data published by the NHS Digital Indicator portal.

CPA 7 day follow up

The data made available to the Trust by the NHS Digital Indicator Portal with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period. The data presented in line with the standard national definition which can be found within the Standard Definitions section of this report on Page 79.

2018/19				
Timeframe	**Benchmark**	**Total number of patients on CPA discharged from psychiatric inpatient care**	**Number of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care**	**Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care**
1st Apr 2018 – 30th Jun 2018	Trust	415	396	95.4%
	England	17,329	16,594	95.8%
	Highest reporting Trust	1,104	1,200	92.0%
	Lowest reporting Trust	5	5	100%
1st Jul 2018 – 30th Sept 2018	Trust	400	382	95.5%
	England	17,080	16350	95.7%
	Highest reporting Trust	1,272	1,149	95.7%
	Lowest reporting Trust	5	5	100%
1st Oct 2018 – 31st Dec 2018	Trust	379	363	95.8%
	England	16,860	16104	95.5%
	Highest reporting Trust	1,282	1146	89.3%
	Lowest reporting Trust	3	3	100%
1st Jan 2019 – 31st Mar 2019	Trust	368	359	97.6%
	England	16,150	15,470	95.7%
	Highest reporting Trust	1,182	1,037	87.7%
	Lowest reporting Trust	3	3	100%

2019/2020				
Timeframe	**Benchmark**	**Total number of patients on CPA discharged from psychiatric inpatient care**	**Number of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care**	**Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care**
1st Apr 2019 – 30th Jun 2019	Trust	350	337	96.2%
	England	17,000	16,159	95.0%
	Highest reporting Trust	1,317	1,136	86.2%
	Lowest reporting Trust	4	4	100%
1st Jul 2019 – 30th Sept 2019	Trust	303	281	92.7%
	England	17,496	16,540	94.5%
	Highest reporting Trust	1,351	1,189	88.0%
	Lowest reporting Trust	4	4	100%
1st Oct 2019 – 31st Dec 2019	Trust	308	301	97.7%
	England	16,582	15833	95.4%
	Highest reporting Trust	1303	1,156	88.7%
	Lowest reporting Trust	6	6	100%
1st Jan 2020 – 31st Mar 2020	Trust	322	309	95.9%
	England	*	*	*
	Highest reporting Trust	*	*	*
	Lowest reporting Trust	*	*	*

2020/2021				
Timeframe	**Benchmark**	**Total number of patients on CPA discharged from psychiatric inpatient care**	**Number of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care**	**Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care**
1st Apr 2020 – 30th Jun 2020	Trust	283	265	93.6%
	England	*	*	*
	Highest reporting Trust	*	*	*
	Lowest reporting Trust	*	*	*
1st Jul 2020 – 30th Sept 2020	Trust	325	312	96.0%
	England	*	*	*
	Highest reporting Trust	*	*	*
	Lowest reporting Trust	*	*	*

1st Oct 2020 – 31st Dec 2020	Trust	309	292	94.5%
	England	*	*	*
	Highest reporting Trust	*	*	*
	Lowest reporting Trust	*	*	*
1st Jan 2021 – 31st Mar 2021	Trust	319	297	93.1%
	England	*	*	*
	Highest reporting Trust	*	*	*
	Lowest reporting Trust	*	*	*

**Please note it is not possible to obtain national benchmarking data because returns were stopped nationally to focus on COVID-19 pandemic* from Q4 – 2019/2020

Midlands Partnership NHS Foundation Trust considers that this data is as described for the following reasons.

- Our staff understand the clinical evidence underpinning this target and are committed to maintaining a high level of compliance
- The Trust has well established mechanisms in place for monitoring and validating data quality relating to CPA.

Midlands Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Continuing to raise awareness with clinical staff regarding their responsibility for providing 7 day follow-up.
- Conducting clinical audits to identify areas that require targeted improvement.

******* It is important to note that in the NHS Contract for 2021/2022, this 7 Day Follow up CPA quality reporting requirement is being replaced with following up people within 72 hours of discharge from an inpatient mental health ward.*

Admission to Acute Wards via Crisis Resolution Home Treatment

The data made available to the Trust by the NHS Digital Indicator Portal with regard to the percentage of admissions to acute wards for which Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period. The data presented is in line with the standard national definition which can be found within the Standard Definitions section of this report on Page 79

Timeframe	Bench-mark	Proportion of admissions to acute wards that were gate kept by the CRHT teams
1st Apr 2018 – 30th Jun 2018	Trust	100%
	England	98.1%
	Highest reporting Trust	100%
	Lowest reporting Trust	85.1%
1st Jul 2018 – 30th Sept 2018	Trust	100%
	England	98.4%
	Highest reporting Trust	100%
	Lowest reporting Trust	81.1%
1st Oct 2018 – 31st Dec 2018	Trust	99.6%
	England	97.8%
	Highest reporting Trust	100%
	Lowest reporting Trust	78.8%
1st Jan 2019 – 31st Mar 2019	Trust	100%
	England	98.7%
	Highest reporting Trust	100%
	Lowest reporting Trust	88.9%
1st Apr 2019 – 30th Jun 2019	Trust	100%
	England	98.2%
	Highest reporting Trust	100%
	Lowest reporting Trust	84.5%
1st Jul 2019 – 30th Sept 2019	Trust	98.4%
	England	98.2%
	Highest reporting Trust	100%
	Lowest reporting Trust	91.2%
1st Oct 2019 – 31st Dec 2019	Trust	95.4%
	England	97.1%
	Highest reporting Trust	100%
	Lowest reporting Trust	79.9%
1st Jan 2020 – 31st Mar 2020	Trust	99.4%
	England	*
	Highest reporting Trust	*
	Lowest reporting Trust	*
1st Apr 2020 – 30th Jun 2020	Trust	99.0%
	England	*
	Highest reporting Trust	*
	Lowest reporting Trust	*
1st Jul 2020 – 30th Sept 2020	Trust	99.6%
	England	*
	Highest reporting Trust	*
	Lowest reporting Trust	*
1st Oct 2020 – 31st Dec 2020	Trust	100%
	England	*
	Highest reporting Trust	*
	Lowest reporting Trust	*
1st Jan 2021 – 31st Mar 2021	Trust	100%
	England	*
	Highest reporting Trust	*
	Lowest reporting Trust	*

**Please note it is not possible to obtain national benchmarking data because returns were stopped nationally to focus on COVID-19 pandemic* from Q4 – 2019/2020

Readmission to Hospital within 28 Days of Discharge

The percentage of patients aged (i) 0 to 15 and (ii) 16 or over and over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period. Please note that this data in not made available to the NHS Digital Indicator Portal as it is not a requirement for mental health trusts. The data to support this indicator has been taken from RiO the Trust clinical electronic record system. Therefore no national benchmarking data is available.

Timeframe	Benchmark	% of patients aged 15 and under readmitted to hospital within 28 days of discharge	% of patients aged 16 and over readmitted to hospital within 28 days of discharge
1st Apr 2018 – 30th Jun 2018	Trust	0%	9.00%
1st Jul 2018– 30th Sept 2018	Trust	0%	13.00%
1st Oct 2018 – 31st Dec 2018	Trust	0%	11.50%
1st Jan 2019 – 31st Mar 2019	Trust	0%	10.10%
1st Apr 2019 – 30th Jun 2019	Trust	0%	7.28%
1st Jul 2019– 30th Sept 2019	Trust	0%	8.07%
1 Oct 2019 – 31st Dec 2019	Trust	0%	9.47%
1 Jan 2020 –31st Mar 2020	Trust	50% *(2 admissions with 1 re-admission)*	8.44%
1st Apr 2020 – 30th Jun 2020	Trust	-	*6.80%*
1st Jul 2020 – 30th Sept 2020	Trust	-	*6.80%*
1st Oct 2020 – 31st Dec 2020	Trust	-	*7.5%*
1st Jan 2021 – 31st Mar 2021	Trust	-	*7.2%*

Midlands Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- We have well established mechanisms for following up people who are discharged from inpatient services and for monitoring and validating data quality relating to 28 day readmission rates.

Midlands Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by as follows;

- Continuing to reinforce to clinical staff the importance of timely and appropriate follow up from discharge
- Continuing to monitor and validate data in line with Standard Operating Procedures

Patient Experience of Community Mental Health Services

The data made available to the Trust by the Care Quality Commission with regard to the Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

To determine our performance against this indicator we have referred to the section score (mean score) for the Health and Social Care Workers section of the CQC Community Mental Health Survey. This section is made up of three areas as follows:

- **Listening**: for the person or people seen most recently **listening carefully to them**
- **Time**: being given **enough time** to discuss their needs and treatment
- **Understanding:** for the person or people seen most recently understanding how mental health needs affect other areas of their life their

Performance	Experience of Care		
	2018 Survey	**2019 Survey**	**2020 Survey**
Midlands Partnership NHS Foundation Trust	**7.0**	**7.0**	**7.1**
Lowest Reporting Trust Score	**5.6**	**6.0**	**6.2**
Highest Reporting Trust Score	**735**	**7.7**	**7.9**
Responses to the survey are converted into scores on a scale of 0-10. A score of 10 represents the best possible score. CQC reports our Trust scores are comparable with other Trusts for this section (within the intermediate 60% of Trusts)			

It should be noted that the peak of the COVID-19 pandemic and the subsequent national lockdown on the 23 March 2021 across England, occurred approximately midway through the fieldwork period for the survey. Although the Community Mental Health Survey primarily asked people to reflect on their experience of care over the last previous 12 months, and therefore prior to the pandemic, our analysis has shown that the national lockdown likely impacted the way service users responded to the survey. As a result, comparisons were not drawn by the CQC between results for 2020 and earlier surveys, or conducting outlier analysis this year.

Midlands Partnership Foundation Trust considers this data is as described for the following reasons.

- That the Trust needs to continue to drive engagement and responsiveness to individual service users' needs
- That the data has been compiled and validated by the Picker Institute

Midlands Partnership NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by;

- Shared the outcomes of the 2020 Patient Survey across the Trust
- Identifying local actions to be taken within the Care Groups
- Suggesting existing measures in place to improve feedback
- Monitoring progress against local action through our Performance Plus Action Tracking
- System and Care Group Quality Governance Forums and Quality Governance Committee.

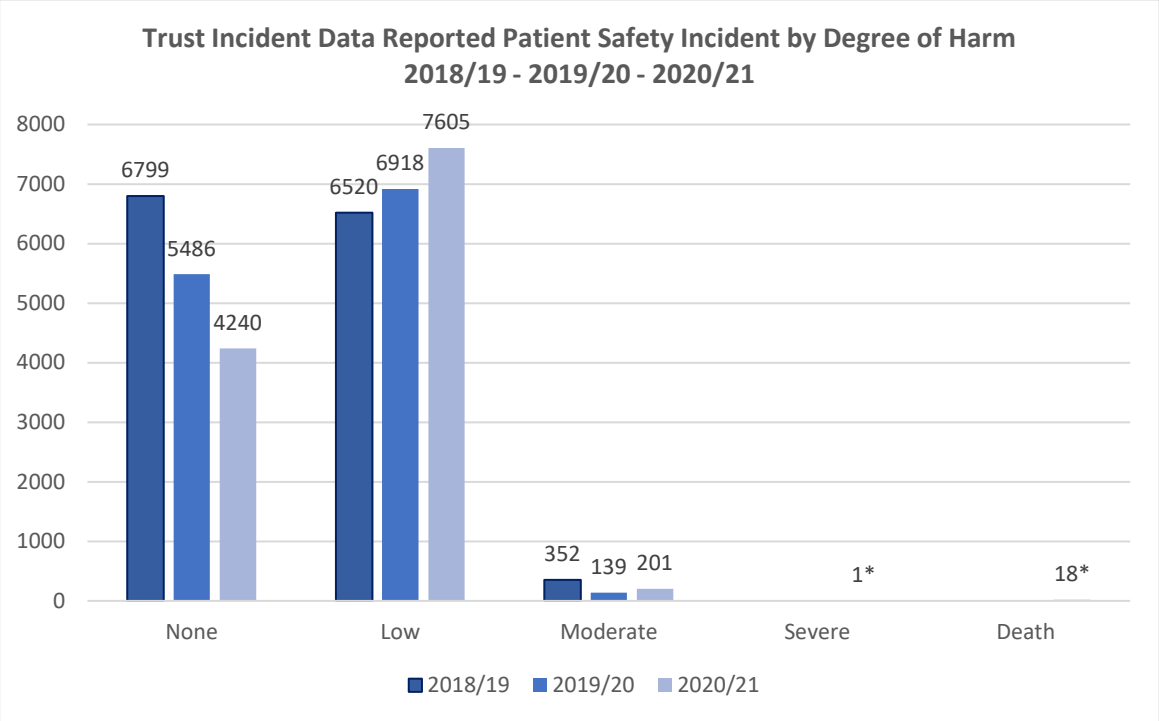
Patient Safety Incidents

NHS England are now publishing the national patient safety incident reports (NaPSIR) once a year rather than every six months. The next publication of this data is due in September 2021 and will use the data the Trust has submitted to the National Reporting and Learning System (NRLS). This change is to improve the official statistics outputs and offer data users and patient safety stakeholders a better resource. This annual publication will cover the most recent financial year of data and consequently in September 2021 NHS England will publish data for April 2020-March 2021. This information is therefore not available for the full reporting period and the data included in the Quality Account is Trust data only.

Incident reporting is a key risk management safety system for the Trust as it allows the Trust to improve service user safety by identifying what goes wrong in patient and non-patient activity, through analysing and tackling the root causes of adverse incidents, learning lessons and taking action to prevent recurrence. The Trust utilises a web based risk management system for the capture and reporting of all incident information.

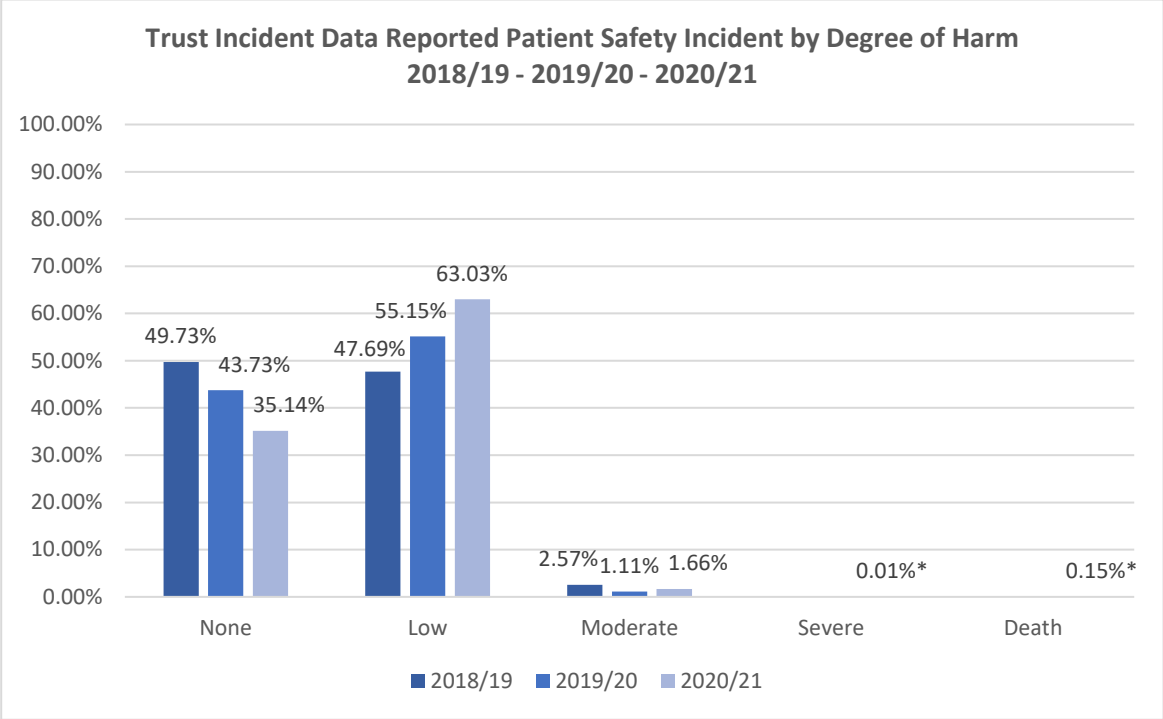
The reporting system is available for all staff to use through the Trust's internet home page and can be accessed by all staff. Use of a web based incident reporting system allows for incidents to be investigated quickly; for practice to be reviewed, and for trends and patterns to be identified and enables the reporting of incidents from all Trust locations. The Trust actively encourages all staff to report all incidents or 'near miss' incidents, whether they seem quite minor or are obviously very serious.

Trust Incident Data reported patient safety incident by degree of harm



Trust Total Reported Incidents by degree of harm 2018/19 – 2019/20 – 2020/21					
	None	**Low**	**Moderate**	**Severe**	**Death**
2018/19	6799	6520	352	0	0
2019/20	5486	6918	139	0	0
2020/21	4240	7605	201	1*	18*

*The severe and death incidents reported are subject to investigation at the time of reporting and are therefore subject to potential change in categorisation of harm following the outcome of an investigation review.



Trust Total Reported Incidents by % Degree of Harm 2018/19 – 2019/20 -2020/21					
	None	**Low**	**Moderate**	**Severe**	**Death**
2018/19	49.73%	47.69%	2.57%	0%	0%
2019/20	43.73%	55.15%	1.11%	0%	0%
2020/21	35.14%	63.03%	1.66%	0.01%*	0.15%*

*The severe and death incidents reported are subject to investigation at the time of reporting and are therefore subject to potential change in categorisation of harm following the outcome of an investigation review.

Midlands Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- Robust risk management is central to the effective running of our organisation and therefore all managers and staff throughout the Trust take responsibility for the reporting of and learning from incidents.
- On an ongoing basis we monitor and seek to improve our processes for reporting and learning from incidents

The Trust will adopt and implement the NHS Patient Safety Strategy (published July 2019) and work alongside system partners to improve patient safety during 2021/2022. The Trust's fundamental principle is that patient safety is everyone's responsibility and we will ensure that patient safety is a core element of all staff training. The vision is to continuously improve patient safety and build on the existing patient safety culture and safety systems currently in place.

The Trust has an identified Patient Safety Specialist to support and develop the patient safety culture and safety systems within the Trust in conjunction with the NHS Patient Safety Strategy. They will work as part of a wider team to ensure that patient safety improvement is appropriately prioritised, adopted and that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes. There are key work programmes identified for the Trust Patient Safety Specialist that will be developed and implemented during 2021/2022. These are;

1. Just culture (embedded principles of a safety culture)
2. Management of National Patient Safety Alerts
3. Improving quality of incident reporting
4. Support transition from National Reporting and Learning System to Patient Safety Incident Management System
5. Involvement in implementing the new Patient Safety Incident Response Framework
6. Implementation of the Framework for Involving Patients in Patient Safety
7. Patient Safety Education and Training
8. National Patient Safety Improvement Programmes
9. COVID-19 Recovery Planning

Midlands Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- Robust risk management is central to the effective running of our organisation and therefore all managers and staff throughout the Trust take responsibility for the reporting of and learning from incidents.

Midlands Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by;

- Continuing to improve our processes for reporting and learning from incidents whilst ensuring that we continue to examine incident trends and clusters taking action to minimise future risk.

PART 3 Our Local Quality Indicators 2021/2022

In Part 3 of this Quality Account we provide an overview of the quality of care provided by Midlands Partnership NHS Foundation Trust during 2020/2021 against a range of local quality indicators.

These indicators have been agreed by the Trust Board of Directors, as unlike any other year, this year we have not formally consulted with our Stakeholders following a national directive that this was not mandated. The national directive was detailed in the Trust Annual Account Guidance.

The indicators set for each year spans the three domains of quality; patient safety, clinical effectiveness and experience and suggestions for priorities are drawn from a number of sources, including historical Commissioning for Quality and Innovation (CQUIN) goals that are locally applied, feedback themes from real-time service user experience, recommendations from national reviews, quality improvement areas identified from our internal annual thematic reviews, Trust's review of its quality performance, for example patient safety incident data and complaints and stakeholder feedback, both external and from internal engagement forums. Our local quality indicators that we intend to report upon for 2020/2021 are set out below. As well as new goals we will also be as taking forward our improvement priorities from 2021/2022.

Patient Safety	
Indicator	**Rationale for Inclusion**
Assessment and documentation of pressure ulcer risk	We would like to build on and continue with this quality priority for this year specifically around documentation (but not excluding assessment). NICE guidance sets out clear best practice for assessing the risk of pressure ulcer development and acting upon the risks identified. Our aim is to reduce the number of pressure ulcers reported and improve the standards of care provided to reduce harm.
Malnutrition Screening	We would like to build on and continue with this quality priority for this year specifically around screening within 24 hours. Improved screening is expected to support prevention, identification and treatment enabling potentially significant reductions in clinical malnutrition linked to associated increased admissions and extended length of stay in our community hospitals.
Safety Planning – Personalised Risk Assessment	This is a new priority for this year. Risk assessment is one part of the whole system approach that should aim to strengthen the standards of care for everyone. Linked in with 10 Ways to Improve Safety National Confidential Inquiry into Suicide and Safety in Mental Health we would like to review our current risk assessment tool within mental health services to support suicide prevention and associated harm.
Clinical Effectiveness Measures	
Indicator	**Rationale for Inclusion**
National Early Warning Score 2 (NEWS2)	There was a limitation to delivering against this quality priority as we were unable to undertake robust clinical audit due to the COVID-19 pandemic restrictions (significantly reduced sample size/not representative). We would like to build on the small audit findings and continue with this quality priority for this year. Linked with the national Patient Safety Improvement Programme Strategic aim, we would like to build on the existing focus on preventing avoidable deterioration and adopting and spreading safety interventions within our inpatient hospitals both physical and mental health services.
Improving staff health and wellbeing.	We did not achieve our desired improvement goal last year in respect of supporting our staff with MSK and therefore we want to continue our focus on this specific key quality priority area.

Reducing Health Inequalities – Improving Inclusivity by Staff and Patient Engagement	This is a new priority for this year. Following the launch of the NHS People Plan (2020), this year MPFT staff survey results and the ongoing impact of COVID-19, we would like to focus on this key priority areas. • Inclusivity – responding to the staff survey results we will focus on the specific, diverse and inclusive staff groups to shape our health and wellbeing offer ensuring it is accessible for all. • Staff Engagement – all staff will be provided with opportunities to be involved in key decisions that impact on patient care and staff experience.
Service User / Carer Experience	
Indicator	**Rationale for Inclusion**
Local Resolution of Patients, Service User and Carers Concerns	This is a new quality priority this year. Handling of complaints can be complex and stressful. It requires time and commitment during a time when people are feeling at their most vulnerable. The first phase of the NHS complaints procedure is 'local resolution' where the Trust tries to resolve the complaint within the respective clinical service prior to a referral into Patient Advice and Liaison Service (2nd local resolution phase). We would like to focus on this key priority area to improve the service user and carer experience and overall satisfaction in a timely way.
Improving Carer Engagement	This is a new priority this year. Following feedback and a review of serious incident investigations learning we were told that family and carers are not always involved with their loved ones admission and discharge planning processes. The National Confidential Inquiry has highlighted that family involvement could improve suicide prevention by services consulting with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans. The Independent Commission on Acute Adult Psychiatric Care cite this in their recommendations, stating that families and carers are an underused resource. As a result of this learning we would like to focus on this as a key quality priority this year to improve family and carer involvement from admission to discharge within specified adult community mental health services.
Effective communication between MPFT clinicians and primary care clinicians for patients with severe mental illness.	We were unfortunate to not have achieved this priority due to the impact of COVID-19 (infection prevention and control measures, re-deployment of staff into high risk areas/delivery of services/crisis management). Our aim during 2020/2021 was to evaluate the effectiveness of the new shared care model by undertaking a formative evaluation study. We would like to report the outcomes of this evaluation in our Quality Account next year.

Our Local Quality Indicators 2020/2021

This section of the report provides details of our performance against our local indicator set. The indicators were chosen following a period of consultation with our Care Groups (stakeholder consultation not mandated this year) and subsequent agreement by our Trust Board. Comparison is made (where relevant) between 2017/2018 performance to 2020/2021 performance and is Trust comparison as national benchmarking data is not available. Please note the data to support compliance with these local indicators is taken from Trust clinical electronic record systems and incident reporting system.

<table>
<tr><th colspan="4">Patient Safety Measures</th></tr>
<tr><th>Quality Indicator</th><th>Rationale</th><th>Data Source</th><th>Target Met</th></tr>
<tr><td>Assessment and documentation of pressure ulcer risk</td><td>NICE updated guidance setting out clear best practice for assessing the risk of pressure ulcer development and acting upon the risks identified. The aim is to reduce the number of pressure ulcers and improve the standards of care provided.</td><td>Clinical Audit
Trust Incident Reporting System</td><td>  </td></tr>
<tr><th colspan="4">Performance 2020/2021 (new Quality Indicator)</th></tr>
<tr><td colspan="2">A pressure ulcer risk assessment using a validated scale that assesses all of:
i. Mobility
ii. Skin
iii. Nutritional status
iv. Continence
v. Sensory perception

99%</td><td colspan="2">Has an individualised care-plan, which includes all of:
i. Risk and assessment outcomes
ii. Recommendations about pressure relief at specific at-risk sites
iii. Mobility and the need to reposition the patient
iv. Co-morbidities
v. Patient preference
80%</td><td>Actions to manage the risks identified by the pressure ulcer risk assessment and document by clinical staff

100%</td></tr>
<tr><td colspan="4">Results of an audit undertaken across all wards at Haywood hospital in Quarter 4 were positive, with March 2021 figures above the original CQUIN target of 60% for each of the key standards. We declare a limitation to the clinical audit due to COVID-19 infection control restrictions (smaller sample size) and would therefore like to continue with this quality priority area next year.

Service users received pressure ulcer risk assessments within 24 hours of admission and if stay is for more than 30 days a re-assessment were completed.

Care plans reflected the pressure ulcer assessment with actions identified documented.

The positive results were achieved despite pressures on the wards bought about through Covid-19 and a significant number of End of Life patients on some wards.</td></tr>
</table>

Quality Indicator	Rationale	Data Source	Target Met
Malnutrition Screening	To improve the screening to support prevention, identification and treatment enabling potentially significant reductions in clinical malnutrition linked to associated increased admissions and extended length of stay in our community hospitals.	Clinical Audit Safeguard – Trust incident reporting system	

Performance 2020/2021 (new Quality Indicator)		
Malnutrition risk screening using a validated tool, such as The Malnutrition Universal Screening Tool; (MUST) that measures all of the below items, with each documented in the management care-plan i. Body mass index (BMI); ii. % unintentional weight loss; iii. Time duration over which weight loss occurred; and, iv. Likelihood of future impaired nutritional intake **91%**	All patients who are identified as malnourished or at risk of malnutrition have a management care plan that aims to meet their complete nutritional requirements **100%**	There is evidence of all actions or goals within the management plan being acted upon **90%**

We declare a limitation to the clinical audit due to COVID-19 infection control restrictions (smaller sample size) and would therefore like to continue with this quality priority area next year quality account.

An audit undertaken in quarter four across all wards at Haywood Hospital, provided March 2021 data that showed an increase from previous months with results above the original CQUIN target for each of the key standards.

Malnutrition screening is undertaken on admission and repeated at least every 30 days of the patient episode of care. If malnourished, management care plans are in place for patients and there is evidence that actions/goals are being acted upon.

The positive results were achieved despite pressures on the wards bought about through Covid-19 and a significant number of End of Life patients on some wards.

Screening was not always carried out within 24hours (achieved 61% compliance), however it is hoped that this will improve as agreed actions are implemented and also as Covid-19 pressures ease. This will continue to be a quality priority during 2021/2022.

Quality Indicator	Rationale	Data Source	Target Met
National Early Warning Score 2 (NEWS2)	Linked with the national Patient Safety Improvement Programme to build on existing focus on preventing avoidable deterioration by adopting and spreading safety interventions within our inpatient hospitals both physical and mental health services	Clinical Audit Trust Incident Reporting System	

Performance 2020/2021 (new Quality Indicator)

The NEW2 score are recorded in the patients records at the time of admission to the inpatient area (excluding end of life patients and those with escalation mental health needs with no evidence of physical illness/deterioration)

i. NEWS2 score and,
ii. Time and date of escalation; and,
iii. Time and date of response by appropriate clinician

Progress made;

- NEWS2 was rolled out Trust wide in March 2020, training has been offered to all clinical teams via the Clinical Education Department.
- Adopted NEWS2 enabled a synchronised approach and language with other Acute Providers during the initial first wave of the pandemic.
- The RIO health records which is predominately across mental health services now has the NEWS2 form built into the system allowing for improved monitoring of physical health of mental health patients and improved early identification of sepsis and other conditions.

We declare a limitation to the clinical audit due to COVID-19 infection control restrictions, some ward areas continue with paper-based NEWS2 tool – a snap shot audit was completed during Quarter 4 2020/2021.

We completed audit on the following ward areas;

- Grange Ward, Haywood Hospital
- Laurel Ward, Redwoods Hospital
- Pine Ward, Redwoods Hospital
- Birch Ward, Redwoods Hospital
- Oak Ward, Redwoods Hospital
- Holly Ward, Redwoods Hospital
- Bromley Ward, St Georges Hospital
-

Measurable standard	Overall % compliance each standard	Overall compliance against all 3 measurable standards (>60%)
NEWS2 score	70%	59%
Time and date of escalation	50%	
Time and date of response by appropriate clinician	50%	

**It is important to note that as a snapshot audit the sample was small with only 10 sets of notes per area being audited due to COVID-19 restrictions.*

We recognise the sample size was small and also did not include ward areas that were providing care to positive COVID-19 patients due to infection control precautions. We did not achieve this quality indicator and therefore would like to continue with this quality priority area in next year Quality Account.

Clinical Effectiveness			
Quality Indicator	**Rationale**	**Data Source**	**Target Met**
Effective communication between MPFT clinicians and primary care clinicians for patients with severe mental illness.	COVID-19 unfortunately prevented us from progressing with the evaluation and therefore we wish to evaluate and share the outcomes.	Evaluation Tool Incident Reporting System Clinical Audit Service User and Patient Feedback	

Performance 2020/2021 –new indicator (evaluation)

We were unfortunate to not have achieved this priority due to the impact of COVID-19 (infection prevention and control measures, re-deployment of staff into high risk areas/delivery of services/crisis management).

Positively despite this we continued to deliver our Physical Health Clinics (PHCs) and make progress in respect of improvements as below;

- Development of standards of work and clinic flow charts.
- During the pandemic we held Multidisciplinary Team sessions virtually.
- Cross Pathway Clinic run to cover broader range of community care pathways
- We appointed a Band 4 Assistant Practitioner to work alongside Registered Practitioner and Prescriber at Hall Court, Telford.
- We extended our PHCs to cover a wider geographical areas
- Continue to monitor CPA review at quality and performance meetings held across the Trust.

Quality Indicator	**Rationale**	**Data Source**	**Target Met**
Cirrhosis and fibrosis test for alcohol dependent patients (order or referral) for a test to diagnose.	This quality improvement builds our improved screening rates, and draws attention to evidence that earlier liver disease diagnosis can improve outcomes.	Rio Clinical Electronic Records System CX Air Report	

Performance 2020/2021 (new Local Quality Indicator)

This quality indicator was a national CQUIN for 2020/2021 which was a joint CQUIN with our Acute Providers. Unfortunately, nationally CQUINs were suspended due to the COVID-19 pandemic and whilst we looked into ways to continue with this quality area it was agreed to halt progress with this because the impact of this quality improvement would add additional pressure onto an already pressured system.

There are no CQUINs for 2021/2022 and therefore given our local and system priorities we have taken the decision to not progress this quality indicator this year. It is important to note during the decision-making process to halt progress with this a review of current practice was undertaken and is against best practice guidance which continues with a standard operating procedure in place.

Quality Indicator	Rationale	Data Source	Target Met
Improving staff health and wellbeing	This quality improvement builds on the goal for last year – to continue our focus	Staff Survey	

Performance from 2017 to 2020

NHS staff survey question	2017	2018	2019	2020
Does your organisation take positive action on health and wellbeing?	35%	30%	31%	43%
In the last 12 months have you experienced musculoskeletal problems as a result of work activities?	20%	21%	23%	24%
During the last 12 months have you felt unwell as a result of work related stress?	38%	38%	41%	40%

2020/2021 has presented significant challenges for staff wellbeing as they worked tirelessly to support our communities and cope with the personal impact of the Covid-19 pandemic. In recognition on the potential impact on staff wellbeing our new SOOTHE Wellbeing Offer was launched in April 2020 - a comprehensive range of support for all staff across MPFT.

Furthermore, additional funding was made available to both the Specialist Staff Psychology Service and the Wellbeing and Recovery College to increase support and intervention. Regular communications have been circulated to staff via the Executive briefing and global updates about the importance of staff looking after their wellbeing and being supported to do so.
A comprehensive programme of risk assessments, welfare checks and Display Screen Equipment assessments were completed to support staff working in different contexts. As we navigate the next phase of the pandemic, staff wellbeing is at the centre of both national and local developments.

During early 2021/2022 a focussed piece of work needs to be undertaken around the increase or work related MSK difficulties as whilst this remains lower than the benchmarking average, it has increased over time. Currently, staff experiencing MSK related issues can self-refer at the earliest opportunity to our Physiotherapy Services directly which has been bought back in house for the majority of staff. We would like to see changes over the next 12 months and how they positively impact on our results relating to MSK.

Service User and Carer Experience			
Quality Indicator	**Rationale**	**Data Source**	**Target Met**
Biopsychosocial assessment by Mental Health Liaison Services	All appropriate patients (80% - self harm referrals) referred to Mental Health Liaison services by A&E will receive a comprehensive biopsychosocial assessment (concordant with NICE Guidelines) which will improve the patient experience in mental health in A&E, thus reducing repeat presentations to A&E and reduce the risk of suicide.	Clinical Audit Business Intelligence data from Trust RIO Patient Record System	

Performance 2020/2021 – new indicator*

We are pleased to report that 81% of our service users through our Mental Health Liaison Services in both Shropshire, Telford and South Staffordshire have received a comprehensive biopsychosocial assessment when presenting in A&E.

This comprehensive biopsychosocial assessment concordat with Section 1.3 of NICE Guidance CG133, including:

- Assessment of needs
- Risk assessment
- Developing an integrated care and risk management plan

A documentation review was carried out to determine how self-harm referrals were captured within RiO across all Trust Mental Health Liaison Services which pan across a significant geographical footprint and as a result of this review changes were made within the referral screen to ensure that a 'referrals reason' of 'self-harm' was available to support capturing this information for all self-harm referrals.

During this process and working collaboratively with our Business Intelligence Team, a quality and performance report was developed to identify any gaps or areas of concern and data quality issues to ensure referral data was recorded and assessment of needs, risk assessment and care planning accurately documented to improve our service users experience following an admission via Accident and Emergency Departments spanning the geographical footprint.

Below are two example case studies to reflect service and quality improvements made as a result of this quality priority;

Patient A – Brought into Accident and Emergency by carers from supported living accommodation. A referral was received by the Mental Health Liaison Team who saw the patient in less than 45 minutes. An assessment of needs was carried out and a risk assessment completed. Patient A's was discharged back to supported living with support put in place from the Crisis Resolution Home Treatment Team. Patient A was open to community mental health services who were informed of Patient A's admission to Accident and Emergency. Patient A was discharged with Discharge and Safety Plan (Integrated Care and Risk Management Plan).

Patient B – Referred to Mental Health Liaison Team following admission due to an overdose. Mental Health Liaison Team referral was received and Patient B was seen in less than under 3 hours on inpatient acute ward. An assessment of needs and risk assessment undertaken and documented. Patient B as to be discharged home when medically fit. Mental Health advice provided to self-refer to Psychology Services, complete safety plan and look at distraction techniques. The Mental Health Liaison Team referred patient to Community Interventions Pathway for further review. Patient B was provided with contact details of services to utilise at time of emotional distress. The GP was informed of outcome and discharge care and risk (safety) management plan.

We will continue to monitor this throughout 2021/2022 as routine service improvement and quality assurance reporting.

Quality Indicator	Rationale	Data Source	Target Met
Engaging meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death.	Building on last year's successful quality priority – to strengthen learning about how we offer support for bereaved families and carer's by focusing on the role of our Family Liaison Officer	Evaluation National Quality Board (NQB) Learning from Deaths	

In response to the publication of the NQB guidance the Trust has implemented a number of improvements to engage meaningfully with families following a death, these changes include:

Performance 2018/2019 to 2020/2021

2018/2019

- The recruitment of a Family Liaison role.
- Producing an information leaflet that offers advice and signposting on bereavement services and more specialist counselling.
- Working with bereaved
- families to identify improved approaches to engaging families when service users do not give consent.
- Changing letters we write to families to make them more personal.

2019/2020

- Producing a family and carer information leaflet that offers advice, guidance and signposting of bereavement services, specialist services and third sector organisations.
- Continuing to work with bereaved families and developing 'Family said, We learned, We did' reporting to help us improve our services.
- Supporting the development of family and carer engagement initiatives across the Trust.
- Family Liaison Officer membership of the Suicide Prevention Working Groups to ensure the family and carers voice is represented.

2020/2021

- Actively listened and translated the voice of the family and carer and in doing so further strengthening the Trust quality assurance reporting in respect of Learning from Deaths and Serious Incident investigation process..
- Strengthen the support for families and carers in respect of internal services such as Patient Advice and Liaison Service.
- Supports the implementation of the Trust statutory Duty of Candour with families and carers.
- Gain accreditation in Suicide First Aid – Understanding Suicide Prevention to identify and signpost families and carers to services such as the GP or Cruse (bereavement counselling) as a first-aid approach.
- Sharing the role and purpose of the role with system partners who were looking into developing provision relating to post-vention support after a loved one dies by suicide.
- Instrumental in setting up an informal peer support group for mutual support and supervision

Quality Indicator	Rationale	Data Source	Target Met
Supporting patients to manage a healthy weight in adult secure settings through interventions that culminate in having a physical health passport	Building on the quality improvement work relating to healthy weight for people in adult secure mental health services by focusing on and aligning with the NHS Long Term Plan ambitions regarding obesity and improving the quality of inpatient care within Forensic Services	Clinical Audit Business Intelligence data from Trust RIO Patient Record System	

This area was chosen as it was an identified an area for improvement in 2019/2020 as a result of the supporting a healthy weight for people in adult secure mental health CQUIN 2019/2020. An audit identified that 82% of service user were classed as being overweight; of these 23% of service users were obese and 32% morbidly obese.

To benchmark and support the direction the '***Managing a Healthy Weight in Adult Secure Services - Best Practice Guidance***' was reviewed which enabled us to identify key areas for development during 2020/2021 which were;

- The development and implementation of a physical heath passport as key educational information, to help service users monitor and track their own physical health journey to provide a structured and consistent approach in supporting and motivating service users.
- To have a physical health passport in place for all individual service users
- Develop an enabling approach for staff and service user engagement to support the successful implementation of the physical health passport.
- All service users have the opportunity to access a range of information and/or interventions to support them around their weight.
- All staff to be equipped with the right skills to support individual service users in improving their physical health and maintaining healthy weight.
- Employment of Physical Health and Fitness Practitioners

Staff and Service User Engagement
A multi-disciplinary working group was established in April 2020 with the focus on engaging both staff and service users in developing our physical health passport. The level of staff and service user engagement was excellent and discussions, feedback and ideas shared in the working group were used to formulate the physical health passport.

The development and implementation of the physical health passport
We co-produced the passport and implemented this during early 2021. Every service users was provided with the opportunity to attend an education session about the passport which included the benefits, how it may help them and all service users were offered a copy of the physical health passport for their own personal use. At the end of March 2021 24 (30%) service users in total had accepted a copy of the physical health passport. All new admissions receive information about the passport and support available.

Next Steps – work is currently underway to develop an easy read version of the physical health passport for the low secure learning disability service as well as it being available for use for service users on the other wards who may benefit from this version. The passport will be subject to ongoing review and will be a working document with extra inserts being developed in other areas relating to physical health such as vaccine insert and other key health promotion information.

Staff Education and Training
We developed and implemented the following against best practice recommendations;
- Implementation of mandatory e-learning modules - "All Our Health" and "Making Every Contact Count".
- One-day staff weight management training course was implemented in July 2020 where 66 staff attended.

"Excellent course I have a much better understanding of calories and eating a balanced diet therefore I can use my knowledge to encourage patients to make healthier choices"

"Great course really well delivered, I'm now able to relate more practically with a patient I key work "

"Extremely informative, helped me to have a great understanding and now feeling more confident in this subject and I can pass this knowledge on to patients on the ward and now have a better insight and provide better support to them".

Physical health passport education sessions

We have facilitated a number of awareness sessions to both staff and service users, these sessions provided an overview of the physical health passport, the benefits, how to use it and support available. During the launch weeks our Health and Fitness Practitioners attended all of the wards and provided a group session to both service users and staff before offering a copy of the passport to service users.

Service user support/interventions

To enhance the support available to service users with regards to making positive lifestyle changes we have introduced a number of mechanisms to assist and these include:

- Personal health improvement plans for service users with key workers supporting service users to complete.
- Lifestyle support/discussion incorporated into gym sessions.
- Introduction of the Health and Fitness Practitioner role which as an emphasis on both supporting physical activity and supporting health promotion interventions particularly around supporting a healthy weight.
- The opportunity for service users to attend a Weight Management Group
- The physical activity pathway has been reviewed and changes made in order to increase access to physical activity, enhance the level of engagement currently offered to those service users who are sedentary and offering a range of both meaningful structured and unstructured physical activity.

Service User Weight Management Group (ENLIGHT10)

We launched the Service User Weight Management Group (Enlight10) on the 21st October 2020 which consisted of six participants, and sessions were delivered as ward based groups (due to COVID restrictions). Participants of the course are tasked to achieve 5% weight loss, by the end of the ten week course. This 5% target is recognised as a benchmark due to its SMART goal affinity and significant reduction in health risks.

Participants achieved an average of 5.4 kg weight loss during the course. Three participants achieved their targeted 5% loss and two more were within 1 kg of their target. The three highest achievers achieved weight losses between 8.5 kg and 9.8 kg.

Patient Story (one example)

I weighed 127kg, after a few weeks I was seen by the dietitian, an initial assessment was completed and we set a target weight of 100kg by June 2021. I sat down with the health and fitness practitioners and completed some 1-1 work which focused on completing and reviewing food diaries and we discussed the opportunity to participate in a weight management group.

One month into my admission I was able to engage in assessment relating to my physical activity with a health and fitness practitioner and from this they developed a physical activity programme with me which would help me improve my fitness level and along with a change in diet would also support me to lose weight.

I started to attend the gym 5 x a week, initially I only wanted to do weight training but with further education and advice form the health and fitness instructors I decided to do some cardiovascular training to support my overall fitness and help me lose weight.

Alongside the physical activity programme I also attended the 10 week weight management group, as a result of both the physical activity and weight management group sessions I started to see changes in myself. I became more confident, started eating less, training more and even did exercises on the ward.

At the end of the 10 week weight management group I had lost 12kg, I continued with my physical activity program and made changes to my diet. I stopped having second helpings, stopped eating puddings (well most of the time!) and just felt more able to eat less. I am now much better at portion control and am now cooking more independently and able to choose healthier options.

Since the group ended I have lost more weight, although a back and shoulder injury has impacted on my training. I have had ongoing support and encouragement during my gym sessions to keep going.

I was sceptical at first as I thought I already knew it all, however I have learned a lot. I'm much more knowledgeable about fats, sugar levels and takeaways as well as knowing the benefits of exercises and I'm better able to identify ways in which I can eat healthier. I found the weight management group supportive and it was really good that the staff member facilitating also joined in with making changes to their diet and losing weight, it made it more real.

As a result of the support of have been given and my 13kg weight loss I am much more body confident and my family have noticed positive changes in my weight , my health and attitude.

Service User Feedback

- Going forward I would like to see more group based physical activities, more resources available in the gym to support a wider range of physical activity and a support group to help those who have attended the weight management group to support them with ongoing weight loss and to maintain positive dietary changes

Next steps….

- Ensure the physical health passport is further embedded and updated to issue easy read versions for diverse and inclusive groups.
- Increase the weight management group sessions
- Introduce post group support sessions and enhance 1 to 1 support available
- Facilitate ward based education and awareness sessions particularly around education on takeaways and portion sizes across all wards. Continuing with staff training by introducing drop in sessions and weekly clinics where both staff and service users can book in for support and advice
- Develop a mix of eLearning and Face to Face training sessions
- Further enhance the pre-admission process and service user information
- Establish physical health inductions on service users admission
- Implement physical health activity pathway and Standard Operating Procedure for Managing Healthy Weight

Performance Against Mandated National Measures

We are committed to delivering all relevant national priorities and targets. Our performance against the access targets and outcome measures are set out in Appendices 1 and 3 of the Single Oversight Framework as detailed below, this does not include those indicators that we have reported elsewhere within this set of Quality Accounts:

National Targets & Regulatory Requirements	Threshold	2017/2018	2018/2019	2019/2020	2020/2021
Early Intervention in Psychosis (EIP). People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	44%	90%	85%	82%
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 week referral ii) Within 18 week referral	50% 75% 95%	52% 86% 98%	53% 88% 99%	53% 86% 99%	54% 97% 100%
Admissions to adult facilities of patients under 16 years old	N/A	0	0	0	3
Inappropriate out-of-area placements for adult mental health services	Overall reduction per year until 2021	94 days	176 days	226 days	212 days

We have not met the national mandated performance reduction target for 'Inappropriate out-of-area placements' for adult mental health services for the last 3 years. We would like to continue our focus on this area and report progress in the Quality Account next year.

Annex 1

Statements from Commissioners, Local Healthwatch and Scrutiny Committee

We are not mandated to consult with external stakeholders on the Quality Account this year as detailed within the NHS Foundation Trust Annual Reporting Manual 2020/2021 published and re-issued on the 31st March 2021. This is due to the ongoing COVID-19 national response to the pandemic.

We value our stakeholders and partners and whilst we are not required to undertake formal consultation as we would normally under the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/2021, we still wanted to share and any statements received will be included within this Quality Account.

ANNEX 2

Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Account) 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 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 2020/2011 and supporting guidance Detailed requirements for quality reports 2020/2021*
- 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 May 2021
    - papers relating to quality reported to the board over the period April 2020 to May 2022
    - feedback from commissioners - not applicable
    - feedback from governors - not applicable
    - feedback from local Healthwatch organisations - not applicable
    - feedback from health overview and scrutiny committee – not applicable
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26/11/2020
    - the 2020 community mental health national patient survey, dated 24/11/2020
    - the 2020 national staff survey 11/03/2021
    - the Head of Internal Audit's annual opinion of the Trust's control environment - not applicable
    - CQC inspection report dated 05/07/2019
    - the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
    - the performance information reported in the Quality Report is reliable and accurate
    - there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
    - the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and prescribed definitions, is subject to appropriate scrutiny and review
    - the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality account 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 of their knowledge they have complied with the above requirements in preparing the quality report.

By order of the board.

/06/2021 **Chairman**

/06/2021 **Chief Executive**

External Auditors Opinion

We are not expected to commission external assurance on their Quality Account as detailed within NHS Foundation Trust Annual Reporting Manual 2020/2021 published and re-issued on the 31st March 2021. This is due to the ongoing COVID-19 national response to the pandemic.

Internally however as part of quality assurance and scrutiny our Quality Account will be reviewed by our Trust Audit Committee, Quality Governance Committee and Trust Board.

Glossary of Technical Terms

ASC - Adult Social Care

Care Programme Approach (CPA) - the process of how mental health services assess users' needs, plan ways to meet them and check that they are being met

CQC - Care Quality Commission checks all hospitals in England to ensure they are meeting government standards, and shares their findings with the public

CQUIN - The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals

Diagnostic Overshadowing - a process where health professionals wrongly presume that present physical symptoms are a consequence of their patient's mental illness

First Steps in QI - Available to all staff who, as part of the training, will identify a small improvement project in their team whilst using basic elements of evidence based quality improvement methodology.

Freedom to Speak Up Guardian and Freedom to Speak Up Champion – helps to protect patient safety and the quality of care, improve the experience of the workforce and promote learning and improvement which was a key recommendation from Sir Robert Francis' Freedom to Speak Up Review (2015) conducted in response to the Mid Staffordshire Enquiry.

GP – General Practitioner

IM&T – Information Management and Technology

Listening into Action – is about re-engaging with employees and unlocking their potential so they can get on and contribute to the success of your organisation, in a way that makes them feel proud.

Medicines Optimisation Committee – is the Trust medicines committee that ensures safe, effective patient centred use of medications

Mortality Case Note Review – a process for reviewing deaths to help improve the overall quality of patient care by distilling the learning.

NHS Digital Indicator Portal - The NHS Information Centre is England's central, authoritative source of health and social care information for frontline decision makers. Their aim is to revolutionise the use of information to improve decision making, deliver better care and realise increased productivity

NICE (National Institute for Health and Care Excellence)- provides national guidance and advice to improve health and social care

NRLS – National Reporting and Learning System

Olanzapine - is an antipsychotic medication used to treat schizophrenia and bipolar disorder. It is usually classed with the atypical antipsychotics, the newer generation of antipsychotics.

PALS – Patient Advice Liaison Service

Pathology - is a medical specialty that is concerned with the diagnosis of disease based on the laboratory analysis of bodily fluids such as blood and urine, as well as tissues, using the tools of chemistry, clinical microbiology, haematology and **molecular pathology.**

Peer Recovery Workers - are powerful recovery role models who have lived experience of mental health and physical health issues and actively use those experiences as way to support others, whilst continuing along their own recovery journey

Physical Observations – using a set of clinical skills to monitor a patient such as pulse, temperature and blood pressure

Picker Institute – A international charity in the field of person-centred care. They have a rich history of supporting those working across health and social care systems measuring patient experience to drive quality improvement in healthcare

POMH (Prescribing Observatory for Mental Health) - helps specialist mental health Trusts improve their prescribing practice by identifying specific topics within mental health prescribing and developing audit-based Quality Improvement Programmes (QIPs). Organisations' are able to benchmark their performance against one another and identify where their prescribing practice meets nationally agreed standards

Postvention Support – refers to the actions taken to support the community after someone dies. Good postvention support can help people to grieve and recover and can be a critical element of preventing further suicides from happening.

Rapid Process Improvement Workshop (RPIW)- an improvement process that brings together a team of staff from either various departments or a single department to examine a problem, eliminate wastes, propose solutions, and implement changes

Recovery - the concept of recovery is about service users staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the 'recovery model' to describe this way of thinking. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms

Restrictive Practice – are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to: Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and end or reduce significantly the danger to the patient or others'. (MHA, CoP 2015).

Rio – an electronic clinical information and patient administration system. There is a clinical record for each individual, including assessment forms, care planning, diagnosis and progress notes; as well as caseload management, inpatient bed management and appointment booking tools

SMI – refers to people who have a severe mental illness

Standard Operating Procedure – a document that describes a procedure, usually brief and including a flow chart or the process to be followed

Tissue Viability – is a specialty that primarily considers all aspects of the skin and soft tissue wounds including; surgical wounds, pressure ulcers and all form of leg ulceration

Virginia Mason Production System – VMPS is a specific form of Lean which has been used extensively in healthcare. Starting in 2000, the Virginia Mason Hospital in Seattle turned themselves around from a weak performing organisation into a quality leader in health. They adopted the basic tenets of the Toyota Production System (TPS), calling it the Virginia Mason Production System, or VMPS. This quality improvement (QI) system is one we use in the Trust and it offers a consistent approach, putting service users and carers at the centre, led by staff to make positive and sustainable improvements.

136 Suite - is a place of safety for those who have been detained under Section 136 of the Mental Health Act by the police following concerns that they are suffering from a mental disorder.

Standard Definitions

Below are the standard definitions of those indicators detailed in Section 2 and 3 of this report (Core & Mandated Indicators):

Core Indicators:

CPA 7 Day Follow up *(Page 49)*

The technical definition is as described in the "Department of Health Mental Health Community Teams Activity Return (MHPRVCOM) Data Definitions August 2012 – Mental Health Performance Framework: Guidance UNIFY2 Collection"

The definition is as follows:

Detailed Definition:

The number of patients who were followed up either by face to face contact or by a phone discussion within 7 days of discharge from psychiatric in-patient care.

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in- reach team.

Exemption:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of a patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CAMHS (child and adolescent mental health services) are not included.

The seven-day period should be measured in days, not hours, and should start on the day after the discharge.

Admission to Acute Wards via Crisis Resolution Home Treatment *(Page 70)*

The technical definition is as described in the "Department of Health Mental Health Community Teams Activity Return (MHPRVCOM) Data Definitions August 2012 – Mental Health Performance Framework: Guidance UNIFY2 Collection"

The definition is as follows:

Detailed Definition:

The number of admissions to the trust's acute wards that were gate-kept by crisis resolution home treatment teams

A crisis resolution home treatment (CRHT) team provides intensive support for people in mental health crises in their own home. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. Teams are required to meet all of the fidelity criteria including gatekeeping all admissions to psychiatry inpatients wards and facilitate early discharge of service users.

An admission has been gate kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission.

Total Exemption to CRHT Gatekeeping:

- Patients recalled on Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admissions for psychiatric care from specialist units such as eating disorder units are excluded.

Partial exemption:

- Admissions from out of the trust area where the patient was seen by the local CRHT (out of area) and only admitted to this trust because they had no available beds in the local area. CRHT team should assure themselves that gatekeeping was carried out. This can be recorded as gate kept by CRHT teams.

Patient Safety Incidents *(Page 55)*

The definition is as described by the National Patient Safety Agency and can be found at: http://www.npsa.nhs.uk/corporate/news/npsa-releases-organisation-patient-safety-incident-reporting-data- england/

The definition is as follows:

Detailed

Definition: No

harm:

Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.

Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.

Low: Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.

Moderate: Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe: Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

Death: Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

Criteria for the local indicator:

Multi-disciplinary care plans for all service users open to learning disability services

The definition is as described in the 2018 clinical audit report

The definition is as follows:

Detailed Definition

"The Trust must ensure staff consistently and regularly review and update care plans. They must ensure all care planning documentation is personalised and addresses the needs identified in the assessment."

In relation to those **care plans**, to establish:

- What percentage of people on our caseloads have a care plan in place.
- What percentage of these care plans are populated appropriately (i.e. are in line with assessment data, personalised etc.)
- What percentage of care plans are up to date/within agreed review date.

Performance Mandated Indicators:

Inappropriate out of-area placements for adult mental health services *(Page 70)*

The technical definition is as described in the Department of Health & Social Care Guidance published 30th September 2016 found at https://www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults- in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care

The definition is as follows:

Detailed Definition:

An 'out of area placement' for acute mental health in-patient care happens when:

A person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services.

By this, we mean an inpatient unit that does not usually admit people living in the catchment of the person's local community mental health service and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning.

Patients should be treated in a location which helps them to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment.

Sending providers are to determine if a placement is classed as an OAP. The definition necessarily allows providers to apply knowledge of local catchment arrangements and the patient's circumstances in taking a decision if a placement is an OAP. OAPs can occur within one NHS provider, in other NHS providers, or independent sector providers (ISPs).

Placement may occasionally be considered appropriate. Possible reasons have been outlined below.

Total number of bed days patients have spent inappropriately out of area. In Detailed requirements for quality reports it is specified that the indicator should be stated as a monthly average.

Early Intervention in Psychosis *(Page 70)*

The technical definition is described in NHS England Guidance for reporting against access and waiting times standards: Children and Young People with an Eating Disorder & Early Intervention Psychosis

The definition is as follows:

Detailed

Definition: Clock

Starts

The waiting time clock for the EIP and CYP ED standards **starts** when:

i) A referral request is received for an assessment for a child or young person with a suspected ED or person with suspected first episode psychosis (FEP), or is recognised as such upon receipt.
ii) The primary reason for referral should be CYP with suspected ED or suspected FEP. The clock start date is defined as the date referral received – this must be recorded accurately so the referral can be tracked.
iii) Where pathways start with an interface service, such as clinical triage, assessment centre, single point of access, the clock start date is the date the interface service receives the referral – not the date the referral is passed onto the relevant clinical team.
iv) Where a service accepts direct referrals (no interface service), the clock will start from the date the referral is received by that service.
v) Where a primary reason for referral is not recorded as suspected FEP or ED, but this is identified during triage/single point of access, the clock start date is the date of initial referral. If this is not suspected during triage but at a subsequent assessment then the date the clock starts is when suspicion is first raised.
vi) If a person is already in contact with mental health services (including acute hospital liaison) the

clock starts when suspicion of FEP or ED is first raised (not backdated to their initial contact with the mental health service). Protocols should be in place so that staff can make timely referrals to the relevant specialist service for assessment and treatment.

Referral sources

Referrals may come from any source and the clock will start regardless of the agency making the request. Referrals may therefore be internal to provider organisations (e.g. a children and young people's mental health service, a CMHT, inpatient ward or forensic mental health service) or external (e.g. a GP, carer, school or self- referral). The clock also starts regardless of any comorbidities, such as learning disabilities, substance misuse, personality disorder or autism

It is therefore important that staff within provider organisations are trained and aware so they can make timely referrals to the relevant specialist service for assessment and treatment. Referrals could be in person, telephone, email, letter, or online.

Vetting referrals

Timely, clinically-led vetting of referrals will ensure referrals are appropriate and can assist in identifying if an alternative pathway may be more suitable. Vetting of urgent referrals should be prioritised and ideally be completed on the day of referral or the morning of the following day. Vetting can be carried out by an appropriately trained team of staff which should help minimise delays. Staff should follow clear protocols and be subject to continuous monitoring and audit. The vetting process should not delay clock start.

Recording clock start in the MHSDS

Clock start is recorded in the MHS101 Table and all the required fields should be completed in line with the data standard. The following will identify referrals to be assessed for the Mental Health AWT standards and the date of the clock start.

Externally assured indicator completeness considerations

Due to Coronavirus pandemic all external audit activity was ceased and therefore external completeness considerations for specific indicators was not carried out.