BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

BOARD OF DIRECTORS TO BE HELD ON WEDNESDAY 27 APRIL 2011

CLINICAL GOVERNANCE REPORT

ACTION:

- Trust Board is asked to review priorities for the Trust quality account as part of the informal meeting.
- The report sets out issues for assurance particularly relating to safety and the YASCC programme.
- In response to the last Board meeting an assessment of issues relating to changes in the PALS service is set out along with a review of incident levels against bed occupancy.

SIGNIFICANT ISSUES

1. Serious Incident Investigations

The committee received an update of progress in relation to serious incident reviews. An update report is provided as part of the serious incident report.

2. Quality Account Priorities

The committee received a presentation of the work undertaken in the Youth clinical programme which has led to the patient safety award. It is proposed that reflection of this work should be undertaken in all programmes as a quality account priority.

The committee also received a long list of potential indicators to reflect clinical quality arising from the recent quality account consultation exercise. The committee identified a number of areas for priority which are reflected in the draft of the quality account which will be presented and further discussed with the Board at the informal meeting.

3. Single Sex Accommodation

The committee reviewed arrangements for ensuring continued compliance with the national standards for same sex accommodation. The Trust has improved compliance arrangements over the past year through a number of initiatives including capital works and also further dedicated single sex wards.

A separate site visit had taken place with the BEN PCT Director of Nursing to assess our compliance arrangements in relation to a number of NAIPS units. Additional advice has been provided which is being addressed.

The committee was able to confirm compliance with the standards and arrangements for ongoing monitoring.

4. Major Incident Planning

The committee received assurance on Major Incident Planning arrangements which had been reviewed by the Risk Management Committee. A summary statement is attached in Appendix 2.

5. Learning Lessons

A summary report of key actions taken as a result of serious incidents was noted.

The committee received a report on an aggregated review of CMHTs which had been completed. This had indicated that there was no single contributing theme to incidents at locations which had reported the highest number of serious incidents.

A number of additional issues however were identified and work has been agreed to review as follows:

- There was evidence that a significant number of service users who are discharged due to non attendance are often received back into the service fairly soon after. Further data has been requested to review and to consider whether changes to the trust referrals and DNA policy should be made.
- The development of a clear process for accessing specialist support and advice for service users with personality disorders.
- There was evidence that in some cases care plans had not been reviewed appropriately. It was proposed to ensure this was included in the care plan audit.

6. Assurance from Clinical Programmes

Assurance reports and top issues from programme risks registers were received from YASCC Division. Key issues identified included:

Prison Healthcare

It was noted that a number of actions previously identified in the CQC compliance action plan were not able to be demonstrated. This was as a result of a recent internal assessment visit which was arranged to test the compliance from submission of the action plan. The committee noted that urgent actions had been identified to address these and that this would be reported to the next meeting. Further concerns were highlighted over the governance arrangements within the service.

Secure and Complex Care:

- Actions relating to a serious incident of missing keys which occurred last year had now all been completed and assurances were received.
- Ardenleigh and Reaside were visited by the peer review team from the quality network for Forensic Mental Health. The committee was informed of the outcome of the visits which were generally very positive, but with a number of issues suggested for improvement.
- Feedback was received on a major incident exercise conducted at Ardenleigh and the lessons learnt from this.

Youth Programme

Key issues identified by the youth programme were:

- To note the HSJ patient safety award presented to the service.
- To highlight improvements made to documentation for CTOs (Community Treatment Orders).
- Improved patient information had been developed with the active support of service users.

Due to staff absence the addictions report was held over to the next meeting.

PALS SERVICE

At the last meeting the Board highlighted the issues relating to the changes made to the PALS service.

This was presented reviewed and approved at the Clinical Governance Committee in March (which was reported to the Board). A summary of the risk assessment and actions reviewed by the Clinical Governance committee is set out below.

Rationale: The original prompt for the review was highlighted as a recommendation following a serious incident review. This incident highlighted that PALS staff were providing support to service users which should have been appropriately provided by clinical staff.

The proposal to introduce an 8am to 8pm service was identified as a result of:

- Activity information (reported to Board quarterly) highlighted the low numbers of service users who were using the service at evening/night times.
- Evidence that the service users who were accessing the service were generally repeat callers highlighting that they were inappropriately accessing the service and demonstrating that generally most issues were addressed in day time hours.
- Most service users who were making calls at night were requiring clinical support which the service was unable (and should not) provide and therefore was only operating as a direction service.
- Historically the service was never intended to be a clinical service and staff were not clinically trained. National best practice reinforces the requirement for urgent issues to be addressed through home treatment teams.
- Sustaining a 24 hour help line was distracting the PALS service from providing its core PALS activities.

In the process of developing the revised arrangements all identified user and carer groups were consulted with.

The following measures were identified to manage the change in service after 8pm as follows:

- Specific referral pathways to clinical support and advice were defined and put into place to be managed by central switchboard.
- Communications process to advise staff and users of the changes.
- The telephone number advertised in Trust information would still be managed and enable appropriate responses and support to be made.
- Resources have been reprioritised to support the mainstream requirements of a PALS service.

BOARD DIRECTOR SPONSORS:
Peter Lewis, Medical Director
Dee Roach, Executive Director of Quality, Improvement and Patient Experience

APPENDIX:

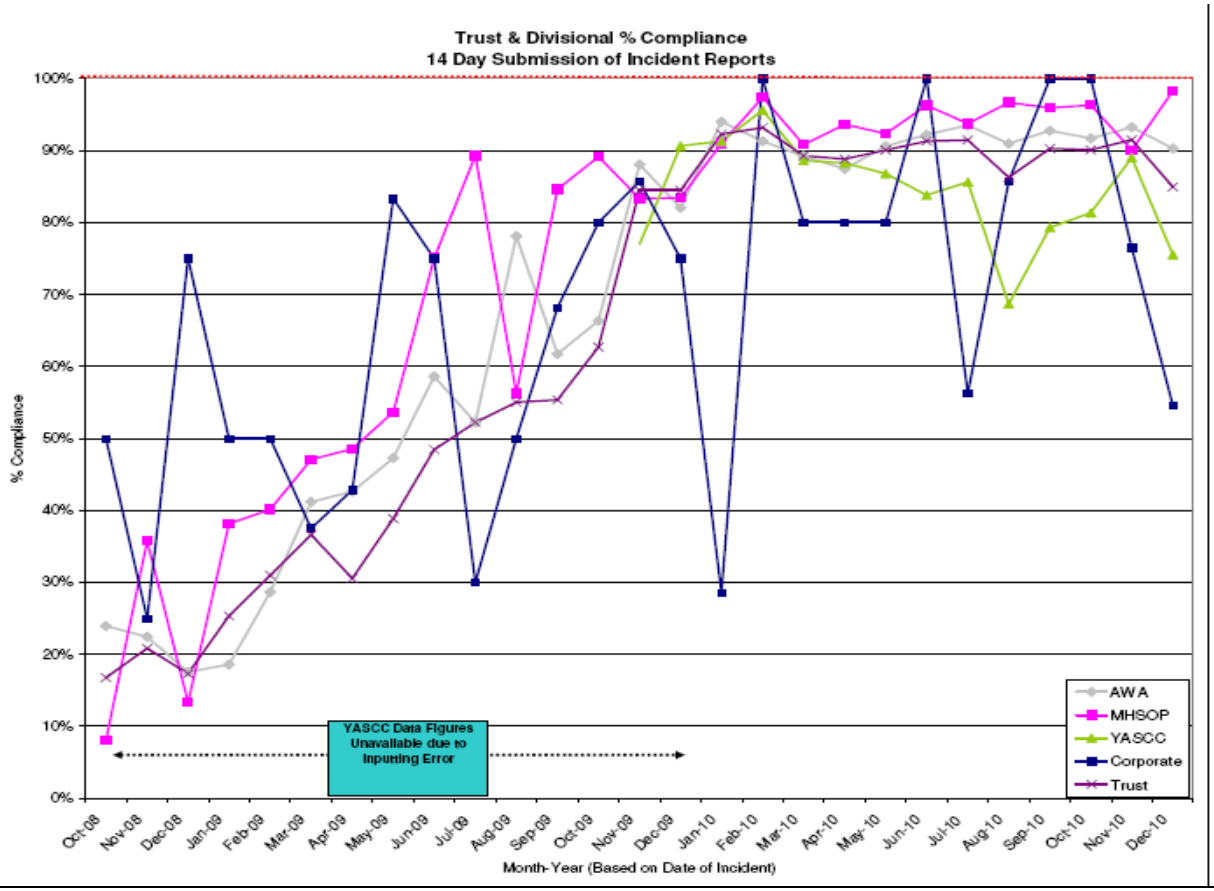
1 - CLINICAL GOVERNANCE DASHBOARD (Safety)

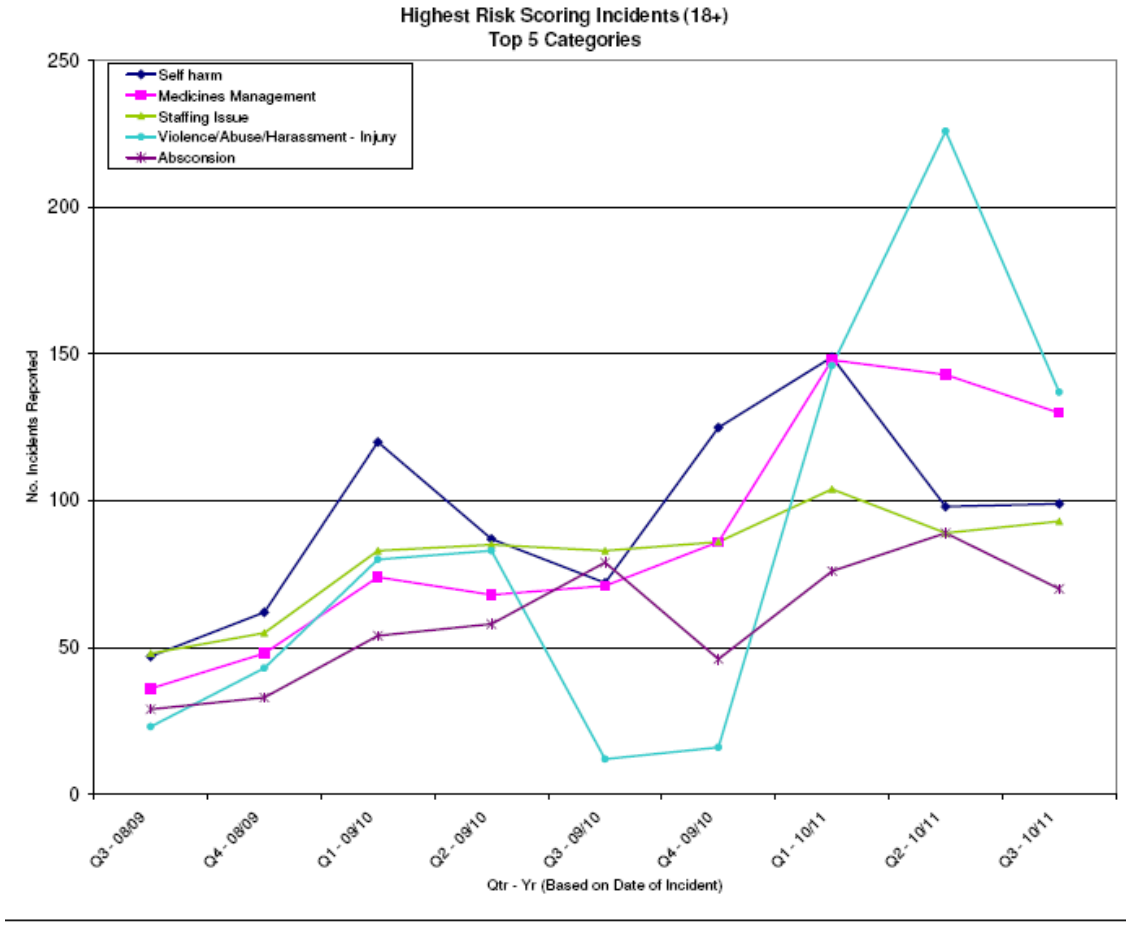
2 – Policy approval

Background papers:

This report relates to papers presented to CGC on the 4 April 2011.

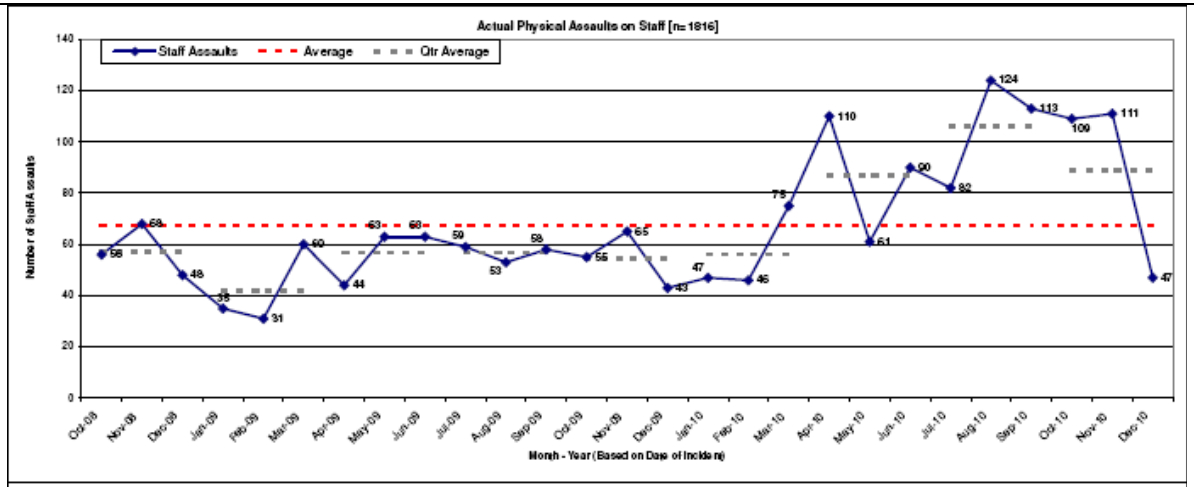
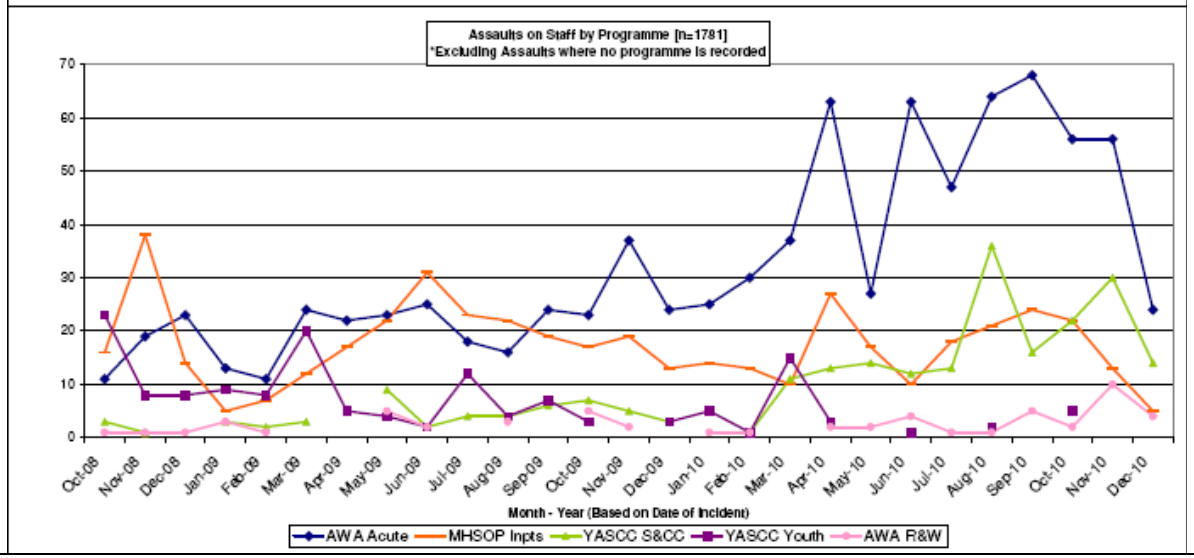
CLINICAL GOVERNANCE DASHBOARD: APRIL 2011
SAFETY

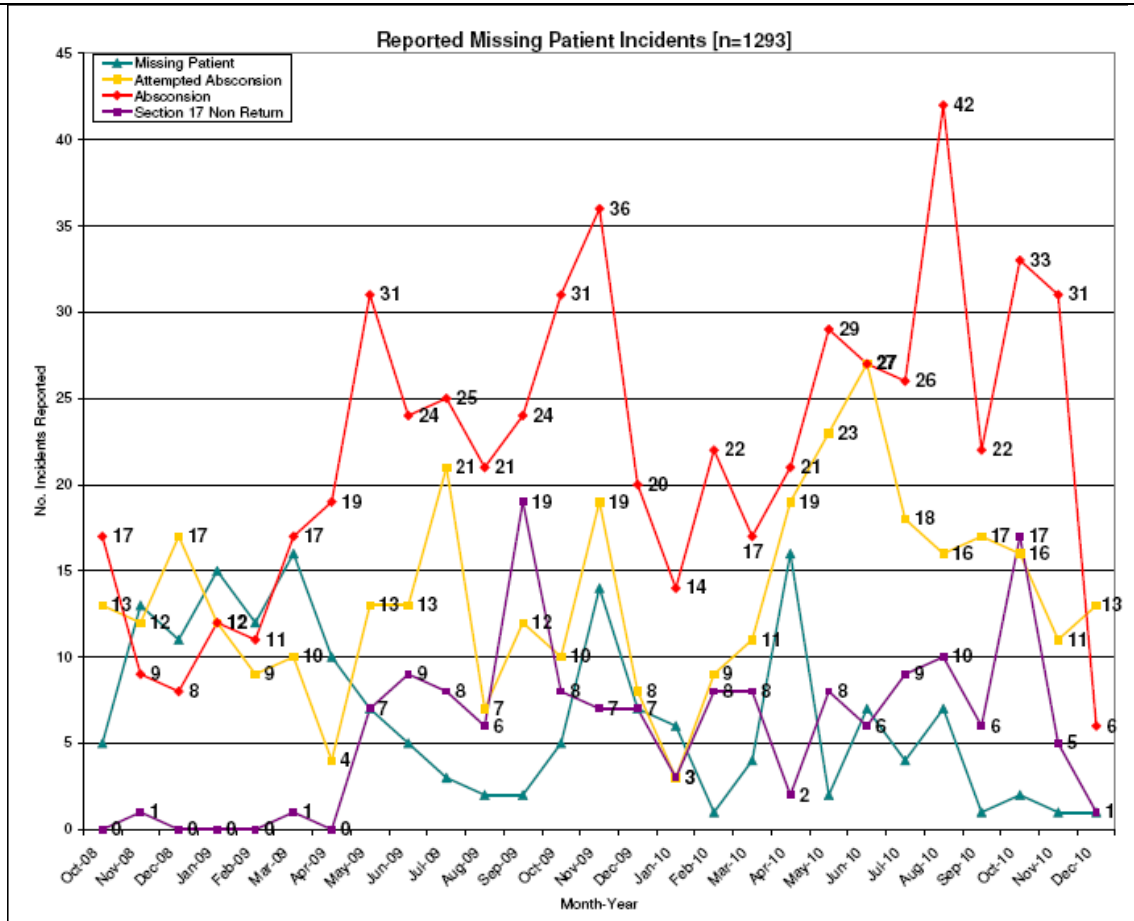
Rationale	Results	Comments
1) Incident reporting timeliness Trust policy states that all incidents should be received at the risk management office no later than 14 days following the incident. This provides time to ensure local managers have responded fully to the incident. **Trigger Point** Incident forms received after 14 working days from date of incident. Target 100% …….. **Data** Previous 18 months of Incident reports received.		The significant variation in relation to corporate reporting generally reflects incidents received from support services although the high variation reflects a relatively small number of incidents. The main location of low compliance in relation to YASCC has been the prison. Issues relating to individual areas are being followed up with relevant managers.

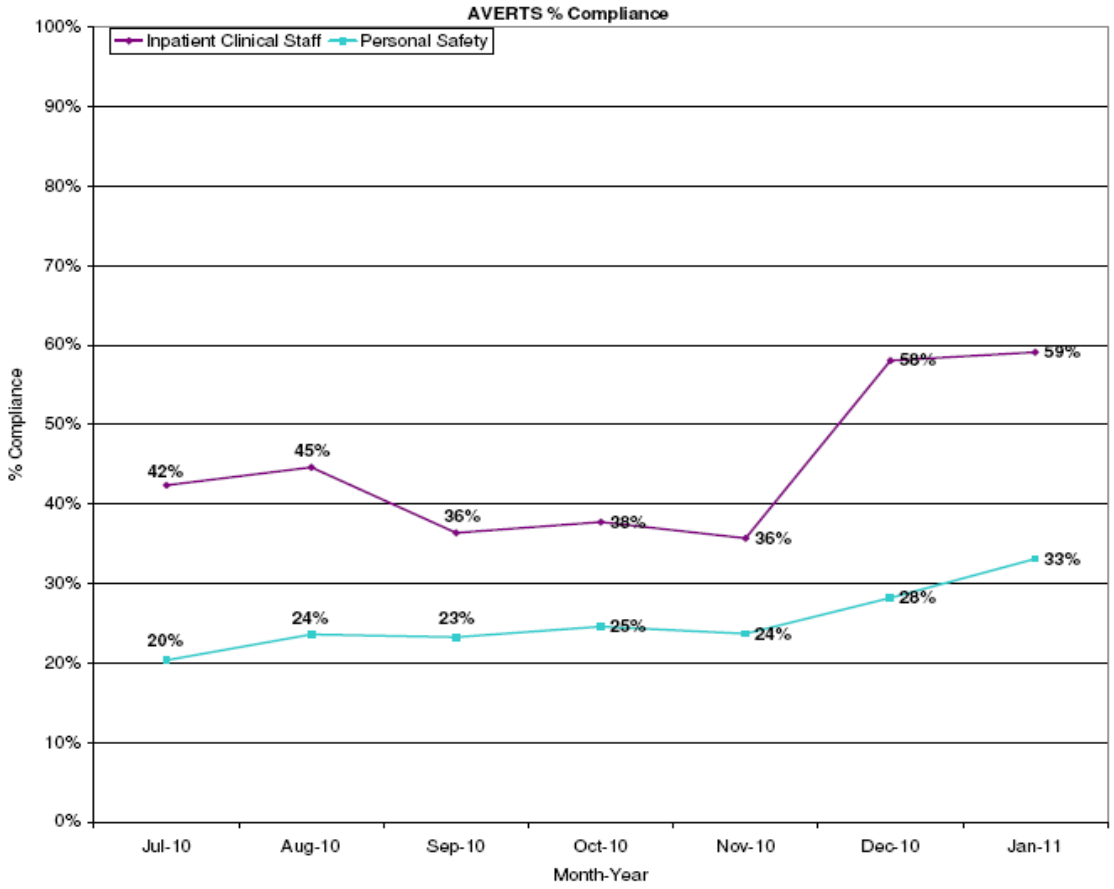
Rationale	Results	Comments
2) High Risk Scoring Incidents Top 5 Incidents Categories Incidents of moderate to high risk (score 18+) (See risk score matrix) **Trigger Point** Increase in number of high scoring incidents **Data** Incident Pivot Table Qtr 3 08/09 to Q4 09/10 inclusive.		The significant increase in incidents resulting in injury has reduced this last quarter. A detailed breakdown of these incidents has been issued to AWA where the increase was demonstrated.

LIKELIHOOD	Insignificant	Minor	Moderate	Major	Catastrophic
Almost Certain	5 Green	10 Yellow	30 Amber	75 Red	100 Red
Likely	4 Green	8 Yellow	24 Amber	60 Red	80 Red
Possible	3 Green	6 Yellow	18 Amber	45 Amber	60 Red
Unlikely	2 Green	4 Green	12 Yellow	30 Amber	40 Amber
Rare	1 Green	2 Green	6 Yellow	15 Yellow	20 Amber

CONSEQUENCE

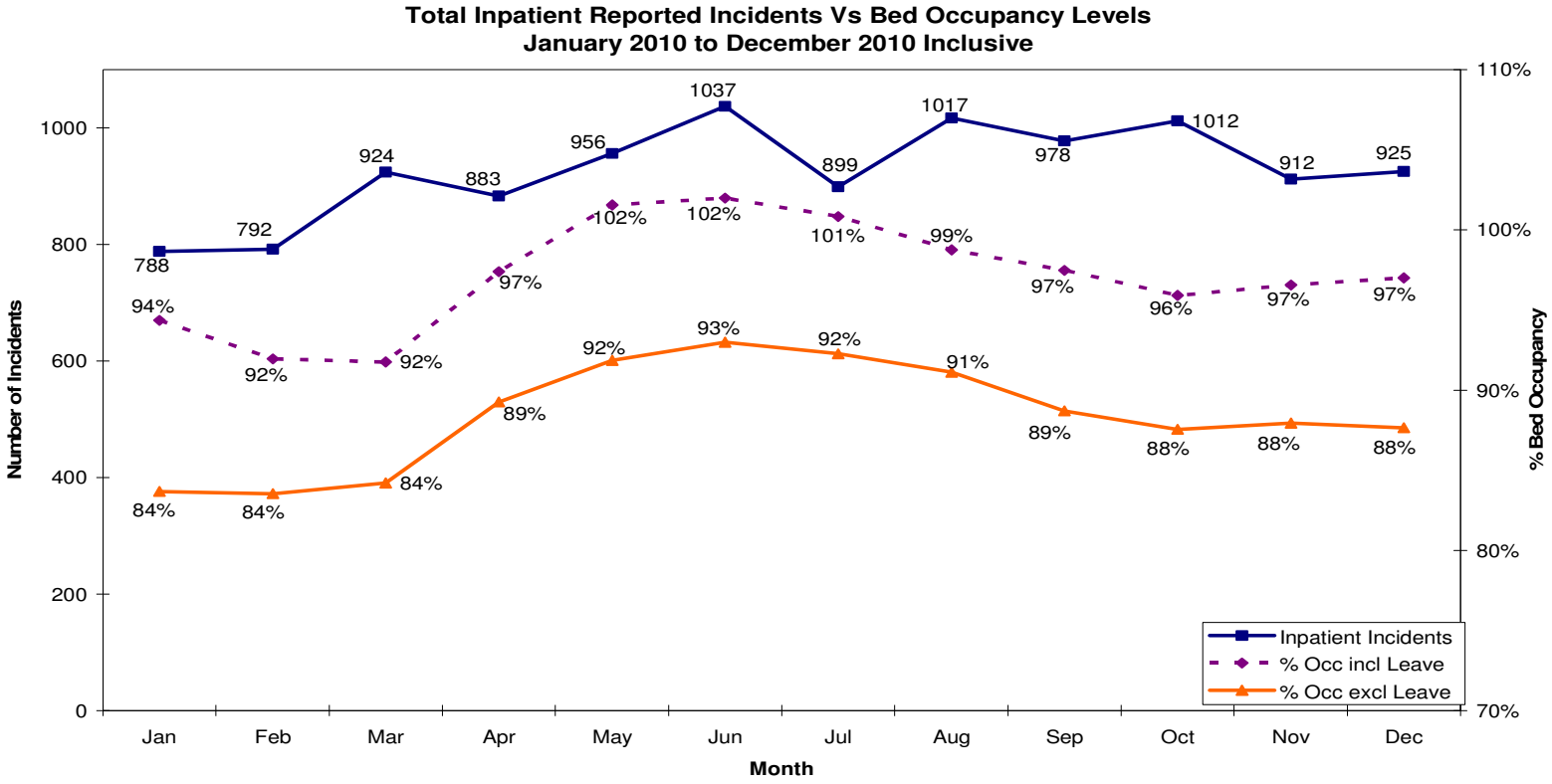
Rationale	Results	Comments
3) Violent assaults sustained by staff Reduce number **Trigger Point** Increase in number from 08/09 average **Data** Incident Pivot Table Brief Incident Description "Assault on Staff"	 	See above. The reduction of incidents in YASCC Youth is a reflection of the significant work undertaken by the programme which results in the HSJ award. The increase in assaults in Qtrs 2/3 has been highlighted previously and reviewed by AWA where these were reported. There has been significant decrease towards the end of Qtr 3 which will be monitored to ensure this is maintained.

Rationale	Results	Comments
5) Missing Patients/ Absconsions Reduce number **Trigger Point** Increase in the number of absconsions **Data** Incident Pivot Table Incident Type sub categories of "Missing Patient" • Absconsion - inpatient who cannot be accounted for • Attempted absconsion - where patient has attempted to abscond but this has been prevented. • S17 leave - where patient has been on leave but has not returned in line with agreement. Not specified – historical missing patient incident which was not classified accurately		Significant variation has been identified in relation to absconsions in September 2010. This reflects a number of serious incidents and recurring incidents to which physical measures have now been introduced to prevent re-occurance.

Rationale	Results	Comments
6) QUALITY ACCOUNT OBJECTIVE: To ensure all staff working in inpatient units have received training in relation to the management and prevention of violence **End of Year target = 95%**		Whilst there remains a number of issues over the timeliness of data overall there is a steady increase in staff who are up to date with their training. However it is unlikely that the target figure identified in the quality account will be achieved.

REVIEW OF INCIDENTS AGAINST BED OCCUPANCY LEVELS

At the request of Trust Board a review of incidents has been undertaken against bed occupancy levels. This has highlighted overall a clear correlation between number of incidents and bed levels. Further analysis against different categories has suggested that there is a correlation with 'clinical' incident category, and also with patient falls in MHSOP. There was no clear correlation with assaults, staffing incidents and medicines incidents. It should be noted that increased bed occupancy could reflect purely a reflection of activity and therefore the increase in incidents may not be significant overall. Further detailed information is being provided for review to individual programmes.



Appendix 1

POLICY ASSURANCE SUMMARY

Meeting held on April 2011

Policy No	Title	New/ revised?	Lead Director	Key Issues	Committee [1]	Date final version approved [2]	Consultation Period [3]
C09	Seclusion	R	Medical	Policy has been updated to reflect MHA code of practice and wider best practice guidance.	Risk Management		
IC01/o	Collection, storage & transport of specimens	R	QI&PE	Policy and procedure has been updated to reflect the new specimens service which was procured by the Trust.	Infection Control		
RS 17	Food Hygiene	R	QI&PE	Minor amendments to appendices			

NOTES:

1 – 'Committee' - This identifies the relevant director led committee to which the policy relates to. Where the policy was approved by a further sub committee this is identified in brackets ( ).
2 – 'Date final version approved' – This reflects the requirement for final sign off of the policy before it is presented to Clinical Governance Committee.
3 – 'Consultation period' – This reflects the requirement for all draft policies to be issued on the intranet for at least 4 weeks and sent to all Directors and Clinical Directors for review.
© - highlights a policy which is required for CNST accreditation.

Appendix 2

STATEMENT OF MAJOR INCIDENT PLANNING ARRANGEMENTS

The CGC received a report from the Risk Management Committee held on the 20th January 2011, which received an annual report (2010) on the Trust's Major Incident Plan (MIP).

It was noted that the following items had been reported by exception:

- There had been no incidents which had required the Trust's MIP to be activated/ implemented in 2010.

- The MIP had been updated to reflect a number of changes in the NHS operating environment - specifically:

  The Care Quality Commission emergency preparedness standards 6D, 10E & 10H effectively replace Standards for Better Health core standard C24.

  The 2010 NHS Operating Framework which identifies emergency preparedness as a priority for the NHS (chapter 2, paragraphs 2.37 – 2.41).

  The NHS West Midlands intend to audit NHS Trusts and PCT major incident and business continuity plans in 2011. (This was completed in February 2011).

- A number of events had been held to test the Trust's MIP in 2010, these included:

  January 2010 – Decision Log Training. This was provided to Executive Directors, Senior Managers and Clinicians expected to be involved in managing and/or responding to a major incident. The training was externally facilitated by the DoH Health Protection Agency.

  May 2010 – Exercise Leopold. Multi-agency, externally facilitated event for West Midlands category 1 NHS responders, including all NHS Trusts; Ambulance, Fire, Police, local authorities, West Midlands Government Office and military responders.

  October 2010 – 'Testing of Fire & Evacuation Procedures and Responding to Clinical Incidents' - Juniper Centre, Moseley Hall Hospital. Both tests/exercises included representatives from Birmingham Healthcare Community Trust, who also provide clinical services from the Moseley Hall Hospital site.

  The tests formed part of the operational commissioning arrangements associated with the new Juniper Centre.

Lessons learnt from these testing events were shared with all clinical and non clinical divisions and departments via the Trust's Major Incident Planning Group.

Main risks relating to major incident planning are also reflected in the Trust's Risk Register and reviewed regularly by the MIP planning group.