BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

BOARD OF DIRECTORS TO BE HELD ON WEDNESDAY 25 MAY 2011

CLINICAL GOVERNANCE REPORT

ACTION

- Trust Board is asked to note that the committee has approved revisions to the Care Management policy to reflect the recent issues relating to care co-ordinator provision (see appendix 2).
- Additional actions have been confirmed following a reassessment of CQC compliance within the Prison Healthcare service.
- The Trust Board is asked to approve the annual programme of work for infection control - a summary is set out in appendix 3.
- An initial update against the CQC responsive review action plan is presented in appendix 4.

SIGNIFICANT ISSUES

1. Care Management Policy

Issues of compliance have been reported previously to Board on the Trust Care Management policy. Following discussion in January a number of issues were identified to address the concerns and these were reported to the committee. The key issues were:

- To provide a tool for managing workload within teams.
- To circulate clear guidance on criteria for CPA.
- To clarify responsibilities as to who can be a care co-ordinator.

An internal audit review had also recently been completed and issues arising from this report were reflected in the revised policy.

The committee agreed that the use of waiting lists for the allocation of care co-ordinators should cease and that where issues of case load pressures are identified these are escalated to ensure staff are able to provide appropriate support.

The revised policy was therefore approved.

2. Study Leave – DNA Charges

The committee approved an increase in charges to services for individual non attendance at statutory and mandatory training courses. It was agreed to review these after three months to ensure that the charges were not having a major impact on clinical budgets. It was further agreed that there would be a supplementary appeal process for cases where non attendance was due to appropriate and legitimate reasons, this was to ensure that patient safety was not prejudiced by the DNA process.

3. Prison Healthcare – CQC Regulations

Additional actions were approved by the committee to achieve compliance with CQC regulation requirements which had been previously reported as met.

It was noted that a number of new actions had already been undertaken and the main focus of outstanding work related to medicines management arrangements.

4. Community Mental Health Team – Pilot

The committee approved a pilot for a revised model for community mental health teams. The committee highlighted the need to ensure that economic factors were included in the evaluation as these have not been identified in the development stage.

Once the pilot has been completed the outcome will be further evaluated.

5. Serious Incident Investigations

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

6. Quality Account Priorities

The committee reviewed quality account priorities – details of which are included in the separate quality account report.

7. Pharmacy and Work Plan of Pharmacological Therapies Committee

The committee received an assurance report from Pharmacy/Pharmacological Therapies committee. In discussion the Medical Director agreed to meet with relevant staff to develop a clear plan and understanding of how pharmacy prescribing data will be reported.

8. Clinical Governance Priorities and Work Programmes

The committee has further agreed actions as part of the Clinical Governance Development Plan for 2011/12.

- All committee reporting to the CGC have been tasked to present their revised terms of reference and work programme, this will be expected to report over the next three months. Specific committees as identified in the Clinical Governance review have also been asked to confirm arrangements to enable the meetings to be ceased.
- All potential priorities identified for the quality account will be incorporated into routine reporting to the committee.
- These priorities are to be incorporated into a clinical team to Board framework of reports which are intended to report to Trust Board by exception. Initial drafts of these reports are under development and again will be reported for approval to Trust Board over the next quarter.

9. Other Assurance

Assurance reports were reviewed and noted in relation to:

- Safeguarding arrangements in the Trust and actions taken against safeguarding review (there were no exceptions to report).
- Research and Innovation.

10. Infection Control

The committee reviewed and approved a work plan and annual plan of activity in relation to infection control. The committee identified that sufficient resources were available to support the programme. A summary of which is attached in appendix 3.

11. Assurance From Clinical Programmes

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

Acute

- Significant progress had been made to review all outstanding serious incidents.
- The programme highlighted its difficulties in obtaining user representation at its committee and it was agreed to review support for this at the next meeting.

CAPS

- Structural improvements were highlighted in relation to patient areas of Harry Watton House and Lyndon Clinic. Proposals were under consideration.

R&W

- Issues relating to availability of bank and agency cover were to be taken up with HR.
- Discussions to take place to review process for potential acute support when service users may become acutely unwell.

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

APPENDIX:

1 - Clinical Governance Dashboard (Clinical Effectiveness)

2 – Policy approval

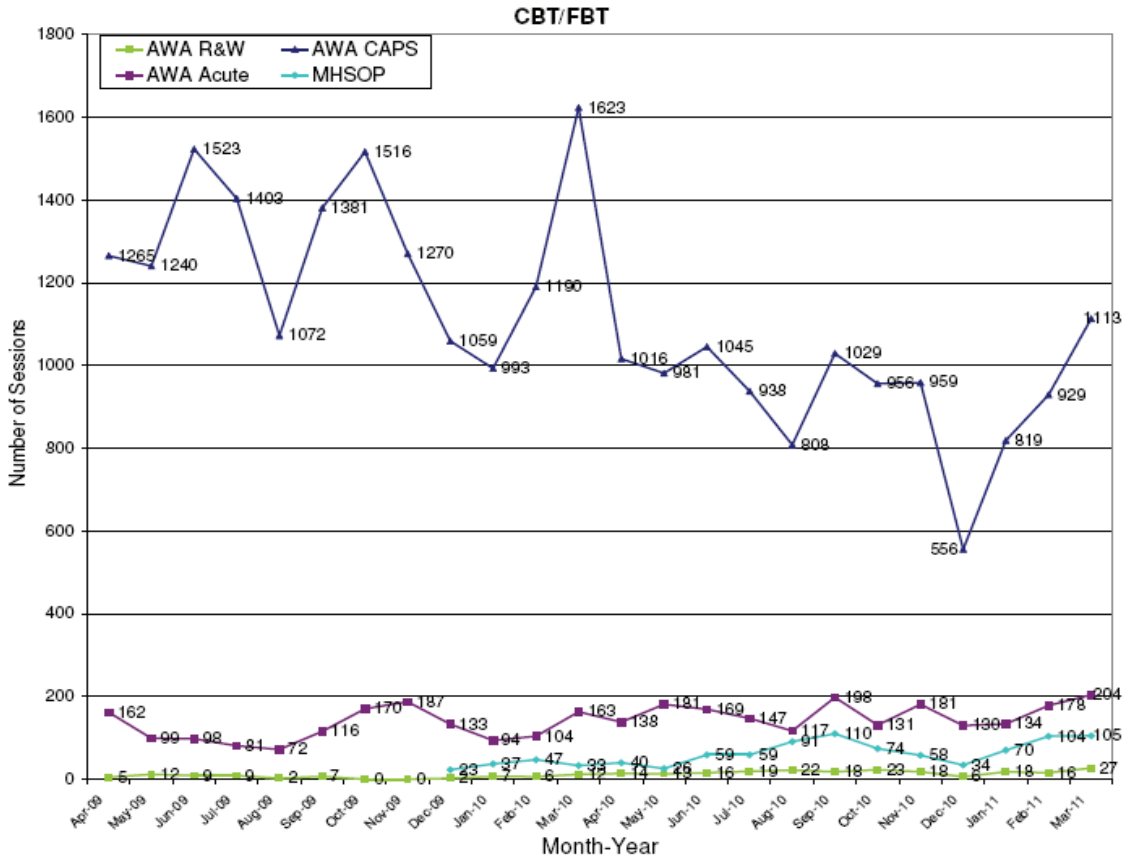
3 – Infection Control

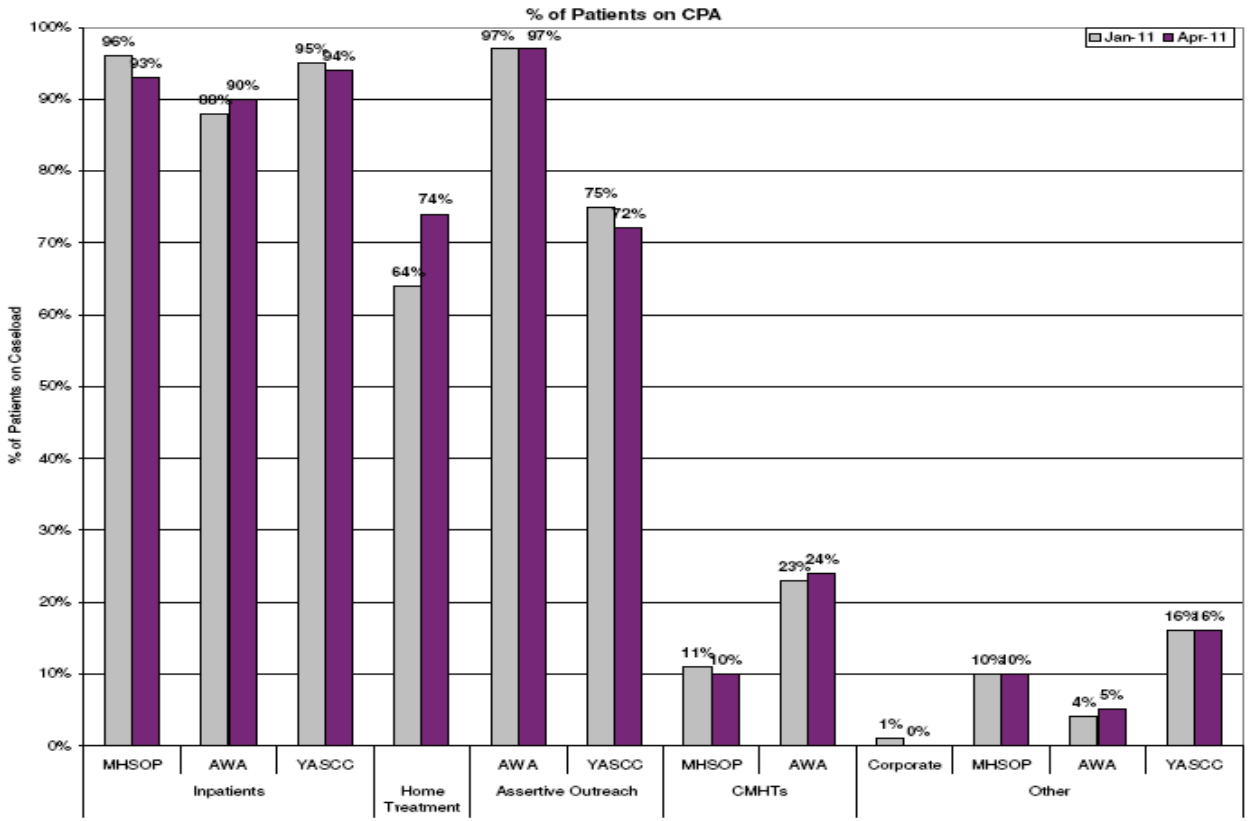
4 – CQC responsive review action plan – update

Background papers:

This report relates to papers presented to CGC on the 3 May 2011

CLINICAL GOVERNANCE DASHBOARD: APRIL 2011
CLINICAL EFFECTIVENESS

Rationale	Results	Comments
CBT/FBT Have been a common point of NICE recommendations for all Mental Health Guidance. The Trust is investing in training and support for staff to provide CBT/ FBT (CG1, CG22, CG23) **Trigger Point** Lack of improvement in activity **Data** Epex data reflecting recorded CBT/FBT sessions ***Paragon is currently being investigated to see if figures for S&CC can be provided in future clinical effectiveness dashboards.* ***ESR to provide data on number of staff currently trained*		The increase over the past quarter of activity relating to AWA CAPS indicates work which has been undertaken to re structure the psychological therapy service in this area. .

Objectives	Results	Comments
ICR Compliance Target 80% compliance **Data** Relates to % completion of all ICR documentation (Data from Insight)		High level compliance is being achieved within inpatient teams and this is an overall improved position from last year. However the performance of community teams is still significantly behind. Lower compliance with HTT often reflects the short periods in which service users are with the service and that these users may be new to the service. Incremental increases in AWA CMHTs appears to reflect care management reviews which provides assurance that mechanisms are in place for records to be appropriately updated. Detailed breakdown by teams is now provided through the Trust intranet and this is being reported to programme clinical governance groups to identify further actions for improvement.

Use of Antipsychotic Drugs in Dementia (Quality account target)

Aims

To achieve 10% below average benchmark levels of usage of antipsychotic drugs in service users who are suffering from dementia.

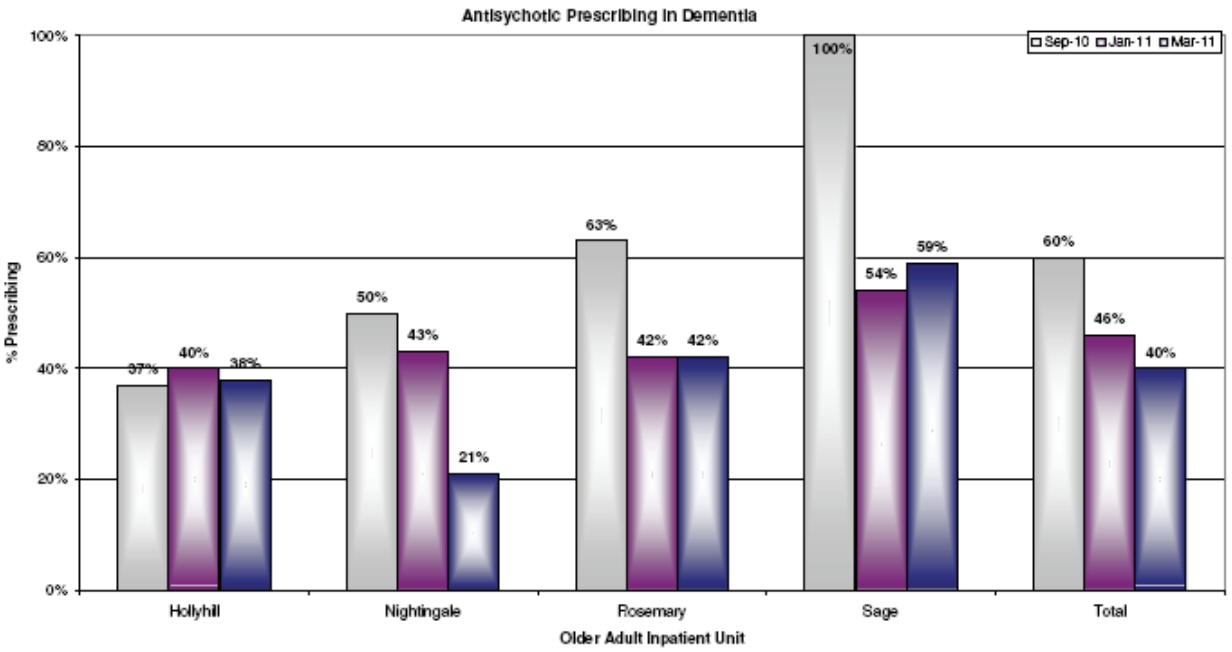
Benchmark Level

MHSOP Division to identify

Data

Ascribe database figures

Update



1 Documentation around antipsychotic use in dementia is improving
2 There has been at least one internal training session on the treatment of BPSD including use of antipsychotics given in January 11 and will be repeated in May 11
3 There appears to have been a step change in approach to use of antipsychotics in dementia for patients on inpatient wards in MHSOP. Anecdotal evidence of this comes from discussions with medical staff as well as input from nursing staff on some wards.
4 The recent POMH-UK audit including inpatients and for the first time community patients. The final report is expected in July 11 and this will enable ourselves to be benchmarked for the first time with other MHTs
5 Pharmacy is supporting a project led by South Birmingham PCT on reducing the use of antipsychotics in dementia, This will cover approaches to patient reviews in nursing home and residential settings and development of e-learning materials. The Trust can contribute to most aspects of this project and will be able to lead by example, given our track record over recent months on inpatients.
6 With reference to the national target of reducing antipsychotics in dementia by two-thirds by November 2011, we are at least half way there. Whether this target is applicable to MHTs is open to debate.
7 Next steps within the Trust is to continue the work started and extend it further into community teams in MHSOP.

As a result of clinical audit and reinforcement of clinical guidelines there has been a stepped change in clinical practice for these wards.

A national audit has recently been undertaken and we are awaiting the results of this to provide benchmark data.

Appendix 2

POLICY ASSURANCE SUMMARY

Meeting held on May 2011

Policy No	Title	New/ revised?	Lead Director	Key Issues	Committee [1]	Date final version approved [2]	Consultation Period [3]
C01	Care Management Policy ©	R	Medical	The revised policy draft was previously reviewed in January and the committee requested further work. The updated policy also reflected additional issues identified in a recent internal audit review.	Clinical Governance Committee	3 May 2011	November 2010

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 3

Infection Prevention and Control Annual Programme of Work 2011 -2012

A summary of the Infection Control Annual Programme is set out below.

- The programme will adhere to CQC registration requirements for Infection Prevention and Control through compliance of the Health and Social Care Act 2008 *code of practice on the prevention and control of infections and related guidance.*
- Trust Board is requested to approve the summary of the Infection Prevention and Control (IPC) Annual Programme of Work (APW) for approval.
- Quarterly reports on progress against plan and by exception will be presented through infection control reporting structures.

KEY POINTS

- The Code of Practice details 10 criteria on which the Trust will be judged on how it complies with registration requirements for cleanliness and infection control.
- Compliance with criterion 1 requires management and monitoring systems being in place to ensure that there are sufficient resources available to secure the effective prevention and control of infection, which should include annual infection prevention and control programme, infrastructure and the ability to detect and report infections.
- The APW identifies objectives that relate to actions required by the IPC team and other identified staff to meet with each criteria.
- The APW comprises of assurance framework activities to demonstrate that IPC is an integral part of quality assurance. These include:
    1. Surveillance systems and reporting to Trust Board of alert organisms such as MRSA and Clostridium Difficile.
    2. Audit programme.
    3. Training & education programme.
    4. Policy development and review.
    5. Quarterly reports to Trust Board.
- The APW includes activity with estates and facilities department to ensure IPC input to new builds and developments, cleaning and decontamination and water management.
- Food, hand and environmental hygiene activities to meet with compliance standards are included in the APW.
- Other key objectives include delivery of the seasonal influenza programme in conjunction with the occupational health provider, participation in activity relating to essence of care
- As directed by the Director of Quality, Improvement and Patient Experience and undertaking joint risk assessments of the environment with the risk and estates department.
- Monitoring of IPC, cleaning and decontamination activity will be reviewed through the infection control meeting structures and key issues reported quarterly to the Clinical Governance Committee.

Items to Note

- A non executive director to champion IPC is not essential in compliance but is deemed as good practice. They would undertake visits to clinical areas with the matrons or IPCT and raise issues relating to IPC and cleanliness to the Board and minutes would reflect this.

  This is a recommendation by an expert advisor to the CQC in IPC and is included in the APW as an objective.

- The IPCT has been limited in resource following maternity leave of the Band 7 Infection Control Nurse in January 2010. This deficit has been met with input 2 days per week from an experienced IPC nurse consultant contracted to partially cover maternity leave. Sufficient funding was available until June 2011 and therefore IPCT resources will be limited until October when maternity leave finishes.

  The APW does not take into consideration any unplanned work and therefore any additional works will need to be prioritised. Any adverse impact upon meeting the programme will be included in IPC reporting structures and brought to the attention of the Director for Infection Prevention and Control.

- The action plan was endorsed and complemented by commissioners at the recent Clinical Quality Review Group meeting hosted by BEN PCT.

Appendix 4

CQC COMPLIANCE ACTION PLAN – Update: May 2011

Outcome 4: Care and Welfare of people who use services

Key issues identified in report:	Actions to be taken	by	Timescale	Update:
Ensure consistent practice for consultants from inpatient and community teams to meet regularly to discuss common issues.	Routine standard for fortnightly meetings between Acute and CMHT consultants and teams to be in place in all areas. Implement revised management structure.	DSD - AWA	30 June 2011 Oct 2011	Arrangements in all teams to be confirmed.
Access to Linden centre does not support patient confidentiality	Alternative options to be identified to address environment.	DSD - AWA	June 2011	Options under review.
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.	Integrated care record require clinicians to record the involvement of service users in their care plan.	MD	May 2011	**COMPLETED** Monitoring is covered by ICR audit.
The risk assessment tool in use was complex.	Revised risk assessment tool introduced.	MD	May 2011	**COMPLETED** Use of the tool is subject to audit.
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.	Receiving teams are required by policy not to take on a transfer until they have received sufficient information from the referring team.	DSD - AWA		**COMPLETED** Monitoring is covered by ICR audit.
Provision of appropriate choices for breakfast	Options for breakfast provision will be further reviewed.	Facilities	July 2011	

Outcome 7: Safeguarding

Staff have an understanding of the differences between serious untoward incidents, notifications and safeguarding.	This element of the policy will be incorporated into our safeguarding training.	QIPE (Hd of Safeguarding)	30th June 2011	Training reinforced this. Policy is currently being updated.
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 Summary report on safeguarding notifications and investigations to be presented to directors.	QIPE (A. Dir of Gov)	1st August 2011	Safeguarding incident analysis report has been completed and presented to head of safeguarding.
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 and approved with the two local authorities	QIPE (Hd of Safeguarding)	1st August 2011	Policy under review.

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.	QIPE Hd of Safeguarding	May 2011	Safeguarding incident analysis report has been completed and presented to head of safeguarding.
A formal and regular reporting process to the local safeguarding partnerships is established	Protocols to be developed for both Birmingham and Solihull Safeguarding Boards.	QIPE (Hd of Safeguarding)	30th June 2011	Under discussion with Safeguarding boards.
A system is in place for ensuring a higher uptake of safeguarding training across the Trust	Training capacity and operational plans met to achieve full compliance by February 2012.	QIPE (Hd of Safeguardg)	February 2012	Monitoring systems in place.
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 (Hd of Safeguardg)	July 2011	

Outcome 13: Staffing.

Staffing levels (Lavender) do not permit Section 17 leave. Consistency of activity in Lavender ward	A full review of Lavender ward including the clinical leadership is to be undertaken	DSD - AWA	30 June 2011	Review is being arranged to be completed by Mid June.
Nurses wanting to join bank but having to obtain additional CRB checks.	Communication to be issued to reinforce staff awareness of this of streamlined process	ODP (HR)	June	

Outcome 14: Supporting workers.

Provision of training in physical health and also mental health.	The training programme to be reviewed as part of TNA process.	QIPE / OWD	July 11	TNA process underway
Inconsistency in clinical supervision	The full review of the ward and the allocation of staff across all duties will address this.	ODP (HR)	N/A	As above – in progress
Could not tell when staff had last received training.	'Real time' reports to be available from 26 April 2011.	ODP (HR)	29 April 2011	**COMPLETED**
Staff are aware of whom DOLS applies to	Informal admission policy to be approved and approved.	MD	June 2011	Policy in draft form.

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

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 to be double checked through the governance information manager	QIPE (Ass Dir of Gov)	Immediate.	**COMPLETED** Actions have already been taken to improve coding practice and this is being kept under regular review.