RESPONSE TO CQC REVIEW OF COMPLIANCE

Outcome 4: Care and Welfare of people who use services

What the CQC have said:
There is a lack of consistency in care practices across the trust. People are not always experiencing effective, safe and appropriate care treatment and support that meets their needs. Overall they found that improvements are needed for this essential standard.

Key issues identified in report:	Actions to be taken	by	Timescale	How will we know these are met?
Ensure consistent practice for Consultants from In patient and Community teams to meet regularly to discuss common issues.	Consistent practice across in-patient and community teams is a priority for the Trust. The Trust is using lean systems methodology and structural change to achieve this. The lean systems work brings together all clinicians across teams in a locality and has been rolled out systematically over the past 18 months. These events have now taken place in the patch visited by the CQC, which was the final stage of the implementation plan. A standard has been agreed for routine fortnightly meetings between Acute and CMHT Consultants and teams in all areas to bring about the desired changes and improvements. A revised management structure which is currently subject to consultation which will further integrate community teams and in-patient services under single clinical and managerial leadership. In the interim the existing Account Clinical Directors will hold the localities to account	DSD - AWA	30 June 2011 Oct 2011	To be reported through to Trust CGC.

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Access to Linden centre does not support patient confidentiality	The Trust has recognised this issue which is severely hampered by the layout of the Lyndon Centre building. Remedial works and capital costs were identified at the end of last year. These costs were prohibitively high, thus outside the scope of the Trust capital programme in 2010/11. Alternative options are under active consideration.	DSD - AWA	June 2011	Identification of agreed option and confirmation this has been implemented.
The care files did not clearly demonstrate what discussions had taken place between the professional and the patient to involve them in planning their care.	There are specific fields identified in our Integrated care record which require clinicians to record the involvement of service users in their care plan. Further, service users are allowed to record their own comments. The Trust has a routine and regular programme of audit to check compliance which has shown systematic improvement over the last year. All clinicians in locality have been reminded of the Trust standard which will be followed up through the audit programme.	MD	N/A	Compliance with these care plan fields are monitored as part of our routine audit process.
The risk assessment tool in use was complex.	The GRIST risk assessment tool is nationally recognised, but it is a complex tool. As a result of feedback from clinical staff the Trust has been developing over the past 18 months a replacement tool which captures the information required to support clinical decision making and is also simpler to use. This was approved for implementation in January 2011 and is now in place and used for all new assessments.	MD	Completed	Use of the tool is subject to quality audit.
Patients computerised care plan was protected to prevent them being changed without the permission or involvement of the patient.	No action proposed. The care plan is the plan which has been issued to the service user – it is therefore a record of what has been agreed with them through the Care Programme Approach review or ward review meeting.	MD	N/A	

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Ward staff were asked what processes were in place to ensure that there was good communication between hospital and community at the time of discharge. Staff told us about the need for good communication, but were not clear what the processes were.	Good communication across in-patient and community teams is a priority for the Trust. The Trust identified this as an area for review and is using lean systems methodology to achieve this. (See previous comments). The lean systems work brings together all clinicians across teams in a locality and has been rolled out systematically. These events have now taken place in the patch visited by the CQC, which was the final stage of the implementation plan. All inpatient services users, are discharged via Home Treatment or Assertive Outreach Services, who attend weekly ward rounds. Consultant Psychiatrists follow up inpatients into home treatment to ensure continuity of care post discharge. Care co-ordinators are required to spend a minimum of one hour per week, with any service users who are inpatient's to ensure care co-ordination is proactive. The Trust has prescribed information within its electronic care record which is required to be completed for any transfer of care between clinical teams. Receiving teams are required by policy not to take on a transfer until they have received sufficient information from the referring team. This has been confirmed and communicated to the patch visited.	DSD - AWA	Completed	The Trust Care record audit reviews this process.

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Difficulty accessing psychiatric intensive care	No further action There are pressures at times of peak demand on PICU beds there is a clear process and agreement in place with P.C.T.'s to use of overspill beds should capacity be compromised.	DSD	N/A	
Provision of appropriate choices for breakfast	The Trust has core standards for meal provision across all units. Options for breakfast provision will be further reviewed.	Facilities	July	Core provision identified to meet needs of community.
Bed management arrangements – releasing beds for service users who are using leave.	The bed management policy sets out a clear process for managing beds when service users are on leave. This was being followed at the time of the visit.	MD / DSD	N/A	Bed Management audit (annual)

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Outcome 7: Safeguarding people who use services from abuse.

What the CQC have said:
People are not fully protected from abuse as the current safeguarding system within the trust is not formally monitored and reviewed to ensure that an effective safeguarding system is in place. Overall we found that improvements are needed for this essential standard.

The trust needs to review their current safeguarding processes This review should ensure that the trust is confident that:

- Staff have an understanding of the differences between serious untoward incidents, notifications and safeguarding.
- The systems for monitoring and reviewing safeguarding incidents and acting on any feedback are strengthened
- Current BSMHFT polices and procedures for safeguarding reflect best practice and systems are in place for lessons to be learnt
- A performance management/audit system is implemented to ensure that safeguarding policies and procedures are being adhered to
- A formal and regular reporting process to the local safeguarding partnerships is Established
- A system is in place for ensuring a higher uptake of safeguarding training across the Trust
- The trust is sure that staff are receiving training that helps them to handle safeguarding appropriately.

Trust Position
The Trust works to approved safeguarding policies for both Safeguarding Children and Safeguarding Vulnerable Adults. Reporting procedures were agreed with both local authorities (September 2009).

The training to support the policies makes explicit the requirement for clinical staff and managers to report incidents directly to the local authority to encourage open reporting. Whilst there is often dialogue between staff and the safeguarding team in relation to cases, staff are reminded in training that they have an individual, professional and contractual duty to report.

The Trust has a safeguarding team who oversee compliance with the policies and are actively engaged with local authority safeguarding boards.

The CQC confirmed that staff have a basic awareness of safeguarding and also that staff actively report any potential untoward incidents. Not withstanding the process for direct reporting to local authorities which is set out in Trust policy, the safeguarding lead is notified of any potential safeguarding incidents which are flagged up through the electronic risk management database. Further the Safeguarding lead actively responds to queries from staff on all safeguarding issues. In this way active support is provided to ensure any appropriate concerns are promptly reported.

Reference to 'informal conversations' with the local authorities is reflective of the excellent working relationship the Safeguarding lead and his team have with the Safeguarding Teams at both Birmingham City Council and Solihull Metropolitan Borough Council and have helped contribute to the development of the local adult safeguarding agenda. There is frequent contact and dialogue that provides many informal opportunities for the exchange of information, but all Serious Incidents are formally reported to the Chair of the Birmingham Safeguarding Adults Board and the Chair of the Solihull Safeguarding Adults Performance, Quality and Audit sub-group. However, in the light of CQC's comments, both Boards have undertaken to review the systems and processes by which NHS organisations provide them with assurances and report serious incidents.

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The 1100 'notifications' identified in the report relate to incidents which are reported to the National Patient Safety Agency as part of the National Reporting and Learning System. The code of 'Abuse' is that used by the NPSA and reflects a wide range of incidents including incidents of disruptive behaviour, aggressive behaviour, bullying, verbal abuse and harassment by patients who are unwell. The Trust has actively sought to improve reporting to this system in order to support the wider learning this supports and is currently the sixth highest reporter of incidents by mental health trusts – which is considered to be a positive demonstration of good risk management practice. The Safeguarding lead reported that there had been approximately 480 alerts raised under the safeguarding procedures in the previous year but CQC challenged him, stating that there had in fact been 1100 incidents of abuse reported, The safeguarding lead was correct, there had not been 1100 safeguarding incidents, there had been 1100 incidents of 'abuse' against NPSA reporting categories, but the majority did not meet the criteria for safeguarding. Never the less, we recognise that there need to be systems and processes in place to provide assurances that this is the case and that incidents that meet the criteria for safeguarding are being reported through the procedures.

Key issues identified in report:	**Actions to be taken**	**by**	**Timescale**	**How will we know these are met?**
Staff have an understanding of the differences between serious untoward incidents, notifications and safeguarding.	The Trust has (along with other partners across the City) prioritised safeguarding children training over the past two years. The safety of children whose parent(s) / other family member(s) suffer from a mental illness is fundamental. There is also a requirement for all teams to ensure staff receive up to date training on safeguarding of vulnerable adults (ie patients themselves) although it is acknowledged that this may need to be intensified. We will update our internal safeguarding policy and training to highlight the definitions and distinction between SI's, notifications and safeguarding incidents, including a clear description of the process by which each should be reported. This element of the policy will be incorporated into our safeguarding training.	QIPE (Head of Safeguarding) Head of safeguarding	30th June 2011 1st August 2011	Revised Policy, and Procedure and training Material.

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The systems for monitoring and reviewing safeguarding incidents and acting on any feedback are strengthened	A revised electronic incident reporting system is in the process of being commissioned and once fully implemented will enhance the current systems and ensure timely e-reporting to all appropriate areas. In addition, to mirror the routine reporting of SIs to the Senior Directors meeting, there will be a similar summary report on safeguarding notifications and investigations reviewed on a systematic basis.	QIPE (Ass Dir of Governance)	1st August 2011	
Current BSMHFT polices and procedures for safeguarding reflect best practice and systems are in place for lessons to be learnt	BSMHFT policy, with highlighted definitions and additional reporting measures will be shared with the two local authorities (Birmingham City Council & Solihull Metropolitan Borough Council) to ensure agreement with partner agencies prior to implementation.	QIPE (Head of Safeguarding)	1st August 2011	Audit trail relating to policy development.
A performance management/audit system is implemented to ensure that safeguarding policies and procedures are being adhered to	All untoward incidents will be explicitly and routinely reviewed against safeguarding criteria, this can happen with immediate effect by sharing reported incidents routinely with the Trusts Head of Safeguarding. Safeguarding notifications and investigations will therefore be reported within the Trust incident reporting system. In addition, to mirror the routine reporting of SIs to the Senior Directors meeting, there will be a similar summary report on safeguarding notifications and investigations.	QIPE Head of Safeguarding	1st August 2011	

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A formal and regular reporting process to the local safeguarding partnerships is established	The local authority in Birmingham has reviewed all safeguarding arrangements, BSMHFT (along with other NHS Trusts) have been involved in this process. Protocols are being developed for both Birmingham and Solihull Safeguarding Boards, which will then be presented for approval. The revised protocols will be included in the revised BSMHFT internal Safeguarding procedure.	QIPE (Head of Safeguarding)	30th June 2011	We will be able to provide copies of the protocols, and evidence of their approval in the minutes of the Birmingham and Solihull Safeguarding Adults Boards. We will be able to provide a copy of a revised BSMHFT Safeguarding Adults procedure that references and details the agreed process.
A system is in place for ensuring a higher uptake of safeguarding training across the Trust	BSMHFT has a comprehensive plan in place for Safeguarding training which is identified as a statutory and mandatory training requirement. This ensures all new staff receive training as part of their induction and that updates are received by all staff every three years. Training capacity and operational plans have been enhanced and developed for all areas to achieve these by the end of February 2012.	QIPE (Head of Safeguarding)	February 2012	Compliance Reports Produced Through Electronic Staff record System (OLM)
The trust is sure that staff are receiving training that helps them to handle safeguarding appropriately.	An audit will be undertaken to assess compliance with safeguarding reporting arrangements.	QIPE (Head of Safeguarding)	July 2011	Result of audit will form part of Safeguarding Report to Clinical Governance Committee.

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Outcome 13: Staffing.

What the CQC have said:
People's health and welfare needs are not consistently being met as at some locations there are not always sufficient numbers of staff to do so. Overall they found that improvements are needed for this essential standard.

Key issues identified in report:	Actions to be taken	by	Timescale	How will we know these are met?
Staffing levels (Lavender) do not permit Section 17 leave.	In response to concerns raised in relation to Lavender ward, a full review of the ward including the clinical leadership is to be undertaken to ensure all perceived concerns are addressed.	DSD - AWA	30 June 2011	Audit of April 2011, S17 leave by end of May 2011
Qualified staff spend most of their time doing paperwork	As above. Concerns from staff about recording requirements will be responded to with support by the CPA team to ensure that duplicate systems are not being applied. Implementation of the Trust new electronic patient record is scheduled to take place later in the year and will ensure that all staff are appropriately trained to use clinical systems effectively and efficiently.	MD (CPA Lead) DoR (RIO Mgr)	June 2011 November 2011	Staff concerns addressed. Effective implementation of new Patient Record system.
Consistency of activity in Lavender ward	The Trust was concerned that the activities available on Lavender ward were not perceived to meet the standards of other units visited. The full review of the ward and the allocation of staff across all duties will address this. The activity in the Lavender ward has been previously praised in CQC MHA reports. Positive feedback from service users has also been very high.	DSD - AWA	Complete	Ongoing monitoring of weekly activity programme

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Nurses wanting to join bank but having to obtain additional CRB checks.	There is a streamlined process for full time staff who wish to join the Trust staff bank and additional CRB checks are not required. To address any misperceptions additional communication to be issued to reinforce staff awareness of this.	ODP (HR)	June	Communication issued to staff.

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Outcome 14: Supporting workers.

What the CQC said:
People's safety, health and welfare needs were compromised as not all staff are properly trained or supervised. Overall we found that improvements are needed for this essential standard.

The Trust needs to make sure that training delivered ensures that:
• Staff are aware of whom DOLS applies to
• Staff are able to identify a possible deprivation
• Staff know what is required should they identify a potential deprivation
Staff told us that they need more mental health training. This was referred to in relation to different mental health illnesses, symptoms, coping mechanisms and treatments.

Key issues identified in report:	Actions to be taken	by	Timescale	How will we know these are met?
Provision of training in physical health and also mental health.	Training is provided in physical health and mental health and details of this training are available and prioritised. The training programme is currently under review as part of the annual TNA for the organisation.	QIPE / OWD	July 11	Revised training programme agreed.
Inconsistency in clinical supervision	Compliance with Trust clinical supervision policy is audited every year and arrangements are reviewed with individual staff as part of their annual appraisal. The full review of the ward and the allocation of staff across all duties will address this.	ODP (HR)	N/A	Compliance with policy reflected in audit results.
Could not tell when staff had last received training.	This is recorded in the staff training database and is available through routine reports issued to managers. As part of the roll out of management access to the system, this will be able to be retrieved 'real time' directly by managers from 26 April 2011.	ODP (HR)	29 April 2011	All managers able to access training database information directly

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Staff are aware of whom DOLS applies to	A specific informal admission policy has recently been developed and once approved this will provide a clear framework for staff to be better aware of whom DOLS applies to. Additional training will be considered in areas identified as part of the policy implementation.	MD	June 11	Completion of policy implementation plan. Annual audit of policy.
Staff are able to identify a possible deprivation	As above.	MD		
Staff know what is required should they identify a potential deprivation	As above.	MD		

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Outcome 18: Notification of death of a person who use services.

What the CQC have said:
Events that affect the welfare, health and safety of people using the service are not always being appropriately reported to the Care Quality Commission or the National Patient Safety Agency. Overall we found that improvements are needed for this essential standard.
The trust should have a system in place for checking and auditing all notifications that fall under outcomes 18, 19 and 20 of the Health and Social Care Act 2008 before incident report information is forwarded to the NPSA.

Key issues identified in report:	Actions to be taken	by	Timescale	How will we know these are met?
The trust should have a system in place for checking and auditing all notifications that fall under outcomes 18, 19 and 20 of the Health and Social Care Act 2008 before incident report information is forwarded to the NPSA.	All potentially notifiable incidents are now double checked through the Governance Information manager to ensure all fields are accurate. We acknowledge that the CQC found 9 such incidents contained coding errors. Actions have already been taken to improve coding practice and this is being kept under regular review. The Trust is unable to take actions on incidents which are reportable to the NPSA and which are received by the CQC when these do not relate to the formal reporting requirement.	QIPE (Ass Dir of Gov)	Immediate.	Summary report on notifiable incidents.

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