BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

BOARD OF DIRECTORS TO BE HELD ON WEDNESDAY 25 MAY 2011

SAFEGUARDING PROPOSAL

ACTION:

Trust Board is asked to receive this report for assurance following the recent Care Quality Commission review.

The Head of Safeguarding has produced a detailed action plan in response to the issues raised by the Care Quality Commission (CQC). Some of the concerns they identified can be addressed through a review of our local policy and the continued approach to testing our staff's understanding of safeguarding arrangements once they have undertaken training through the audit cycle. Through the implementation of the Quality Strategy this testing will become more systematic. The Board should be assured that these actions will be completed promptly and within the agreed timescale.

The CQC raised three further areas of concern in relation to the monitoring of safeguarding incidents, the systems in place to ensure that lessons are learnt and the formal reporting processes to local safeguarding boards. None of these areas can be addressed in isolation of partner agencies and moreover, it has been acknowledged that any concerns of this kind in relation to BSMHFT, are likely to equally apply to any if not all of the partner organisations as they relate to the local safeguarding multi-agency arrangements, not BSMHFT alone. Therefore, the Head of Safeguarding has shared the outcome of the review with both the Birmingham Safeguarding Adults Board and the Solihull Safeguarding Adults Board, and both have established short life working groups to strengthen the way in which organisations (and in particular NHS organisations) report incidents to the safeguarding boards and ensure that serious incidents that meet the criteria for a multi-agency Serious Case Review, are identified and actioned. Both groups have met and completed this work and will be presenting a proposal to their Board for approval.

It is proposed that contained within the regular quarterly safeguarding report that is presented to the Clinical Governance Committee, data is presented that compares and contrasts the number of abuse incidents reported to the National Patient Safety Agency, with the number of safeguarding incidents notified to the safeguarding team and the number of safeguarding referrals raised with the local authority that relate to a user of our services. The Head of Safeguarding has formally requested this information from the local authority leads for safeguarding in both Birmingham and Solihull.

However, when looking at incident trends, there is a danger that we establish separate parallel safeguarding processes that mirror our existing governance arrangements and add no additional value. It is therefore essential that our safeguarding monitoring processes are properly aligned and congruent to our governance systems and processes and for this reason, the safeguarding team will be accountable to the Head of Governance as part of my corporate restructuring. This does not affect the direct relationship with the Executive Director of Quality, Improvement and Patient Experience (and the Director with Board responsibility for Safeguarding).

It is important that the distinction is made between the broader safeguarding agenda and its implications for the organisation and child and adult protection where there is an actual individual subject to abuse or neglect. Furthermore, it is also crucial to remember that the core purpose of the safeguarding arrangements is to ensure that these concerns are raised and that there is a multi-agency approach to the development of individual plans that will keep children and vulnerable adults safe and free from abuse.

BOARD DIRECTOR SPONSOR:

Dee Roach, Executive Director of Quality, Improvement & Patient Experience