

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

REPORT TO THE ASSEMBLY OF GOVERNORS

TO BE HELD ON 5th MARCH 2009

Item:	Clinical Services Report
To be Reported by:	Karen Martin - Deputy Chief Executive Chris Tidman - Director of Resources
Author:	Ros Alstead - Director of Nursing Peter Hughes - Associate Director of Healthcare Governance

PURPOSE OF THE REPORT:

To update the Governors on clinical services issues, particularly changes to the NHS Complaints System

KEY POINTS:

CSCI Inspection – Solihull Adult Health and Social Care

This inspection took place in February 2009. . BSMHFT health and social care staff participated in the inspection as well as the Director of Nursing as our multi agency members of the Adult Safeguarding Board. The inspection included an examination of case files and interviews and visits. Formal feedback has not been received. There does not appear to be any significant issues emerging.

Changes to the NHS Complaints System from April 2009

The Board has previously been informed about BSMHFT invitation to be an early adapter of proposed changed to the complaints system. This has been running since the summer 2008. The Director of Nursing on behalf of the Chief Executive attended the official launch of this new process on February

From April 2009 a single simpler complaints process will be introduced for the NHS and social care in England.

From that date people who are not satisfied with the way the local NHS Organisations has dealt with their complaint following the enhanced local resolution process they can ask the Health Service Ombudsman to look into it. This reduces the complexity removing once stage of the current process the review by the Healthcare Commission social care complaints that are not resolved will be brought to the social care Ombudsman.

The Health Service Ombudsman identifies 5 principles for good complaints handling and administration;

1. Getting it right

2. Being customer focussed
3. Being open and accountable
4. Acting fairly and appropriately
5. Putting things right
6. Seeking customers improvement

Complaints generally want to understand more about what happened/went wrong, why it went wrong and most importantly to ensure it doesn't happen to anyone else. The final guidance is due to be issued in March 2009.

As an early adapter BSMHFT has been implementing some of the key changes, this includes:

- An increased focus on resolution for the individual by involving them directly at the outset throughout the complaint and in understanding what happened and what lessons have been learnt. Local managers have a greater role to play, actively participating with complainants to seek resolution and training activity to support staff, senior managers, particularly the CEO have always been involved in seeking resolution of complex complaints whilst unusual now, this will become the norm for all trusts in the future.
- Timely resolutions of complaints by resolving as many as possible at source – through PALS modern matrons and front line staff, for more complex complaints agreeing a suitable timescale for resolution.
- A single process for health and social care mental health complaints has been in place for 5 years.
- Once referral to the Healthcare Commission is no longer an option, a process for Re-review either within the Trust or by an independent panel will need to be established. This will require a small amount of resources to find panel members time and travel. Referral to the Ombudsman will only take place when all channels for local resolution have been exhausted. If the Ombudsman takes on the complaint it is likely to become a matter to be notified to Monitor as the Ombudsman's findings will be made public.
- Continuing to ensure that there is learning from complaints across out Trust remains a critical activity to minimise the likelihood of reoccurrence of the same complaint.
- The Clinical Governance Committee is considering a detailed implementation plan. BSMHFT as an early adapter is ahead of most NHS & social care organisations and it is recognised that adapting these proposed changes does require a change in culture in all organisations from a paper focussed and target based administration system to a people focussed process with the individuals need for understanding resolution the highest priority.

Nationwide NHS Quality Framework Event

This took place on February 16th in Birmingham where David Nicholson, CEO of the NHS set out how the focus on quality following the next stage review was the key priority for the NHS through the development of Board quality frameworks and quality accounts, the developments of commissioners quality indicators and the development of metrics for clinical quality and safety. A more detailed report together with the final version of BSMHFT Quality Framework is scheduled for March Trust Board with onward briefing to Governors via the Governor Newsletter.

IMPLICATIONS:

Legal:	NA
Assurance:	To provide information on the proposed operation of the new Complaints system and assurance on the CSCI assessment

Training:	NA
Financial:	NA
Other:	NA

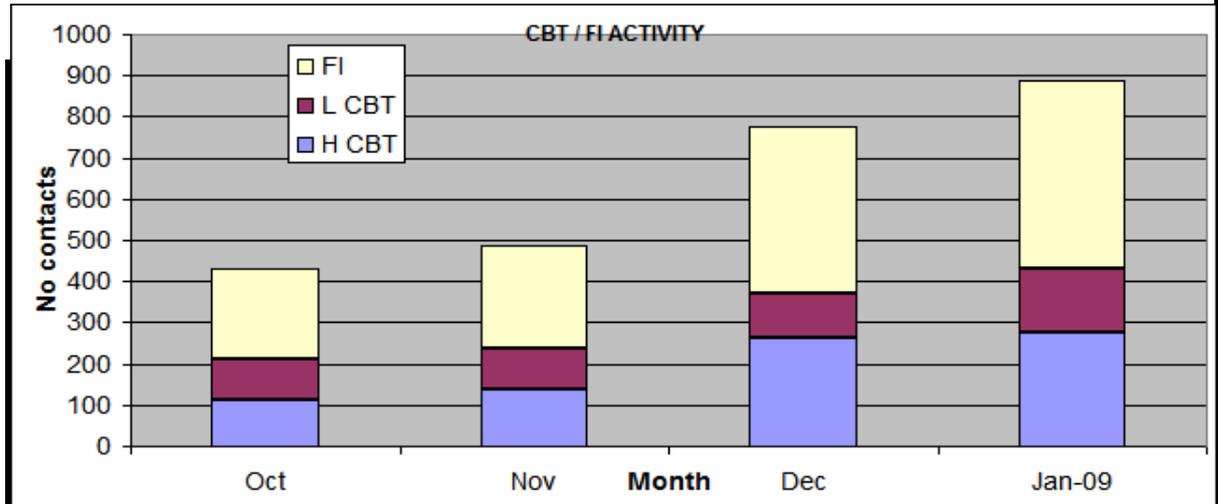
RECOMMENDATION(S):

The Assembly is asked to note this report

CLINICAL GOVERNANCE DASHBOARD

GRAPH 1: CBT (Cognitive Behavioural Therapy) / FI (Family Interventions)

Rationale:	CBT / FI have been 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 new codes introduced in October 08. L CBT = Low intensity, H= High intensity

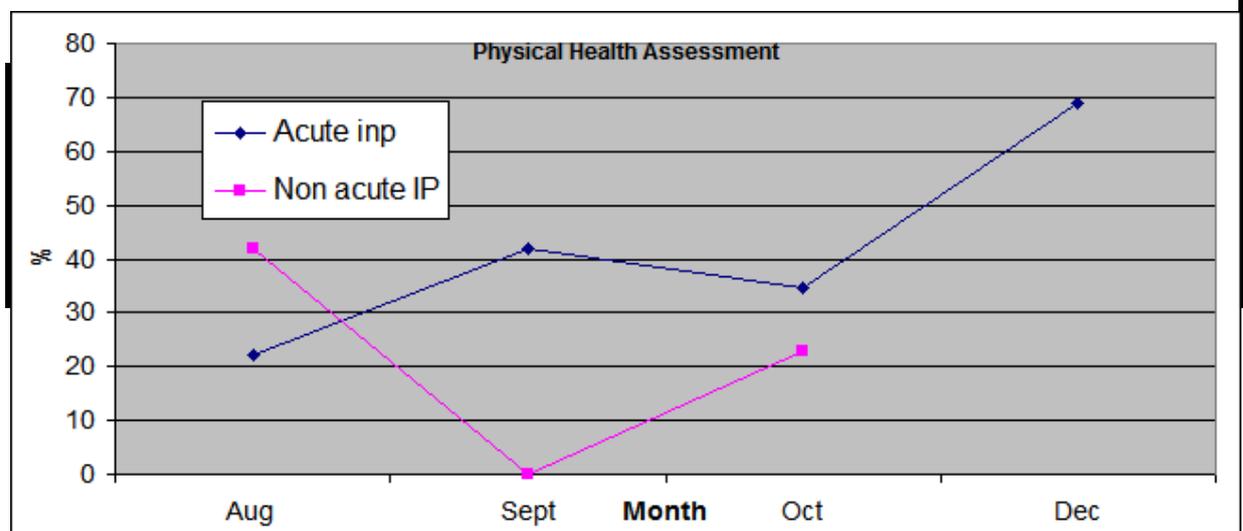


The graph demonstrates an increase in recorded activity of CBT and FBT and follows the introduction of new codes in October 2008. The increase appears to reflect more accurate coding rather than a significant improvement in activity. (Similar data reported in 2007 reflected similar levels of activity -900 contacts over a month.). The provision of CBT and FI presents a significant challenge to meeting the requirements of NICE guidance, as all clinical guidelines have included recommendations in this area.

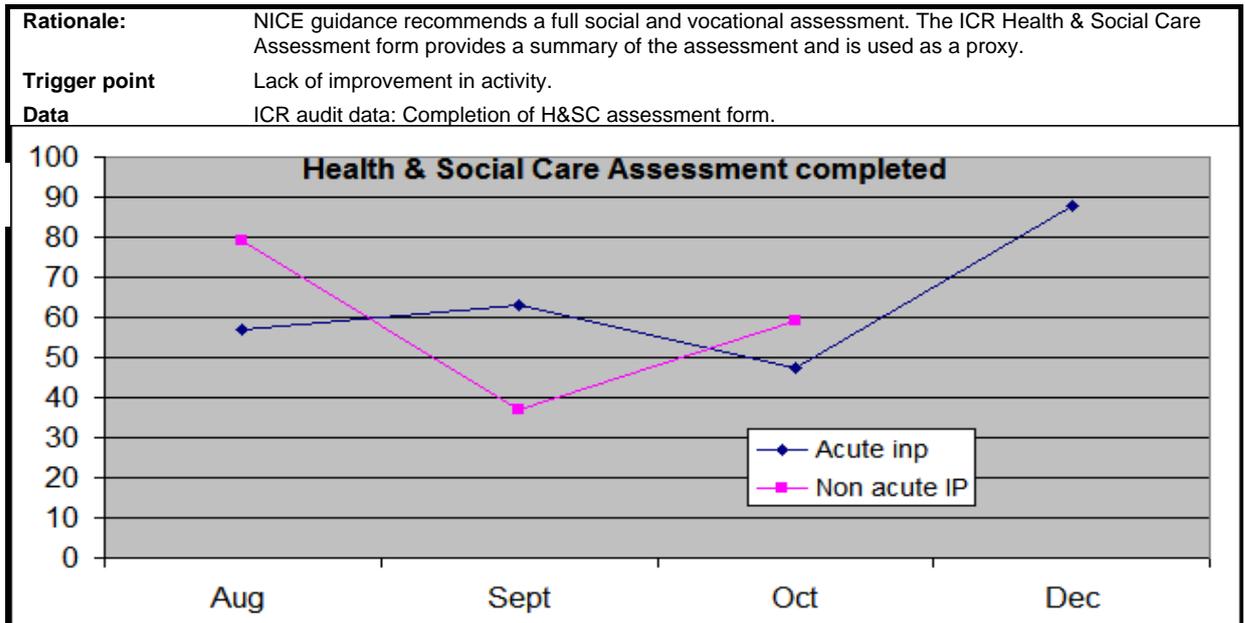
GRAPH 2: PHYSICAL HEALTH ASSESSMENTS

See comments in relation to both graphs (2 & 3) below.

Rationale:	Physical Health Assessments are a key requirement for all Mental Health NICE guidance (also reflected in patient survey). Requirement is to provide a PHA or to have details confirmed by service users GP.
Trigger point	Downward trend
Data:	ICR case note audit

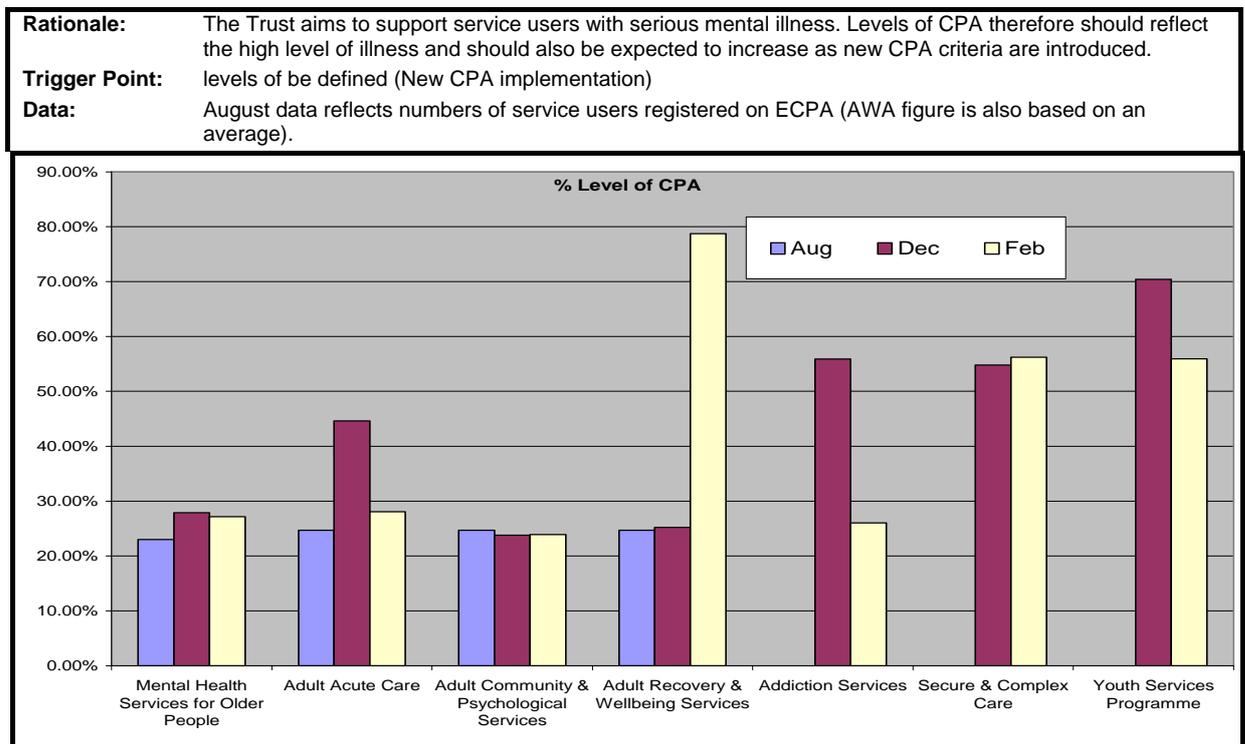


GRAPH 3: SOCIAL CARE ASSESSMENTS



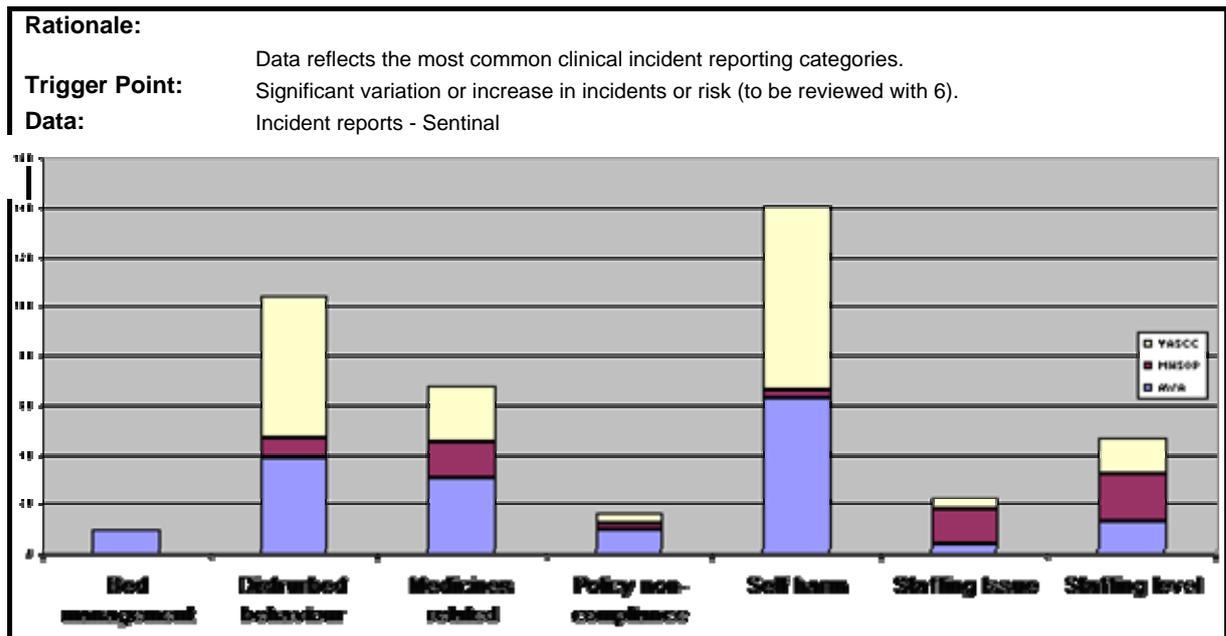
Both graphs relate to data from ICR audits. At present the period of data is limited however this will develop over coming months. Variance between months reflects different samples.

GRAPH 4: LEVEL OF CPA (Care Programme Approach)

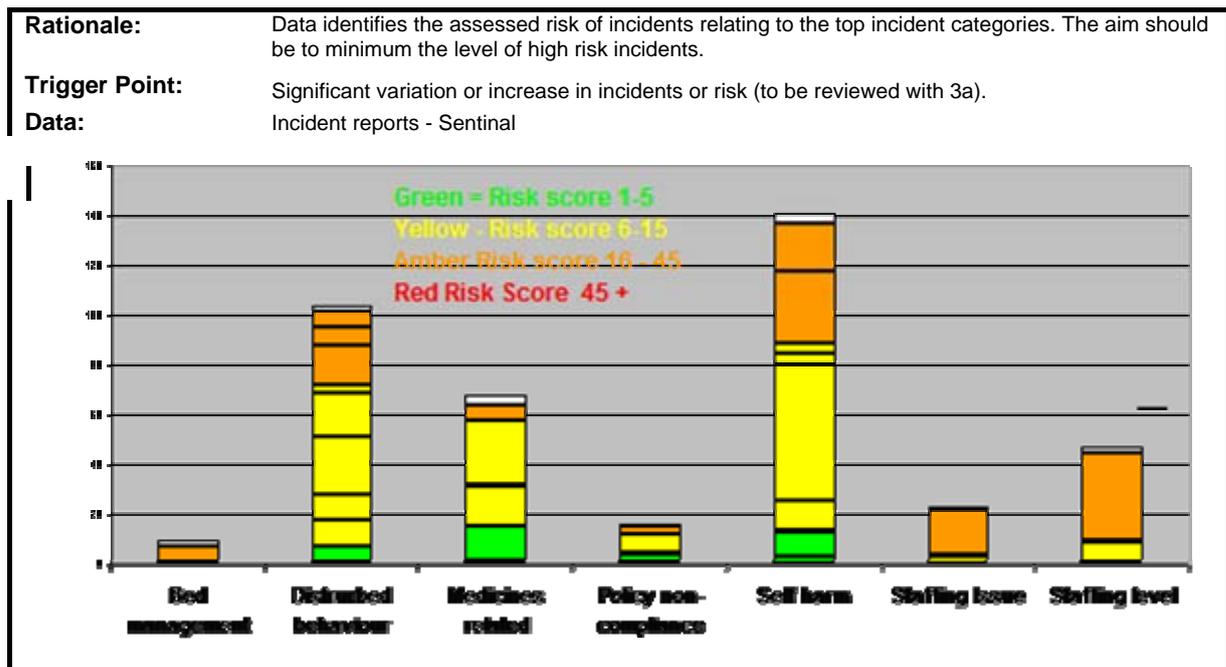


This graph reports on the % of service users registered on CPA. Comparison data for August is used (where this was previously reported) and in relation to AWA this data is aggregated for the whole Division. IN line with Trust policy and best practice all service users should have their care reviewed on an annual basis and therefore this information should indicate a steady increase in the level of service users.

5: TOP INCIDENT CATEGORIES (Trend)



6: TOP INCIDENT CATEGORIES - RISK BREAKDOWN



These two graphs taken together highlight the profile of most recurring incidents and the level of risk reflected by these. Additional work has been identified to review the staffing issues (due to the relatively high level of assessed risk) which are to be reviewed by relevant programmes.