

Birmingham Women's



NHS Foundation Trust

PUBLIC SESSION

MEETING OF THE BOARD OF DIRECTORS
to be held in the Seminar Room, Birmingham Women's Hospital
on Thursday 25th February 2010 at 9 am

AGENDA

		Enc
1	Welcome and apologies Apologies should be sent to Jackie Howell at jackie.howell@bwhct.nhs.uk, tel 0121 627 2601	
2	Questions from the public on matters relating to the agenda	
3	Declarations of interest	
4	Minutes of the meeting held on 28 th January 2010	1
5	Matters arising from the minutes of the meeting held on 28 th January 2010 (where not covered by agenda items)	
PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE		
6	Red Risk Register and Assurance Framework	SIP 2
ASSURANCE		
7	Matron's reports and Infection Control Reports <i>Including presentation by team</i>	JO 3
8	Quarterly Complaints report	JO 4
9	Cancer targets update	JO 5
ORGANISATIONAL PERFORMANCE		
10	Integrated Performance Report, January 2010	JO NS JaB 6

11	Patient Safety Report	PT	7
12	Safeguarding Children Annual Report	JO	8
13	Safeguarding Vulnerable Adults Annual Report	JO	9
14	Trust Chair's report	HH	10
15	Report of the proceedings of the Board in private session	HH	Oral
16	Report by the Chief Executive	SP	11

MEMBERS' COUNCIL MATTERS

17	Update from the Chairman of Council <i>- Meeting of Council, 9th February 2010</i>	HH	Oral
18	Proposals to amend the Trust Constitution	SIP	12
19	Proposal paper re structure of Public Constituencies	SIP	13

CLASS 'A' POLICIES FOR APPROVAL

20	Trust Risk Management Strategy	JO	14
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Dates of next meetings

Thursday 25th March 2010
Thursday 29th April 2010 (Medical School)
Thursday 27th May 2010
Thursday 24th June 2010

Birmingham Women's



NHS Foundation Trust

**Unconfirmed Minutes of the
MEETING OF THE FOUNDATION TRUST BOARD
HELD IN PUBLIC
in the Seminar Room, Birmingham Women's Hospital,
on Thursday 28th January 2010**

PRESENT:	Helen Hemberg Jason Burn David Draycott Nigel Gardner Jane Owen Steve Peak Robin Rison Neil Savage Peter Thompson	In the Chair Interim Finance Director Non-Executive Director Non-Executive Director Director of Nursing & Midwifery Chief Executive Non-Executive Director Director of Workforce & Organisational Development Medical Director
IN ATTENDANCE:	Steve Parsons Sam Pretlove	Head of Corporate Affairs

ACTION

FTP/0110/1 WELCOME AND APOLOGIES

FTP/0110/1.1 The Chairman offered a welcome on behalf of the Board to the visitors to the meeting, and in particular to Sam Pretlove, who was attending all Board sessions as career development.

FTP/0110/1.2 The Chairman also reminded the Board that the Burdett Trust, as part of their work on the Executive Nurse, would be observing the February Board.

FTP/0110/1.3 Apologies for absence were received from Professor Ian Booth (work commitments).

FTP/0110/2 QUESTIONS FROM THE PUBLIC ON MATTERS RELATING TO THE AGENDA

FTP/0110/2.1 Sarah Francis (a Governor attending) indicated that she had questions around items on the agenda, and the Chairman agreed that they could be taken at the appropriate point in the proceedings.

FTP/0110/3 DECLARATIONS OF INTEREST

FTP/0110/3.1 No interests were declared in any item on the agenda for the meeting.

ENCLOSURE 1

FTP/0110/4	MINUTES OF MEETING HELD ON 16th DECEMBER 2009	
FTP/0110/4.1	The minutes of the meeting held on 16 th December 2009 were approved	
FTP/0110/5	MATTERS ARISING FROM THE MINUTES OF THE MEETING HELD ON 16th DECEMBER 2009	
	<u>Constitutional Changes</u>	
FTP/0110/5.1	In response to a question, it was confirmed that it was intended to give a further presentation on the Constitutional proposals to Council, with the Board expected to be asked to decide on the matter in February.	SIP/ HH
	<u>AMMALIFE</u>	
FTP/0110/5.2	It was noted that this issue had now been resolved, and appropriate discussions were being taken forward to develop the relationship.	SP
FTP/0110/6	TRUST CHAIR'S REPORT	
FTP/0110/6.1	The Chairman referred to Enclosure 2, and the following points were noted: <ul style="list-style-type: none">• Issues around the current consultation on extending the NHS Constitution were under active consideration and would be responded to in an appropriate way• The Board's attention was drawn to the proposal to start the public session at 9am, which was believed to represent a more logical ordering of the business of the Board.	SP
FTP/0110/6.2	The Board: <ul style="list-style-type: none">• Noted the report of the Chair• Agreed that the public session of the Board should be held at 9am, with the private session to follow	SIP
FTP/0110/7	MEETING OF THE BOARD IN PRIVATE SESSION	
FTP/0110/7.1	The Chairman reported that the private session of the Board had considered the following items: <ul style="list-style-type: none">• Reports of the proceedings of Board Committees• A review of the performance of the Trust during Q3• Possible impacts on the Trust of the changed funding structures from April 2010, and the business planning associated	

ENCLOSURE 1

ven for the documentation
required for registration with the Care Quality
Commission to be submitted

- A Root Cause Analysis had been considered

FTP/0110/8

REPORT BY THE CHIEF EXECUTIVE

FTP/0110/8.1

The Chief Executive drew the Board's attention to the following points from his report (Enclosure 3):

HIEC's

FTP/0110/8.2

The Trust's bid to be involved with these had been successful, and guidance on implementation was now awaited.

NS

Early Adopter/ Lorenzo

FTP/0110/8.3

The Trust was making progress and remained on schedule for implementation in May 2010; the next stage was a full testing regime prior to implementation. The Board's attention was also drawn to the recent reports of a review of the national IT programme by the Department of Health. It was noted that at this stage there was indication the review findings would affect the current scope of the Early Adopter project.

Execs

NNU Building Scheme

FTP/0110/8.4

The Chief Executive noted that building was going forward on schedule and to budget. He also drew the Board's attention to the proposal to upgrade the link corridor, which had not been included within the original project but would appear to be a necessary variation, given its importance in terms of both presentation, patient experience and safety.

FTP/0110/8.5

In response to a question, it was confirmed that the estimates for the variation had been carefully considered and the Trust's position was protected through the independent project management arrangements. If progress continued satisfactorily, it was possible that the variation could be accommodated through the allowed contingency for the overall project.

JaB

Lean working

FTP/0110/8.6

The Board noted the update in the circulated report, and supported the identified need to apply the principles coherently to advance quality. It had been agreed that NHS Elect would support 8 lean projects within the Trust during the forthcoming financial year, and these would be spread over the portfolio; Directorates had been asked to identify appropriate projects.

ENCLOSURE 1

ESR

FTP/0110/8.7 The Chairman recorded the thanks of the Board to the staff who had put great effort into the data quality on ESR, leading to the Trust obtaining the best rating for ESR data quality in the country.

FTP/0110/8.8 The Board:

- Noted the Chief Executive's report
- Approved the proposed variation to the NNU scheme to address the link corridor

JaB

PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE

FTP/0110/9 Red Risk Register and Assurance Framework

FTP/0110/9.1 The Head of Corporate Affairs referred to Enclosures 4 and 5, and the Board noted the following points:

- Both ORAG and the Clinical Governance Committee were actively reviewing both Red and Amber Risks; these processes were developing to be more effective
- In respect of risk 106 (Financial Income 2010-11), it was confirmed that the controls could not be assessed until the final tariff was published in February 2010
- Reference was made to risk 109 (Radiology Ultrasound machines), and the Chief Executive confirmed that the Management Board had discussed the issues further, and the actions were being addressed through a tender process. It had been decided to replace three machines at once, as representing the best value approach. In response to a question, it was confirmed that issues around maintenance of the machines were under consideration
- Risk 91 (Clinical Genetics Patient Records) was referred to, and it was reported that the issues related to ensuring that appropriate records were available in the community clinic situation; the Trust was looking at space for solutions
- The Board was referred to risk 113 (Somerset database manager), and it was confirmed that this was being addressed in the annual business planning process

JaB

Execs

JO

Execs

FTP/0110/9.2 The Board noted the reports on the red and amber risk registers

ENCLOSURE 1

FTP/0110/11 Patient Experience Reporting

FTP/0110/11.1 The Director of Nursing, Midwifery and Operations presented Enclosure 6 and the following points were noted:

- A number of methods of obtaining patient feedback were currently used; there was a possibility of 'survey fatigue', and the Trust needed to focus the process better
- The current processes were generating a large amount of data, but little usable information
- The intention was to identify consistent areas of research, with clinical area leads having oversight
- It was proposed to manage this as a project for an initial 12 months, with responsibility then devolving to the Directorates under the supervision of the Executive lead
- The Management Board had discussed the proposal and were supportive in principal, although there had been discussion about the proposal to retain a project manager. It was noted that capacity issues were driving that proposal

FTP/0110/11.2 The Board noted the following points during discussion:

- A focus on this area was important given the impact of both CQC requirements and CQUIN's **JO**
- In response to a question, it was confirmed that internal applicants for the project management position would be welcomed, but there would still be a need to provide cover for 'the day job' if there was a secondment
- These matters needed to feed into a larger organisational development strategy, which was under development and would include items arising from the Listening into Action document. **NS**
- There was a small investment which would lead to significant potential returns
- There was a large amount of data being collected within the organisation, and a need had been identified to enable this to be analysed to enable understanding; the development of CQUIN-led funding would also drive this need forward
- There were large numbers of initiatives to improve patient experience that the data would support, but these could not be identified without a proper analytical process. The Trust needed to address these as an investment in quality and safety
- In response to a question, it was confirmed that Governors input into the system would be sought, with a view to their active involvement when it was established **JO**

ENCLOSURE 1

- FTP/0110/11.3 The Board:
- Agreed in principle with the approach set out in the paper
 - Agreed to the main areas of focus as set out in the paper
 - Noted that this area will be included within planning
 - Requested that the Board receive frequent update reports to monitor progress **JO**
 - Noted that research into the practice in other Trusts will inform the process **JO**

ASSURANCE

FTP/0110/12 Cancer Targets update

- FTP/0110/12.1 Jane Owen presented Enclosure 7, and the following points were noted:
- Progress with the action plans was generally on target, although some items were running slightly behind schedule
 - The performance targets had been achieved for Q3, although this had involved use of the 6% allowance agreed by Monitor and CQC
 - The Management Board was examining in detail potential breaches of the 62-day pathway **Man Bd**

FTP/0110/12.2 The Board noted the report.

FTP/0110/13 Integrated Performance Report

- FTP/0110/13.1 Jane Owen presented the reports for both November and December 2009, and the following points were noted:
- The Management Board had considered in detail the issues around the delays in responding to complaints; the PCT were also taking an active interest. Training and analysis were being undertaken in this area **JO/ Man Bd**
 - It was noted that the stillbirth rates were now reported in three places; the Board agreed that they should be withdrawn from the dashboard in favour of the patient safety report **JO**
 - A question was raised as to whether the total headcount numbers should be reported within the dashboard; this would be reviewed further outside the meeting **NS**

FTP/0110/13.2 Neil Savage referred the Board to the workforce data, and the following points were noted:

ENCLOSURE 1

- Of the 10 indicators, 6 showed positive change, 2 were level, and 2 adverse change
- There had been 2 consecutive months of improvement in sickness absence; this resulted from a significant resource investment. The Management Board had also approved additional interventions
- Staff with PDR's within the past 12 months were disappointing at 42%. However, the initial results from the staff survey indicated a level of about 47%, so there could still be reporting issues to be resolved **NS**
- Pay as a percentage of income was noted, and it was reported that the variations were believed to reflect natural movements. It was also suggested that the current benchmark was unrealistically low, having happened to have been at 58.96% at the year-end; a target in the lower 60%'s might be more realistic. It was noted that the target submitted to Monitor was in the mid-to-high 60%'s, and the Board favoured a return to this approach. **Execs**
- Attention was drawn to the Internal Audit review of the dashboard and the risks of inaccuracy that had been identified in a manual procedure to complete it
- It was noted that the vast majority of the Trust's resource was people-based, and therefore benchmarking needed to be approached with caution; there were also differing ways of organising services, such as outsourcing, which meant that like-for-like comparisons were rare
- The Board agreed that the target for pay as a percentage of income should be reviewed for the following financial year **JaB**
- The progress of the Trust relating to membership was noted

FTP/0110/13.3

Jason Burn referred the Board to the Finance Report, and the following points were noted:

- The surplus at the end of December was £793k, £347k above plan and converting to an FRR of 4. The range for the year-end forecast was now £0.8m to £1.2m.
- In response to a question, it was confirmed that Monitor will wish understand the reasons for over-performance, but will worry less about missing plan on that side
- The position with Clinical Support remained concerning, and was being subjected to a line-by-line analysis. The new Associate Director would need to focus on performance, and the new performance monitoring arrangements would also address this across all Directorates **Execs**
- CIP's continued to perform well, with only £38k

ENCLOSURE 1

	<p>considered as Red and £469k as Amber. The split had improved slightly but was still considerably away from the target; these would be validated through annual planning, to identify any where a cautious approach was leading to mis-classification.</p> <ul style="list-style-type: none">• The FRR rating was on the border between 3 and 4- it happened to round to 4 this month, but could round to 3 on a small variation• Debtors over 90 days were holding position, but it was noted that more work needed to be done in this area• It was confirmed that elective underperformance had been included within the figures• It was suggested that the capital spend was behind track, and assurance sought that it would be met in year; the Director of Finance confirmed that this was the expectation, and necessary arrangements had been made, but this was dependent on the timing of the NNU contractor's invoices. The cash-flow had been based on the contractor's own projections• It was suggested that Monitor were really seeking good evidence of control, to be identified by minimal variation from plan; this might suggest that more hands-on support from the Executive team for Clinical Support's Associate Director would be necessary.• It was noted that there were significant forecast end of year variations in individual Directorates indicated in the supporting pack, and the Board should understand the position to ensure that the line was at least held; Mr Burn commented that the forecast had started with the plans submitted, but several were affected by additional spending for which the related additional income could not be linked under Monitor's reporting rules. It was noted that Monitor were proposing a half-year reforecast, which would be a step forward.• The Board would need to consider the split between recurrent and non-recurrent CIP's in the future, possibly with a view to reducing it to 60:40 or less	<p>Execs</p> <p>JaB</p> <p>JaB</p> <p>Board</p>
FTP/0110/13.4	The Board noted the Integrated Performance Report.	
FTP/0110/14	Patient Safety Report	
FTP/0110/14.1	<p>The Medical Director presented Enclosure 10, and the following points were noted:</p> <ul style="list-style-type: none">• This was the first of a monthly series of reports; the figures reflected a 15th January 2010 start-date, apart from MRSA and <i>C.Diff</i>.• Mortality rates had been included, and it was	

ENCLOSURE 1

- intended to develop the commentary around these; perinatal reporting was also intended to be developed **PT**
- The report would also include appropriate information regarding Serious Untoward Incidents and the Executive walkabout programme **PT**
 - It was intended that safety themes identified from the walkabout programme would be included on a quarterly basis
 - The inclusion of SUI data in the dashboard would be reviewed **Execs**
- FTP/0110/14.2 The following points were made in discussion:
- It was still intended to include Non-Executive Directors, and in due course Governors, in the walkabout programme, and this would be reviewed with the Board in due course. However, this was a new process and the organisation was still becoming comfortable with this new approach. **Execs**
 - There was now a weekly e-mail from the Medical Director to all Trust staff to provide information on the previous 7 days' performance, ensuring immediate feedback on Trust performance.
- FTP/0110/14.3 The Board noted the Patient Safety report.
- (Mr Gardner left the meeting)
- FTP/0110/15 Monitor Quarter 3 return**
- FTP/0110/15.1 The Head of Corporate Affairs presented the draft return (Enclosure 11), and the following points were noted:
- There was a typographical error in the papers, in that the Trust had achieved 79% for the 62-day cancer target rather than 89%. However, this remained within the band for a green governance rating
 - The Trust had achieved all other national and Monitor targets, and therefore a green governance return and Declaration 1 (compliance) was recommended
 - The return also gave details of changes to the Board and Members' Council
- FTP/0110/15.2 The Board
- Approved the making of a green governance return and Declaration 1 (compliance) in respect of Quarter 3 of 2009-2010
 - Authorised the submission of the Declaration and supporting documents to Monitor **JaB/ SIP**
 - Congratulated those involved in ensuring that the

ENCLOSURE 1

Trust had met the 62-day target for Q3.

MEMBERS' COUNCIL MATTERS

FTP/0110/16 Report of the Members' Council Chair

FTP/0110/16.1 The Chairman noted that there had not been a meeting of Council, and that at the meeting on 9th February Governors would be invited to be involved in the planning process, prior to requesting their formal commentary in the March meeting.

CLASS 'A' POLICIES FOR APPROVAL

FTP/0110/17 Use of the auditor for non-audit services

FTP/0110/17.1 The policy (Enclosure 12) was presented, and the Board noted that it had been considered and recommended for approval by the Audit Committee.

FTP/0110/17.2 Subject to leave to correct any formatting changes, the Board approved the policy.

Dates of next meetings

Thursday 25th February 2010

Thursday 25th March 2010

Thursday 29th April (Stanley Barnes Room, Medical School)



SUBJECT :	Red Risk Register
REPORT BY :	Steve Parsons, Head of Corporate Affairs
AUTHOR :	Steve Parsons, Head of Corporate Affairs

CONTEXT AND BACKGROUND FOR REPORT

The Board, as part of its risk monitoring strategy, receives a monthly report on the identified 'Red Risks' for the Trust. This report includes an indication of the adequacy of controls for the risk identified, as Adequate, Inadequate or Uncertain.

The attached paper extract is valid on the date of production, 15th February 2010. As the risk register is a live document, further work will have been undertaken between this date and the date of the Board meeting.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

Changes to the red risk register since the last report

One new red risk has been added to the register since the previous Board report- risk number 113, relating to training on medical devices. In addition, a decision has been taken to re-open risk 83 in respect of not meeting the cancer referral to treatment target in Gynaecology

Review and assurance

At its meeting on 11th February, ORAG reviewed the red risk register entries that related to corporate risks. It also reviewed an amber risk selected at random, and intends to continue this approach.

At its meeting on 8th January, the Clinical Governance Committee held an in-depth review of the red risks related to the Maternity Directorate, and identified where further assurance was needed.

RECOMMENDATIONS

ENCLOSURE 2

The Board is invited to note the Red Risk Register as presented, and the assurance work undertaken respectively by the Clinical Governance Committee, and the Organisational Risk and Governance Committee.

CURRENT RED RISKS							
ID	Title	Opened	Review date	Risk Type	Risk Subtype	Adequacy of controls	Manager
3	Norton Court	14/10/08	31/03/10	Corporate	Complex		Neil Savage
6	Delivery of the laboratory Down's Screening Service	13/12/07	02/02/10	Corporate	Complex		Helen Samson
8	Neonatal Unit capacity	01/03/05	29/01/10	Clinical	Clinical		Michele Emery
9	Lack of midwifery staff	12/10/06	31/03/10	Clinical	Clinical		Jenny Henry
10	Delivery of category 1 caesarean section within 30 minutes	28/08/07	31/03/10	Clinical	Complex		Becky Williams
83	Not meeting cancer waiting times - Gynaecology (This risk re-opened)	12/03/09		Corporate	Complex		Masood Afnan
98	Risk to Trust services from Pandemic Flu	03/07/06	31/01/10	Corporate	Organisational		Steve Peak
100	CCL Maternity Information System	07/08/09	31/12/09	Clinical	Compliance		Tracey Johnston
102	Insufficient Radiologist cover for neonatal directorate	29/09/09	29/01/10	Clinical	Clinical		Imogen Morgan
106	Financial Trust income 10/11	27/10/09	25/01/10	Corporate	Financial		Damon Harris
109	Radiology - Ultrasound Machines	17/11/09	31/03/10	Clinical	Clinical		Samantha Mattis
111	Compliance with Cancer Waiting standards	05/01/10	16/02/10	Corporate	Compliance		Delreita Bernard
112	Compliance with Cancer Waiting standards for treatment at Cancer Centre	05/01/10	16/02/10	Corporate	Compliance		Delreita Bernard
113	Medical Devices Training	12/01/10	21/01/10	Clinical	Compliance		Jane Owen

15th February 2010

SUBJECT :	Matron's reports Q3 2009-2010
REPORT BY :	Jane Owen DIPC
AUTHOR :	Michelle Emery, Jacky Cotton, Justine Jeffrey Charlotte King

CONTEXT AND BACKGROUND FOR REPORT

These reports provide information on issues affecting infection prevention and control, across the directorates. They have been presented and discussed in full at the January Infection Control Committee.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

- The format of the reports has been amended to give greater clarity and assurance and now covers all areas of activity relating to infection prevention and control.
- Hand hygiene compliance remains below the 95% target in some staff groups
- Compliance with audit of high impact interventions needs to improve within maternity services. Actions are in place to address this
- Systems for ensuring cleaning of medical equipment are under review

RECOMMENDATIONS

To discuss and note the content of these reports



**DIRECTORATE REPORT TO
THE INFECTION PREVENTION & CONTROL COMMITTEE**

Quarterly period	October - December 2009
Directorate	Gynaecology
Matron	Jacky Cotton

1. Infection Control Surveillance

1.1 Newly detected cases of colonisation or infection with MRSA

4 cases (2 detected at pre-op screening and deemed to have been acquired elsewhere. 1 detected at preop screening – had previously been positive and husband was also positive so treated before admission. Deemed to have been acquired elsewhere

1 detected when patient transferred in from another unit).

1.2 Mandatory MRSA & VRE bacteraemia surveillance

No cases to report

1.3 Mandatory Clostridium difficile surveillance

No cases to report

2. Audit Data

HAND HYGIENE AUDITS (Compliance Scores - Green \geq 95% Amber 90 – 94% Red \leq 89%)				
Ward/Dept	Oct	Nov	Dec	Process used to feed back results to all ward staff
Ward 7	80%	80%	95%	Graphs on display Discussed at ward meetings
Ward 8	80%	90%	75%	Graphs on display Discussed at ward meetings
Exception Report – action undertaken for compliance scores < 95%				
Nursing staff consistently above standard- other staff groups below it in both ward areas. More work required to meet standard. Ward managers constantly reminding staff in ward areas of need to undertake hand hygiene after contact with patient environment Actions planned: <ul style="list-style-type: none"> • Ward managers to raise at Staff meetings • Head of Nursing/Clinical Director to raise at consultant meeting • Head of Nursing to raise with Head of Facilities 				

WARD KITCHEN AUDITS (Compliance Scores - Green ≥ 85%, Amber 76 – 84% Red ≤ 75%)			
Ward	Month	Score	Process used to feed back results to all ward staff
Ward 7	Nov	96%	Discussed at ward meetings
Ward 8	Nov	100%	Discussed at ward meetings
Exception Report – key areas of non-compliance & actions taken			
Ward 7: Toaster – crumbs and debris were evident. Housekeepers to clean toaster. Ward 8: No issues identified			

STANDARD PRECAUTIONS (Compliance Scores - Green ≥ 85%, Amber 76 – 84% Red ≤ 75%)			
Ward	Month	Score	Process used to feed back results to all ward staff
Ward 7	Dec	84%	Discussed at ward meetings
Ward 8	Dec	83%	Discussed at ward meetings
Exception Report – key areas of non-compliance & actions taken			
<p>Ward 7 Yellow aprons not easily available for isolation rooms Disposable gloves not easily available for isolation rooms. Goggles not available Spill packs not immediately available</p> <p>Ward 8 Staff knew how to access IC policies but not specific one relating to standard precautions Disposable gloves not easily available for isolation rooms. Goggles not available Disposable face masks not available</p> <p>On both wards, managers addressing these deficits. In the case of yellow aprons and disposable gloves not being readily available for isolation facilities, this may be because the area was not used for isolation at time of audit. When a patient is being isolated, a trolley is made available outside the room with appropriate protective clothing. The apron dispensers outside the rooms usually have white aprons in as these are used far more frequently than yellow ones as patients often nursed in single rooms for reasons other than isolation e.g. medical management of miscarriage. Glove dispensers now restocked</p>			

3. Patient Environment & Medical Equipment Cleanliness

Quarterly Environment Audit		
Ward/Dept	Audit Completed (Y/N)	Score
Ward 7	Y	98%
Ward 8	Y	98%
EPAU	Y	87%
Exception Report Key areas of non-compliance that could not be resolved locally & actions taken		
Whiteboards above beds now written on to indicate bed space has been cleaned		

Ward 7

Sharps container in lift bay

Some handgel dispensers still missing drip trays – orders being placed by ward manager

Ward 8

2 beds missing handgel dispensers at end of bed.

Some handgel dispensers still missing drip trays – orders being placed by ward manager

EPAU

Main areas of non-compliance related to dusting of patient trolleys, blinds, air vents, high surfaces and workstation. Areas of responsibility clarified between clinic and housekeeping staff.

Medical Equipment Cleanliness Audit				
		Oct	Nov	Dec
Ward 7	Audit Completed (Y/N)	Y	Y	Y
	Score (%)	100%	100%	100%
Ward 8	Audit Completed (Y/N)	Y	Y	Y
	Score (%)	92%	94.8%	97.4%
EPAU	Audit Completed (Y/N)	Y	Y	Y
	Score (%)	88%	100%	100%
Exception Report				
Key areas of non-compliance that could not be resolved locally & actions taken				
Ward 8				
Main area of non-compliance related to dust around computers on nurses' workstation				

Mattress and Pillow Audit		
Ward	Audit Undertaken (Y/N)	Date
Ward 7	No	Due Q4
Ward 8	No	Due Q4
Exception Report – key issues identified & actions taken		

ENCLOSURE 3

4. High Impact Interventions

No. 2a PVC Insertion						
Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
Ward 7	5	1		Hand Hygiene		
Ward 8	5	5		Correct PPE & documentation		
EPAU	5	12		Correct PPE		

No. 2b PVC On-going care						
Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
Ward 7	5	8		Cannula access – use of correct skin prep		
Ward 8	5	7		Dressing - soiled		

No. 6a Urinary Catheter Care - Insertion						
Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
Ward 7	5	3		None		
Ward 8	5	4		None		

No. 6b Urinary Catheter Care – On-going care						
Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
Ward 7	5	2		None		
Ward 8	5	0		N/A		

5. Response to recent national guidance

Planning being undertaken to implement MRSA screening for all patients.

6. Progress against key objectives in the Annual Programme

Further work required by Head of Nursing to implement full range of relevant audits in outpatient areas

7. MRSA Screening Compliance

All patient seen in preoperative assessment screened during assessment procedure. Snapshot audit identified some elective patients attending Outpatient Hysteroscopy clinics as not being screened. On investigation these patients were undergoing diagnostic outpatient hysteroscopy procedures and so were not elective admissions but showed up due to an anomaly of coding. Patients admitted to Ward 7 as day cases for operative hysteroscopy in One stop clinic are being screened.

8. Antibiotic Use

Revised formulary agreed for use in gynaecology directorate. Monitoring of patients who are inpatients for longer than 6 days continues on weekly basis.

9. Untoward Incidents

1 incident reported of a sharp's needle from an intravenous cannula being found by a patient's bed

1 incident reported of a needlestick injury after administering an IM injection.

1 incident reported of an inoculation injury whereby staff member sustained splash to eye of transport medium when putting swab into medium. All appropriate action taken



**DIRECTORATE REPORT TO
THE INFECTION PREVENTION & CONTROL COMMITTEE**

Quarterly period	October - December 2009
Directorate	Maternity
Matron	Justine Jeffery

3. Infection Control Surveillance

1.4 Newly detected cases of colonisation or infection with MRSA

2 cases (detected via pre-admission screening)

1.5 Mandatory MRSA & VRE bacteraemia surveillance

No cases to report

1.6 Mandatory Clostridium difficile surveillance

No cases to report

4. Audit Data

HAND HYGIENE AUDITS (Compliance Scores - Green ≥ 95% Amber 90 – 94% Red ≤ 89%)				
Ward/Dept	Oct	Nov	Dec	
				Process used to feed back results to all ward staff
Ward 1	95%	80%	90%	Displayed in ward area.
Ward 3		100%	88%	Staff made aware at team meeting as midwives reducing overall %. Medical staff at 100%
Ward 4		95%	88%	Staff made aware at team meeting as midwives reducing overall %. Medical staff at 100%
Delivery Suite	80%	90%	90%	Raising awareness sessions for medical staff introduced for infection control week in November with a positive response.
Exception Report – action undertaken for compliance scores < 95%				
<u>Delivery Suite</u>				
Hand hygiene awareness sessions introduced for one week during the November infection control week. Medical staff provided with information around hand hygiene. Percentage continues to rise over the quarter.				

Database figures displayed for staff and visitors to view.

Ward 1

The figures for this quarter appear to be falling, however it is noted by the area that the previous audits were not completed correctly and this is now a more accurate assessment.

Ward 3&4

There is now an identified infection control lead for this area and awareness amongst the team is now being raised.

WARD KITCHEN AUDITS (Compliance Scores - Green \geq 85%, Amber 76 – 84% Red \leq 75%)			
Ward	Month	Score	Process used to feed back results to all ward staff
Ward 1	Nov	93%	
Ward 3	Nov	93%	
Ward 4	Nov	96%	
Delivery Suite	Nov	85%	
Birth Centre	Nov	81%	
Exception Report – key areas of non-compliance & actions taken			
<p>Delivery Suite- Kettle required as water heater currently out of service-estates aware. No other inappropriate items noted following inspection. Cupboards and drawers clean. Bread bin cannot store the large amount of bread delivered to the department. Toaster remains full of crumbs-housekeeper reminded.</p> <p>Birth Centre-bread bin ordered. Inappropriate items removed. No uncovered food noted since inspection. Unlabelled food in fridge-manager to discuss with staff.</p> <p>Minor problems completed at ward level.</p>			

STANDARD PRECAUTIONS (Compliance Scores - Green \geq 85%, Amber 76 – 84% Red \leq 75%)			
Ward	Month	Score	Process used to feed back results to all ward staff
Ward 1	Dec	88%	
Ward 3	Dec	92%	
Ward 4	Dec	80%	
Exception Report – key areas of non-compliance & actions taken			
<p>No feedback available from areas.</p>			

10. Patient Environment & Medical Equipment Cleanliness

Quarterly Environment Audit		
Ward/Dept	Audit Completed (Y/N)	Score
Ward 1	Yes	100%
Ward 3	Yes	94%
Ward 4	Yes	96.5%
Delivery Suite	Yes	72%
Exception Report		
Key areas of non-compliance that could not be resolved locally & actions taken		
<p><u>Delivery Suite</u></p> <p>It has been identified that cleanliness standards and the standard of the environment have fallen during this quarter. It was also noted that many room are missing a variety of dispensers-request sent to Estates Jan 2010. Some works already completed by the estates department to improve compliance in the triage area. An action plan has been developed to address a number of issues identified by the audit and the ICT.</p> <p><u>Ward 1</u></p> <p>No issues raised</p> <p><u>Ward 3/4</u></p> <p>No issues raised that have not been dealt with locally. Only one request made to the estates department.</p>		

Medical Equipment Cleanliness Audit				
		Oct	Nov	Dec
Ward 1	Audit Completed (Y/N)	Y	Y	
	Score (%)	100%	100%	No results
Ward 3	Audit Completed (Y/N)	N	N	Y
	Score (%)			94%
Ward 4	Audit Completed (Y/N)	N	N	Y
	Score (%)			94%
Delivery Suite	Audit Completed (Y/N)	Y	Y	Y
	Score (%)	79%	82%	76%
Exception Report				
Key areas of non-compliance that could not be resolved locally & actions taken				

Ward 1

No issues raised

Ward 3&4

Staff reminded of responsibility for completing the documentation with regards to questions 1-3

Delivery Suite

It has been identified that medical equipment is often dusty on the bases and at high level. As part of the action plan a new procedure for weekly cleaning is to be introduced for 2010.

Matress and Pillow Audit		
Ward	Audit Undertaken (Y/N)	Date
Ward 1	Yes	December
Ward 3	Yes	December
Ward 4	Yes	December
Delivery Suite	Yes	December
Exception Report – key issues identified & actions taken		
<p><u>Delivery Suite</u></p> <p>Birthing bed mattresses checked and some covers noted to be discoloured (appears to be bleaching). The covers were intact, however these were removed and new covers ordered. 2 resuscitaire mattresses replaced and a further order made to ensure replacement readily available. 1 complete birthing mattress also available.</p> <p><u>Ward 3&4</u></p> <p>All mattresses checked. 2 mattresses noted to be soiled, removed and replaced immediately. Pillow audit completed and a number of pillows disposed.</p> <p><u>Ward 1</u></p> <p>No issues raised from the audit carried out by ward 1</p>		

ENCLOSURE 3

11. High Impact Interventions

No. 1a CVC Insertion						
Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
DS - HDU	5	6	Average CVC insertion 2 per month	None	The number of suggested observations is not achievable. To discuss with ICT and reset.	

No. 1b CVC On-going care						
Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
DS - HDU	5	6	Average CVC insertion 2 per month	None	The number of suggested observations is not achievable. To discuss with ICT and reset.	

No. 2a PVC Insertion						
Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
Ward 1	5	0	No results received			
Ward 3	5	5	n/a	Personal protective equipment and documentation. Gloves used but no apron	Member of staff informed.	
Ward 4	5	5	n/a			

ENCLOSURE 3

DS	5	5	n/a	Poor use of aprons and completion of documentation..	New pack identified and to be shared with ICT for consideration	
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No. 2b PVC On-going care

Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
Ward 1	5	0	Results not received			
Ward 3	5	0	Results not received			
Ward 4	5	0	Results not received			

No. 6a Urinary Catheter Care - Insertion

Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
DS	5	0	It has been identified that the department will not be compliant as the sterile pack often used for catheterisation does not contain a sterile field.		Alternative packs being sourced. This has been identified as a cost pressure for the Directorate.	Communication meeting.

ENCLOSURE 3

No. 6b Urinary Catheter Care – On-going care						
Ward	Target No. obs per week	No. obs in Quarter	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
Ward 3	5	0	Newly appointed link			
Ward 4	5	0	Newly appointed link			
DS	5	0	Ongoing care will take place in the post natal areas.			

DS – Delivery Suite



**DIRECTORATE REPORT TO
THE INFECTION PREVENTION & CONTROL COMMITTEE**

Quarterly period	October - December 2009
Directorate	Neonatal
Matron	Michele Emery/ Charlotte King

5. Infection Control Surveillance

1.7 Newly detected cases of colonisation or infection with MRSA

1 case (baby in the community, mum known to be colonised)

1.8 Mandatory MRSA & VRE bacteraemia surveillance

No cases to report

1.9 Mandatory Clostridium difficile surveillance

No cases to report

6. Audit Data

HAND HYGIENE AUDITS (Compliance Scores - Green \geq 95% Amber 90 – 94% Red \leq 89%)				
Ward/Dept	Oct	Nov	Dec	Process used to feed back results to all ward staff
NNU	90%	75%	85%	Email to all staff highlighting areas for improvement. Results displayed publicly at NNU entrance.
TC	100%		100%	Congratulations to all staff via email. Results displayed publicly
Exception Report – action undertaken for compliance scores < 95%				
Spot checks undertaken by Head of Nursing and Infection Control Lead. Local notices and constant encouragement through team meetings to improve results. Individuals targeted. On going hand hygiene education continues.				

WARD KITCHEN AUDITS (Compliance Scores - Green ≥ 85%, Amber 76 – 84% Red ≤ 75%)			
Ward	Month	Score	Process used to feed back results to all ward staff
TC	Nov	93%	Results communicated to ward manager and disseminated to staff via email and communication at shift handover.
Exception Report – key areas of non-compliance & actions taken			
Cupboard below the sink requires replacement as laminate damaged. Quotation for replacement to be obtained. Staff reminded that food is to be stored in labelled containers.			

STANDARD PRECAUTIONS (Compliance Scores - Green ≥ 85%, Amber 76 – 84% Red ≤ 75%)			
Ward	Month	Score	Process used to feed back results to all ward staff
NNU	Dec	96%	Improved results communicated to staff by email.
TC	Dec	92%	Improved results communicated to staff by email.
Exception Report – key areas of non-compliance & actions taken			

12. Patient Environment & Medical Equipment Cleanliness

Quarterly Environment Audit			
Ward/Dept	Audit Completed (Y/N)	Score	
NNU	Y	Nov: 78%	Dec: 90%
TC	Y	94%	
Exception Report Key areas of non-compliance that could not be resolved locally & actions taken			
NNU environmental audit repeated in December following poor results in November's audit. The main cause for concern in November was dust however following increased monitoring and communication the results show a marked improvement in December. Health Care Assistants will now be aiding compliance with this activity.			

Medical Equipment Cleanliness Audit				
		Oct	Nov	Dec
NNU	Audit Completed (Y/N)	N	Y	Y
	Score (%)		72%	80%
TC	Audit Completed (Y/N)	N	N	Y
	Score (%)			89%
Exception Report Key areas of non-compliance that could not be resolved locally & actions taken				

The accumulation of dust continues to raise concerns on the NNU. Nursing staff are trained on the importance of cleaning the baby's environment and medical equipment, however, at busy times this is missed. Extra Health Care Assistants have now completed their induction programme and will be undertaking damp dusting as part of their daily routine to ameliorate this problem.

Intravenous drug stand on TC was found to be dusty. Also there is no record of cleaning blood pressure cuffs for adults – to be added to cleaning schedule. Babies' cuffs are disposable.

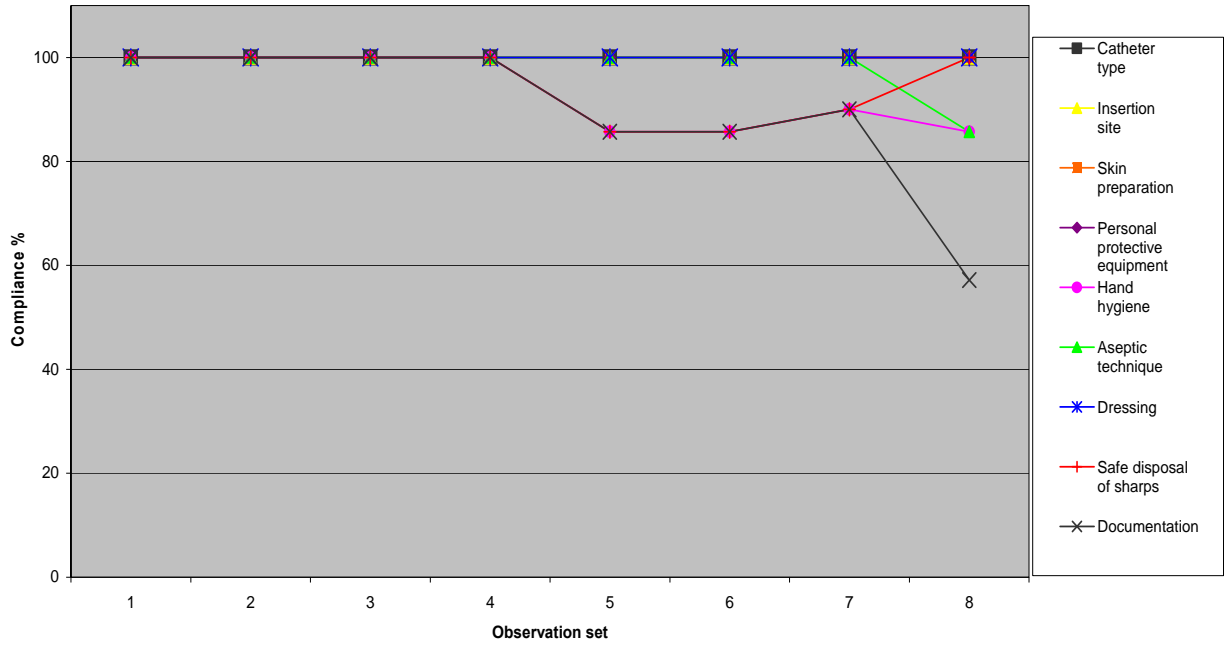
Staff given feedback concerning results both individually and via email. Monitoring frequency to be increased until results improve.

Mattress and Pillow Audit		
Ward	Audit Undertaken (Y/N)	Date
NNU	N	
TC	Y	December 2009
Exception Report – key issues identified & actions taken		
See Appendix 1		
!0 adult mattresses were audited on Transitional Care. Five mattresses were found not to have numbers.		
One mattress was found to be wet and stained inside and was immediately discarded and replaced.		

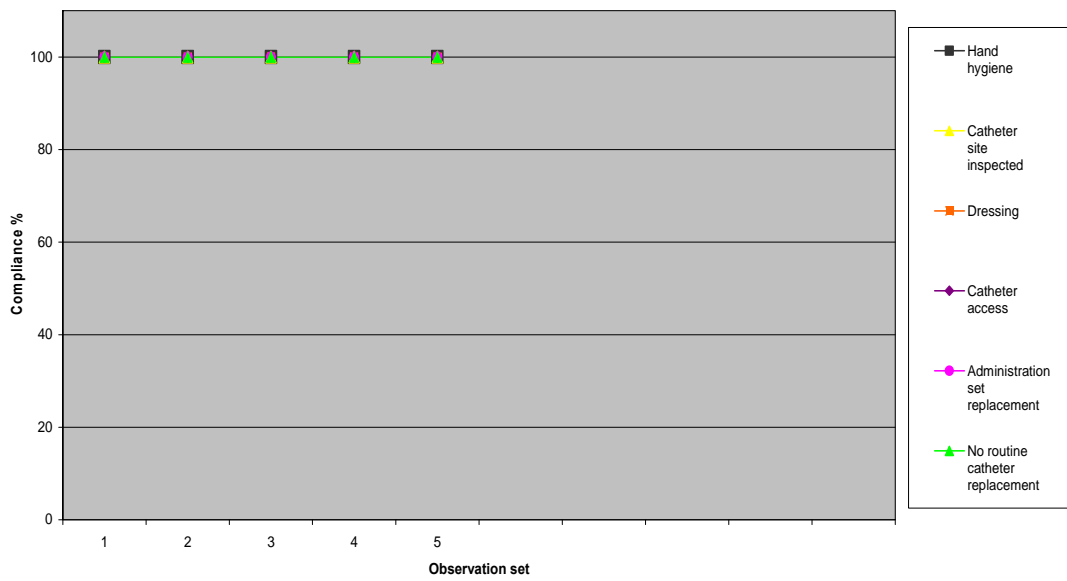
13. High Impact Interventions

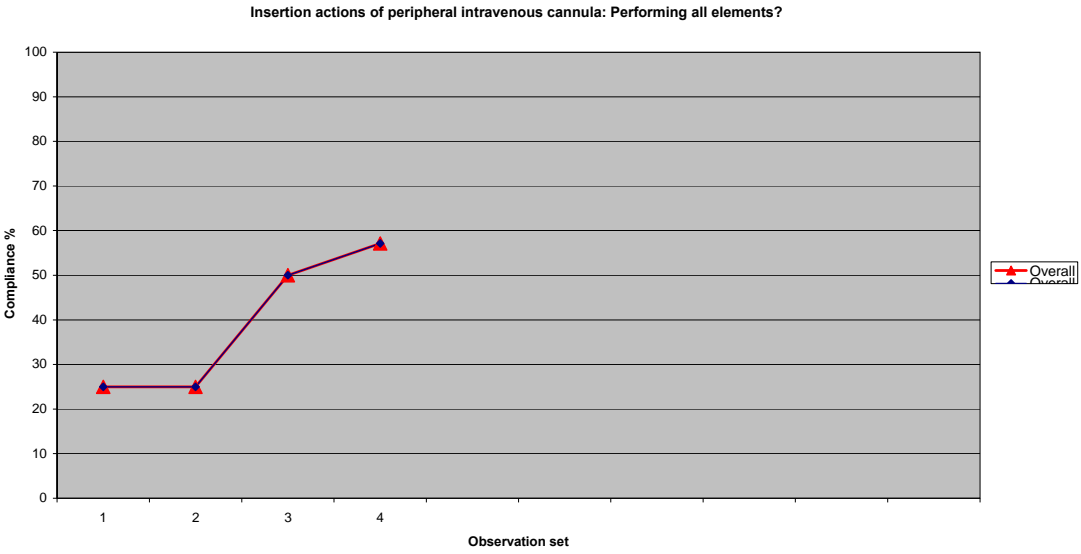
HII	Score	Issues Identified	Action Taken
No. 1 CVC			
No. 2 PVC			
Overall Summary			
See graphs below			
The main issues identified with both Central Venous Catheters and Peripheral Venous Catheters are the failure to wear personal protective equipment during insertion. There is also low compliance with documentation particularly following the insertion and removal of peripheral catheters.			

Insertion actions of central venous catheter: Combined elements



Ongoing care of central venous catheter: Combined elements





Care of ventilated patients

Care Bundle under review, to adapt to neonatal care

ENCLOSURE 3

Appendix 1

Ward Transitional Care							Date of Audit: December 2009					
Number of foam mattresses tested: 10							Auditor: Amanda Hilton & Nattchar Samra					
Number of foam mattresses unable to test:												
Mattress No:	Age and Type of Mattress		Cover			Foam			Outcome			
	Type i.e. Softform Premaflex Hillrom	Date of Purchase	Damaged Yes/No	Stained Outside Yes/No	Stained Inside Yes/No	Bottomed Out Yes/No	Stained/ Wet Yes/No	Malodour Yes/No	Acceptable	New Cover Required State Type	Condemn	Retesting For Bottoming Out
none	Permaflex	No date	No	No	No	No	No	No	Yes			
None	Permaflex	No date	No	No	No	No	No	No	Y			
None	Permaflex	No date	No	No	No	No	No	No	Y			
None	Permaflex	No date	No	No	No	No	No	No	Y			
None	Permaflex	No date	No	No	No	No	No	No	Y			
4.18	Permaflex	No date	Yes	No	Yes	No	Yes	No	no	No	Yes	Removed & replaced
4-4	Softfoam	No date	No	No	No	No	No	No	Y			
4.16	Clinisert	No date	No	No	No	No	No	No	Y			
4.12	Linknurse	No date	No	No	No	No	No	No	Y			
n.1	Cromarty	No date	No	No	No	No	No	No	Y			



Birmingham Women's **NHS**
NHS Foundation Trust

SUBJECT:	Quarterly PALS & Complaints Report for the Clinical Governance Committee
REPORT BY:	Jane Owen – Director of Nursing & Midwifery
AUTHOR:	Christine Yarnold, Complaints Manager

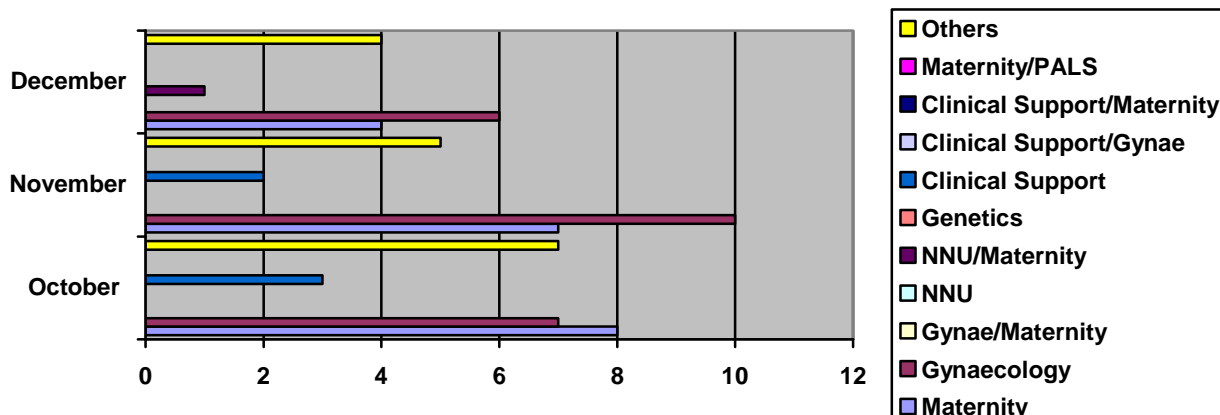
KEY ISSUES FOR BOARD OF DIRECTORS CONSIDERATION.

<ul style="list-style-type: none"> • PALS Trend regarding sonographers • Note the number and distribution of complaints • Note the source of the complaints • Response times by Directorates • Organisational Changes & Actions taken following complaints • Trends in Complaints 	<p>Page 2</p> <p>Page 3</p> <p>Page 3</p> <p>Page 4</p> <p>Page 5 & 6</p> <p>Page 6</p>
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RECOMMENDATIONS:

To discuss and note the content of the report
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**PALS
QUARTER 3
OCTOBER – DECEMBER 2009**



The graph above shows the number of PALS enquiries between October and December 2009. The yellow bar represents other enquiries such as changing appointments, information about accommodation within the hospital and information about Parentcraft classes.

Trends

A significant area of concern has been relating to the attitude of sonographers. A number of the issues raised about sonographers with PALS have since been investigated as formal complaints. There have been five complaints about the attitude of sonographers in this quarter.

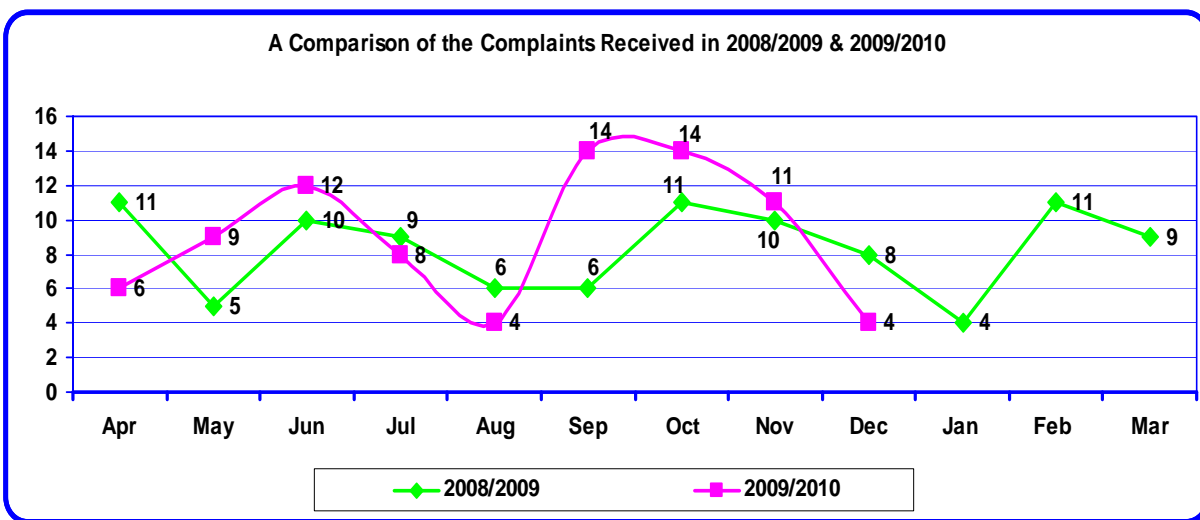
Overall the PALS Department has not had to address any significant problems during this quarter. Any serious matters have been taken forward as formal complaints. There were 5 that went to formal complaint in this quarter: Two from maternity relating to aspects of clinical care, two from gynaecology relating to communication and one from clinical support regarding staff attitude.

FORMAL COMPLAINTS QUARTER 3 OCTOBER – DECEMBER 2009

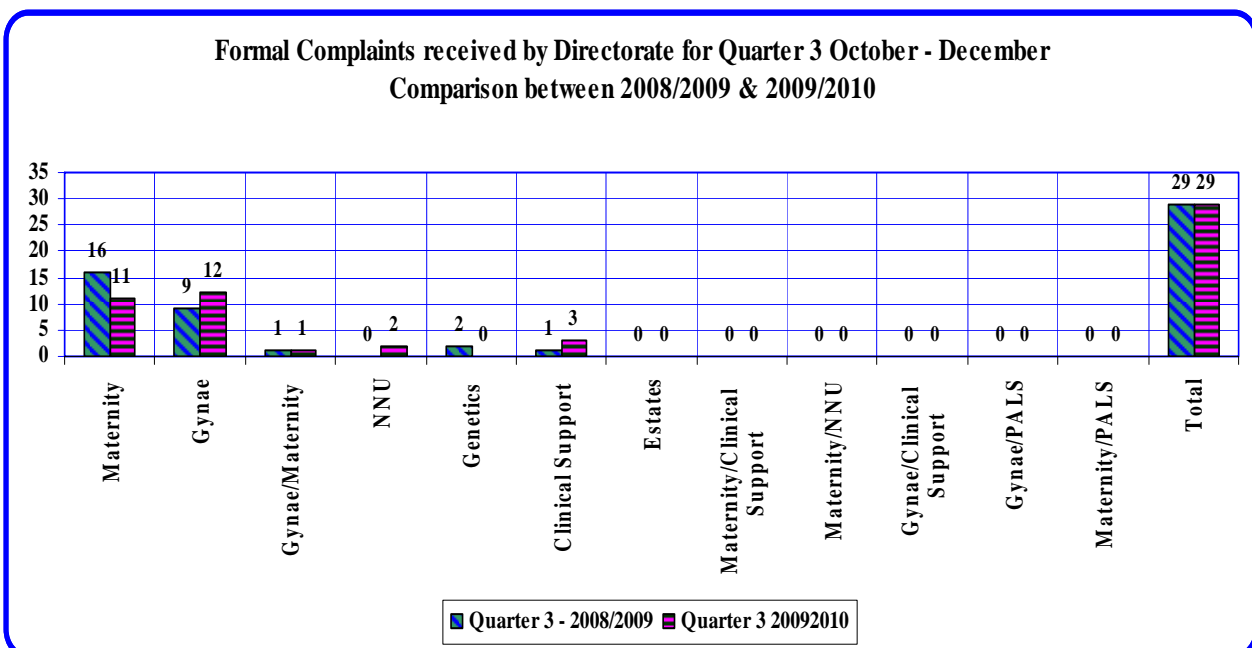
COMPLAINTS RECEIVED

The graph below shows a comparison of the formal complaints received in the Trust for each month of 2008/2009 and April - December 2009/2010. In the Quarter 3 of this year (2009/2010) 29 complaints were received which is the same number of complaints received in Quarter 3 2008/2009.

In this quarter 1 complaint was received from a patient's solicitor who is acting as her advocate, 1 complaint from Sandwell Primary Care Trust on behalf of a patient and 1 from South Birmingham Primary Care Trust on behalf of a patient.



The graph below shows a comparison of the formal complaints received in Quarter 3 2008/2009 and 2009/2010 by the Directorate responsible for investigating the complaint.



TIMESCALE OF RESPONSES FOR QUARTER 3 2009/2010

The timescale agreed for the written response is not always achievable and when the individual specified timescale is not achieved the complainant is contacted by telephone or letter to apologise for the delay.

Below is a table showing how many complaints did not achieve the agreed individual timescale in Quarter 3. However, it is important to not only achieve the deadlines but to ensure that a full and satisfactory response is sent leading to a satisfactory resolution of the complaint.

Number of responses due to be sent out in Quarter 3 = 39 (Late = after the agreed timescale for the individual complaint)						
	Month in which response due to be sent					
	OCTOBER 09 (12 responses due)		NOVEMBER 09 (10 responses due)		DECEMBER 09 (17 responses due)	
	On Time	Late	On Time	Late	On Time	Late
Maternity	2	1	1	2	4	5
Gynaecology		4	4		2	4
Gynae/Maternity	1					
NNU		1	1			1
NNU/Maternity						
Genetics	1					
Clinical Support		2	2		1	
Clinical Support/Gynae						
Clinical Support/Maternity						
Maternity/PALS						
TOTAL	4	8	8	2	7	10

- 20 responses, which are 51%, were not completed within the individual agreed timeline.

ACTIVITY AFTER COMPLAINT RESPONSE HAS BEEN SENT TO COMPLAINANT

If complainants are not satisfied with the response they receive following the investigation they have the option to request a complaint meeting with the clinical staff involved in the investigation. The clinical staff who attend the meeting are usually the ones responsible for the service about which the complaint has been made or a member of staff with a particular knowledge of the issues of the complaint. If a resolution cannot be achieved the complainant can request an Independent Review, which is carried out by the Health Service Ombudsman.

Complaint Meetings in Quarter 3:

- 1 complainant met with the appropriate clinical staff as she still had continuing concerns which she wanted to discuss after receiving her complaint response. At the end of the meeting the complainant made it clear that, although some of her concerns were satisfactorily resolved during the meeting, not all concerns were resolved and she would be requesting an independent review from the Parliamentary Health Service Ombudsman.

QUARTER 3 (2009) - ORGANISATIONAL CHANGES FOLLOWING INVESTIGATIONS INTO CONCERNS RAISED BY COMPLAINANTS WHICH WERE RESPONDED TO DURING QUARTER 3:

- The Assisted Conception Unit (ACU) had followed the correct protocol in not undertaking routine testing for Chlamydia in a patient who had not had any change in her medical history, since previous testing, when she attended for donor insemination. Unfortunately following the treatment, when the patient experienced bleeding, she was subsequently diagnosed as having Chlamydia. The ACU Consultants and the Consultant Microbiologist will review the Protocol as a result of this complaint.

QUARTER 3 (2009) - ACTIONS TO BE TAKEN FOLLOWING INVESTIGATION INTO CONCERNS RAISED BY COMPLAINANTS WHICH WERE RESPONDED TO DURING QUARTER 3.

Genetics Services

- Clinical staff made aware of the Trust Protocol for handling telephone calls.

Maternity Services

- Training and support have been provided for a Breastfeeding Support Worker
- Issues concerning a baby's blood glucose test were raised with staff at the Ward Staff Meeting
- A doctor has been referred to her supervisor for reflection on her attitude
- Improvements made to how the Trust communicates Thyroid Function Test results to mothers. In future all patients requiring change in their treatment will receive details in writing within one week of their test and a copy will be sent to their GP. A named midwife will work in the endocrine clinic to complete a data line for thyroid patients.
- A telephone advice sheet detailing calls is to be kept by the community midwives and clinic staff.
- Staff have been reminded of the importance of introducing themselves to patients.

- The Post Natal Floor Manager has reminded the midwives of the post natal services available to women living outside South Birmingham.

Gynaecology Services

- Ward staff reminded of the importance of showing patients the emergency call button.
- Admissions Officer will in future ensure that when she is on leave that the Admission Diary is sent to the ACU for admissions to be booked.
- Untoward wait in the Gynaecology clinic – New Consultant now appointed and Clinic Co-ordinator to remind staff to keep patients fully informed of delays.
- Clinic Co-ordinator to remind staff to ensure rescheduled appointments are scheduled into appropriate clinics.
- Medical staff reminded of the importance of introducing themselves at the beginning of the consultation.
- Consultant has decided not to offer medication treatment immediately following surgery/anaesthesia, but to wait until the follow up appointment to discuss medication treatment.

Clinical Support Services

- Radiology staff to be reminded of Trust Breastfeeding Policy and to ensure Breastfeeding leaflets are available in the waiting area.
- Customer Care Training to be undertaken
- Staff reminded of the importance of introducing themselves and also other staff who enter the consulting area.
- *Not all responses sent out yet for Quarter 3 complaints as some investigations are on-going because of the complexity of the complaint*

TRENDS IN COMPLAINTS RECEIVED IN QUARTER 3:

3 complaints raised concerns about the lack of introduction by the clinicians during the consultation. These incidences included Maternity Services, Gynaecology Services and Ultrasound Scanning Services and all clinical staff in these areas have been reminded of the importance of introducing themselves at the outset of the consultation.

9 of the complaints received in Quarter 3 were regarding communication and were resolved by providing an explanation of the processes the patients underwent – 5 of these were Gynaecology Services and 4 were Maternity Services

2 complaints were received about staff attitude (Neonatal Unit and Clinical Support Services (Ultrasound Scan) and apologies were given for these incidences. The concerns raised have been discussed with the relevant staff and the staff have reflected on their attitude to their contact with patients.

SUBJECT:	Cancer Waiting Times Action Plan
REPORT BY:	Jane Owen
AUTHOR:	Delreita Bernard

CONTEXT AND BACKGROUND FOR REPORT

This report highlights updates in January 2010 from the Gynae Directorate action plan.

KEY ISSUES FOR THE BOARD OF DIRECTOR'S CONSIDERATION AND DECISION:

- Escalation plan to identify named individual for contact when delays – **Complete:** Personnel identified for each pathway, named individuals identified to escalate unresolved queries. (To be included in Gynae Oncology Operational Policy)
- Clinical champions to be identified for each pathway – **Complete:** Champions identified.
- Identify named person to be responsible for tertiary referral system – **Complete.**
- Review referral system and information and communication strategy with tertiary centres – **In progress:** Communication strategy drafted.
- National reporting requirements including Weekly PTL and End of Month Report – **Near Completion:** 31 day PTL outstanding only.
- Develop a cancer team to navigate patients through the diagnostic and treatment pathways – **In progress:** Interviews for MDT Co-ordinator and Patient Navigator both scheduled for Feb 2010.
- Review access policy for patients referred on the 2ww - **In progress:** Trust Patient Access policy to be amended to incorporate new Pan Birmingham Cancer Network guidance on 2ww, target date amended to March 2010.
- Put in place systems and processes to ensure that the trust switches from reactive to proactive management of patients – **In progress:** Data pathways complete for each clinical pathway, to assist tracking, a variety of additional control measures have been incorporated into tracking process, however, work still ongoing.

RECOMMENDATIONS:

To note the content of the report and progress against the agreed action plan.

GYNAECOLOGY ONCOLOGY

Achieving and Sustaining Cancer Waiting Time Targets

ACTION PLAN 2009-10

This plan develops robust systems, processes and behaviours so that high quality cancer services are developed and embedded into mainstream operational practice whilst enabling the delivery of cancer waiting time targets. To achieve this, clear lines of responsibility and accountability will be developed at all levels.

Objective	Action Required	Person Responsible	Action By	Progress
<p>Operational Effectiveness</p> <p>Develop the Operational Policy for Cancer Services so as to Clearly identify responsibilities for cancer tracking team.</p>	<p>Policy to include:</p> <ul style="list-style-type: none"> ▪ Identification of tailored reports to meet organisational needs ▪ Performance management arrangements across the Trust ▪ Integration of cancer team into operational management on a daily basis ▪ Escalation Policy with clearly defined roles and responsibilities for individuals including tertiary referrals ▪ Management of Tertiary referrals <p>Cancer waiting times management eg DNAS, unfit for treatment, refuse diagnostics and including management of 2ww referrals</p>	<p>Gynaecology Oncology Unit Lead</p>	<p>Mar 2010</p>	
	<p>Formulate escalation Policy identifying named individuals to be contacted when patient delays occur on clinical pathway which Oncology Administration Department are unable to resolve.</p>	<p>Gynaecology Oncology Unit Lead / Gynaecology General Manager</p>	<p>Dec 2009</p>	<p>Completed – Jan 10</p> <p>Contacts identified for each pathway: Cervix, Endometrial, Ovary, PMB and Vulva,</p> <p>Agreed named individuals to escalate queries to if resolution not found:</p> <p style="padding-left: 40px;">Parveen Abedin Delreita Bernard.</p> <p>(To be documented in operational policy)</p>

	Sustaining Cancer Waiting Times Plan to be circulated to all stakeholders.	Gynaecology General Manager	Dec 2009	Completed Plan shared with Board, GOL 10.12.09. PCT 17.12.09. To be shared with MDT 11.01.10 on return of Unit Lead.
	Plan to be endorsed by Trust Board		Nov 2009	completed

Effective Pathway Design - Effective pathways deliver quality and timely care to patients throughout their cancer journey. Effective pathway development, implementation and evaluation across organisational boundaries will support the delivery of sustainable Cancer Waiting Times	Identify Clinical Champions for each pathway.	Gynaecology General Manager	Dec 2009	Completed – Jan 10 Colposcopy: N.Qureshi All others: P.Abedin
	Audit patients against clinical pathway	Oncology Data Manager Service Improvement facilitator (SIF)	Ongoing	In progress Review being undertaken
	Share audit results with clinical teams	Oncology Data Manager Service Improvement facilitator	Ongoing	
	Review and redesign clinical pathways (including tertiary referrals) in conjunction with Clinical Champions and MDT. Pathways will be timed and designed to ensure treatment is well within the 62 day target. Pathway redesign will be prioritised addressing most problematic areas first.	Gynaecology Oncology Unit Lead	Mar 2010	In progress Data Pathways for all pathways now in draft. Cancer Mgr to continue to work with SIP to draft a standard for each clinical pathway.
	Capacity Issues - As part of pathway redesign, capacity issues to be identified and resolved with relevant diagnostic teams to ensure sufficient diagnostic and treatment slots are available to treat patients coming through the 2 week wait route.	Gynaecology General Manager	Ongoing	No current pressures in pathways identified.
	Review referral system and information and communication strategy with tertiary centres to support referrals	Oncology Data Manager	Jan 2010	In progress Comms strategy for Tertiary Centres drafted Jan 2010.

	Identify named person to be accountable for tertiary referral system in Trust	Gynaecology General Manager	Dec 2009	Completed – Jan 10 Agreed to be Jane Bennett, Cancer Manager.
	Document and share pathways with stakeholders	Gynaecology General Manager	Apr 2010	
	Test redesigned pathways against national best practice	Oncology Data Manager	Sep 2010	Rescheduled from March to Sept
	Audit redesigned pathways quarterly	Oncology Data Manager	July 2010 - Ongoing	First audit scheduled July 2010
Robust Data Information and Administrative Systems - Information systems must be complete and robust to guarantee delivery of the standard for all patients. Effective navigation of patients will only be possible if data is complete and the information tells you where patients are in the pathway.	Develop clear protocols to support data capture with clarity about which individuals own and revise it.	Oncology Data Manager	Feb 2010	In progress Meeting arranged with informatics re data capture
	National reporting requirements including Weekly PTL and End of Month Report <ul style="list-style-type: none"> ▪ Traffic Light Report – <i>Performance Report</i> ▪ Tertiary Referral Report – <i>Monthly report now provided</i> ▪ Target Date Report – <i>PTL reviewed weekly</i> ▪ Performance Reports – <i>as above</i> ▪ Highlight Report – <i>Alert report, completed fortnightly.</i> ▪ Suspended patient report - <i>not relevant, to be removed.</i> ▪ Breach Report – <i>Monthly report</i> ▪ 31 day Report – <i>PTL report capable of providing (JB to look into)</i> 	Oncology Data Manager	Jan 2010	Near Completion 31 day report outstanding. In addition to this –Oncology reporting schedule to be completed during Feb. Meet weekly with General Mgr and/or Unit Lead to review PTL and performance report. Tertiary referral report to be forwarded to General Mgr and Unit Lead monthly wef from Dec 09.

	<ul style="list-style-type: none"> ▪ Review use of Somerset database and Business continuity plan ▪ Scope benefits and feasibility of using MDT functionality on Somerset creating an electronic patient record which can be accessed by all clinicians. 	Oncology Data Manager	Mar 2010	<p>In Progress Scoping use of Live MDT, Have reviewed system, clinicians in full support, costings to be provided for equipment purchase to support.</p>
<p>Prospective Patient Management and Navigation - Prospective management of patients allows you to know where patients are in the system, navigate patients through the pathway ensuring they are in the right place at the right time receiving the right care whilst enhancing the flow in the patient's journey between departments within and across organisations.</p>	<p>Develop a cancer team to navigate patients through the diagnostic and treatment pathways:-</p> <ul style="list-style-type: none"> ▪ Develop a job description to incorporate tracking, patient navigation. ▪ Review skill mix and identify whole time equivalents required to undertake all duties ▪ Ensure the Trust has the resilience within the oncology administrative Department to support effective delivery of service. ▪ Present results to Trust Board with recommendation to implement new structure. ▪ Recruit to post subject to approval 	Oncology Data Manager	Jan 2010	<p>In Progress Interviews for both posts scheduled for Feb 2010.</p> <p>JD drafted and submitted for matching 10.12.09. Job Matched, VAF submitted Jan 2010.</p> <p>Patient Tracker Post submitted in the Directorate Business Plan 2010/11.</p> <p>Succession planning – MDT co-ordinator retiring Feb 2010. VAF submitted Dec 2009.</p>
	<p>To underpin the navigational role and clearly identify responsibility and accountability, incorporate into Operational Policy the following:-</p> <ul style="list-style-type: none"> ▪ Tracking role ▪ MDT coordination ▪ Clinical data capture ▪ How to "track a patient" through the clinical pathways - escalation policy 	Gynaecology Oncology Unit Lead	Mar 2010	

	<ul style="list-style-type: none"> ▪ Local and National guidance on patient management i.e.suspensions, DNAs, when to remove a patient from the database, breaches 			
	<p>Review access policy for patients referred on the 2ww.</p> <ul style="list-style-type: none"> • Monitor adherence to policy. 	Oncology Data Manager	March 2010 ongoing	<p>In Progress</p> <p>Mtg undertaken with Patient Access Manager, Patient Access Policy needs to be amended to incorporate NSSG guidance on 2ww. Completion date amended from Jan to March 2010.</p>
	Put in place systems and processes to ensure that the trust switches from reactive to proactive management of patients. This will encompass the role clarity needed for MDT coordinators and more active management of patients on the PTL.	Development of PTL reporting to assist tracking. Improved monitoring of PTL Managerially	Jan 2010	<p>In Progress</p> <p>Weekly operational report identifying patients attending Colposcopy appointments to facilitate tracking.</p> <p>New tracking system implemented in Colposcopy Nov 2009, feedback positive to date.</p> <p>Proposal to pilot similar system in hysteroscopy .</p> <p>Pilot use of comments field in Lorenzo for inputting of target dates, which gets printed on the clinic lists, identifying patients on 62 day pathway.</p>
	It is recommended that the Directorate closely monitor notice periods for clinical annual leave and that leave is managed in such a way that it does not impact on patient treatment in line with the annual leave policy.	Review policy to ensure 6 week notice is enforced and that appropriate "cover" is agreed.	Ongoing	
	<p>CNS Capacity</p> <p>Exploring options to appoint and additional gynae CNS to see follow up patients, releasing consultant time to see more potential cancer patients</p>	Lead Consultant / CNS	Jun 2010	Review rescheduled from Mar to Jun 2010

Birmingham Women's

NHS Foundation Trust



SUBJECT :	Dashboard /Integrated Performance Report
REPORT BY :	Jane Owen/Jason Burn/ Neil Savage
AUTHOR :	Jane Owen

CONTEXT AND BACKGROUND FOR REPORT

The revised Dashboard/Integrated Performance Report provides detailed information relating to the activity quality targets and performance of the organisation according to national and local standards.

This dashboard presents performance for January 2010.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board are asked to consider the enclosed Dashboard Report that highlights detailed activity quality targets and performance information set against national and locally agreed benchmarking information.

Where there is a variance within a particular item against the figures presented in the previous month, this will be highlighted in the text description as favourable or adverse. The colour indication refers to the position against the target and for red indicators. An exception report will be provided giving further details on this matter for variances which fall outside the definition of normal. The picture is completed by the end of year forecast position which indicates with the current actions where the position is expected to be as at the 31st March 2010.

RECOMMENDATIONS

The Board are asked to consider the performance information and to be assured that this has been managed appropriately by the Executive Management Team.

Market Trend Awareness Strategy

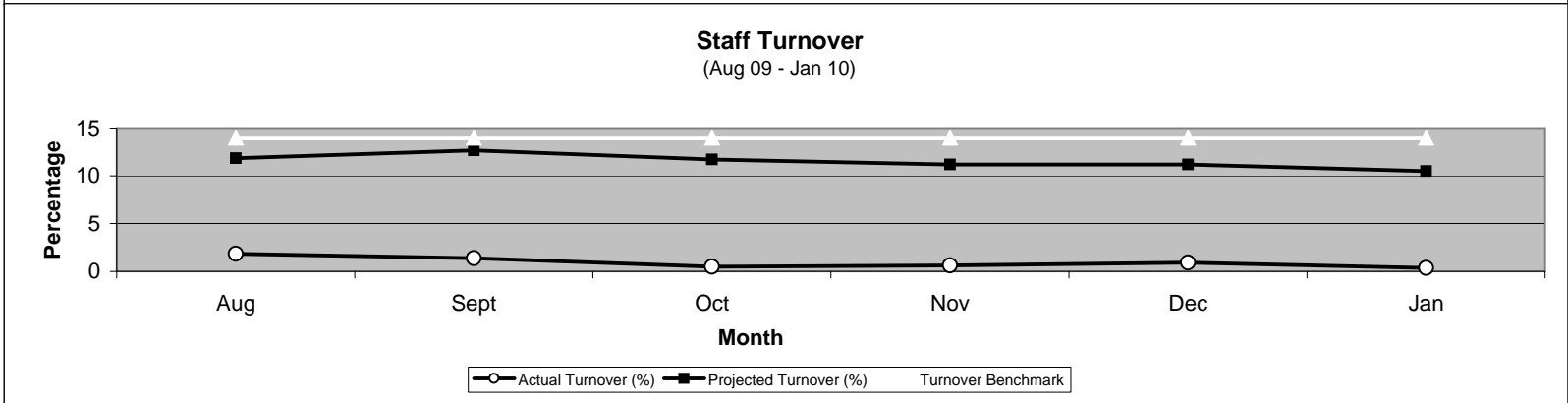
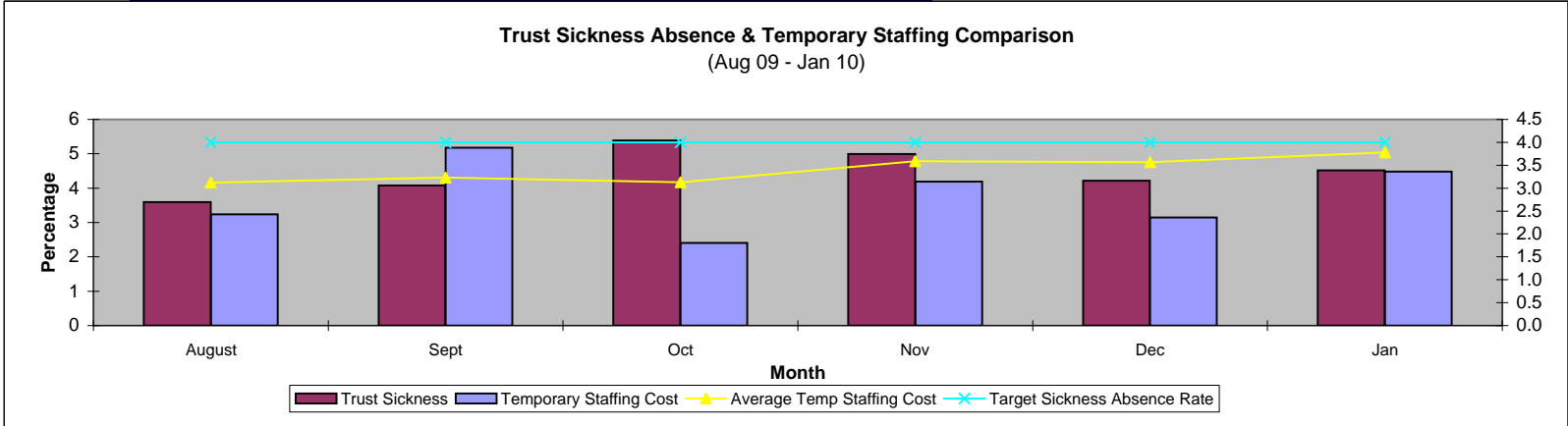
Productivity & Efficiency

Clinical Quality

Core Standards

Finance

Workforce



CQC Targets

Vital Signs

Commissioner Set

Birmingham Women's NHS Foundation Trust

Finance Report for the Period
April 2009 to January 2010

Summary Financial Position

Key Points

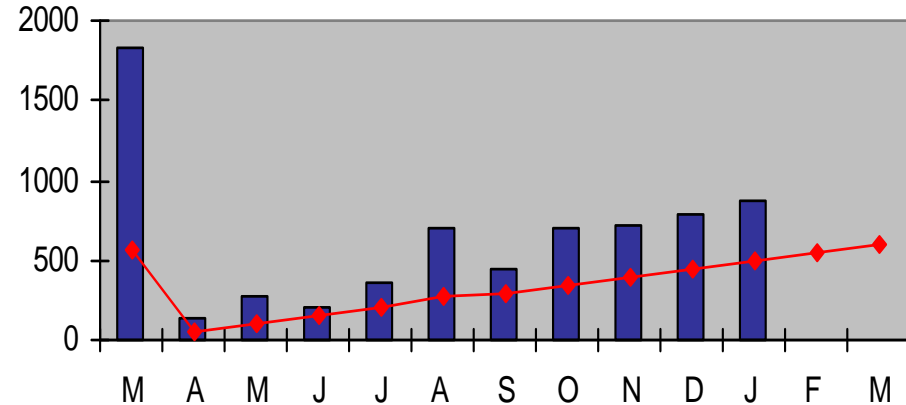
- This is the finance report to the end of January 2010, Month 10. The results show a net surplus of £868k, which is £372k above plan and converts to a Monitor risk rating of 3.

Details of how the Monitor risk rating is calculated are provided within this report.

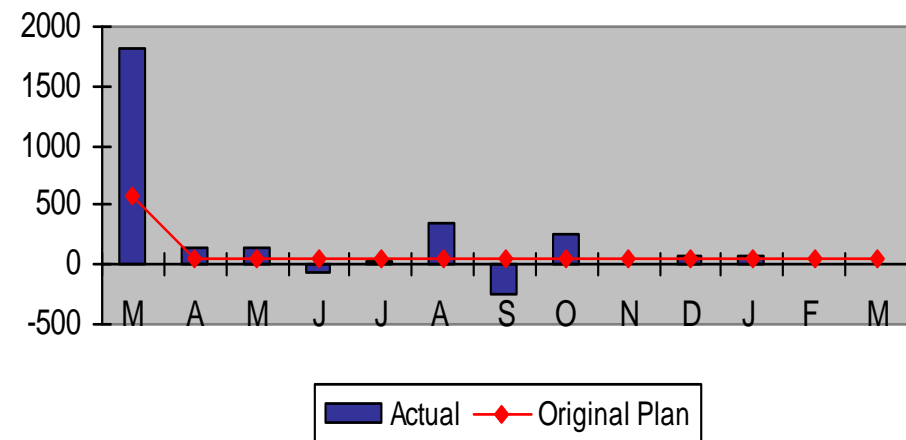
- The summary £372k variance comprises the following:-
 - A favourable £157k income variance;
 - A favourable £166k expenditure variance;
 - An above plan EBITDA position totalling 6.3%
 - A favourable £174k variance for depreciation;
 - An adverse variance of £290k for interest receivable.
- The in-month position was a net surplus of £75k, further details of which are included within the income and spending trends sections of this report.
- The planned end of year position is a surplus of £0.6m. The current forecast based on the overall position stands at £1.1m.

The forecast range for the year, when considering potential up and down-side risks, is a surplus between £0.8m and £1.2m.

Cumulative plan, results & forecast



Month by month plan, results & forecast



Actual Original Plan

Income

Key Points

- The income attributable to the end of month 10 is £70.7m, which is £157k ahead of target. This favourable variance consists predominantly of additional income received from the Specialist Commissioners and from non-contracted activity. Income in ACU continues to be behind plan with the year end forecast adjusted to reflect this. R&D income also shows a significant adverse variance but this is offset by favourable expenditure variances.

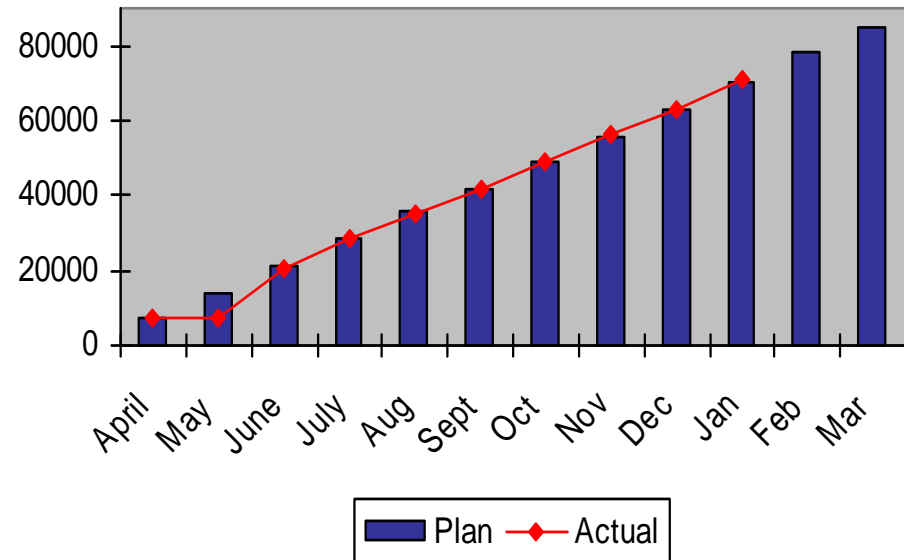
Healthcare Income

- At Month 10 this is £140k above target which includes an assessment of cumulative contract over-performance equating to £69k, and the additional funding received from the Specialist Commissioners.
- Private patient income is behind plan at Month 10 and is forecast to under-achieve at year end. The current forecast income (£709k) would equate to 1.1% in terms of the private patient cap, which is well within the Trust's maximum level of 2.2%.

Performance with Commissioners

- An assessment of cumulative over-performance has been made for Month 10, which equates to £69k and is included within the financial position.

Table f2a & f3 summarise the Trusts Income Performance for the year.



Performance by Specialty

- Gynaecology – adverse variance of £351k for elective and non-elective and a further £44k under-performance on other Gynaecology contract lines.
- Maternity – favourable variance of £212k for non-elective and outpatients which is much lower than in previous months.
- Neonatology – favourable variance of £359k predominantly with specialist commissioners outside the region.
- Clinical Genetics – referrals are currently ahead of target; and Laboratory Genetics – number of tests currently ahead of target.

Spending Trends within Directorates

Key Points

- The table opposite shows the combined positions of pay, non-pay and directorate income variances. Healthcare income is not shown here but is included in the service line reports.
- The table has been expanded to show the hosted organisations (National Genetics Education Centre, Cancer Intelligence Unit and Public Health Observatory) and R&D separately. R&D especially has large counteracting variances across pay, non-pay and income so the intent is to provide greater clarity in the expanded table.
- At Month 10 there is a favourable variance of £36k across all the directorates. This represents a decrease from last month in all areas with the exception of Genetics. Clinical Support's position has deteriorated significantly in January.
- Clinical Support's end of year forecast has been revised again given the deterioration and now stands at a deficit of £766k. The Directorate continue to be tasked with reviewing their expenditure position and year end forecast in detail to address the situation and clearly this is a priority for the newly appointed Associate Director who joined the Trust in February.
- Genetics also continue to investigate their expenditure position, analysing trends in non-pay consumables expenditure linked to income generation. Directorate income has improved substantially again this month and an exercise is underway to ensure any new project monies are matched to expenditure each month.
- Whilst an under spend in pay together with over-achievement of income offset the deficit on non pay, tight control of expenditure needs to be maintained along with ensuring the delivery of the efficiency programme.

The more detailed figures behind the tables are shown on appendices f3, f4 and f5.

Directorate Pay and non-pay variances from budget

Year to date £ 000s	Month 10				Month 09			
	Pay	Non-Pay	Dir'ate Income	Total	Pay	Non-Pay	Dir'ate Income	Total
Maternity	236	-69	46	213	213	-19	33	227
Gynaecology	386	-80	-92	214	383	-73	-85	225
Genetics	-268	-299	650	83	-237	-270	418	-89
Neonatal	-95	-13	49	-59	-74	11	22	-41
Clinical Support	-333	-353	-107	-793	-263	-213	-95	-571
Facilities	-45	51	51	57	-31	59	37	65
R&D	242	313	-549	6	225	280	-500	5
Corporate Services	243	-29	101	315	312	-9	83	386
Hosted Organisations	0	0	0	0	0	0	0	0
	366	-479	149	36	528	-234	-87	207

Directorate Pay and non-pay variances from budget

Year to date £ 000s	Month 08				Forecast EOY			
	Pay	Non-Pay	Dir'ate Income	Total	Pay	Non-Pay	Dir'ate Income	Total
Maternity	188	-20	23	191	246	-100	62	208
Gynaecology	353	-95	-69	189	419	-75	-119	225
Genetics	-209	-264	265	-208	-59	-331	447	57
Neonatal	-42	9	11	-22	-112	-40	52	-100
Clinical Support	-179	-215	-72	-466	-444	-312	-10	-766
Facilities	-3	75	34	106	-76	82	56	62
R&D	207	241	-444	4	266	189	-448	7
Corporate Services	302	-6	95	391	262	-88	97	271
Hosted Organisations	0	0	0	0	0	0	0	0
	617	-275	-157	185	502	-675	137	-36

Cost and Efficiency Improvements

Update on performance

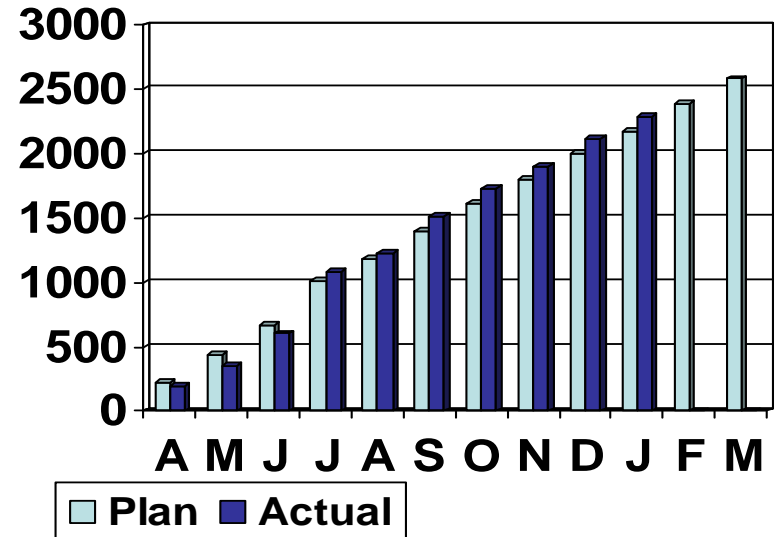
Overall Summary

- As at the end of January 2010 savings of £2,288k have been identified as achieved against a target of £2,173k. The forecast for year-end is to achieve the full target of £2.6m, identified at the start of the year.

Traffic light summary

- The CIP annual targets have been updated from the meeting held in December. The traffic light results are (split by the 2.6m plan) :-
 - Red £203K
 - Amber £289K
 - Green £2,079K
 - Total £2,571K
- This proportion of schemes rated as green, amber and red remains similar when compared to month 9. Work will continue on identifying alternative schemes to replace any red schemes and amber schemes will be monitored closely to ensure that any barriers to delivery are understood.
- The recurrent/non recurrent split is planned to be 70/30%, which is consistent with the approach adopted in previous years. The assessment of this as at month 10 is showing a split of 53/47%, which will continue to be reviewed and challenged on a monthly basis to ensure that overly cautious approaches have not been adopted when declaring whether a scheme is recurrent or not.

Savings delivery - cumulative



NB savings include additional income with respect to the some directorates

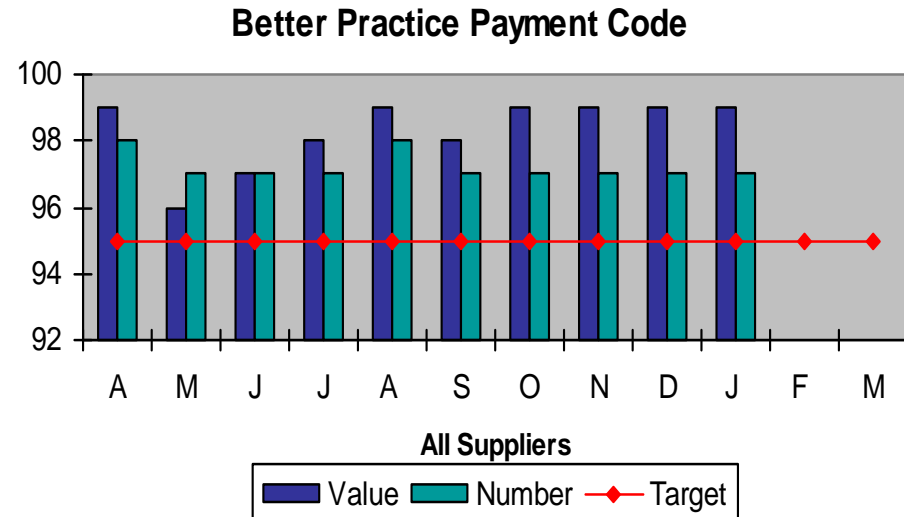
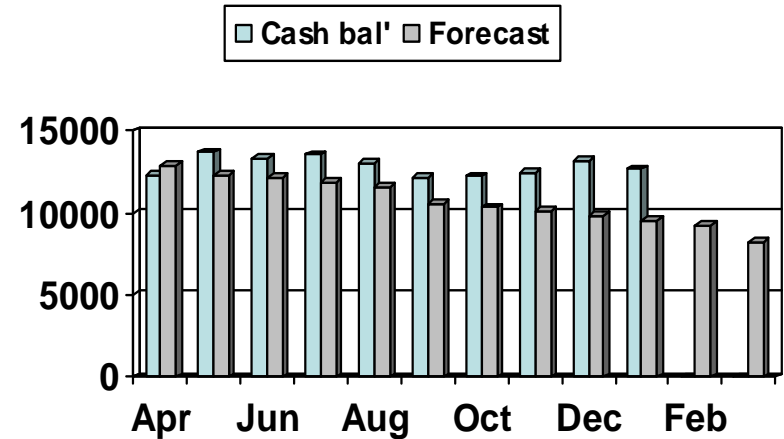
Cash Flow 1

Cash Balances

- The cash position remains strong with a balance at the end of December totalling £12.7m. Deferred income and accruals are recorded as £6.6m.
- The reserve account held with our commercial bank was converted to a Special Interest Bearing Account (SIBA) with effect from the 4th September. This account now pays an interest rate of base + 0.20% (currently 0.70%) and currently holds just over £4.5m. A further £3m has now returned from a 3 month deposit with Lloyds TSB and has been transferred into the SIBA until reinvested.

Creditors (money owed **by** the Trust)

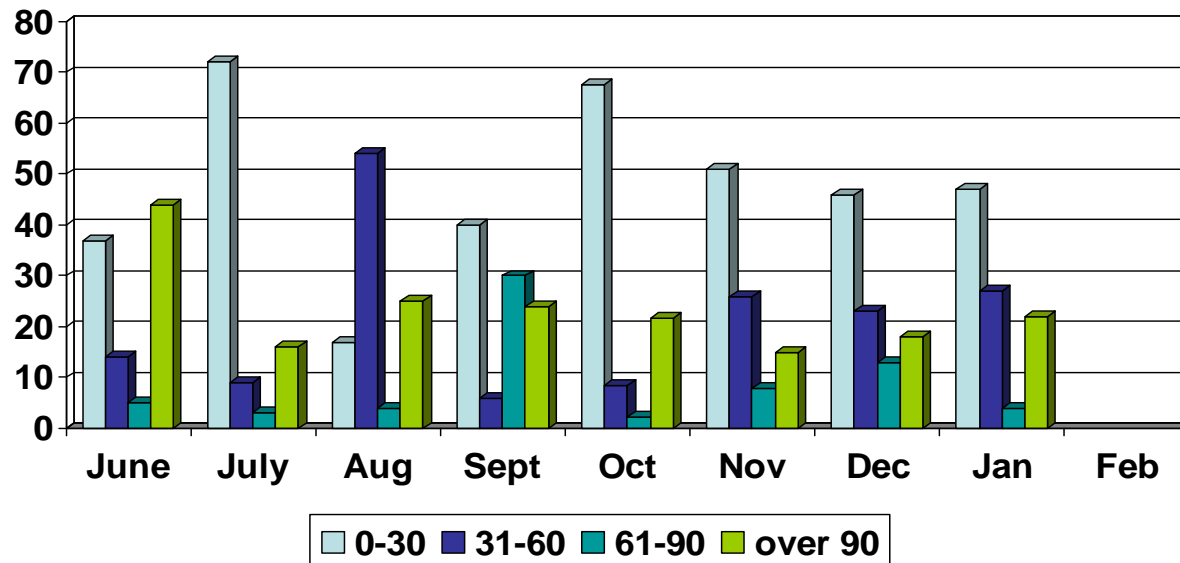
- The Better Practice Payment Code (formerly PSPP) targets NHS organisation to pay 95% of all supplier invoices within a period of not more than 30 days. Within this, the payment for local trade suppliers has been adjusted to payment within 10 days; this is in line with the Prime Minister's request to all public bodies.
- The cumulative performance for Month 10 by number is 97% and by value is 99%.



Cash Flow 2

Debtors (amounts owing to the Trust)

- Total Debtors valued £4.5m at the end of January, which represents a £0.7m increase compared to the end of December. Of the £4.5m, £2.7m relates to trade debtors and £1.8m to accrued income.
- In terms of aged debt information, the total value of debts over 90 days is just over £500K.
- The importance of monitoring and acting upon aged debt continues to be expressed to finance managers and the credit control section, and will be actively managed on a monthly basis, particularly in relation to those currently over 90 days.

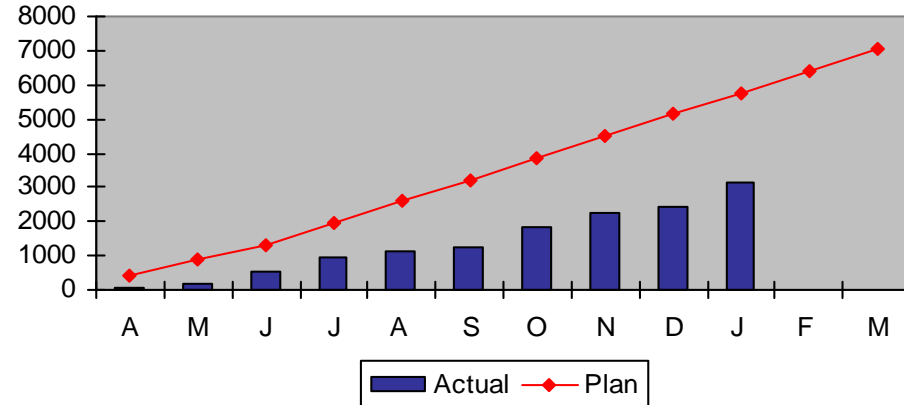


Cash Flow 3 – Capital Spending

Key Points

- The total planned spend for the year is £7.0m as recommended within the 2009/10 annual plan. The planned programme is shown opposite and the delivery of this is being managed through the Capital Development Group.
- The Group has allocated funding to the highest priorities for those schemes over and above the Neonatal Unit. It will focus on continued performance management of all the agreed schemes to ensure they are progressed throughout the year.
- The Month 10 position shows expenditure of £3.1m against all schemes. The current forecast is for the original programme to be fully utilised by year-end with a further scheme considered in addition, being:
 - £116k Neonatal Surgical cot – as previously advised

Monthly build up of the programme



2009/10 Capital Plan

Capex program

PACS
 Neonatal Unit Upgrade / Decant
 Genetics White Paper
 CHP Installation
 Replacement PCs
 Capital Equipment Replacement
 Backlog Maintenance
 Norton Court Roof
 Other

Plan Actual

0 (5)
 4,944 1,271
 0 26
 0 8
 150 162
 780 981
 929 602
 150 0
 91 92

TOTAL CAPITAL PROGRAMME

7,044 3,138

Up & Down-side Risks

<u>Risk</u>	<u>Maximum</u>	<u>Likelihood</u>	<u>Included in forecast</u>
Challenge to income by PCTs	Circa 1% £0.7m	Low	Yes
Failure to deliver 18 weeks	Maximum 5% penalty - £458k	Low but needs to be kept under review	No (is included in forecast range)
Elective Activity underperformance	Maximum £500k	Likely	Will be incorporated into the overall forecast for healthcare income
Failure to deliver CIP plans fully	Red schemes & 50% amber not delivered	Low – green schemes currently account for 88% of the total programme	Yes
Expenditure creep Unplanned & unavoidable non-pay expenses	TBC	High	£492k covered by pay position
CQUIN Payment (upside)	£308k	Likely	Currently held in reserves (is included in forecast range)

Conclusions and Recommendations

CONCLUSIONS

1. The Trust is reporting a £868k surplus to the end of January, Month 10, which equates to a Monitor risk rating of 3.
2. Within the overall position and as explained previously, there are positive variances on both income and expenditure. This position will continue to be monitored and reviewed as we progress through the final quarter of the financial year.
3. As highlighted last year tight control of expenditure was and still is required throughout 2009/10, particularly in relation to non pay where this is not linked to increased activity.
4. Whilst being offset by other areas the Clinical Support position continues to deteriorate and will be a priority for the newly appointed Associate Director who joined the Trust in February, together with increased monitoring by the Executive Team.
5. The full year forecast is currently a £1,122k surplus, with a surplus range for the year between £0.8m and £1.2m.

RECOMMENDATIONS

- The Board is asked to:
 - Consider the financial position of the Trust at the end of January 2010.
 - Note the current forecast is that the Trust will exceed its planned financial surplus as submitted to Monitor.

BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE
REPORTING PERIOD : - January 10 (Period 10)

Form F1	This Month			Year To Date			Full Year Forecast		
	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's
<u>Income (+)</u>									
Healthcare Income	5,530	5,429	(101)	55,911	56,051	140	67,112	67,300	188
Private Patient Income	103	19	(84)	938	556	(382)	1,144	709	(435)
Other Income	1,637	1,952	314	13,656	14,055	399	16,601	17,022	421
Total Income	7,271	7,400	129	70,505	70,662	157	84,857	85,031	174
<u>Operating Costs (-)</u>									
Pay Costs	(4,756)	(4,772)	(16)	(46,970)	(46,325)	644	(56,704)	(55,720)	984
Non Pay Costs	(2,103)	(2,348)	(245)	(19,417)	(19,895)	(479)	(23,211)	(23,837)	(626)
Total Operating Costs	(6,859)	(7,120)	(261)	(66,386)	(66,221)	166	(79,914)	(79,557)	358
EBITDA	412	280	(132)	4,119	4,441	322	4,943	5,474	532
EBITDA % Margin	5.7%	3.8%	-1.9%	5.8%	6.3%	0.4%	5.8%	6.4%	0.6%
Depreciation (-)	(281)	(259)	22	(2,808)	(2,635)	174	(3,370)	(3,223)	147
Interest (+/-)	33	2	(31)	327	37	(290)	392	41	(351)
Surplus / Deficit before dividend	164	23	(141)	1,637	1,843	206	1,965	2,292	327
Dividend (-)	(114)	52	167	(1,142)	(975)	167	(1,370)	(1,170)	200
Surplus / (Deficit) cfd	50	75	26	496	868	372	595	1,122	527

Birmingham Women's

NHS Foundation Trust



SUBJECT :	Patient Safety Report
REPORT BY :	Peter Thompson
AUTHOR :	Peter Thompson

CONTEXT AND BACKGROUND FOR REPORT

This is the second patient safety report in its new format. Following on from the meeting of the Board of Directors in November 2009. This includes data for the mortality rates and our most recent weekly patient safety indicators.

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

The weekly patient safety indicators were first published on Friday 15th January 2010. We hope that this will continue unchanged for one year and at that time can review the chosen indicators.

Corrected Neonatal mortality and Stillbirth rates are now expressed both as a rolling 1 year rate and graphically with statistical process charts. Last month we reported all mortalities up to and including December 2009, however as not all post-mortem reports are available within a month we have reported this time period again with slightly corrected figures and will continue reporting 2 months behind from this point onwards.

Number of Serious Untoward Incidents in previous month
Note this is reported quarterly on the dashboard.

RECOMMENDATIONS

To discuss and note the findings of the report

Weekly Safety indicators published 12th February 2010

Indicator	Number of weeks since last occurrence (start date 7/1/2010)	Number of occurrences year to date
MRSA bacteraemia *	7 years 7 months	0
Clostridium Difficile *	5 years 1 month	0
Inadvertent bowel damage during surgery	0	1
Unexpected returns to theatre †	0	6
Caesarean sections for placenta praevia where the consultant anaesthetist and obstetrician were not present	5	0
Intrapartum stillbirth after 25 weeks and 6 days gestation where the fetus was considered viable at the onset of labour	5	0
Ventilated inborn babies below 28 weeks gestation where administration of surfactant within 1 hour of birth was not achieved	5	0
Inborn births before 25 weeks where the neonatal consultant was not present at the resuscitation when required to be present by the Trust's early care guideline	5	0
Incorrect laboratory report released by genetics laboratories	5	0

*These indicators include the time since mandatory reporting of these infections was introduced

† A small number of these cases will be expected each year

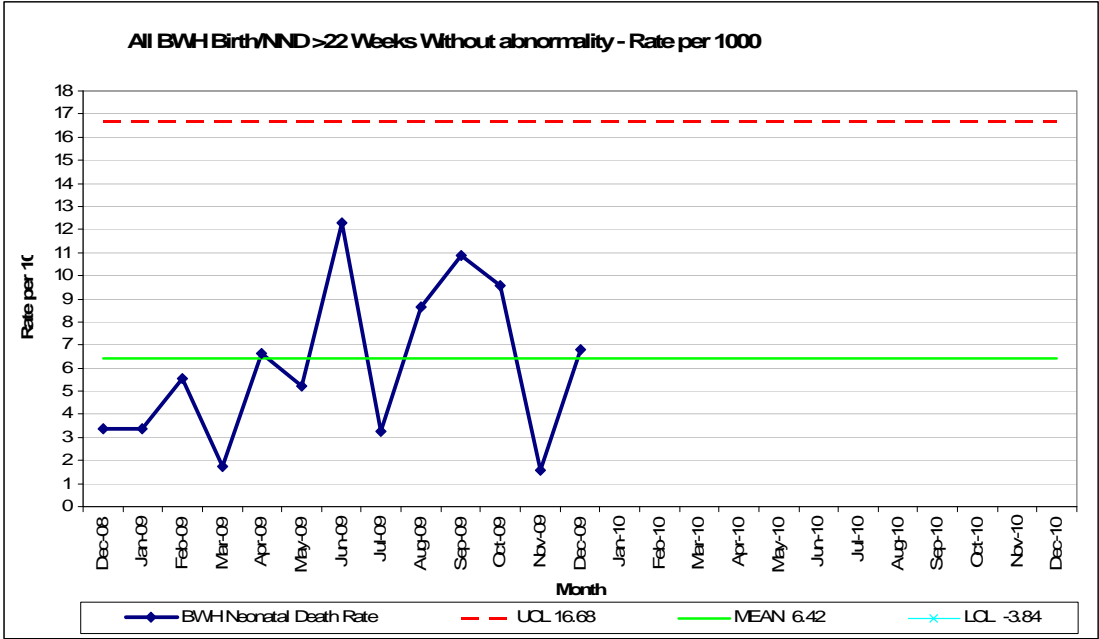
The returns to theatre in Gynaecology are presently being investigated by the Directorate

Mortality Rates

The following statistical process charts show the expected variation in the monthly mortality figures and as long as the results are within the control limits and there is not a continual upward trend variations around the mean are secondary to natural variation, not necessarily changes in systems.

Corrected Neonatal Mortality Rates for period up to December 2009

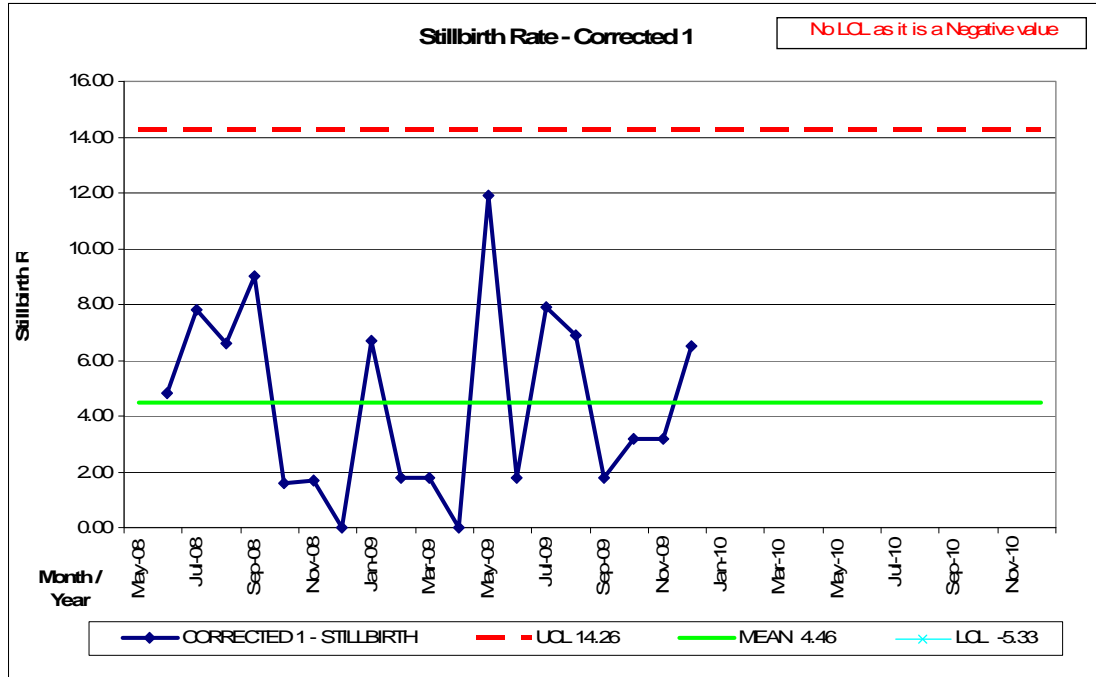
Rolling annual rate corrected for lethal congenital abnormalities, delivery <22 weeks gestation and birth weight <500g is 6.2/1000.



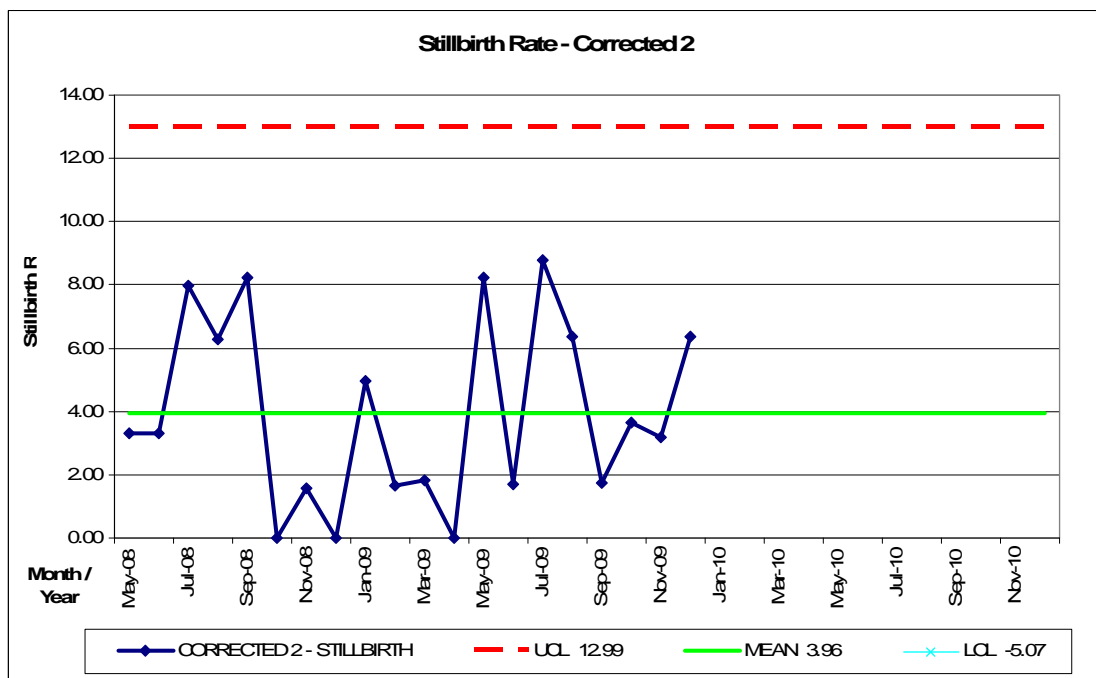
UCL = Upper control limit
LCL = Lower control limit

Corrected Stillbirth Rates

Rolling annual rate corrected for lethal congenital abnormalities and birth weight <500g is 4.5/1000.



Rolling annual rate corrected for lethal congenital abnormalities, birth weight <500g and intrauterine transfers is 4.1/1000.



Serious Untoward Incidents (SUI)

Table of the occurrence of SUIs in the month 1st January to 31st January

Directorate	Number of SUI s this month
Clinical support	0
Genetics	1
Gynaecology	0
Maternity	1 shared with Neonatology
Neonatology	2 + 1 shared with obstetrics

Executive Walkabouts

To date as an Executive Team we have visited the following areas of the hospital;

- Cyto-genetics
- Acute Labs

We plan to provide safety information, actions and progress from these visits on a quarterly basis.

PJ Thompson
Medical Director

Birmingham Women's



NHS Foundation Trust

SUBJECT :	Safeguarding Children – Annual report.
REPORT BY :	Jane Owen
AUTHOR :	Elaine Giles

CONTEXT AND BACKGROUND FOR REPORT

This annual report is to advise the Clinical Governance Committee and Board of Directors of the progress made against Safeguarding Children arrangements for the Trust against the standards laid down by the Care Quality Commission and Monitor.

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

- The Trust's representation on Birmingham Safeguarding Children Board.
- Progress against the action plan for retrospective CRB checks.
- Compliance against the Care Quality Commission Standards.

RECOMMENDATIONS

- To note and approve the content of the annual report.
- To acknowledge the continued progress and achievements made in relation to Safeguarding Children.
- Acknowledge the need to improve the quality of Safeguarding Services Trust wide.
- Note the increase capacity regarding domestic abuse and mental health referrals.
- Note and agree the progress being made against CQC Standards.

1. Introduction

This report reflects the progress and achievements made by the Trust in 2009 regarding Safeguarding Children.

The report demonstrates that the trust has worked successfully in fulfilling the standards laid down by the Care Quality Commission and Monitor.

The priority for 2009 has been the recommendations following the Care Quality Commission's review of arrangements in the NHS for Safeguarding Children following the conclusion of the legal case relating to Baby Peter. The report from the audit [Review of Safeguarding Children](#) summarised the findings of the review, giving a national picture. The findings indicated that the majority of organisations have the right people and systems to help protect children. However, gaps were highlighted. As a result, a letter was sent to all Trust's from the NHS Chief Executive, Department of Health highlighting the key issues of the report requesting that Boards be assured that best practice and statutory requirements are followed.

The letter identified 5 key areas that required urgent attention. These 5 areas are as follows:

- There should be a Board Level Executive Director Lead for Safeguarding.
- Designated and Named professionals should be clear about their role and have sufficient time and support to undertake it.
- Organisations must comply with the statutory requirements to carry out CRB checks for all staff employed since 2002.
- All eligible staff should have undertaken and are up to date with Safeguarding Children training at level 1.
- Child protection policies should be up to date and robust, including a process for following up children who miss out patient appointments.
- The Board should review Safeguarding across the organisation at least once a year and have robust audit programmes to assure it that Safeguarding systems are working.
- All Trusts were required to publish a Board agreed declaration on their website by 31st December 2009.

2. Board Level Executive Director Lead

- Jane Owen, Director of Nursing and Midwifery is the appointed Safeguarding Executive Lead and fulfils the role of Safeguarding Champion, ensuring that Safeguarding Children remains a high priority within the Trust and that the Named Professionals are supported in fulfilling their role within the Trust.
- Safeguarding Children Boards are the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to Safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do. In November 2009 Birmingham Safeguarding Children Board (BSCB) announced a review of its Board membership and chairing arrangements with a plan to introduce an Independent Chair from January 2010 and the inclusion of Acute Trust membership. As a result Jane Owen is now a member of BSCB representing acute services.
- The Executive Lead continues to hold quarterly meetings with the Named Professionals.

3. Named professionals

As in the previous year, the post of the Lead Nurse/Midwife for Safeguarding Children remains funded for 0.8WTE plus 0.2WTE funded by Maternity Directorate to undertake line management responsibilities for the Safeguarding Team which remains at:

- 3 WTE specialist midwives
- 1 administrator
- 1 specialist nurse/ midwife (Corporate)

The role of Lead for Vulnerable Adults has also been added on to the role of the Lead Nurse/Midwife.

- Mike Hocking, Consultant Neonatologist, remains as the Named Doctor for Child Protection but due to retirement this post is due to be taken on by Dr Debbie Derbyshire, Consultant Neonatologist, in May 2010. Allocate time (1PA) to undertake the additional role is in place.
- Both have current job descriptions.
- The Named professionals met bi-monthly to discuss professional Safeguarding issues.

4. Criminal Records Bureau (CRB) checks

There has been an increase in the number of CRB checks undertaken since the previous report and the Trust action plan remains on target to deliver 100% compliance by March 2010 (Appendix A).

Staff in the Cancer Intelligence Unit and Public Health Laboratory is included in the Corporate figure below but are not required to have CRB checks as they have no patient contact. These figures will be removed at the next report.

5. Safeguarding Children Training

- The Trust has a robust training strategy in place with regard to delivering safeguarding children training. It continues to be reviewed and updated annually, taking into account new legislation, national guidance.
- The levels referred to in this section are those cited in the Intercollegiate Document (2006) [Intercollegiate doc.](#)
- All staff, on induction receives the Trust's Safeguarding Children leaflet and the DfES guide What to do if you're worried a child is being abused (2006). [What to do.](#) Existing staff receive the Trust leaflet attached to their payslips every 3 years; therefore all staff are up to date with level 1 training.
- Attendance for levels 2 and 3 are shown in Appendix B. There is clearly a requirement for those staff requiring level 2 and 3 to fulfil this mandatory requirement and for line managers to take responsibility in ensuring that the staff in their area are compliant. A copy of the Safeguarding Training database is distributed to managers on a monthly basis. This demonstrates to managers those staff who are not up to date with training. Reminders are also sent to staff 3 months prior to their training being out of date to remind them that they need to book their training. Training for level 2 and 3 is currently provided by the Lead Nurse/ Midwife, Specialist Nurse/Midwife and hospital Social Worker.

- This year there is a plan to introduce an 'update' training day for those who have previously done levels 2 and 3. The day will include all aspects of levels 2/3 but will introduce new concepts of safeguarding i.e. in depth analysis of Serious Case Reviews and their recommendations.
- CQC recommended that a new e-Learning package be implemented across the health community. In order to access this would mean implementing a package, National Learning Management System (NLMS), to run on-line training programmes for staff. This has resource implications and only addresses one aspect of mandatory training requirements across the Trust. Other e-Learning packages are being looked at as an option to replace current Level 2 training.
- Additional training continues to be provided to include other aspects of training. This has been an addition to last years Safeguarding Training Programme with demand outweighing the places available with evaluations being extremely positive. There is a future plan to extend some of this training to professionals and agencies from outside the Trust which will generate income.

6. Child Protection Policies

The Child Protection Policy was out of date from September 2009. A new policy is in the consultation stage. This policy is far more robust than the previous policy and makes reference to the policy 'Did Not Attend – Neonatal Outpatients Clinic (BWFT,2009).

In addition this year has seen the development and implementation of other policies that support the Safeguarding agenda. They include:

- Safeguarding Children Information Sharing Policy
- Safeguarding Children Policy and procedure for managing internal management reviews (IMR), processing serious case reviews (SCR) and reporting child deaths.
- Safeguarding Children Mandatory Supervision Policy.

7. Audit

Small audits have been conducted by the Safeguarding Team. For example, Information Sharing between Midwives and Health Visitors, Cannabis use in Pregnancy. A more robust audit plan is required which reflects the introduction of new policies.

8. Monitoring

- The Trust's declaration of compliance was published on the web-site on 29th September 2009.
<http://www.bwhct.nhs.uk/index/about-us/quality-cg/quality-newpage.htm>
- The progress this year will mean that compliance will be met against Standards for Better Health, Core standard C2, which specifically relates to Safeguarding' in preparation for CQC registration.

9. Staff support/ supervision.

- All staff have access to support and guidance from the Safeguarding Team.
- In line with national guidance and last years objectives a more formalised approach to supervision was required. A policy for mandatory access to Safeguarding Supervision has been developed and is expected to be rolled out soon for those staff working directly with children and families.

10. Referrals relating to potential Safeguarding concerns.

- The number of referrals where there is a potential Safeguarding concern about a child, compared to the previous 2 years, shows a slight decrease. However, overall the referrals remain consistently high (Appendix C).
- Professionals are being encouraged to consider the benefit of undertaking a Common Assessment (CAF) [The Common Assessment Framework](#) if the concerns do not meet the criteria for an inter-agency referral to social services. Staff have been reluctant to use this because of the perceived increased workload. Activity around CAF has recently been reported to South PCT and although this has been minimal to date it is expected to increase.

11. Administrative support

The increase in secretarial support to 0.8 WTE last year has helped the with the volume of work. However, the specialist midwives do not have access to administrative support and therefore also access this service.

12. Partnership Working

The Named Professionals continue to represent the Trust on the Health forum and Local South forum, sub-groups of BSCB.

The Lead Nurse/Midwife is part of 2 multi-agency Task and Finish Groups relating to Child Protection Case Conference Process and Parents with Mental Health problems.

In addition, other multi-agency working relates to the development of multi-agency policies for Female Genital Mutilation (FGM) and Honour Bases Crime and Forced Marriage.

Requests to Safeguarding guidance and advice from other Trusts across the country, as far as the Isle of Man has increased this year as the reputation of the Safeguarding work at the Trust becomes wide spread.

Links with Birmingham City University has led to providing Safeguarding Training to various groups of student.

13. Family Finding Medical Reports

Requests for medical reports that are completed by the Lead Nurse/Midwife and provide information for children who could be placed for adoption has decreased this year (Appendix D).

The reports generate income for the Trust as each report completed for each mother and each child generates £22.50.

14. Risk management

- Safeguarding concerns that generate an incident form are managed by the Lead Nurse/Midwife.
- There were 12 reported incidents in 2009.
- The general theme from these incidents has been communication difficulties between different agencies and a lack of understanding of individual's roles and responsibilities. This arises mainly with those staff who have not completed mandatory Safeguarding training.

- Two incidents involved staff who did not feel confident to complete a Court report. As a result 2 training sessions on Writing Statements was facilitated by Legal Services which 16 staff attended.

15. Specialist midwives

The 3 specialist midwives are employed by the Maternity Directorate. This creates problems when there is a need for advice, guidance and training from other areas of the Trust. Although these services are provided on request, for the benefit of the women and staff involved, the resource allocation does not meet the demand and has led to an inequality in the service being provided to all women being cared for by the Trust.

Quality would be greatly improved if all Safeguarding Services were a Corporate function.

16. Domestic abuse

- The number of domestic abuse referrals received by the Safeguarding Team has increased on previous years (Appendix E).
- These figures represent just the tip of the iceberg because there are many others of which we are unaware including those women who may access Gynaecology Services pregnant women who have not received routine enquiry by the community midwife as per national recommendations.
- There have been huge developments over 2009 regarding domestic abuse. Including changes in the way Multi Agency Risk Assessment Conferences (MARAC's) are undertaken and the introduction of additional Screening Meetings to assess impact of domestic abuse on children. These have huge resource implications as each Police Operational Command Unit (OCU), of which there are 6 that have women booked to give birth at BWFT, each OCU hold a monthly MARAC meeting plus 2 Screening meetings per week. Under the guidance of Working Together (2006) the expectation is that we participate in these meetings where pregnant women are being discussed.
- Updated hand held pregnancy notes were introduced in June 2009 by Perinatal Institute which are directed towards routine screening for domestic abuse. The introduction of routine screening has again been delayed until safe processes can be identified which will not place these vulnerable women at greater risk. This would mean providing mandatory domestic abuse training for midwives and current guidelines for domestic abuse. Currently this is not possible with the excessive workload within the team, in particular the Lead for Mental Health and Domestic Abuse.

16. Mental health

- As a result of the increasing referrals (Appendix F), the referral form was amended Jan 2009 and referrals triaged quite aggressively.
- New hand held notes were introduced in June 2009 which may have some impact on the numbers of women referred to the mental health clinic.
- It is extremely difficult to categorise the different reasons why women are referred to this clinic but alongside significant mental illness, other reasons why women are referred are anxiety disorders, previous pregnancy loss and inability to cope with new pregnancy, previous untreated depression requiring additional support.
- 60 women were identified as having significant mental illness (bipolar disorder, schizophrenia, severe depression, previous puerperal psychosis)
- 105 ladies were currently/ or had been involved with psychiatric services
- The remaining women were a combination of having currently prescribed antidepressants or had recently stopped or had depression in the past but not currently medicated.

- 27 were referred back to referrer to discuss with GP.
- There were 3 postnatal admissions to Mother and Baby Unit at The Barberry.
- 26 obstetric ward visits for various reasons: 14 to review women who have attended the mental health clinic at BWFH and 12 women where staff had concerns regarding the mental state of a woman.
- There are continued discussions in order to streamline the clinic due to increasing numbers of referrals. The development of the Integrated Care Pathway for Perinatal Mental Health will immensely assist this process.

17. Substance misuse

- The number of women referred for substance misuse issues has remained fairly constant over the last 3 years (Appendix G) .
- Whilst referrals for alcohol and heroin misuse have shown a slight decline, referrals for cannabis use have increased from 27 to 37 this year (37%).
- A retrospective audit conducted in August 2009 on the pregnancy hand held notes showed that a significant number of women are still not referred for smoking cessation or specialist advice despite disclosure of cannabis use.
- 39 babies were born to women receiving treatment for heroin addiction and 6 (15%) babies required treatment for neonatal withdrawal syndrome, a slight decrease from last year's figures.
- Women with complex alcohol issues continue to present in pregnancy although there has been a slight drop in numbers.
- The guidelines for substance misuse have now been updated to include guidance on the care of these women.
- The number of substance misuse cases with input from Children's Services has increased for the third year running from 43% last year to 47%.
- Close links are maintained with the local drug and alcohol services and drug workers continue to participate in the study days for staff. Study days continue to be well attended by hospital staff and it is hoped that these can be extended to staff from other units in 2010. Input is provided for the maternity care module of first year student nurses at Birmingham University
- The number of women smoking at delivery remains above the PCT target of 11%. This year has seen a slight decrease in the number who have continued to smoke and an increase in those not smoking. There has however also been a slight increase in the missing data for this field at delivery (Appendix H).

18. Teenage pregnancy

Referrals have been consistent with other previous years (Appendix I). However, the complexity of young parents lives has increased which has led to an increase in social service interventions.

This year there has been several new initiatives and successes in this field.

- Guideline for the Care of Pregnant Teenagers completed.
- Postnatal home visits for identified case load aged for those in South and under 16yrs.
- Introduction of Chlamydia screening in the specialist teenage pregnancy clinic.
- Building Blocks Randomised Control Trial-Family Nurse Partnership Programme.
- Working with 'Midwives for Young Parents Initiative'; parent education in the community.
- Vulnerable Women's Training Day commenced to continue Bi-Yearly.

19. Next steps

- Progress the themes from last year, reflecting local and national priorities laid out in the Laming Report (2009).
- Develop an audit plan.
- Identify ways of extending Safeguarding Team training to external delegates.
- Promote the use of the Common Assessment Framework amongst front line health professionals.
- Identify resources for an improved service for women and children living with domestic violence.
- Family Planning outreach clinic provided by BRASH (Birmingham Relationship and Sexual Health) within the antenatal specialist clinic.
- Family planning administration on the postnatal floor prior to transfer home.
- Develop and implement an ICP for women with mental health problems

20. Conclusion

The establishment of a core Safeguarding Team to support the role of the Named Nurse/Midwife and Named Doctor roles has built up our Safeguarding capacity to support front line professionals. This joint working, which cuts across both adult and children Safeguarding has helped to bridge the gap between services, thus providing a more effective service to protect children from abuse and neglect, whilst at the same time supporting families. However, there are clearly gaps in the provision of services to women and children who are affected by domestic abuse.

The objectives for the year ahead are, as always, challenging but achievable and will continue to ensure that the trusts Safeguarding arrangements remain within national legislation and guidance.

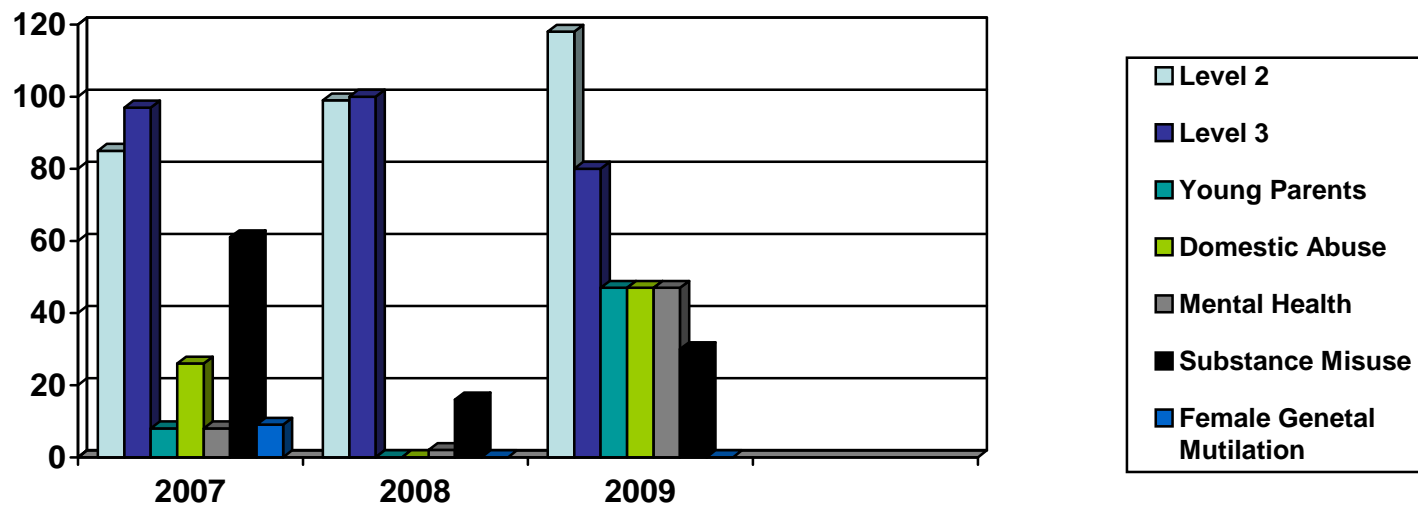
Appendix A – Criminal Records Bureau checks.

COMPLETED CRB INFORMATION - JAN '10			
DIRECTORATE	TOTAL STAFF	STAFF WITH COMPLETED CRB'S	DIRECTORATE % COMPLETED
CLINICAL SUPPORT	162	117	72.22
CORPORATE	206	69	33.50
FACILITIES	149	97	65.10
GENETICS	260	165	63.46
GYNAECOLOGY	200	141	70.50
MATERNITY	469	274	58.42
NEONATAL	175	146	83.43
TRUST TOTAL	1621	1009	62.25

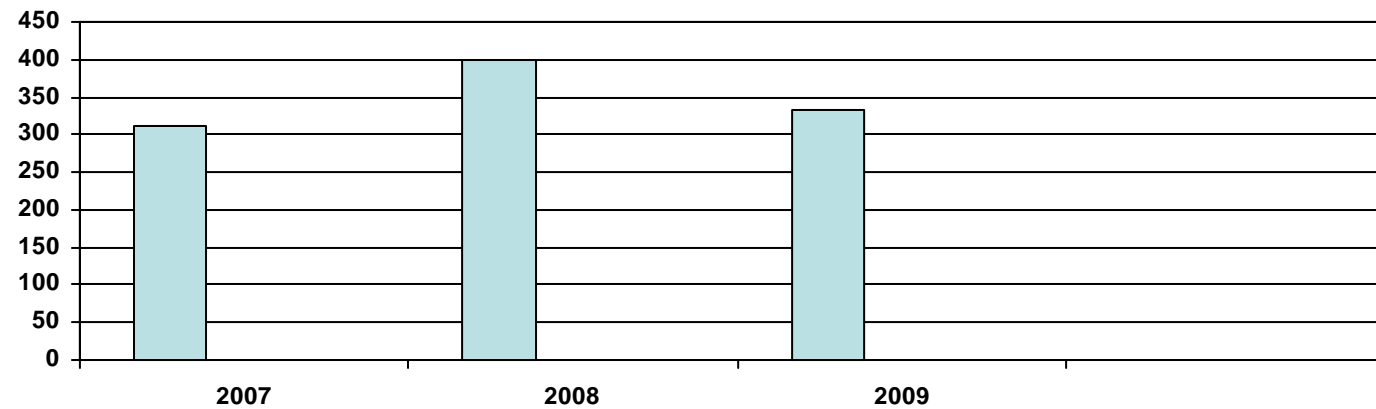
Appendix B -Safeguarding Training Attendance Rates.

SAFEGUARDING CHILDREN - OVERALL ATTENDANCE %	
LEVEL 1	100%
LEVEL 2	40%
LEVEL 3	41%

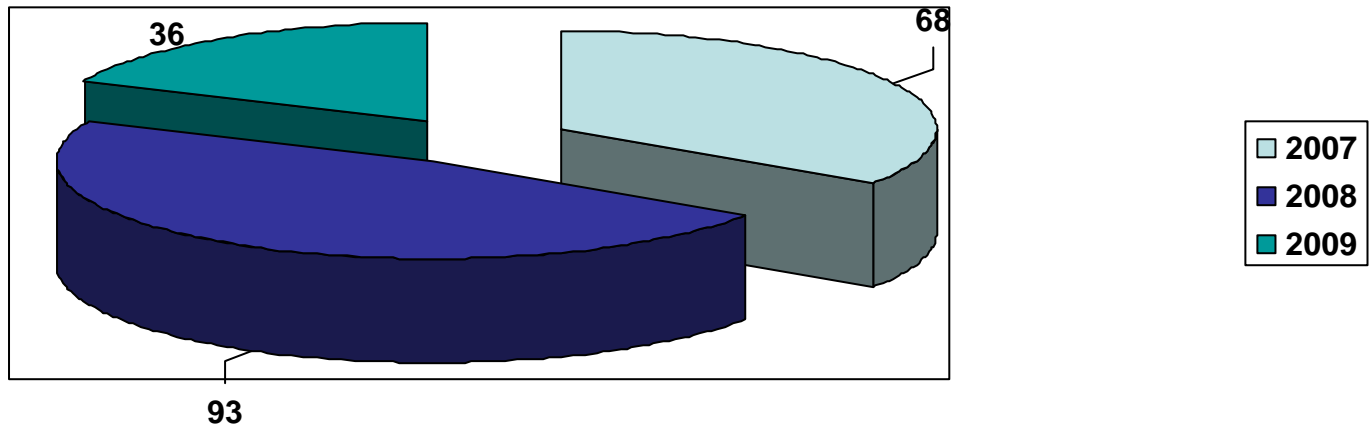
Type of training provided and number of attendance.



Appendix C – Number of families referred for potential Safeguarding concerns

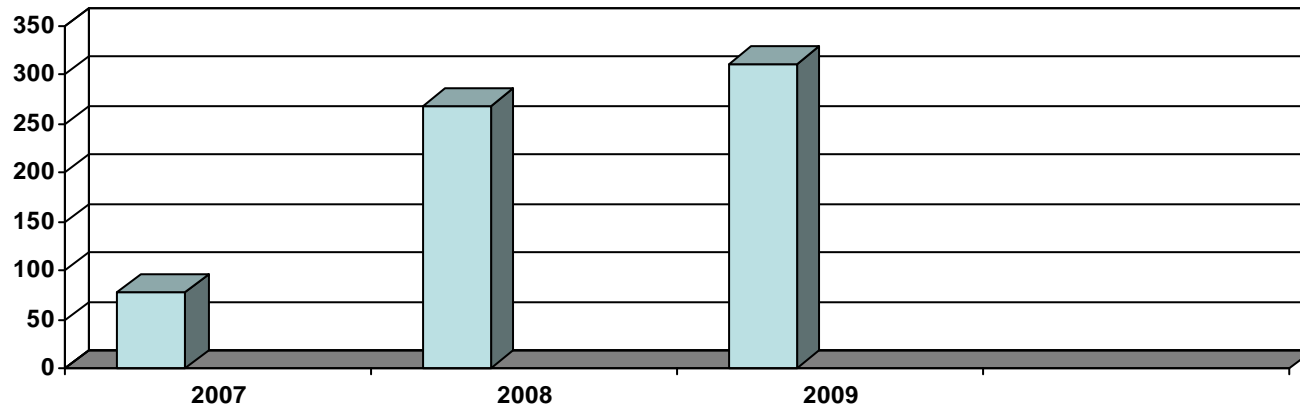


Appendix D – Number of Family Finding medical reports completed

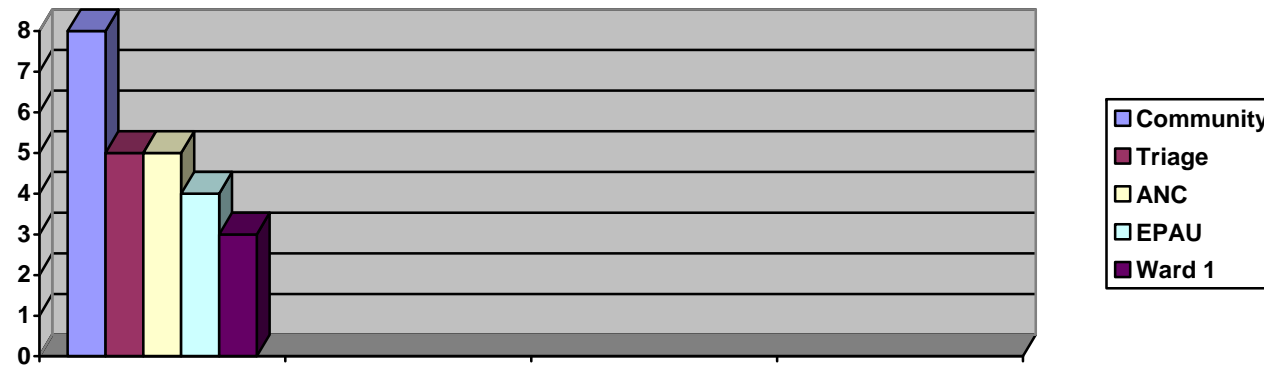


Appendix E - Domestic Abuse Referrals

From the Police (392's)



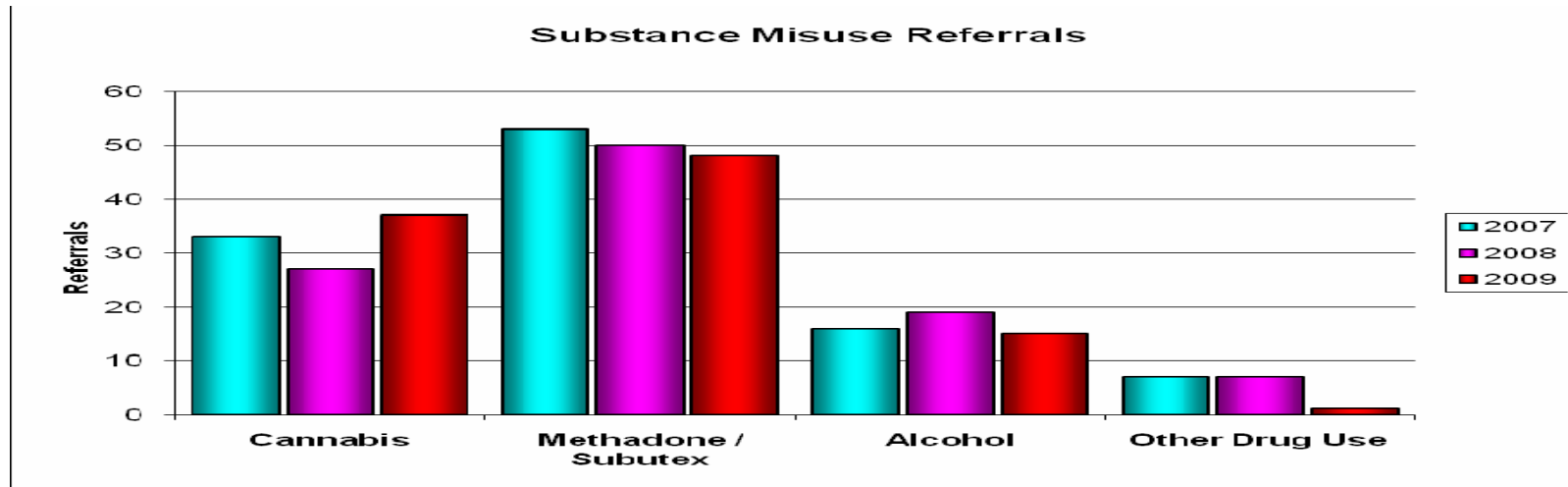
Domestic abuse referrals from the Trust



Appendix F - Referral to Perinatal Mental Health Team

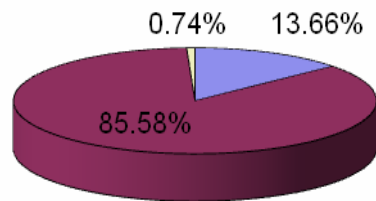
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	TOTAL
2007	-	-	-	-	-	-	-	23	25	31	15	18	112
2008	31	28	26	27	30	23	21	10	24	43	14	31	318
2009	27	20	32	16	37	53	11	43	22	38	34	27	368

Appendix G – Substance Misuse Referrals



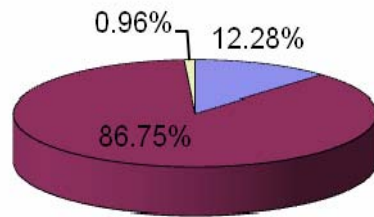
Appendix H – Smoking statistics

Percentage of Total Deliveries 2008



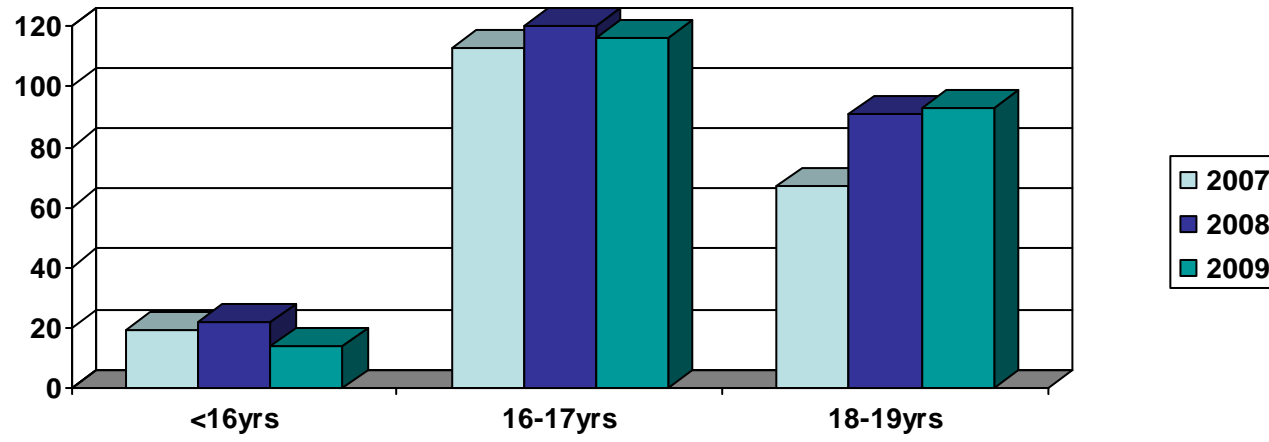
- No of women smoking at delivery
- No of women not smoking at delivery
- No of women whose smoking status is not disclosed

Percentage of Total Deliveries 2009



- No of women smoking at delivery
- No of women not smoking at delivery
- No of women whose smoking status is not disclosed

Appendix I – Teenage Pregnancy Referrals



Birmingham Women's

NHS Foundation Trust

SUBJECT:	Safeguarding Vulnerable Adults – Annual report
REPORT BY:	Jane Owen
AUTHOR:	Elaine Giles

CONTEXT AND BACKGROUND FOR REPORT

This is the third annual report for Safeguarding Vulnerable Adults aimed at providing an update to the Clinical Governance Committee and Board of Directors as to the progress made by the Trust around the issues of protecting vulnerable adults.

KEY ISSUES FOR THE BOARD OF DIRECTOR'S CONSIDERATION AND DECISION:

- Low referral rate for vulnerable adults.
- Dissemination of the Safeguarding Vulnerable Adults training leaflet to all staff.
- Completion of the Safeguarding Vulnerable Adults policy.

RECOMMENDATIONS:

To note and approve the contents of the report.

1. Introduction

The purpose of this annual report is to summarise the activity, achievements and developments against the national Safeguarding Adults agenda set out in the 'No Secrets' Guidance in 2000 [No Secrets](#).

The report builds on the philosophy of the NHS Constitution, in particular 4 key principles that guide the NHS which are:

- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients and local communities.
- The NHS provides a comprehensive service available to all.
- The NHS must reflect the needs and preferences of patients, their families and their carers.
- The NHS aspires to high standards of excellence and professionalism

The aim of 'Safeguarding Adults' work is to help vulnerable adults to live a life that is free from abuse and neglect. This includes, but is not limited to, arrangements for responding to allegations of abuse.

Local authorities have a responsibility to follow the Department of Health guidance outlined in No Secrets (2000) and co-ordinate a multi-agency response to Safeguarding against abuse and taking appropriate action when somebody is being abused or is at risk of abuse.

Staff employed by the Trust have a duty to recognise and report any suspected abuse of an adult to the Local Authority.

2. Safeguarding Adults Referrals

The very nature of our business means that there is unlikely to be an excessive number of Safeguarding Adult referrals. In 2009 there was 1 case from gynaecology and 4 from maternity services. It is expected that an awareness raising campaign amongst staff which is planned for 2010 may increase the number of referrals.

It is a misconception that domestic abuse and Safeguarding Adults are the same; however, domestic abuse also becomes a Safeguarding adults issue when the victim is a vulnerable adult.

Many of the concerns relating to adults in our care e.g. women with mental health problems or domestic abuse are managed through the Safeguarding Children process with adult services contributing to the development of a support package. These women have either an existing significant learning disability or a physical disability which has had a detrimental effect on her being able to care for a child without adequate support from adult social care services.

3. Training

All staff need to access training for Safeguarding Vulnerable Adults at an appropriate level for their job role.

Following consultation and training needs analysis (Trust Mandatory Training Matrix) a decision was made that the information required by staff could be delivered in the form of a leaflet, as with Level 1 Safeguarding Children training. The leaflets will be made available to new starters at the Trust Induction and have been distributed to all other staff with the January 2010 payslips. Retention of the leaflet and a record on OLM will provide the evidence of completion of the training.

In addition, in 2009, the Safeguarding Team facilitate a 'Vulnerable Adults' study day twice which included in the programme Vulnerable Adult issues and the implications of the Mental Capacity Act 2005.

4. Policies and Procedures.

A Trust Safeguarding Vulnerable Adults policy has recently been completed. It will be used in conjunction with Birmingham Safeguarding Adults Board Procedures.

5. Partnership working

Partnerships have been developed with the local Vulnerable Persons Officer (VPO) based at Bournville Lane Police Station who will offer guidance and will take referrals from Trust staff when there are concerns about a vulnerable person. This link will also enhance any future training as their participation in future training events has recently been agreed.

6. Governance implications

Unlike Safeguarding Children, there is no specific Safeguarding Adult legislation in England. However, Safeguarding Vulnerable Adults does sit within a wide legislative framework and our statutory duty to safeguard and take appropriate action when abuse is thought to have occurred is incorporated into a number of Acts, including:

- The Human Rights Act (1998)
- The NHS and Community Care Act (1990)
- The Care Standards Act (2000)
- The Mental Capacity Act (2005)
- The Safeguarding Vulnerable Groups Act (2006)
- The Mental Health Act (2007)

7. Care Quality Commission

Having systems in place to Safeguard Vulnerable Adults is also a requirement for the registration process with the Care Quality Commission (Regulation 11, Safeguarding and Safety).

8. Achievements

Although Safeguarding Vulnerable Adults represents only a small part of the work of the Safeguarding Team there has been considerable progress in 2009:

- Development of the Safeguarding Vulnerable Adults Policy.
- Training sessions for staff.
- Training leaflets distributed to all staff with their payslips.
- Partnership development with local Vulnerable Persons Officer.
- BASB leaflets distributed to all areas.

9. Next steps

- Continue with the themes from the previous year.
- Continue to raise the profile of Safeguarding Vulnerable Adults within the Trust.
- Develop a system within the Safeguarding Team for more effective system of recording of referrals for vulnerable adults.
- Audit of compliance with the policy.

Birmingham Women's



NHS Foundation Trust

**Chair's Report to the Board
Public session- February 2010**

Update on Ned recruitment - verbal update provided at meeting.

Activities

- Meetings with clinical directors and general managers of Genetics, gynaecology, histopathology
- Local chairs seminar hosted by Children's chair Jo Davis and Capsticks
- Meetings with governors, outside formal Members' Council meeting
- Meeting with Chief Exec of Birmingham Chamber of Commerce.
- Meeting with Moira Dumma and David Cox of S Birmingham PCT
- Various meetings with interested NED applicants
- NED shortlisting meeting and interviews
- FTN chairs meeting

HH Feb 2010

Birmingham Women's



NHS Foundation Trust

SUBJECT:	Chief Executive's Monthly Report – PUBLIC (February 2010)
REPORT BY:	Steve Peak
AUTHOR:	Steve Peak

CONTEXT AND BACKGROUND FOR REPORT

The purpose of this paper is to update the Board on a number of items of interest.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The paper updates the Board on :

- 2010 Local Clinical Excellence Awards
- Patient Environment Action Team (PEAT) Visit
- Facing the future head on - Update on Lean Methodologies
- Swine Flu Update

RECOMMENDATIONS

- The Board is asked to consider and note the Chief Executive's update for the month of February 2010.

1. 2010 Local Clinical Excellence Awards (CEA)

To note that the CEA panel met in early January and agreed Clinical Excellence Awards for the following Consultants in the 2010 round of applications:

Dr Andy Ewer – 2 points
Professor Khalid Khan – 2 points
Mr Ari Coomersarmy – 2 points
Dr Jenny Morton – 1 point
Mr Mathew Parsons – 1 point

I would like to congratulate Consultant colleagues for their awards and also note the high standard of the applications submitted.

2. Patient Environment Action Team (PEAT) Visit

The Trust welcomed an external assessor on 9th February to review the Trust's environment and patient food standards. The outcome of the visit will be confirmed in due course, however, the PEAT representatives were very positive in their verbal feedback.

Once again I would like to thank all our teams for their continued hard work and commitment in maintaining such high standards.

3. Facing the future head on – Update on Lean Methodologies

Productive Ward

Productive Ward continues at pace. The programme has now commenced in Maternity Ward 1. More staff on all the participating wards are getting awareness of the programme and there is growing enthusiasm for the benefits it is bringing.

The programme will be rolled out further to Wards 3 and 4 within the next month. Two additional modules are being implemented on Wards 7 and 8 – Knowing How We are Doing (KHWD) and Well Organised Ward (WOW). From the implementation of the KHWD module the Trust will soon be able to clearly identify the time saved and efficiencies gained. From the WOW module implementation the wards will be able to make better use of ward space and systematically reduce the stock levels. One additional module, Patient Status At a Glance (PSAG) is being discussed with Ward Managers next week.

A full programme update report is being provided to the Management Board at the end of February.

NHS Improvements Pilot - Histopathology

Good progress is being made with this pilot:

- By the end of January the department was reporting 95% of specimens within 7 days, a 7% improvement from the starting point in November. This enables quicker diagnoses
- The main histology laboratory has re-developed a high level “current state map” of the laboratories processes
- All 3 departmental areas continue to have a 5 – 10 minute meeting each morning to discuss issues, problems and concerns from the day before, to allocation of jobs / roles, improvements and suggestions. This has proved to be very beneficial and the numbers of problems have been reduced
- The department trialled a digital pocket memo to determine whether it improved the reporting process. The trial proved successful and a working solution is currently being drawn up
- The department started implementing the “5S” approach. On the 12th February 2010, the secretary’s office was re-organised – all non essential items/paperwork/folders were removed allowing better accessibility and completely changed the appearance of the room

LEAN projects supported by NHS Elect

Eight initial lean projects are being scoped with NHS Elect during February and March with the projects commencing in earnest in April. The first projects are:

1. Maternity Services Capacity and Service Improvement Project. This is to include the potential for expansion of maternity services (including full capacity study); improvements in triage and DAU facilities and usage; and the induction of labour, discharge, and admission pathways. It will map the current patient pathways and processes before measuring the current system and activity before designing a model to test against the potential for increasing activity and income.
2. Radiology and Antenatal - improving patient flow and ensuring Radiology and Antenatal Clinic has the capacity to meet all follow up scan/review requests required by consultants on the day of their clinic is an area that requires further work. This work extends across Maternity and Clinical Support Directorates
3. Clinical Chemistry/ Antenatal services –the introduction of glucose tolerance testing

4. Physiotherapy - to understand and manage capacity & demand better, reducing the DNA rate and exploring options of processes that can be done differently
5. Lean stock management, procurement systems, and storage facilities within Neonatal Services
6. Laboratory Genetics – improvement of Oncology Turnaround Times
7. Clinical Genetics Unit – development of a waiting list process to improve the management of capacity and demand
8. Gynaecology Directorate -pathways and processes review for improving efficiency of infertility patients going through OPD / ACU

4. Swine Flu Update (H1N1)

Levels of H1N1 are currently low and reducing in both primary and secondary care. As a result the Department of Health has reduced its response to the pandemic. The risk to the Trust has been reviewed and the risk subsequently reduced to Amber on the register.

While the mortality rate from H1N1 – 2009 influenza collectively has been lower than previous pandemics and some previous ‘flu seasons’ what has been different was the manner in which the virus disproportionately affected young people, particularly those with pre-existing chronic illness.

The National Pandemic Flu Service (NPFS) – the online and telephone assessment service - was stood down on 11 February 2010. However, the NPFS can be reactivated within seven days if needed.

There remains considerable uncertainty about how the virus may behave over the coming months and years. In light of this, surveillance, monitoring and vigilance will continue in primary and secondary care.

Within the Trust a number of approaches were taken to minimise the risk to services, patients and staff. These are summarised below:

- A briefing note - “I think I might have swine flu, what do I do?”- was globally communicated to staff and managers in June 2009
- Regular operational manager swine flu meetings were scheduled by Jacky Cotton with Director input from Jane Owen, Peter Thompson and Neil Savage
- A policy for interim staffing in the event of a pandemic flu was developed in partnership with staff side

- The Trust ran a voluntary H1N1 vaccination programme for priority front line staff between November 2009 and February 2010. 230 staff chose to have the vaccine, with a very high uptake from medical staff. Thirteen vaccination sessions were offered on different days and times to maximise the uptake. Venues included clinical areas to minimise the disruption to staff and services.

Ultimately the Trust had very few staff and patients with confirmed H1N1 and the impact on operational services and staffing was negligible. However, the local and regional requirements for daily and weekly monitoring and associated returns had a significant impact on the workload of the Emergency Planning lead and other operational managers. Jane Owen is factoring this in to her current review of Emergency Planning.

Both the Trust and the wider Health Community response to the H1N1 pandemic to date has been successful as a result of much planning, hard work and commitment. As a result of our experiences over the past 6 months, the Trust and the wider NHS is much better placed to deal successfully with future pandemics.

Finally, the Board of Directors should note that 2010/11 Operating Framework states that there are ongoing responsibilities in preparing to respond to threats and hazards including future outbreaks of pandemic flu. The Emergency Planning Group will continue to take this forward within the Trust.

Birmingham Women's



NHS Foundation Trust

SUBJECT :	Proposed amendments to the Trust Constitution
REPORT BY :	Steve Parsons, Head of Corporate Affairs
AUTHOR :	Steve Parsons, Head of Corporate Affairs

CONTEXT AND BACKGROUND FOR REPORT

Over the summer of 2009, a desk-top review of the Trust Constitution was undertaken to identify any areas for potential change after the Trust's first year as a Foundation Trust. Several areas of possible change were identified.

The various areas for change were discussed with Directors, and also with the relevant Committees of Members' Council (Membership and Nomination & Remuneration). Following consideration of the comments received, final wordings were presented to Council for their comments, in accordance with the Trust Constitution, at the December 2009 meeting, with a further explanatory presentation being made at the February 2010 meeting.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

At the meetings in December 2009 and February 2010, the Council commented on the following areas:

Standing Appointments Committee

Governors expressed some concern that the proposed structure of the Standing Appointments Committee had only one Public Governor, and requested that 2 Public Governors be in membership of the Committee.

In regulatory terms, this is acceptable as there is also a Patient and Carer Governor on the proposed Committee, and these two categories are taken together for regulatory purposes (there is no requirement to have a separate patient category under the Act). The proposed structure is designed to give a balance of around 60:40 between Governors and Directors on the Committee, whilst ensuring that it does not become too large to be effective.

After consideration, it is recommended to the Board that this suggestion from Council is accepted. The wording attached to this report has been amended

ENCLOSURE 12

to reflect this change.

Governors expressed concerns about the position of the Chief Executive as able to attend all sessions of the Committee

The proposed wording reflects that currently in the Trust Constitution (Annex 9, Appendix 3, para 1.2.6), which on its face permits the Chief Executive to attend all meetings of a NED Appointments Committee in an advisory capacity.

Concerns were expressed that this permitted the Chief Executive to be present when appointment and removal decisions were made in respect of those who were responsible for holding the Chief Executive to account. The Chief Executive noted that he could conceive of no circumstances where he would regard it as appropriate for him to remain at that point. The Board will also be aware that the law requires that the appointment of Non-Executive Directors is undertaken by a full meeting of Council, and this cannot be delegated to a Committee.

Concern was expressed regarding the proposal for Governor members to be elected annually

The proposed amendments suggest that the Governors on the Standing Appointments Committee should be subject to annual election at the Annual Meeting of Members' Council (the September meeting). Some Governors expressed concern about this proposal, in that it might prevent the accumulation of skills within the Committee. Reference was made to an alternative proposal for 'core' and 'additional' members of the Committee.

After consideration of the comments of Governors in this area, it is proposed to the Board that the original proposals be adopted. The proposals ensure that the membership of this Committee is subject to regular refreshment, at the pleasure of Council. It would be for Governors in each Constituency (who will elect their representative member) to determine in each year whether the same Governor should continue, by a process of secret ballot. It is suggested that one of the considerations will be the effectiveness of that Governor in the role; and that Council should have the opportunity to change membership in a regular way without the need for a negative vote on a Governor (i.e., on a motion to remove).

The Board will also be aware that a similar arrangement is proposed for the position of Senior Governor, on which no adverse comment was received.

RECOMMENDATIONS

The Board is invited to approve, and submit to Monitor for ratification, the proposed changes:

ENCLOSURE 12

- a. Relating to Volunteer Members (Section A)
- b. Relating to membership of the Patient and Carer Constituency (Section B)
- c. Relating to a rotational basis of election for Governors (Section C)
- d. Relating to the position of Senior Governor (Section D)
- e. Relating to the appointment process for the Trust Chairman and the Non-Executive Directors (Section E)
- f. Relating to the correction of drafting infelicities (Section F)

Birmingham Women's



NHS Foundation Trust

SUBJECT :	Possible re-organisation of the Public Constituency
REPORT BY :	Steve Parsons, Head of Corporate Affairs
AUTHOR :	Steve Parsons, Head of Corporate Affairs

CONTEXT AND BACKGROUND FOR REPORT

The Board will be aware that the Trust has experienced ongoing difficulties in electing Governors to serve for the Heart of Birmingham and North & East Birmingham area of the Public Constituency, having not had a serving Governor since Autumn 2008. Work is ongoing to encourage members to stand in this area, and it was hoped that candidates would come forward in Autumn 2009, but ultimately those who had indicated an interest chose not to stand.

Consequent on this, consideration had been given by the Secretariat to possible alternative approaches, including the possibility of 're-districting' the Public Constituency. This would be along the lines of a 'doughnut' – South Birmingham would remain as the 'hole', with West Midlands North and West Midlands South around the outside. Such a change would require amendments to the Constitution, and the distribution of seats between North and South would need to be considered.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

- The public in the HoB/ N&E Birmingham area is formally unrepresented in the structure of the Trust, as there are no Governors for the area
- The other two areas in the Public Constituency had consistently produced Governors, and have usually had contested elections. Therefore, representation should be achievable
- It would be hoped that having active Governors in place would encourage those living in HoB/N&E Birmingham area to become more involved and eventually seek election
- In broad terms, the North and South areas would be separated by a line running East-West through the centre of Birmingham. The precise line would 'jig' slightly as it must follow local government wards, and not cross the South Birmingham constituency boundary
- With the re-drawing of the boundaries, it would be likely that the Governors

ENCLOSURE 13

in the current (wider) West Midlands area would need to seek re-election within the new constituencies

- The split of seats (there are currently 5 across HoB/ N&E Birmingham and West Midlands) would need to be considered; either one would have an extra seat or an additional seat would need to be created.

RECOMMENDATIONS

The Board is invited to:

- a. Comment on this possible solution, and
- b. If thought fit, refer it to Members' Council for comment.



Trust-wide Risk Management Strategy

Policy category and number:	A
Version:	5.2
Name of approving committee:	Board of Directors
Ratified by:	Board of Directors
Date ratified:	[Add text here]
Date issued:	[Add text here]
Review date:	[Add text here]
Name of Lead Officer	Peter Thompson
Name of originator/author:	Cath Roper
Job title of author:	Risk Manager
Target audience:	Trust-wide

Version Control Sheet

Version	Date	Author	Status	Description of Amendment
1.0	February 2003	Diane Halliley, Risk Manager	Archived	
2.0	October 2004	Diane Halliley, Risk Manager	Archived	
3.0	October 2006	Diane Halliley, Risk Manager	Archived	
4.0	October 2007	Malcolm Bowcock, Clinical Effectiveness Manager	Archived	
5.0	January 2009	Cath Roper, Risk Manager	Approved	Ratified by Board of Directors
5.1	August 2009	Cath Roper, Risk Manager	Draft	Updated in line with new format and BAF review and recommendations. Reference to training matrix amended.
5.2	February 2010	Michelle Walsh, Clinical Effectiveness Facilitator	Draft	Reformatted. Objectives, review section and monitoring table amended. Emergency Planning added. Appendix relating to Membership and responsibilities of forums removed.

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1. Introduction

The purpose of this strategy is to ensure that the Trust will take all steps (reasonably practicable) in the management of all risks to service users, staff, visitors, structures, reputation and any other issue which could impact upon, or compromise the ability of the Trust to carry out its normal activities. The management of risk is therefore an integral part of the Trust's everyday business.

2. Objectives

The Strategy identifies an overall vision that encompasses risk management awareness and training for all staff. It provides the framework to develop and maintain a clear and effective structure of responsibility and accountability across the whole Trust, together with clear systems for identifying and managing risks, so that all Trust employees will be able to fulfil their responsibilities in protecting others, themselves and the organisation from risk.

The Trust will aim to achieve this vision by implementing the following objectives:

- Provide risk management training and support to meet the needs of staff as identified in the Trust Training Needs Analysis within the Trust Mandatory and Statutory Training Policy.
- Continue to develop robust arrangements in all Directorates for identifying, assessing, recording and managing risks, in line with key Trust risk management policies, as listed in Section 9 of this Strategy.
- Record the results of risk assessments as per the Trust's Risk Assessment and Risk Register Policies, ensuring that risks are escalated to the appropriate levels.
- To encourage a culture of openness in terms of reporting, investigating and learning from incidents, complaints and claims, by the continued implementation of Datix web and the Trust's commitment to the Patient Safety Campaign.
- The Trust will continue to implement a system of internal control based on an ongoing risk management process, using the principles of the assurance framework. It is supported by compliance with external standards, for example the Care Quality Commission registration requirements and the NHS Litigation Authority (NHSLA) Risk Management Standards. Other assurances are gained from Internal Audit. These assurances are included within the registration with the CQC, the Statement on Internal Control and the requirements of Monitor.

3. Scope

This document sets out the Trust's overall organisational approach to risk management as determined by the Board of Directors. The strategy outlines

management arrangements for the identification, assessment, treatment and monitoring of all risk, whether clinical or non-clinical.

4. Indemnity Statement

“The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise
- Have been fully authorised by their line manager and their Directorate to undertake the activity
- Fully comply with the terms of any relevant Trust policies at all times
- Only depart from any relevant Trust guidelines providing that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where; in the judgement of the responsible clinician it is fully appropriate and justifiable. Such decisions are to be fully recorded in the patient notes.”

5. Document Definitions

Risk can be defined as uncertainty of outcome, whether positive opportunity or negative threat, of actions and events.

Risk Management includes all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.

Risk Assessment is the evaluation of risk with regard to the impact if the risk is realised and the likelihood of the risk being realised.

Inherent Risk the exposure arising from a specific risk before any action has been taken to manage it.

Residual Risk the exposure arising from a specific risk after action has been taken to manage it and making the assumption that the action is effective.

Risk Appetite is the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.

Control is any action, originating within the organisation, taken to manage risk. These actions may be taken to manage either the impact if the risk is realised, or the frequency of the realisation of the risk.

Risk Profile is the documented and prioritised overall assessment of the range of specific risks faced by the organisation.

Assurance is an evaluated opinion, based on evidence gained from review, on the organisation’s governance, risk management and internal control framework.

6. Duties and Responsibilities

All staff working in the Trust have an individual responsibility for risk management activities.

The following have specific roles in the risk management system:

6.1 Board of Directors

The Board of Directors will determine the risk appetite of the organisation.

6.2 Chief Executive

The Chief Executive has overall responsibility for an effective risk management system in the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance.

- Continuously demonstrating personal commitment and support for the promotion of risk management and an open and fair culture
- Ensuring that a risk management structure is in place to encompass all elements of risk and that a reporting framework is in operation to enable the Board of Directors to be assured that the risks, in accordance with agreed quality of service and the risks associated with the organisation, are effectively managed
- Ensuring that Executive Directors are assigned responsibilities for the management of clinical and non-clinical risks
- Overseeing the handling and monitoring of complaints and litigation claims arising from direct patient care

6.3 Executive Directors

The Executive Directors are responsible for directing the risk management system and ensuring the necessary assurance arrangements are in place through staff whom they are managerially and professionally accountable by:-

- Continuously demonstrating personal involvement and support for the promotion of pro-active risk management and governance
- Setting objectives for risk management in line with the Trust's Corporate Business Plan and monitoring progress
- Ensuring managers and safety representatives within their areas of responsibility are appropriately trained in risk assessment and health and safety
- Ensuring all staff are of appropriate professional and technical competence and adequately trained for the tasks they are required to undertake
- Overseeing the handling and monitoring of complaints and litigation claims arising from direct patient care
- Ensuring that there is a robust system in place for the management of all "Red" risks bringing these to the attention of the Chief Executive and Trust Risk Manager
- Ensuring systems are in place to continue the development of Building a Memory: Preventing harm, reducing risks and improving patient safety

- Accountable to the Chief Executive

6.4 Non-Executive Directors

Non-Executive Directors will provide scrutiny and assurance to the Board of Directors by being members of the Audit Committee, Clinical Governance Committee and Risk and Organisational Governance Committee.

6.5 Medical Director

In addition to the general responsibilities of Executive Directors of the Trust, the Medical Director has the following responsibilities for risk management throughout the Trust:

- Lead of the Clinical Governance Directorate
- Responsibility for delivering clinical governance in the Trust
- Lead Director with responsibility for Maternity Services
- Ensuring that systems are in place to provide an educated, skilled and competent medical staff workforce within the Trust
- Managing the strategic development and implementation of clinical risk management and clinical governance
- Meeting the clinical risk management conditions of the NHS Litigation Authority
- Ensuring the development of the Standards for Better Health / Health and Social Care Regulations, monitored by the Care Quality Commission
- Responsible for advising on legislation and guidance
- Responsible for bringing all “Red” risks to the attention of the Chief Executive and Trust Risk Manager
- Participate in the reporting to external organisations of “red risks”/ serious untoward incidents where appropriate.
- Ensuring root cause analyses are carried out where required and in the case of serious untoward incidents, leading the process.

6.6 Director of Nursing, Midwifery and Operations

In addition to the responsibilities laid down for Executive Directors and Directors, the Director of Nursing, Midwifery and Operations shall have the following responsibilities:-

- Joint lead of the Clinical Governance Directorate
- Ensuring that systems are in place to provide an educated, skilled and competent nursing\midwifery workforce within the Trust
- Ensuring compliance with the statutory requirements of the NMC
- Working with the Medical Director in implementing and monitoring clinical governance throughout the clinical areas of the Trust and in particular overseeing the development of clinical audit
- Responsible for advising on legislation and guidance
- Professional responsibility for Heads of Nursing and Midwifery
- Ensuring the maintenance of the Standards for Better Health / Health and Social Care Regulations, monitored by the Care Quality Commission
- Ensuring that all “Red” risks are brought to the attention of the Chief Executive and Trust Risk Manager
- Ensuring systems are in place for the continued development of Building a Memory: Preventing harm, reducing risks and improving patient safety

6.7 Director of Workforce and Organisational Development

In addition to the responsibilities laid down for Executive Directors and Directors, the Director of Workforce and Organisational Development shall have the following responsibilities:-

- Chair of the Organisational Risk and Governance Committee (ORAG)
- Working closely with Executive Directors to ensure that systems are in place to provide an educated, skilled and competent workforce within the Trust
- Ensuring compliance with the statutory requirements of professional regulatory bodies not falling under the jurisdiction of the Nursing and Medical Director
- Working with the Executive Directors in implementing and monitoring governance throughout the non-clinical areas of the Trust

6.8 Director of Finance

In addition to the responsibilities of Executive Directors and Directors, the Director of Finance has responsibility for managing the strategic development and implementation of financial risk management and the security of IT systems.

6.9 Clinical Governance Manager

- Ensures risk management responsibilities of staff within the Clinical Governance Directorate are undertaken
- Has line management responsibility for the Trust Risk Manager
- Has line management responsibility for the Lead Clinician for Clinical Risk
- Accountable to the Medical Director
- Is a member of the Clinical Governance Committee

6.10 Trust Risk Manager

- Supports the Trust and its directorates in developing and delivering a programme of risk management in line with the Trust Risk Management Strategy
- Supports the development of the clinical and non-clinical incident reporting system across the Trust
- Project manages processes for participation in external assessment for NHSLA Acute and CNST Maternity Risk Management Standards
- Provides advice and support on Risk Management and reports as required to the Trust and its directorates
- Works with the Lead Clinician for Clinical Risk on responses including actions and learning from incidents and near misses
- Advises the Legal Services Manager of incidents with the potential for litigation and acts upon feedback from the Legal Services Manager through the litigation process
- Participates in root cause analysis as required
- Is a member of the Clinical Governance Committee
- Is a member of the Organisational Risk and Governance Committee
- Accountable to the Clinical Governance Manager

6.11 Lead Clinician for Clinical Risk (Trust Wide)

- The Lead Clinician for Clinical Risk is a member of the Clinical Governance Committee and oversees management of clinical risk
- Can be consulted on any specific issues as required
- Works with the Risk Manager, Legal Services Manager and Clinical Governance Manager on outcomes and learning from incidents and near misses
- Ensures effective communication of clinical risk management in both induction and training of junior medical and nursing staff
- Participates in root cause analysis as required
- Accountable to the Clinical Governance Manager

6.12 Directorate Responsibilities

Each Clinical Director is responsible for the implementation of risk management within their Directorate, supported by other professional staff with Clinical Governance / Risk Management Responsibilities. These responsibilities are defined in the individual job descriptions and in the local Directorate Risk Management Strategy. These include:

- Maternity Services Risk Management Strategy
- Gynaecology Services Risk Management Strategy
- Clinical Support Services Risk Management Strategy
- Clinical Genetics Services Risk Management Strategy
- Neonatal Services Risk Management Strategy

7. Procedures

The management of risk across the Trust is undertaken using the following processes.

7.1 Risk Prevention

All areas within the Trust must be diligent in the identification and assessment of clinical and non-clinical risk, and draw up action plans to minimise the occurrence of incidents and accidents. In the event of an incident or accident occurring, the processes described in this document must be followed in order to identify systems failure and reduce the potential for recurrence.

7.2 Incident Reporting Policy

All staff have a duty to adhere to the principles of the Incident Reporting Policy.

7.3 Risk Identification

This is the process of identifying what has happened or could happen, why and how. Once a risk has been identified, it should be assessed.

7.4 Risk Assessment

The Risk Assessment Policy describes the risk assessment process i.e. the identification of actual and potential risks, and ensures adequate control measures are in place to eliminate or reduce risks to the lowest level reasonably practicable, by identifying specific responsibilities to both employer and employee and defining recognised risk assessment tools.

- Risk analysis addresses frequency and impact
- Risk Evaluation determines priorities by comparing against criteria/standards
- Risk Matrix provides a scoring system for prioritising risks by examining the likelihood of a risk happening multiplied by the severity of its consequence.

Once an inherent risk has been assessed, controls should be put in place and details recorded on the Trust Risk Register.

7.5 Risk Treatment and Control

This is a process of selecting and implementing appropriate options to manage identified risk, in order to minimise or eliminate that risk.

7.6 Risk Register of Clinical and Non Clinical Risk Assessments

The Trust Risk Register Policy identifies the process by which the Trust Board reviews the organisation wide risk register.

The 2 categories of risk we use are:

- Clinical
- Corporate

Further sub categorisation enables clearer focus of what aspect of the organisation may be affected if the risk occurs. E.g. reputation, financial, Health and safety, Infection Control.

All managers must be familiar with the assessment tools, recording assessments and use of the Risk Register in order to ensure that an effective system is in place for identification and control of risks to the safety of patients, as well as to the non clinical aspects of our business.

7.7 Action Planning

Identification and assessment of the risk and the controls in place will facilitate a structured approach to the management of that risk. With all issues documented in one place, the development of an action plan to identify next steps, responsibilities and timescales is necessary.

Staff must be aware of the action plans identified from these assessments within their specific area of work.

7.8 Monitoring and Reviewing Risk

7.8.1 External Monitoring

This is undertaken by the NHS Litigation Authority (NHSLA) through the Clinical Negligence Scheme for Trusts (CNST) Maternity Standards assessments and the NHSLA Risk Management Standards for Acute Trusts assessments.

All staff must be familiar with, and comply with the NHSLA Risk Management Standards for Acute Trusts and proactively work towards compliance with Level 3 status. In addition where applicable, staff must actively work to achieve the requirements of CNST Maternity Standards at Level 3.

The Care Quality Commission undertakes formal review of activity through monitoring of compliance with Standards for Better Health / Health and Social Care Act Regulations through Registration and as part of its Annual Health Check. Staff should be equally aware of these standards and how their area of work complies with and is affected by them.

Monitoring of serious untoward incidents is performed externally by Monitor and the main purchaser of the Trusts' services, South Birmingham PCT.

The Trust also participates in further speciality and department specific accreditation programmes which aim to minimise risk by setting standards and assessing against them, e.g. CPA.

7.8.2 Internal monitoring

This is facilitated through:

- Risk register review
- Trend analysis
- Incident reporting
- Complaints and litigation
- The Raising Concerns at Work (whistle blowing) Policy
- Progress against the Corporate Objectives
- Integrated Performance Report / Dashboard
- Assurance from Internal and External Audit
- Compliance levels with National Standards
- Compliance levels with the NHSLA Risk Management Standards
- Committee reporting structure
- The Board Assurance Framework
- The Statement on Internal Control

7.8.3 Internal Risk Management Reporting Structures

Refer to Appendix A and the Directorate-specific Risk Management Strategies for an overview of risk management reporting structures within the Trust.

The Clinical Governance Committee, the Organisation Risk and Governance Committee and the Audit Committee are the three sub-committees of the Board of Directors with responsibility for risk.

The Clinical Governance Committee has primary responsibility for risks within the clinical work of the Trust, as set out in their terms of reference. This is achieved by consideration, discussion and overview of the following:

- Quarterly risk reports from the Directorates regarding numbers, types, details and trends of incidents, complaints, and claims.
- Quarterly aggregated reports of incidents, complaints and claims produced by the Risk Manager.
- Formally receiving on behalf of the Trust, external sources of learning and best practice recommendations including National Institute of Health and Clinical Excellence (NICE), Confidential Enquiry into Suicide and Homicide (CISH), National Confidential Enquiry into Patient Outcome and Death (NCEPOD), appropriate professional bodies, the Care Quality Commission and other national guidance issued which may affect clinical practice.
- Ensures benchmarking of our service is undertaken against these, identifying gaps, producing action plans, overseeing implementation of these.
- Monitoring responses and disseminating learning via the CGC Directorate Quarterly Quality Indicator reports. Where there are trends and in the case of serious incidents, RCA is used to gain an understanding of the problems and to identify changes that need to be made. This is a multi-disciplinary process which involves operational staff and incorporates the patient perspective. Solutions are developed that are realistic and sustainable and have local ownership. These are collated annually in the BWH clinical annual report
- Considering reports of RCAs undertaken in the directorates
- Monitoring the use of Clinical Audit across the Trust to ensure standards are met and that practice is continuously improved.
- Oversees implementation of required changes highlighted by patient surveys including the national inpatient, outpatient and maternity surveys

The Organisational Risk and Governance Committee has primary responsibility for risks that affect the corporate and non-clinical work of the Trust, as set out in their terms of reference, including, for example:

- market and competitive risk
- regulatory risk (including risk of non-compliance with the terms of the Trust's Authorisation as an NHS Foundation Trust)
- health, safety and environmental risk
- ethical and reputational risk
- information security risk
- risk to business continuity

In carrying out this principal duty, the Organisational Risk & Governance Committee will:

- raise awareness of corporate governance and corporate risk management throughout the Trust
- regularly review the Trust's corporate governance and corporate risk management strategy and framework and monitor the overall level of corporate risk within the Trust, taking into account the requirements of the NHS Litigation Authority and Monitor guidance
- liaise with the Clinical Governance Committee on matters which fall within the terms of reference and responsibilities of both committees

- ensure that the Board and executive management have available to them clear, timely and intelligible corporate risk registers and other information as necessary to enable them to ensure themselves of the effectiveness of the Trust's corporate risk management arrangements and to detect and act upon changes in individual risks or the Trust's overall corporate risk profile
- carry out investigations and prepare reports as required by the Board
- receive and consider quarterly aggregated reports of incidents, complaints and claims produced by the Risk Manager.

The Audit Committee has primary responsibility for risks that relate to financial controls, as set out in their terms of reference. They also:

- Give the Board of Directors written independent verification on the risk management systems in place in the Trust
- Review the establishment and maintenance of an effective system of internal control and risk management in particular:
 - the adequacy of all risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board
 - structures, processes and responsibilities for identifying and managing key risks facing the organisation
 - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements
 - The operational effectiveness of policies and procedures
 - The policies and procedures for all work related fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud Services.

All of the above reports are recognised as useful resources in identifying risk which may be incorporated onto the risk register where appropriate. The reports, associated action plans and changes in practice are discussed, monitored and reviewed at the directorates' clinical improvement groups and at the directorate meetings.

7.9 Staff Induction and Training

All new employees are required to attend the Trust Induction training day on commencement of employment, followed by a flexible individualised area specific induction programme. Staff will be informed of the principles of this strategy and all associated policies at Induction. Attendance at training will be monitored through the Trust training database.

A Risk Management Training matrix has been developed that identifies the necessary training for different staff groups within the Trust. The matrix can be found in the Trust Mandatory and Statutory Training Policy, and is supported by a training needs analysis (TNA), specific for each particular area of training.

Permanent members of the Medical Staff and Junior Doctors who work within the Trust for more than a year must attend mandatory training annually.

Health Care Assistants and non-clinical staff must attend mandatory training relevant to their roles as described in the Trust TNA.

Staff working in the Maternity Directorate may need additional training. Training requirements and relevant Training Needs Analyses are also included in the Trust Mandatory and Statutory Training Policy.

7.10 Professional Development Plans

All Medical, Nursing and support staff must have annual appraisals and complete a professional development plan in line with their job's KSF.

7.11 Recommended Best Practice Guidance

All clinical staff have a professional responsibility to ensure they are familiar with the best practice guidance which applies to them e.g. Trust Guidelines for Professionals, Royal College of Midwives' Midwifery Guidelines, the Royal Marsden Manual of Clinical Nursing Procedures, Essence of Care etc.

7.12 Trust Policies

Staff must be familiar with, and adhere to the principles stipulated within Trust policies.

Individuals producing policies and guidelines must ensure they comply with the Policy for the Development, Distribution and Maintenance of Trust Policies and Procedural Documents.

7.13 Clinical Audit

All clinical staff are required to be actively involved in clinical audit. Directorates produce Core Audit Plans on a 1 to 3 year basis prioritised according to risk assessment involving the following criteria:

- The needs of women and their families who use the Trust
- National Confidential Enquiries
- National guidance e.g. NICE guidance, Essence of Care
- Clinical Indicators of Outcomes
- Professional bodies
- Outcomes of Incident and formal reviews including action plans and changes in practice
- Complaints
- Integrated Care Pathways
- NHSLA Risk Management Standards for Acute Trusts

7.14 Emergency Planning

Under the requirements of Civil Contingencies Act 2004 the Trust has a statutory duty to be prepared to respond to an emergency, continue to support emergency response partners and continue to provide essential services to the public as is reasonably practical under such circumstances.

Health emergency preparedness is met through the implementation of the Major Incident Plan and Business Continuity Plans. The Emergency Planning Group reports to Management Board and is responsible for:

- Planning the Trust's response to any emergency situation
- Reviewing current operational arrangements and recommendations for improvements in practice.
- Ensuring all Trust plans and procedures reflect local and national guidance
- Ensuring Trust has up-to-date Business Contingency Plans
- Ensuring regular training and testing exercises are undertaken
- Providing assurance to the Board of Directors

7.15 Supporting Staff

It is important that staff involved in serious adverse clinical events are supported appropriately as they may be psychologically traumatised. Some may find it difficult to continue working. There may be an adverse impact on their personal lives and mental health. The amount and type of support required will be determined by the individual and their line manager. The Trust Policy for Supporting our Staff outlines support systems available.

7.16 Communication and Co-ordination

Various communication forums in the Trust enable all staff members to meet to discuss risk management issues and subsequently disseminate information to staff in all areas. These are described in Appendix A and in the Directorate-specific Risk Management Strategies.

8. Review, Monitoring, and Revision Arrangements

Monitoring	Method	Frequency	Lead	Reporting to
Patient Safety Reports	Report	Monthly	Medical Director	Board of Directors
Integrated Performance Report / Dashboard	Report	Monthly	Executive Directors	Board of Directors
Progress with Corporate Objectives	Report	Quarterly	Executive Directors	Board of Directors
Monitor requirements	Report	Quarterly	Executive Directors	Board of Directors
Care Quality Commission Registration	Report	Annually	Director of Nursing, Midwifery and Operations	Board of Directors
Board Assurance Framework	Report	Annually	Internal Audit	Chief Executive and Audit Committee
Statement on Internal Control	Report	Annually	Internal Audit	Chief Executive and Audit Committee

The duties of the Clinical Governance Committee, Audit Committee and Organisational Risk and Governance Committee will be monitored as detailed in their respective Terms of Reference.

Directorate arrangements for risk management will be monitored as detailed in Directorate-specific Risk Management Strategies.

As the Trust Risk Assessment and Risk Register Policies form the operational basis for how risk is managed within the Trust, this will also form the basis for the monitoring of this strategy; this process is outlined in the Risk Register Policy.

Other risk management systems, such as Incident Reporting and Managing Complaints will be monitored as detailed in the policies and procedures listed in Section 9 of this strategy.

9. Associated Documents

This strategy relates to systems and processes detailed in various other documents and should be read in conjunction with these. The list below is not exhaustive but highlights associated policies staff must be aware of:

- Audit Committee Terms of Reference
- Clinical Governance Committee Terms of Reference
- ORAG Terms of Reference
- Risk Register Policy
- Risk Assessment Policy
- Incident Reporting Policy
- Policy and Procedure for Managing Patient Concerns, Complaints and Compliments
- Claims Management Policies and Procedures
- Root Cause Analysis Policy
- Aggregated Data and Sharing Learning from Incidents, Complaints and Claims Policy
- Best Practice Policy
- Infection Control Policies
- Health & Safety Policy
- Security Policy
- Slips, Trips and Falls Policy
- Manual Handling Policy
- Raising Concerns at Work (Whistle Blowing) Policy
- Corporate and Local Staff Induction Policy
- Mandatory and Statutory Training Policy, including Training Needs Analysis
- Policy & Procedures for the Verification of Registration of all Health Care Professionals
- Policy for Supporting Our Staff
- Policy for the Development, Distribution and Maintenance of Trust Policies and Procedural Documents
- Policy for External Agency Visits
- Standing Financial Instructions
- Major Incident Plan

- Directorate-specific Risk Management Strategies
- Clinical Governance Strategy
- Patient & Public Involvement Strategy
- Clinical Audit Strategy

10. References

Risk Management in the NHS. NHS Executive 1994

HSC 1998/ 113 A A First Class Service. Quality in the new NHS

HSC 1999/ 065 Clinical Governance. Quality in the new NHS.

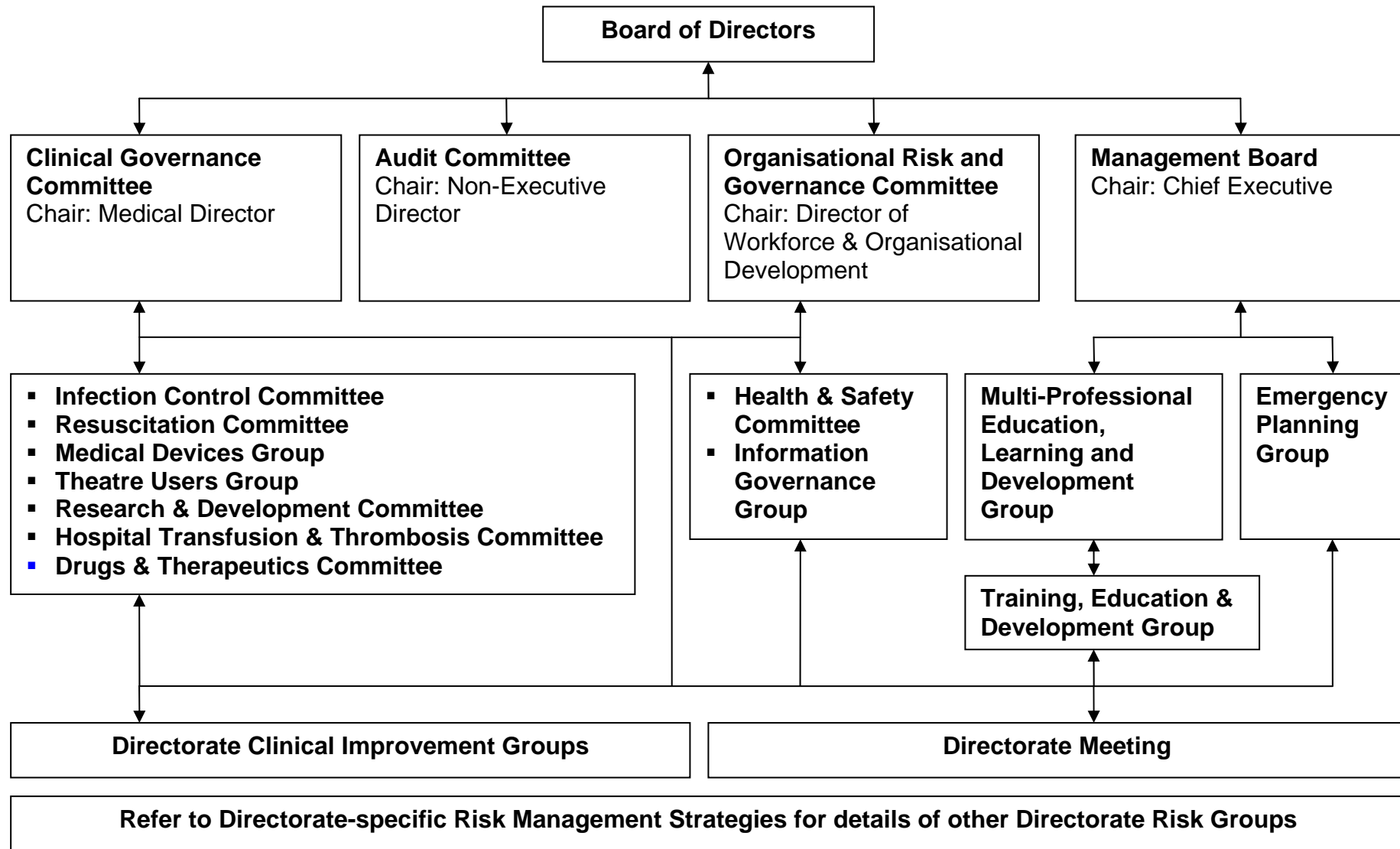
Clinical Risk Management for Obstetricians and Gynaecologists - Clinical Governance Advice No 2 . RCOG January 2001

NHSLA Risk Management Standards for Acute Trusts Standards April 2007.
NHS Litigation Authority

The Orange Book, Management of Risk - Principles and Concepts. October 2004. HM Treasury

Risk Management Strategy 2008-2010. University Hospitals Birmingham NHS Foundation Trust 2008

Appendix A – Trust Risk Management Structure



Appendix B – Plan for Dissemination of Procedural Documents

To be completed by the Head of Corporate Affairs and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Trust Risk Management Strategy		
Date finalised:	February 2010	Dissemination lead: Print name and contact details	Jenna McGlinchey Ext 2695
Previous document already being used?	Yes		
If yes, in what format and where?	Intranet		
Proposed action to retrieve out-of-date copies of the document:	Archive previous version and replace with version 6.		
To be disseminated to:	How will it be disseminated, who will do it and when?	Paper or Electronic	Comments
All Staff	Intranet	E	

Dissemination Record to be used once document is approved.

Date put on register / library of procedural documents		Date due to be reviewed	
Disseminated to: (either directly or via meetings, etc)	Format (i.e. paper or electronic)	Date Disseminated	No. of Copies Sent

Appendix C – Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy/Function Details	
Name of Policy/Function ¹ , Service, Plan, SLA, Function, Contract or Framework:	Trust Risk Management Strategy
Is this a new policy or function?	New <input type="checkbox"/> Existing <input type="checkbox"/> Updated <input checked="" type="checkbox"/>
Responsible Manager	Cath Roper
Date Assessment Completed:	18 August 2009
Sources of Data	

Screening Assessment					
Equality Group	Impact		Status of Impact		Brief Detail of impact
	Yes	No	Positive	Negative	
Race, Ethnicity, Colour, Nationality or national origin (incl. Romany Travellers, refugees and asylum seekers)		X			
Gender or Marital Status of Men or Women		X			
Gender or Marital Status of Transsexual or Transgender people		X			
Religion or belief		X			
Physical or Sensory Impairment		X			
Mental Health Status		X			
Age or perceived age		X			
Sexual Orientation (Gay, Lesbian, Bisexual)		X			
Offending Past		X			
Other Grounds (i.e. poverty, homelessness, immigration status, language, social origin)		X			
<i>Please provide details of any mitigation you can provide against negative impacts highlighted above</i>					

¹ Policy/Function for the purpose of this document also includes Services, Plans, SLAs, Contracts, Care Pathways and Service or Care Frameworks.

Assessment Narrative	
Are there any alternative service/policy provisions that may reduce or eradicate any negative impacts?	
N/A	
How have you consulted with stakeholders and equalities groups likely to be affected by the policy?	
Members of CGC and ORAG consulted.	
What are your conclusions about the likely impact for minority equality groups of the introduction of this policy/service?	
No impact	
How will the policy/service details (including this Equality Impact Assessment) be published and publicised?	
TBC	
How will the impact of the policy/service be monitored and reviewed?	
As detailed in section 8 of the document	
Assessor Name:	Catherine Roper
Assessor Job Title:	Risk Manager
Date Completed:	18 August 2009

Appendix D – Policy Checklist

	Title of document being reviewed:	Yes/No/Unsure	Comments
1.	Title		
	Is the title clear and unambiguous?	Yes	
	Has all the information on the front page been completed?	Yes	Further information required following ratification process
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	Rationale		
	Are reasons for development of the document stated?	Yes	
3.	Development Process		
	Is the method described in brief?		
	Is the responsible policy leads name and title clearly printed?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	Content		
	Is the objective of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Is the language used in the document clear, jargon free and spelt correctly?	Yes	
5.	Format		
	Does the policy conform to the prescribed policy format?	Yes	
6.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited using Harvard referencing?	Yes	

	Title of document being reviewed:	Yes/No/Unsure	Comments
7.	Approval		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
8.	Document Control		
	Has a version control sheet been placed at the front of document, and been filled out correctly?	Yes	
9.	Process to Monitor Compliance and Effectiveness		
	Is there a plan to review or audit compliance with the document?	Yes	
10	Review Date		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11	Equality Assessment		
	Has an equality impact assessment been carried out?	Yes	
Individual Approval			
If you are happy to approve this document, please sign and date it below, and put the document onto the DMS for final approval			
Name	Michelle Walsh	Date	February 2010
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			