

# Birmingham Women's



NHS Foundation Trust

## PUBLIC SESSION

**MEETING OF THE BOARD OF DIRECTORS**  
to be held in the Seminar Room, Education Resource Centre  
on Thursday 30<sup>th</sup> September 2010 at 9 am

### AGENDA

		<b>Enc</b>
1	Welcome and apologies Apologies should be sent to Jackie Howell at jackie.howell@bwhct.nhs.uk, tel 0121 627 2601	
2	Declarations of interest	
3	Minutes of the meeting held on 29 <sup>th</sup> July 2010	1
4	Matters arising from the minutes of the meeting held on 29 <sup>th</sup> July 2010 (where not covered by agenda items)	
5	Report of the proceedings of the Board in private session, July 2010	HH 2
<b>Items for Discussion</b>		
6	Red Risk Register and Assurance Framework	SIP 3
7	Integrated Performance Report, August 2010	JO NS JaB 4
8	Patient Safety Report	PT 5
9	Facing the Future Head on – update on Lean, Service Line Management & Listening Into Action	SP 6
10	Cancer targets update	JO 7
<b>Items of Report</b>		
11	Trust Chair's report	HH 8

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|-----------|--|-----------|-------------|
| <b>12</b> | Report by the Chief Executive  | SP        | <b>9</b>    |
| <b>13</b> | Update from the Chairman of Council  | HH        | <b>Oral</b> |
| <b>14</b> | Updated Register of Director's Interests   | SIP       | <b>10</b>   |
| <b>15</b> | Questions from the public on matters relating to the agenda  |           |             |
| <b>16</b> | <b>Exclusion of the public</b><br>To RESOLVE that representatives of the press and other members of the public be excluded from the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. | <b>At</b> | <b>11am</b> |

**Dates of next meetings**

Thursday 28<sup>th</sup> October 2010  
Thursday 25<sup>th</sup> November 2010

# Birmingham Women's



## NHS Foundation Trust

**Unconfirmed Minutes of the  
MEETING OF THE FOUND TRUST BOARD  
HELD IN PUBLIC  
In the ERC Seminar Room,  
On Thursday 29 July 2010**

<b>PRESENT :</b>	Helen Hemberg	In the Chair
	Ian Booth	Non-Executive Director
	Jason Burn	Director of Finance
	Jane Owen	Director of Nursing, Midwifery and Operations
	Steve Peak	Chief Executive
	Robin Rison	Non-Executive Director
	Neil Savage	Director of Workforce & Organisational Development
	Marianne Skelcher	Non-Executive Director
<b>IN ATTENDANCE:</b>	Jackie Howell	PA to Chair & Chief Executive
	Jenna McGlinchey	Membership Officer
	Steve Parsons	Head of Corporate Affairs

**FTP/0710/1 Welcome and Apologies**

FTP/0710/1.1 The Chair welcomed attendees to the meeting, including Vicki Davies, newly appointed Staff Engagement Facilitator, and Jackie Howell, who would be recording the minutes in the absence of Diana Wyllie on annual leave.

FTP/0710/1.2 Apologies were received from Nigel Gardner and Peter Thompson

**FTP/0710/2 Declarations of Interest**

No interests were declared in relation any agenda items for the meeting

**FTP/0710/3 Minutes of the meeting held on 24 June 2010**

FTP/0710/3.1 The minutes of the meeting were approved with the following amendments:

- Anne Gaynor's title to be consistent throughout the minutes as 'Senior Nurse, Education and Professional Deveopment'
- FTP0610/12/1, Last bullet point to read *"to survey complainants as to their perceptions of the **process** followed in respect of their individual complaints"*

**FTP/0710/4 Matters arising from the minutes of the meeting held on 24 June 2010**

FTP/0610/17.4; The Director of Workforce & Organisational Development

reported that he was not yet in a position to provide an update on the details of the contract position with regard to the NNU new build due to the absence of the Project Manager who is currently on annual leave. This will be circulated to members as soon as it is available.

**ACTION:** *Neil Savage to circulate detailed response as soon as possible*

**FTP0710/4a Outstanding actions List (public)**

The Board received Enclosure 2 which had been updated to reflect actions agreed since the last review. The following matters were discussed:-

- FTP0710/4a.1 • The Chair proposed the nomination of Robin Wall, newly appointed NED, to replace David Draycott as “champion” of the NHS Constitution. It was agreed that the Board would discuss this separately outside this meeting
- FTP0710/4a.2 • Given recent feedback from CQC and OFSTED with regard to arrangements for safeguarding children, it was agreed that identification of funding for mandatory training should be a priority. It was agreed that the Executive Team would action this.

**ACTION:** *Executive Team to identify funding for mandatory training for safeguarding children by September 2010*

**FTP0710/5 Report of the proceedings of the Board in private session, May 2010**

FTP/0710/5.1 The Board received and noted Enclosure 3. No queries or questions were raised

**ITEMS FOR DISCUSSION****FTP/0710/6 Red Risk Register and Assurance Framework**

The Board received and noted Enclosure 4 and the following points were noted:-

- FTP/0710/6.1 • *Risk No 10 – delivery of category 1 caesarean section within 30 minutes.* It was confirmed that Rosey Monaghan will assume responsibility for this item, working with the maternity directorate to ensure that RCOG guidelines are met
- FTP/0710/6.2 • *Risk No 111 – Non compliance with cancer waiting targets.* A question was raised around the potential implications of the recent White Paper with regard to the abolition of performance targets. It was reported that the current targets still remain in place through our contracts, and that indications are that these will in fact get tighter. The Chair noted that arrangements would be made for the Board to have detailed discussions around the recently published consultation document on the White Paper and implications for the Trust

**ACTION:**

*The Head of Corporate Affairs and the Directorates to update entries on the Red Risk register prior to the next Board meeting*

*The Chair and the Head of Corporate Affairs to schedule a Board discussion on the White Paper, no later than September 2010*

**FTP/0710/7 Amber Risk Register**

FTP/0710/7.1 The Board received and noted Enclosure 7. The following points were noted:-

- Although some of the review dates had recently been updated, it was noted

that these were not reflected in the report circulated earlier with Board papers.

- As a “live” document, there was some discussion around how this data might best be reported to future Board meetings to ensure the most accurate and up to date information is received. It was agreed that members would consider this prior to the next meeting
- A question was raised around the implications for the Trust of the reconfiguration of maternity services at Sandwell and City Hospitals. It was reported that the new Birth Centre at City Hospital had recently opened and there has been no evidence of any significant changes to numbers of bookings at BWH to date.
- *Risk No 120: Pharmacy SLA unsigned.* It was noted that the SLA has now been signed off. The risk register will be updated accordingly.

**ACTION:** *Head of Corporate Affairs and Directorates to update the amber risk register prior to the next quarterly report.*

**FTP/0710/8**

FTP/0710/8.1

**Integrated Performance Report – May 2010**

The Board noted the dashboard and cover sheet as part of Enclosure 5. The following comments and items were noted:-

- Genetics referral rates continue to exceed the target. Discussions are taking place with commissioners and it has been made clear that the Trust cannot continue to take on additional work without appropriate payment
- *Complaints:* Despite the highest level of complaints received this month, all response time targets have been met. The Board congratulated the complaints team, and the Directorates, for this excellent result
- *Cancer targets:* It was agreed that this item would be discussed in detail later in the agenda under the performance report
- *Dashboard:* The Chair explained, for the benefit of public members in attendance, that, following discussions at the last Board meeting, it was agreed that the format of the dashboard would be reviewed to provide a more effective way in which the metrics are presented. This work is currently ongoing
- *Agency/Bank spend:* It was noted that there been a significant increase in spend in the last month and it was reported that the situation was discussed in detail with Directorates at the July Performance Management meeting. It was noted that the increase in costs is not related to any specific Directorate but that this is a general uplift across the Trust. A rigorous and robust authorisation process has subsequently been implemented and some improvement has already been seen.
- Some concern was expressed by Board members about the significant level of increase in agency spend, in particular it was noted that costs had doubled in comparison with figures produced for the January Board meeting. It was reported that the reasons for the monthly increase are linked primarily to sickness absence but further detailed scrutiny is now ongoing to identify if this is indeed a one off “blip” or symptomatic of a growing trend associated with other issues. The situation will be monitored extremely carefully over the next months, including scrutiny of sickness absences and return to work interviews.
- It was suggested and agreed that a graph giving data over the previous 12 months should be produced for consideration at the next Board meeting.
- Following a question from a Board member in relation to agency/bank costs

it was confirmed that regular reviews are undertaken, in line with National Procurement processes, to ensure the most competitive rates are obtained where external staff are used.

**ACTION:** *Jason Burn to provide an analysis of agency costs over the last twelve months for the next Board meeting:*

FTP/0710/8.2 The Board received the Finance Report as part of Enclosure 5 and the following comments/items were noted:-

- A small surplus of £10K at the end of June and a year end forecast of surplus of £225K. It was noted that this is £275K below the planned position and shows a significant deterioration since the last Board meeting.

FTP/0710/8.3 The following points were noted:-

- Efficiency programmes for the first quarter are behind plan due primarily to phasing issues around CIPS. Detailed discussions were undertaken with individual Directorates at the Performance Management meetings held on 27 July and Directorates were asked to provide further explanation of their positions and to identify actions to improve the performance
- *Genetics – delay in invoicing:* Following a query raised by a Board member it was noted that support is currently being provided to the Directorate to ensure that invoices are sent out speedily. It was suggested that, when it is not possible for any reason to get invoices out in a timely manner, then the implications should be factored into the finance report to ensure a more accurate reflection of the position is provided to the Board.
- It was agreed that it would be helpful for the Board to have an opportunity to go through CIPs in some detail to give assurance that there are no underlying issues around service delivery. It was agreed that the necessary analysis should be provided to the next meeting
- Concern was expressed by some Board members with regard to the significant deterioration in the financial performance at such an early stage in the financial year. The Finance Director commented that, with the actions that have now been put in place within Directorates, and the recognised delay in earlier improvements feeding through, he felt more confident that the year end target performance is likely to be nearer to a surplus of £500K than the lower range figure of £0, although both ends of the range remained possibilities.
- *Clinical Support:* A question was raised about the extent to which the deficit within the Clinical Support Directorate could be recovered, and whether it reflected the significant deficit at 31<sup>st</sup> March 2010. It was noted that the cessation of agency usage in Radiology at the end of July; actions taken to reduce agency usage in other areas; reduced costs associated with bringing antenatal screening in-house from July and work being undertaken on the phasing of income are all factors that are expected to significantly improve the position; and the budget process had identified some £300k of additional and unavoidable costs that had been provided for. However, the current worst case scenario for the year end forecast position will be maintained, as a prudent position, whilst the situation is monitored and reviewed on a regular basis.

**ACTION:**

*A review of CIPs and progress towards achievement to be considered at the*

*September meeting; Jason Burn to provide the necessary analysis  
Jason Burn to review the reporting to Board of delayed invoicing, as part of  
review of the Finance Report to the Board.*

**FTP0710/9 Patient Safety Report**

FTP0710/9.1 The Board received Enclosure 7 and the following comments were noted:-

- *“Unexpected returns to gynaecology theatre”*; Following a query around the significance of the numbers reported, it was confirmed that the figure of 17 is a relatively small percentage when compared with the number of procedures undertaken annually which is approximately 3,000. It was also confirmed that this data is not currently benchmarked as it is not possible to obtain a “like for like” comparison. However, detailed reviews of individual cases are being undertaken on a regular basis by the Medical Director and his clinical colleagues to provide assurances that appropriate control checks are in place. There has been no evidence of any recurring themes associated with these incidents to date.
- *Neonatal Mortality Rates*: It was noted that the Perinatal Institute has recently published the findings of the Perinatal and Infant Mortality Survey for 2008/09 for Birmingham. It was noted that the report would be discussed in some detail at the Clinical Governance Committee at its meeting in August.
- *Weekly Patient Safety Report*: The Medical Director has previously indicated that he is planning to produce an annual report when 12 months data is available. The Chief Executive agreed to discuss this with the Medical Director with a view to providing a report to the January Board meeting.

**ACTION:**

*The Chief Executive to discuss with the Medical Director the production of a 12 month patient safety report (for trend purposes) for the January Board meeting.  
CGC to report to the Board on its discussions on the Perinatal and Infant Mortality Survey 2008-2009, for the September Board meeting.*

**FTP0710/10 Progress on corporate objectives and Directorate performance – Quarter 1**

FTP0710/11.1 The Board received and noted Enclosures 8 and 9. The two reports were taken together and the following comments and items were noted:-

- *Gynaecology*: Following discussions at the recent performance management group meeting and the compelling evidence provided at the meeting, the Directorate’s indicator for Finance has been upgraded to green from amber. Performance indicators are now green in all areas and the Board congratulated the Directorate on the significant achievement in producing such an improved performance
- *Clinical Support*: It was recognised that, despite earlier concerns in relation to the significant challenges facing the Directorate, substantial progress has been made and the Board congratulated the staff on this achievement.

**ACTION:** *The Director of Nursing, Midwifery and Operations will feed back the Board’s congratulations to Directorates as agreed above.*

FTP0710/12 **Facing the Future Head On – update on Lean, Service Line Management and Listening into Action**

FTP0710/12.1 The Board received and noted Enclosure 10. The following items were noted:-

- *Listening into Action:* The LiA (Listening into Action) programme has now kicked off and the Sponsor Group and Core Teams have been established and will take this forward within the organisation. Vicki Davies has commenced in the role as Staff Engagement Facilitator and is leading on this initiative.
- A number of dates have been identified in September for the programme launch and staff engagement sessions; details will be circulated to Board members who were invited and encouraged to attend the sessions. A letter setting out details will go out to all staff shortly. Regular “pulse checks” will be undertaken to get quick response feedback from teams around staff perceptions with regard to staff engagement.
- *Lean methodologies – The productive ward:* The roll out of the programme across the organisation continues and has produced significant benefits, both in terms of quality of care provided and financial savings. There has been some positive staff feedback despite the difficulties around time commitment that has been required. A full analysis of the benefits produced by the project will be undertaken in the Autumn.
- *Lean projects supported by NHS Elect:* The Director of Workforce and Organisational Development reported on his recent meeting with the NHS Elect lead. It was noted that arrangements have been made for “deep dive” exercises to be undertaken for each of the projects in August and September. A further and more detailed update will be provided to the September Board meeting.
- *Service Line Reporting and Management:* The Project Manager, Roger Smith, joined the Trust on 14 June and has made good progress in identifying information that is currently available in the Trust and how this needs to be presented by Directorates. An exercise to produce a “dummy report” will be undertaken in August within one Directorate and this will then be rolled out across the organisation. A review of possible software solutions to produce the reports has been undertaken and one system in particular has been identified as being particularly useful to the Trust’s requirements. Arrangements are also being made for financial management training sessions to be available for clinicians, led by the Finance Director.
- *Reward and Recognition:* The Executive Directors have discussed additional initiatives that could be introduced to further develop the scheme to further recognise staff achievements. A detailed paper will be brought back to the September Board meeting.
- *Leadership & Management Development:* The Chief Executive met with other Directors on 28 July to discuss ways of developing a Leadership Academy in the organisation. A briefing paper will be presented to the Management Board in September on ways of achieving a consistent approach to leadership in the organisation.

**ACTION:**

*The Director of Workforce and Organisational Development to provide a detailed update on the Lean projects for the September Board meeting (within the regular report)..*

*The Executive Team to provide proposals on Reward and Recognition for*

*consideration at the September Board:*

**FTP/0710/13 Cancer Waiting Times Performance Report**

FTP/0710/13.1 The Board received Enclosure 11 and the Director of Nursing, Midwifery and Operations presented this. The following items were noted:-

- All waiting times standards have been achieved in June. This has improved the year to date position but is not sufficient for the Trust to reach target for two standards in Quarter 1. The Trust was in discussion with Sandwell and West Birmingham Hospitals Trust to re-allocate part of a 62-day breach, the but this will not alter the Trust's performance.
- Arrangements have now been made to ensure the appropriate level of data validation checks and control checks are in place to ensure accuracy of data.
- The MDT Coordinator has been appointed and commenced duties on 5 July. This now offers greater flexibility to the team which will support the achievement of the cancer waiting times action plan
- Progress against the cancer waiting times action plan is being made but the situation continues to be monitored closely. There are early warning systems in place to raise awareness of any potential breaches. The Director of Nursing, Midwifery and Operations should be advised by the team if there are any early signs of breaches
- Performance against targets for July is looking positive at this stage

FTP/0710/13.2 The Board noted the report.

**FTP/0710/14 Approval of changes to Policy for the Development, Distribution and Maintenance of Trust Policies and Procedural Documents (Policy for Policies)**

FTP/0710/14.1 The Board received and noted Enclosure 12. The Chair reported on comments received, primarily in relation to typographical errors, from one of the Trust's Governors subsequent to circulation of Board papers. The comments were considered to be helpful and the input welcomed. It was noted, however, that the monitoring and/or reviewing of Trust polices was an operational procedure and changes to policies could only be made within that process.

The Board APPROVED the Policy for Polices subject to the correction of typographical errors.

**ACTION:** *The Head of Corporate Affairs to proof check the policy for typographical errors and make the necessary amendments, prior to issue.*

**FTP/0710/15 Approval of changes to the Trust Risk Management Strategy**

The Board received and noted Enclosure 13 and thanks were extended to the author for highlighting the changes made to the strategy. The following items were noted:-

- Following a question with regard to the frequency of reviewing the Risk Strategy document, it was reported that, although the majority of policies are only required to be reviewed every three years, the Risk Strategy policy is required to be reviewed on an annual basis in line with NHSLA requirements

The Board APPROVED the Trust Risk Management Strategy as presented

subject to the rectification of any typographical errors identified

FTP/0710/16

**Submission to Monitor, Q1 2010-2011**

The Board received and noted Enclosure 14. The quarterly return was presented by the Head of Corporate Affairs and the following items were noted:-

- The Trust has acquired half a penalty point this quarter in relation to the failure to meet the target for cancer patients to have no more than 31 days from referral to treatment.
- The Trust has failed to meet the 62 day referral to treatment target for this quarter, however, the Trust remained below the *de minimis* level set in the *Compliance Framework* and therefore does not incur any penalty points
- There is a requirement for the first time for the Trust to make a declaration if it does not expect to achieve at least FRR level 3 in the following 4 quarters
- There is now a requirement to provide details of changes to telephone numbers and email addresses for Board members on the quarterly return.

The Board considered the recommendations made in the covering sheet and the following comments were noted:-

- The recently introduced requirement for Board to make a declaration around anticipated future financial performance was considered by Members to be a particularly onerous responsibility and there were concerns expressed around the difficulties inherent in giving this level of undertaking
- The Director of Finance suggested that it would not be unreasonable to forecast an FRR score of at least 3 in the following 4 quarters based upon the forecast year end position and the current FRR score of 3.
- It was noted that there was a difference between the Capex figure provided in the financial summary of the Monitor submission and that provided in the finance report. The Director of Finance agreed to review this.

The Board:

- APPROVED the submission to Monitor for Q1 2010-2011 as circulated with the Board papers
- APPROVED a declared Governance rating of "green" for the quarter
- AUTHORISED the Chair to sign Governance Declaration 2 (not full compliance)
- AUTHORISED the Chair to sign Finance Declaration 1 (FFR3 expected for the next four quarters)
- AGREED that the finance position be reviewed in detail at each quarter to see if any of the Trust's expectations have changed. In the event that expectations have changed, the mechanisms for reporting this to Monitor were outlined
- AUTHORISED the submission of the return to Monitor subject to verification of the Capex figure as detailed above

**ACTION**

*Jason Burn to review systems to support the Board making the Finance Declaration (FRR 3 for following 4 quarters) prior to the consideration of the Q2 return in October 2010.*

**ITEMS OF REPORT**

FTP/0710/17

**Trust Chair's Report**

- FTP/0710/17.1 The Board received and noted Enclosure 15. The Chair presented her report and the following key items were noted:-
- Following discussions at the Board Away Day on 28 June, and to allow more time to focus on strategic issues, it was recommended that two Board sessions be set aside for informal discussions around the Trust's longer term strategy.
  - It was recommended that the August and December Board meetings should be set aside for strategic discussions and thereafter there should be regular seminar sessions (suggested on a quarterly basis) for Board learning and development. Details of what would be included in the sessions would be confirmed shortly.

The Board APPROVED:

- a. The revised dates for meetings in 2010;
- b. The dates for meetings in 2011

**ACTION:** *The Head of Corporate Affairs to send out confirmation of dates for Board sessions around strategy, by end July 2010.*

FTP/0710/18 **Report by the Chief Executive**

- FTP/0710/18.1 The Board received and noted Enclosure 16 which the Chief Executive presented to the Board and highlighted the following key points:-
- *Lorenzo IT Implementation:* The Trust remains on course to 'go live' on 6 September. As we move nearer to that date the current weekly monitoring teleconference calls will be escalated progressively culminating in a daily conference call during week beginning 16 August
  - *Capital Schemes:* There has been a delay in handing over the mortuary scheme due to the fact that the newly laid floor failed inspection. Arrangements are being made for the floor to be re-laid at no extra cost to the Trust. The Board's thanks were extended to the Pathology Team for their efforts dealing with the temporary working arrangements and to the Estates Team for their efforts in getting the refurbishment work completed.
  - *Re-launch of Birmingham Women's Fertility Centre:* The re-launch of the centre went extremely well and has generated a lot of positive feedback from staff. This has already produced an increase in terms of activity volumes and will help foster positive relationships with general practitioners.
  - *UNICEF Baby Friendly status – stage 2 assessment:* Despite the disappointing outcome of the recent assessment, the tremendous efforts made by the breast feeding team were recognised and applauded. Substantial progress has been made and the Trust now has a clear focus on the areas that need to be worked upon prior to the reassessment. The Chief Executive has sent a letter of thanks to the team for their efforts and has offered his support.
  - *Anthony Nolan Trust – Cord Blood Collection:* Agreement has been reached, in principle, for partnership working with the Anthony Nolan Trust for the Trust to provide cord blood, with appropriate consent, as part of their blood collection services. Discussions have taken place with the University of Birmingham to ensure a good working relationship is maintained with regard to research and development. It is anticipated that there will be significant benefits for the Trust not least of which will be the 24 hour presence of this highly reputable organisation on site.
  - *CQC In-Patient Survey:* The Trust's results of the 2009 survey are

particularly pleasing with 80% of patient responses placing us in the top 20% of Trusts. Only one question was placed in the bottom 20%. The results are a reflection of the quality of services provided and the commitment of colleagues and staff in the Trust

- *Status of Management Board:* It was noted that, as agreed at the Board's Away Day session in July, the Management Board would no longer be a formal Committee reporting to the Board but would act as an advisory group to the Chief Executive and Executive Team

The Board:

- Noted the report from the Chief Executive;
- Agreed to the change in status for the Management Board

**FTP/0710/19 Update from the Chair of Council**

The Board received and noted the contents of Enclosure 17. The Chair highlighted the following points from the report:-

- Robin Wall has been appointed to the post of new Non Executive Director and will commence with the Trust on 1 August 2010.
- Following the recent workshop to evaluate governance effectiveness in the Trust, a number of areas for improvement have been identified and an action plan will be produced and presented to Governors.

**FTP/0710/20 Questions from the Public**

The following comments and questions were raised by members of the public attending the meeting:

- FTP/0710/20.1 • *Red Risk Register Risk no 31:* A question was raised about the implications for the Trust of staff not attending mandatory training. The Director of Workforce & Organisational Development confirmed that a system has been put in place across the Trust whereby Managers receive regular reminders of when individual members of staff are required to undertake their mandatory training and appropriate arrangements are made to accommodate training around clinical commitments. The risk has been evaluated and assurances given around the adequacy of controls in place, and that the situation is being managed appropriately.
- FTP/0710/20.2 • *Trust Policy for Policies:* One of the Governors reported that the comments noted earlier in the meeting with regard to the policy for policies were made from a governance role perspective and had meant to of a constructive nature. The Chair noted that the comments were considered to be helpful although it was recognised that the policy review process remains an operational responsibility.
- FTP0710/20.3 • *Executive Safety Walkabouts:* Following a question raised by one of the Governors, it was noted that a new schedule of visits commencing in September 2010 is currently being produced. It was confirmed that further details will be circulated shortly and that Governors would be asked to nominate a representative to join the visits along with a Non Executive Director representative.

There being no further questions raised, the meeting closed at 11am.

# Birmingham Women's



NHS Foundation Trust

<b>SUBJECT :</b>	Report of the proceedings of the Board in private session, July 2010
<b>REPORT BY :</b>	Helen Hemberg, Chairman
<b>AUTHOR :</b>	Steve Parsons, Head of Corporate Affairs

### CONTEXT AND BACKGROUND FOR REPORT

In accordance with Standing Orders, proceedings in the private session are reported to the following public session of the Board, to promote the transparent operation of the Board.

### KEY ISSUES FOR BOARD OF DIRECTORS' CONSIDERATION AND DECISION

At the private session of the Board in July 2010, the following matters were considered:

- Minutes from the meetings of Clinical Governance Committee, Organisational Risk and Governance Committee, and the Audit Committee
- Four Root Cause Analyses, together with an indication of those that were due to come forward to the Board in the future
- A review of the 'external assurance' report on the Quality Accounts
- An update on possible options in relation to the Norton Court site
- Update reports from the Chairman and Chief Executive

### RECOMMENDATIONS

The Board is invited to note the private proceedings in July 2010.



<b>SUBJECT :</b>	Red Risk Register
<b>REPORT BY :</b>	Steve Parsons, Head of Corporate Affairs
<b>AUTHOR :</b>	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. Red Risks are required to be reviewed on a monthly basis.

The attached paper extract is valid on the date of production, 17<sup>th</sup> September 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, relating to the lack of training for theatre staff (number 128). This is a clinical risk under the oversight of the Clinical Governance Committee.

Risk 9, relating to levels of Midwifery staff, has been reviewed and down-graded from red to amber.

#### *Review and assurance*

At its meeting on 9<sup>th</sup> September, ORAG reviewed the red risk register entries that related to corporate risks. It also reviewed two amber risks selected at random, and identified actions that should be taken to provide additional assurance for both red and amber risks.

At its meeting on 3<sup>rd</sup> September, the Clinical Governance Committee held an in-depth review of the red risks related to Maternity Directorate, and identified where further assurance was needed. In addition a risk in relation to Clinical Genetics was reviewed.

# ENCLOSURE 3

## RECOMMENDATIONS

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.

## Red Risk Register Report for September 2010

### Current Red Risk Register

A brief listing of all current red corporate and clinical risks on DATIX risk register module that have been finally approved.

ID	Title	Description	Opened	Review date	Risk Type	Risk level (current)	Adequacy of controls	Directorate	Manager
128	Lack of training for theatre staff	Staff in the operating theatres have no allocated time for carrying out audit/ training/ nor development. There is a high sickness level with stress, low morale/ high agency staff usage/ manager off sick. Lack of training has been identified by clinical staff as posing a risk to patient safety. Staff are already doing additional hours to cover the service.	29-Jul-2010	26-Aug-2010	Clinical	Extreme risk	Inadequate	Clinical Support	Ms Rosey Monaghan
8	Neonatal Unit capacity	Insufficient capacity in Neonatal Unit to meet service needs	1-Mar-2005	31-Aug-2010	Clinical	Extreme risk	Adequate	Neonatal including Transport Team	Mrs Michele Emery
10	Delivery of category 1 caesarean section within 30 minutes	If we do not achieve the delivery of category 1 caesarean sections within 30 minutes, particularly when a second theatre is required, then we will be in breach of NICE guidance leading to a significant risk to patients.	28-Aug-2007	30-Jul-2010	Clinical	Extreme risk	Inadequate	Clinical Support	Mrs Gael Peters

102	Insufficient Radiologist cover for Neonatal Directorate	<p>On occasions neither consultant radiologist from BWH is available. This may be due to leave or sickness, or part time contracts. There is currently no formal or informal arrangement for any other consultant radiologist to be available in an emergency or for a second opinion on these occasions.</p> <p>Risk of PACs viewer on unit not fit for purpose and to correct standard.</p>	29-Sep-2009	31-Aug-2010	Clinical	Extreme risk	Uncertain	Neonatal including Transport Team	Dr Imogen Morgan
3	Norton Court	<p>Norton Court building is in need of major refurbishment or complete replacement and has sizeable on-going maintenance and backlog maintenance issues, rendering it non compliant with DDA and possibly other statutory standards. Cost to comply with DDA is circa £2m. Fire alarm system (wireless system) is life expired and in need of total replacement. Circa £350K. General building fabric is life expred.</p>	14-Oct-2008	30-Sep-2010	Corporate	Extreme risk	Inadequate	Facilities and Estates	Mr Neil Savage
112	Non-compliance of Cancer Waiting Standard due to shared accountability for Tertiary Referrals	<p>BWH holds shared accountability for patients referred to other Cancer Centres for further treatment in line with guidelines and is reliant on the receiving organisation to also achieve compliance.</p>	5-Jan-2010	10-Sep-2010	Corporate	Extreme risk	Adequate	Gynaecology	Ms Delreita Bernard

111	Non-Compliance with Cancer Waiting standards	Patients must be offered a choice of appointment and admission dates. Adjustments can no longer be made regarding patient choice to comply with cancer waiting times resulting in potential breaches of the target. Due to the low throughput of cancer patients this may result in widely varying percentages against compliance	5-Jan-2010	10-Sep-2010	Corporate	Extreme risk	Adequate	Gynaecology	Ms Delreita Bernard
31	Staff not attending mandatory training	Staff not attending mandatory / statutory training within requisite time period. This has implications for CQC registration. NHSLA compliance, staff and patient safety as well as litigation outcomes.	28-Jul-2005	30-Sep-2010	Corporate	Extreme risk	Adequate	Corporate including HR	Mr Neil Savage

## Birmingham Women's



NHS Foundation Trust

<b>SUBJECT :</b>	Integrated Performance Report August 2010
<b>REPORT BY :</b>	Jane Owen, Director of Nursing, Midwifery and Operations Neil Savage, Director of Workforce and Organisational Development Jason Burn, Director of Finance and Information
<b>AUTHOR :</b>	Jane Owen, Director of Nursing, Midwifery and Operations Neil Savage, Director of Workforce and Organisational Development Jason Burn, Director of Finance and Information

### CONTEXT AND BACKGROUND FOR REPORT

The Board has agreed that performance data should be provided monthly in the form of a 'dashboard', covering the main areas of performance for the Trust. The dashboard shows the target, performance and direction of trend for each line. Where there are national benchmarks, they are shown in grey.

For areas that are below target for two consecutive months, further trend information is attached in the alerts reports.

### KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

Genetics. Referral rates continue to exceed the target.

#### Complaints

As from April the target for responding on time is set at 80%. Performance this month has dropped to 50% 16 responses were due and only 8 were on time. One was a shared complaint with another trust which despite very regular reminders, failed to meet the agreed timescales. In addition, the directorates received 36 complaints over the previous 2 months which created on going investigation work during August.

#### Cancer referral to treatment target times

All cancer waiting times have been achieved for the fourth consecutive month .A detailed report is included in the board papers.

# ENCLOSURE 4

## *Workforce*

### Staff Appraisal

Completion of Staff Appraisal continues to improve significantly. At 66% uptake there has been a 12% improvement over the previous month.

Directorate rates are currently :

- Neonates – 98.7%
- Corporate Facilities – 83.11%
- Genetics – 75%
- Corporate Management – 68.06%
- Gynaecology – 60.53%
- Clinical Support – 56.25%
- Maternity – 46.19%

A sharp focus needs to be maintained by the Executives and Directorates to ensure we meet the set target in advance of year end.

### Agency/Bank Spend as a % of directorate/Trust paybill

At 5.78% this has improved slightly over the previous month, but it still remains far too high. The measures introduced by Executives for the increased scrutiny and authorisation of bank and agency shifts are beginning to have an effect. However, with recruitment lead times in some areas full progress will not be evident for another month or two. The biggest spend areas remain Delivery Suite, Neonatal Unit and Theatres as well as junior medical staff. A recent recruitment drive attracted many applications and promises further improvements in Theatre agency spend once new staff commence.

### Sickness Absence

At 5.67% this has worsened slightly over last month's rate of 5.06%.

Areas with higher sickness absence include:

- Corporate Facilities – 8.9%
- Clinical Support - 8%
- Neonates - 7.18%
- Maternity - 6.91%

Best performing areas include:

- Corporate Management – 2.78%
- Genetics – 2.39%

Executives continue to scrutinise directorate performance, with written reports being received for actions being taken in departments with persistently high sickness absence.

The Trust remains consistently in the top 50% range for good attendance within the West Midlands SHA area.

## ENCLOSURE 4

### *Finance*

- Details of financial performance are given in the attached Finance Report.

### **RECOMMENDATIONS**

The Board is invited to note the Trust's performance in August 2010.

2) Key Performance Indicators - Aug 2010

Dataset	Indicator	Bench mark	Trigger	Target	Monthly Actual	Position against target (colour). Trend from previous month 'text'.	Detailed report	Forecast Year End Position	
		National Benchmark							
Market Trend Awareness/ Strategy	Total inpatient and daycase waiting list size		>500	500	470	Favourable Change	Performance	470	
	Total Gynae outpatient waiting list size		>1500	1500	1584	Favourable Change	Performance	1584	
	Total Genetics waiting list size		>1400	1400	1190	Adverse Change	Performance	1190	
	Referral Rates - Gynae	1586	<1507 and >1665	1586	1533	Favourable Change	Performance	1730	
	Referral Rates - Maternity	1894	<1799 and >1989	1894	1964	Favourable Change	Performance	2051	
	Referral Rates - Genetics	691	<588 and >650	619	680	Favourable Change	Performance	768	
Productivity & Efficiency	Maternity LOS postnatal	1.93		1.93	1.88	Adverse Change	Performance		
	Gynae Length of Stay (exc daycases and emergencies)	3.1		2.90	1.95	Favourable Change	Performance		
	Daycase rate 1 - as % of all elective admissions	50%		>50%	56%	Favourable Change	Performance		
	Gynaecology Daycase Over Stay Rate	13.86%	>10%	5%	6.02%	Adverse Change	Performance		
	Gynae Pre operative Avg Los	0.15			0.03	no change	Performance		
	Theatre utilisation	80%	<75	80%	85.6%		Performance		
	Gynae New to FU ratio	1.40		<1.50	1.56	Adverse Change	Performance		
	Occupancy Rate - Neonatal ITU	80%	<76%	80%	80%	Favourable Change	Performance		
Clinical Quality (Monthly)	Written Complaints	<9	>10	9	7	Favourable change	Clinical Governance		
	Responded to within agreed timescale	80%	80%	80%	50%	Adverse Change	Patient Experience		
	PALS	20 cases	>25 cases	20 cases	20 cases	Favourable change	Quarterly report to CGC		
	Compliments						Patient Experience		
	Experience of Patients-top 20% of in patient survey			To be in the top 20%					
	MRSA Bacteramia	<6 cases	>0	0	0.0	no change	Infection control		
	Cdiff	0	>0	0	0.0	no change	Infection control		
Clinical Quality (Quarterly)	Essence of Care Indicators				Neonates	Maternity	Gynae	Clinical Support	Genetics
	1 Communication		not achieved	to be audited in Q2			Audited Sept 09.	to be audited Q3	audited
	2 Continence		not achieved	Not relevant			Audited Sept 09.	to be audited Q3	Not relevant
	3 Hygiene		not achieved	to be audited in Q2	Not relevant		Audited Sept 09.	to be audited Q3	Not relevant
	4 Nutrition		not achieved	to be audited in Q2	Not relevant		Audited Sept 09.	to be audited Q3	Not relevant
	5 Pressure Ulcers		not achieved	Not relevant	Not relevant		Audited Sept 09.	Not relevant	Not relevant
	6 Privacy & Dignity		not achieved	to be audited in Q2			Audited Sept 09.	to be audited Q3	Not relevant
	7 Record Keeping		not achieved	to be audited in Q2			Audited Sept 09.	to be audited Q3	audited yearly
	8 Safety		not achieved	to be audited in Q2			Audited Sept 09.	to be audited Q3	Not audited -
	9 Self Care		not achieved	Not relevant	Not relevant		Audited Sept 09.	to be audited Q3	Not relevant
	10 Promoting Health		not achieved	to be audited in Q2	Not relevant		Audited Sept 09.	Not relevant	audited
11 Care Environment		not achieved	to be audited in Q2			Audited Sept 09.	to be audited Q3	audited	
Clinical Quality (Quarterly)	PEAT Annual Inspection Results			maintain excellent					
	CQUINS								
Finance	Reduce deaths through VTE risk assessment	Compliance	<100%	100%	43%				
	Improve responsiveness to needs of patient (CQC inpatient survey)	Compliance	not achieved	Achievement	Measured May 2011				
	Improve assessment of <17yrs pregnant teenagers - home visit	Compliance	not achieved	Achievement	Assessment tool developed				
	Redesign pathway for treatment of hyperemesis	Compliance	not achieved	Achievement	Pathways re-designed				
	Improving diabetic service in antenatal clinic	Compliance	not achieved	Achievement	Completed patient survey				
	Create surgical option for management of miscarriage in OPD	Compliance	not achieved	Achievement	Information Leaflet created				
	Identification/intervention for women with significant alcohol consumption	Compliance	not achieved	Achievement	All women are risk assessed at booking				
Finance	Breastfeeding at time of discharge from maternity services to health visiting service	Compliance	not achieved	Achievement	Baseline data collected				
	Year to date I&E position	plan or >	off plan	£211K	£(5)k	Adverse Change	Finance	£169K	
	In month run rate	plan or >	off plan	£42K	£(28)k	Adverse Change	Finance	N/A	
	Year to date Ebitda	plan or >	off plan	£2,040K	£1,854k	Adverse Change	Finance	£4,649K	
	Year to date Ebitda margin	plan or >	off plan	5.6%	5.1%	Adverse Change	Finance	5.3%	
	Year to date CIP performance	plan or >	off plan	£1,352	£931k	Positive Change	Finance	£3,362k	
	CIP recurrent/non-recurrent delivery	plan or >	off plan	60/40	47/53	Positive Change	Finance	43/57	
Workforce	Contracted WTE	1322	>1388	<1322	1450.36	Adverse Change	Head Count:1663		
	Agency/Bank spend as a % of directorate payroll	2.85	>2.85%	<2.85%	5.78%	Positive Change			
	Sickness Absence Rate %	4%	>4%	<4%	5.67%	Adverse Change	2,301.02 Days Lost		
	Staff Turnover Rate %	14%	>14.10%	<14.10%	12.91%	Adverse Change	Leavers:42 (M&D Rotation)		
	Employee Investigations	4weeks	>4 weeks	<4 weeks	0	No Change			
	KSF - Staff who have received PDR %	80%	<80%	>80%	65.74%	Positive Change	969/1474		
	Pay as a % of Trust Income	58.69%	>58.69%	<58.69%	64.04%	Positive Change			
	Staff Grievances	tbc	2	1	0	No Change			
	Harassment and Bullying	tbc	2	1	0	No Change			
	NHS Staff Satisfaction	70%	<70%	>70%	70%	No Change	2009 score benchmarked against 2008 Annual Staff Survey		
CQC Targets	Cancer 2 week wait	No lapses	Outside Tolerance	93%	97%	No change	Performance	97	
	Cancer 1 month diagnosis to treatment	No lapses	Outside Tolerance	96%	100%	Favourable Change	Performance	94.1	
	Cancer 1 month subsequent treatment standard	No lapses	Outside Tolerance	94%	100%	No change	Performance	100	
	Cancer 2 month GP urgent referral to treatment	No lapses	Outside Tolerance	85%	100%	Favourable Change	Performance	84.2	
	Cancer 2 month Cervical Screening Report Received to treatment	No lapses	Outside Tolerance	90%	100%	No change	Performance	100	
	Cancer 2 month from upgrade to treatment	No lapses	Outside Tolerance	To be Determined	100%	No change	Performance	100	
	Cancelled Operations on day of surgery	1	>1	<1	0	Favourable Change	Performance	18	
	Cancelled Operations not admitted within 28 days	No lapses	Breach	No lapses	No lapses	No change	Performance		
	Admitted patients seen within 18 weeks			>90% by Dec 08	93.3%	Favourable change	Performance		
	Non-admitted patients seen within 18 weeks			>95% by Dec 08	96.9%	No change	Performance		
Data quality on ethnic group	100%	<85%	100%	91.0%	No change	Performance			
Engagement in clinical audits	implemented	Breach	Implemented			Clinical Governance			
Maternity HES data quality indicator		>15%	<15%	5.9%	Favourable change				
Vital Signs	BreastFeeding initiated	67%	>60%	67%	64%	Favourable change	Performance		
	Smoking during pregnancy	11%	13%	11%	10%	Favourable change	Performance		
	% of Women seen by 12 weeks	80%	<78%	80%	93%	No change	Performance		
	Referral to stop smoking service: % referral to stop smoking service			100%			Commissioning Report		
Commissioner Set	% time slots available for 'Choose and Book'	100%	<95%	100%	95.1	Adverse Change	Commissioning Report		
	Percentage of SUS data altered in period	5%	>10%	5%	0%	No change	Commissioning Report		
	Information Governance Toolkit Level 2 minimum attainment		<100%	100%	Not measured till Oct 2010		Commissioning Report		
Foundation Status	Number of Members	5000 by end of year	Negative	Net 50				5000	

Birmingham Women's



NHS Foundation Trust

## **Finance Report**

**Month 5 – April to August 2010**

## 1. Overview

Results for the first five months show a small net deficit of £5k at the end of August, which is £216k behind plan.

The summary £216k variance comprises the following:-

- A favourable £66k income variance;
- An adverse £253k expenditure variance;
- A behind plan EBITDA position totalling 5.1%;
- An adverse £28k variance for depreciation;
- An adverse variance of £1k for interest receivable;

Details of how these results compare with the previous month's performance are provided in tables 1.1 and 1.2 below, together with a comparison of the Month 5 position for 2009/10.

Table 1.1 - In-month position compared to previous month and previous year

	Month 5 (10/11)		Month 4 (10/11)		Month 5 (10/11)		Month 5 (09/10)	
	Actual £ 000's	Variance Fav/(Adv) £ 000's	Actual £ 000's	Variance Fav/(Adv) £ 000's	Actual £ 000's	Variance Fav/(Adv) £ 000's	Actual £ 000's	Variance Fav/(Adv) £ 000's
Total Income	7,185	(109) ▼	7,457	171	7,185	(109) ▼	7,225	299
Total Operating Costs	(6,837)	49 ▲	(7,070)	(191)	(6,837)	49 ▲	(6,507)	7
EBITDA	348	(60) ▼	388	(20)	348	(60) ▼	718	306
EBITDA % Margin	4.8%	-0.8% ▼	5.2%	-0.4%	4.8%	-0.8% ▼	9.9%	4.0%
Depreciation (-)	(287)	(6) ►	(287)	(6)	(287)	(6) ▼	(265)	15
Interest (+/-)	1	(3) ►	1	(3)	1	(3) ▲	3	(30)
Dividend (-)	(89)	0 ►	(89)	0	(89)	0 ►	(114)	0
Surplus / (Deficit) cfd	(28)	(70) ▼	13	(30)	(28)	(70) ▼	341	291

Table 1.2 - Year to Date position compared to previous month and previous year

	Month 5 (10/11)		Month 4 (10/11)		Month 5 (10/11)		Month 5 (09/10)	
	Actual £ 000's	Variance Fav/(Adv) £ 000's	Actual £ 000's	Variance Fav/(Adv) £ 000's	Actual £ 000's	Variance Fav/(Adv) £ 000's	Actual £ 000's	Variance Fav/(Adv) £ 000's
Total Income	36,191	66 ▼	29,007	175	36,191	66 ▲	35,473	(40)
Total Operating Costs	(34,338)	(253) ▲	(27,501)	(302)	(34,338)	(253) ▼	(32,884)	544
EBITDA	1,854	(186) ▼	1,506	(126)	1,854	(186) ▼	2,589	504
EBITDA % Margin	5.1%	-0.5% ►	5.2%	-0.5%	5.1%	-0.5% ▼	7.3%	1.4%
Depreciation (-)	(1,433)	(28) ▼	(1,146)	(22)	(1,433)	(28) ▼	(1,333)	71
Interest (+/-)	20	(1) ▼	19	2	20	(1) ▲	13	(151)
Dividend (-)	(446)	0 ►	(357)	0	(446)	0 ►	(571)	0
Surplus / (Deficit) cfd	(5)	(216) ▼	22	(146)	(5)	(216) ▼	698	425

Key: ▲ Improved performance compared to previous month / year  
▼ Worsened performance compared to previous month / year  
► No change in performance compared to previous month / year



## 1.2 Financial Risk Rating

The Trust's Financial Risk Rating (FRR) at Month 5 is a 3, which is in line with the planned rating for the year.

The projected end of year FRR, based on the current forecast position, remains at a 3.

Table 1.4 - Financial Risk Rating

	FRR as at Month 5			FRR as at Month 4			Year End Forecast As at Month 5		Annual Plan Submission	
<b>Metric</b>										
EBITDA margin	5.1%	3	▶	5.2%	3		5.3%	3	5.6%	3
EBITDA, % achieved	90.9%	4	▶	92.3%	4		94.9%	4	100.6%	5
ROA	1.3%	2	▶	1.4%	2		1.6%	2	3.9%	3
I&E surplus margin	0.0%	2	▶	0.1%	2		0.2%	2	0.6%	2
Liquid ratio	29.6	4	▶	29.4	4		32.8	4	26.6	4
<b>Weighted Average</b>		<u>3.0</u>	▶		<u>3.0</u>			<u>3.0</u>		<u>3.3</u>
<b>Financial Criteria</b>										
Underlying Performance		3	▶		3			3		3
Achievement of Plan		4	▶		4			4		5
Financial Efficiency		2	▶		2			2		3
Liquidity		4	▶		4			4		3
<b>Overriding rules</b>										
Lowest ranked metric a '1'?	NO			NO			NO		NO	
One financial criterion scored at '1'	NO			NO			NO		NO	
One financial criterion scored at '2'	YES	3		YES	3		YES	3	NO	
Two financial criteria scored at '2'	NO			NO			NO		NO	
Two financial criteria at '1'	NO			NO			NO		NO	
PBC breached	1			1			1		1	
<b>Overriding rules rating</b>		<u>3</u>	▶		<u>3</u>			<u>3</u>		<u>0</u>
<b>Overall Rating</b>		<u><u>3</u></u>	▶		<u><u>3</u></u>			<u><u>3</u></u>		<u><u>3</u></u>

Key: ▲ Improved performance compared to previous month  
▼ Worsened performance compared to previous month  
▶ No change in performance compared to previous month

## 2. Healthcare Income & Activity

Total income attributable to the end of Month 5 is £36.2m, which is £66k ahead of target.

Whilst overall there is a favourable variance on income, Directorate income for Maternity Services, Neonatal and Clinical Support is behind plan.

Genetics income shows a favourable variance but this is more than offset by an adverse expenditure variance.

R&D income shows a large adverse variance (£200k) but this is offset in full by a favourable expenditure variance.

Included within the position is an assessment of the additional funds due to be received in support of the revised timescale for the implementation of the Trust's new patient administration system.

- Healthcare Income

At Month 5 healthcare income is behind plan, showing a deficit of £241k. This is linked to deterioration in performance against contract income targets for the month of August. The most notable change being Gynaecology contract income, which has moved from a surplus of £86k to a deficit of £18k.

Both Neonatal and Maternity income levels continue to under-perform against contract targets. Further details of the performance by specialty are provided in table 2.1 below.

Table 2.1 - Contract activity by specialty

		Activity to date - Month 5			Activity to date - Month 4			Full Year
		Target	Actual	Variance	Target	Actual	Variance	Target
Maternity	Normal spells inc. excess bed days	4,613	4,245	(368) ▼	3,689	3,390	(299)	11,063
	Outpatients (New & Follow up)	24,099	26,024	1,925 ▲	19,276	20,992	1,716	57,837
Gynaecology	Elective spells	1,588	1,455	(133) ▼	1,269	1,219	(50)	3,807
	Non elective spells	729	685	(44) ▼	580	544	(36)	1,745
	Outpatients (New & Follow up)	12,699	13,352	653 ▼	10,159	10,862	703	30,477
	Outpatient procedures	4,093	4,136	43 ▼	3,272	3,334	62	9,816
Neonatal	Intensive Care cot days	1,078	929	(149) ▼	863	755	(108)	2,587
	High Dependency cot days	772	776	4 ▼	618	653	35	1,851
	Special Care cot days	4,319	3,757	(562) ▼	3,453	3,029	(424)	10,362
Genetics	Laboratory tests	15,930	15,478	(452) ▲	12,741	12,094	(647)	38,225
	Clinical referrals	3,102	3,842	740 ▲	2,479	3,162	683	7,440

Key: ▲ Improved performance compared to previous month  
▼ Worsened performance compared to previous month  
▶ No change in performance compared to previous month

- Private patient income

Private patient income is ahead of plan at Month 5, and forecast to over-achieve against the full year target of £749k (current forecast £994k), by year end. Performance remains within the Trust's private patient income cap of 2.2%.

### 3. Directorate Positions

The tables below show the combined positions of pay, non pay and directly coded directorate income variances. Healthcare income is shown separately. From Month 5 private patient income has been included within the directorate income variance. NB comparator months have also been adjusted to reflect the same.

At Month 5 there is an adverse variance of £305k across all directorates, which is a minor improvement on Month 4.

Table 3.1 - Directorate variances from budget compared with previous month

	Cumulative position to date							
	as at Month 5				as at Month 4			
	Pay	Non Pay	Directorate	Total	Pay	Non Pay	Directorate	Total
£'000	£'000	Income*	£'000	£'000	£'000	£'000	Income*	£'000
Maternity	14 ▲	-16 ▼	-155 ▼	-157 ▼	0	0	-118	-118
Gynaecology	7 ▼	-76 ▼	159 ▲	90 ▼	13	-29	142	126
Genetics	-258 ▼	-3 ▲	118 ▲	-143 ▲	-212	-63	116	-159
Neonatal	-34 ▲	7 ▼	-80 ▼	-107 ▼	-40	10	-67	-97
Clinical Support	-166 ▼	-213 ▼	-178 ▼	-557 ▼	-141	-193	-121	-455
Facilities	5 ▲	-5 ▼	14 ▲	14 ▶	-2	3	13	14
R&D	-2 ▼	202 ▲	-200 ▼	0 ▶	7	147	-154	0
Corporate Services	-59 ▲	137 ▲	477 ▲	555 ▲	-61	125	316	380
Hosted Organisations	0 ▶	0 ▶	0 ▶	0 ▶	0	0	0	0
<b>TOTAL</b>	<b>-493 ▼</b>	<b>33 ▲</b>	<b>155 ▲</b>	<b>-305 ▼</b>	<b>-436</b>	<b>0</b>	<b>127</b>	<b>-309</b>

Table 3.2 - Directorate variances from budget compared with previous year

	Cumulative position to date							
	as at Month 5 - 2010/11				as at Month 5 - 2009/10			
	Pay	Non Pay	Directorate	Total	Pay	Non Pay	Directorate	Total
£'000	£'000	Income*	£'000	£'000	£'000	£'000	Income*	£'000
Maternity	14 ▼	-16 ▼	-155 ▼	-157 ▼	76	20	-13	83
Gynaecology	7 ▼	-76 ▼	159 ▲	90 ▼	269	-8	-129	132
Genetics	-258 ▼	-3 ▲	118 ▼	-143 ▼	-113	-172	153	-132
Neonatal	-34 ▼	7 ▼	-80 ▼	-107 ▼	8	17	-7	18
Clinical Support	-166 ▼	-213 ▼	-178 ▼	-557 ▼	-36	-18	-46	-100
Facilities	5 ▼	-5 ▼	14 ▲	14 ▼	10	72	5	87
R&D	-2 ▼	202 ▲	-200 ▲	0 ▶	164	136	-300	0
Corporate Services	-59 ▼	137 ▲	477 ▲	555 ▲	224	-106	19	137
Hosted Organisations	0 ▶	0 ▶	0 ▶	0 ▶	0	0	0	0
<b>TOTAL</b>	<b>-493 ▼</b>	<b>33 ▲</b>	<b>155 ▲</b>	<b>-305 ▼</b>	<b>602</b>	<b>-59</b>	<b>-318</b>	<b>225</b>

Key: ▲ Improved performance compared to previous month / year  
▼ Worsened performance compared to previous month / year  
▶ No change in performance compared to previous month / year

\* Includes private patient income

- Maternity Services

The directorate's current position is a deficit of £157k, being driven by the underperformance on the extra births target the directorate set as part of its efficiency programme.

In order to address the underperformance the directorate put forward a plan, which included increasing the number of bookings against a forecast 'drop out' rate of 2% to achieve the required number of deliveries. Whilst there was a significant increase in activity for July the 'drop out' rate for August has been higher than forecast so the target number of deliveries has not been met.

Early indications are that the target number of deliveries for September will not be met and so on the basis of this and the performance in August the Directorate are being asked to re-assess the number of bookings, per month, with a view to increasing them. The Directorate will also be asked to put forward alternative plans should it not be possible to achieve the required activity levels.

- Gynaecology

The directorate's current position is a surplus of £90k including the over-performance on private patients.

Whilst the directorate is in surplus as a whole action needs to be taken with regard to their contract income, which is below target at Month 5. This will include a review of the productivity of Theatre lists.

- Neonatal

The directorate's current position is a deficit of £107k being driven by an overspend on pay and underperformance against the additional, out of area, activity target the directorate set as part of its efficiency programme for the year.

The pay deficit of £34k relates to consultant cover for sick leave and nursing bank staff costs in the first part of the year. The consultant cover ceased in July and the directorate has stopped the use of bank shifts within the nursing rotas so this expenditure has reduced, which is reflected by the improvement of the pay deficit between months 4 and 5.

Whilst the directorate have undertaken some out of area activity it has not been sufficient to improve their income position. As it may not be possible to recover the activity and so achieve their income target, the directorate have been asked to identify alternative plans. In the absence of an alternative plan other actions to address the position will be considered.

- Genetics

The directorate's current position is a deficit of £143k driven by the overspend on pay, which includes under-performance on CIPs of £76k, alongside an overspend against clinical scientists.

Following discussion with the directorate they have indicated that they believe there should be additional income within their position to offset the pay overspend (project income), and have asked for time to review their income in more detail, as this is not currently reflected within their position. If it's confirmed that the income is in fact already included within their position then they have given assurance that they will identify alternative courses of action to address the current position.

- Clinical Support

The directorate's current position is a deficit of £557k across pay, non pay and income.

Included in the pay deficit are high levels of agency spend in Theatres (£134k) and Radiology (£34k). Agency usage in Radiology ceased at the end of July and action is being taken to reduce agency usage within Theatres.

The non-pay deficit includes the high costs of antenatal screening blood tests prior to the service being brought in-house (£90k), outsourcing of Radiology activity (£25k), antenatal screening reagent costs in Haematology & Microbiology and under-performance on CIPs. The in-house antenatal screening service started on 5th July, although there was a period of dual running to validate test results. Outsourcing of Radiology activity has now ceased.

The shortfall in income is linked to Clinical Chemistry activity. The Head of Department has indicated that there is capacity to increase the number of tests undertaken per week but it will need to be determined if the demand exists to undertake this. They have also indicated that they would expect to see a benefit from the change in triple testing to quad testing but it should be noted that this would need to be agreed and supported by the PCT.

Directorate positions continue to be reviewed on a regular basis with forecasts updated as appropriate. The end of year forecasts, for directorates, are provided in the table below together with the end of year forecast at Month 4 for comparison.

Table 3.3 - Directorate variances from budget forecast end of year position

	Forecast End of Year position							
	as at Month 5				as at Month 4			
	Pay	Non Pay	Directorate	Total	Pay	Non Pay	Directorate	Total
£'000	£'000	Income*	£'000	£'000	£'000	Income*	£'000	£'000
Maternity	7 ▼	-78 ▼	-172 ▼	-243 ▼	11	-33	-132	-154
Gynaecology	-59 ▲	-132 ▼	258 ▼	67	-88	-74	294	132
Genetics	-160 ▼	-81 ▲	16 ▲	-225 ▲	-152	-114	-5	-271
Neonatal	19 ▼	-12 ►	-75 ▼	-68 ▼	31	-12	-60	-41
Clinical Support	-347 ▼	-158 ▲	-195 ▲	-700 ▼	-250	-197	-213	-660
Facilities	74 ▲	53 ▲	19 ►	146 ▲	58	-83	19	-6
R&D	-54 ▼	366 ▲	-312 ▼	0 ►	-48	279	-231	0
Corporate Services	104 ▲	-156 ▼	461 ▲	409 ▲	49	-79	357	327
Hosted Organisations	0 ►	0 ►	0 ►	0 ►	0	0	0	0
<b>TOTAL</b>	<b>-416 ▼</b>	<b>-198 ▲</b>	<b>0 ▼</b>	<b>-614 ▲</b>	<b>-389</b>	<b>-313</b>	<b>29</b>	<b>-673</b>

Key: ▲ Improved performance compared to previous month  
▼ Worsened performance compared to previous month  
► No change in performance compared to previous month

\* Includes private patient income

#### 4. Efficiency Programme

The total efficiency programme for 2010/11, submitted as part of the Trust's Annual Plan to Monitor, totalled £3,603k. This target has been allocated to directorates as shown in the table below, which also provides a split between cost reduction and income generation based on the schemes put forward by the directorates.

Table 4.1 - Efficiency Programme analysed by Directorate

	Cost Reduction		Income Generation		Total £'000
	£'000	%	£'000	%	
Maternity	326.1	45.4%	392.9	54.6%	719
Gynaecology	377.0	100.0%	0.0	0.0%	377
Neonatal	140.5	39.7%	213.5	60.3%	354
Genetics	320.0	55.7%	254.0	44.3%	574
Clinical Support	475.0	85.0%	84.0	15.0%	559
Corporate	1,020.0	100.0%	0.0	0.0%	1,020
<b>Total</b>	<b>2,658.6</b>	<b>73.8%</b>	<b>944.4</b>	<b>26.2%</b>	<b>3,603</b>

At the end of August savings of £931k have been identified as achieved against a target of £1,352k. Further details of how this has been achieved across the directorates, together with the forecast for the remainder of the year are provided in table 4.2 below.

Table 4.2 - Current and forecast performance against target

	Months 1 to 5		Months 6 to 12		Total		
	Actual £'000	Plan £'000	Forecast £'000	Plan £'000	Forecast £'000	Plan £'000	Variance £'000
Maternity	153.8	299.6	381.5	419.4	535	719	(184)
Gynaecology	45.8	125.7	219.9	251.3	266	377	(111)
Neonatal	125.8	147.5	170.3	206.5	296	354	(58)
Genetics	95.3	258.2	378.3	315.8	474	574	(100)
Clinical Support	68.9	181.3	409.4	377.8	478	559	(81)
Corporate	441.1	340.1	595.2	680.2	1,036	1,020	16
<b>Total</b>	<b>931</b>	<b>1,352</b>	<b>2,155</b>	<b>2,251</b>	<b>3,085</b>	<b>3,603</b>	<b>(518)</b>

Using the RAG rating system the current split of the £3.6m planned efficiency programme is as follows:

- Red        £1,020k
- Amber    £658k
- Green    1,925k

Where the original schemes will not achieve or are unlikely to achieve their target (Red & Amber) has been included within the directorates' forecasts.

The target recurrent/non recurrent split is 60/40%, which is slightly below that planned in 2009/10, reflecting the more challenging financial environment in 2010/11. An assessment at Month 5 is showing a current split of 47/53%, with total efficiencies achieved also behind plan.

## 5. Balance Sheet

### 5.1 Capital

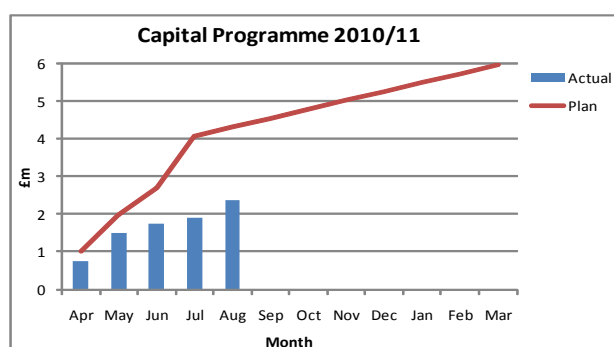
The planned capital spend for the year is £5.9m as recommended within the 2010/11 Annual Plan, included within which are the final payments required for the completion of the new Neonatal Unit.

Within the Trust's 3-year plan the basic programme has been increased to £2.5m in 2010/11 and £3m in 2011/12 & 2012/13 to allow the flexibility to consider service developments as part of reviewing the organisations strategy.

Delivery of the capital programme is managed through the Capital Development Group. Further details of the main areas of capital spend together with the current position are provided in the table below.

Table 5.1 - Capital Programme

Programmes	Full Year Plan £'000	Month 5 Actual £'000	Month 4 Actual £'000
Neonatal Unit Upgrade / Decant	3,130.0	1,367.5	1,343.2
Replacement PCs/Servers/PC equipment	200.0	98.1	49.7
Capital Equipment Replacement	1,371.8	801.8	394.6
Backlog Maintenance	960.2	96.6	77.9
Other	300.0	7.4	37.5
<b>Total</b>	<b>5,962.0</b>	<b>2,371.5</b>	<b>1,902.8</b>

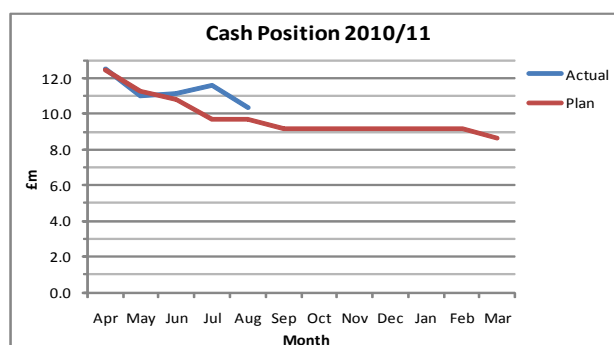


### 5.2 Cash Position

The Trust's cash position remains strong with a balance at the end of August totalling £10.3m. Deferred income and accruals are recorded as £4.9m

Table 5.2 - Cash position

	Month 5 Actual £'000	Month 4 Actual £'000
Cash held	10,320	11,604
Deferred income & accruals	4,869	5,579



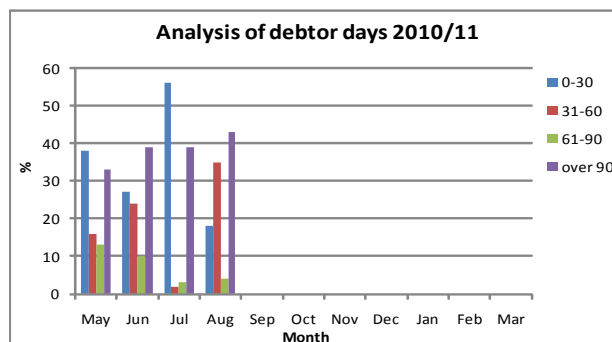
### 5.3 Debtors

Total debtors at the end of August valued £3.1m, of which £1.6m relates to trade debtors and £1.4m to accrued income.

The value of debts over 90 days is just over £500k compared with £600k at Month 4.

Table 5.3 - Debtors

	Month 5 %	Month 4 %
0-30 days	18	56
31-60 days	35	2
61-90 days	4	3
over 90 days	43	39

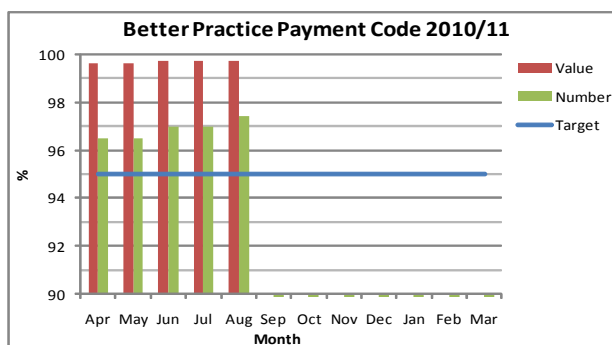


### 5.4 Creditors

The Better Practice Payment Code (formally PSPP) targets NHS organisations to pay 95% of all supplier invoices within a period of not more than 30 days. Cumulative performance at Month 5 remains above target with 99.7% of invoices, by value, paid within the 30 day target and by number 97.4%.

Table 5.4 - Better practice payment code

	Month 5 Actual %	Month 4 Actual %
Performance by value of invoices paid	99.7	99.7
Performance by number of invoices paid	97.4	97.0





**BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST**  
**INCOME & EXPENDITURE**  
**REPORTING PERIOD : - August 10 (Period 5)**

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
<b><u>Income (+)</u></b>									
Healthcare Income	5,644	5,435	(209)	28,218	27,977	(241)	67,724	67,650	(74)
Private Patient Income	62	75	12	312	445	133	749	994	245
Other Income	1,588	1,675	87	7,595	7,770	175	18,455	18,447	(8)
<b>Total Income</b>	<b>7,294</b>	<b>7,185</b>	<b>(109)</b>	<b>36,125</b>	<b>36,191</b>	<b>66</b>	<b>86,927</b>	<b>87,091</b>	<b>164</b>
<b><u>Operating Costs (-)</u></b>									
Pay Costs	(4,840)	(4,894)	(54)	(24,175)	(24,654)	(479)	(57,597)	(57,997)	(400)
Non Pay Costs	(2,045)	(1,943)	103	(9,910)	(9,684)	226	(24,434)	(24,446)	(12)
<b>Total Operating Costs</b>	<b>(6,886)</b>	<b>(6,837)</b>	<b>49</b>	<b>(34,085)</b>	<b>(34,338)</b>	<b>(253)</b>	<b>(82,031)</b>	<b>(82,442)</b>	<b>(412)</b>
<b>EBITDA</b>	<b>408</b>	<b>348</b>	<b>(60)</b>	<b>2,040</b>	<b>1,854</b>	<b>(186)</b>	<b>4,896</b>	<b>4,649</b>	<b>(248)</b>
<b>EBITDA % Margin</b>	<b>5.6%</b>	<b>4.8%</b>	<b>-0.8%</b>	<b>5.6%</b>	<b>5.1%</b>	<b>-0.5%</b>	<b>5.6%</b>	<b>5.3%</b>	<b>-0.3%</b>
Depreciation (-)	(281)	(287)	(6)	(1,404)	(1,433)	(28)	(3,370)	(3,455)	(85)
Interest (+/-)	4	1	(3)	21	20	(1)	50	46	(4)
<b>Surplus / Deficit before dividend</b>	<b>131</b>	<b>62</b>	<b>(70)</b>	<b>657</b>	<b>440</b>	<b>(216)</b>	<b>1,576</b>	<b>1,239</b>	<b>(337)</b>
Dividend (-)	(89)	(89)	(0)	(446)	(446)	0	(1,070)	(1,070)	0
<b>Surplus / (Deficit) cfd</b>	<b>42</b>	<b>(28)</b>	<b>(70)</b>	<b>211</b>	<b>(5)</b>	<b>(216)</b>	<b>506</b>	<b>169</b>	<b>(337)</b>

# Birmingham Women's



NHS Foundation Trust

<b>SUBJECT :</b>	Patient Safety Report
<b>REPORT BY :</b>	Peter Thompson
<b>AUTHOR :</b>	Peter Thompson

## CONTEXT AND BACKGROUND FOR REPORT

Following on from the meeting of the Board of Directors in November 2009 it was decided to produce a monthly board patient safety report. This includes data for the mortality rates and our weekly patient safety indicators.

## KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

The weekly patient safety indicators were first published on Friday 15<sup>th</sup> 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. As not all post-mortem reports are available within a month we will continue reporting 2 months behind from this point onwards.

A brief summary is included of the Surgical Safety Check list and our progress with this initiative.

## RECOMMENDATIONS

To discuss and note the findings of the report

## Weekly Safety indicators

Please find this week's patient safety indicator results, 17/09/2010.

Indicator	Number of weeks since last occurrence (start date 7/1/2010)	Number of occurrences year to date
MRSA bacteraemia *	8 years 2 months	0
Clostridium Difficile *	6	1
Inadvertent bowel damage during surgery	9	5
Unexpected returns to gynaecology theatre †	2	19
Caesarean sections for placenta praevia where the consultant anaesthetist and obstetrician were not present	12	1
Intrapartum stillbirth after 25 weeks and 6 days gestation where the fetus was considered viable at the onset of labour	36	0
Ventilated inborn babies below 28 weeks gestation where administration of surfactant within 1 hour of birth was not achieved	0	4
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	3
Incorrect laboratory report released by genetics laboratories	0	3

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

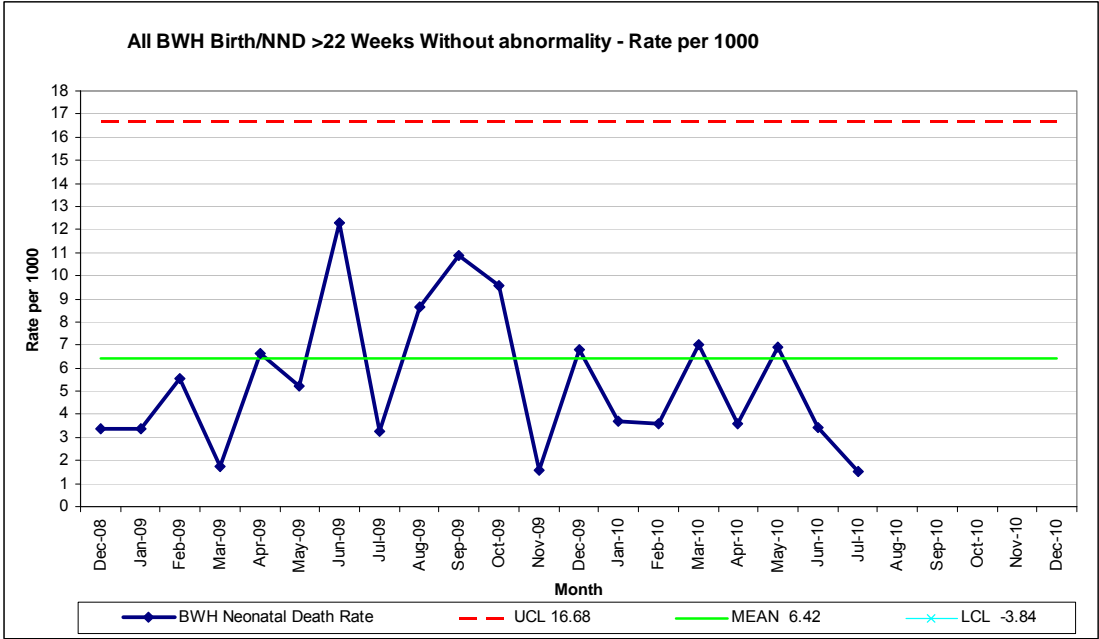
† A small number of these cases will be expected each year

**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 end of July 2010

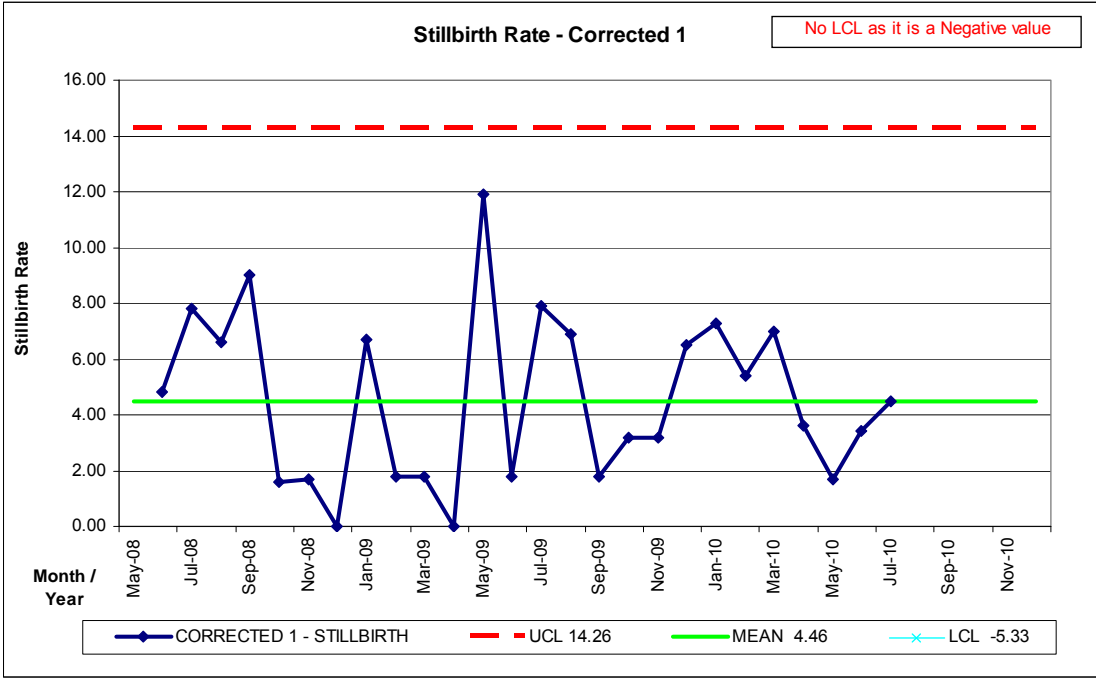
Rolling annual rate corrected for lethal congenital abnormalities, delivery <22 weeks gestation and birth weight <500g is 5.6/1000.



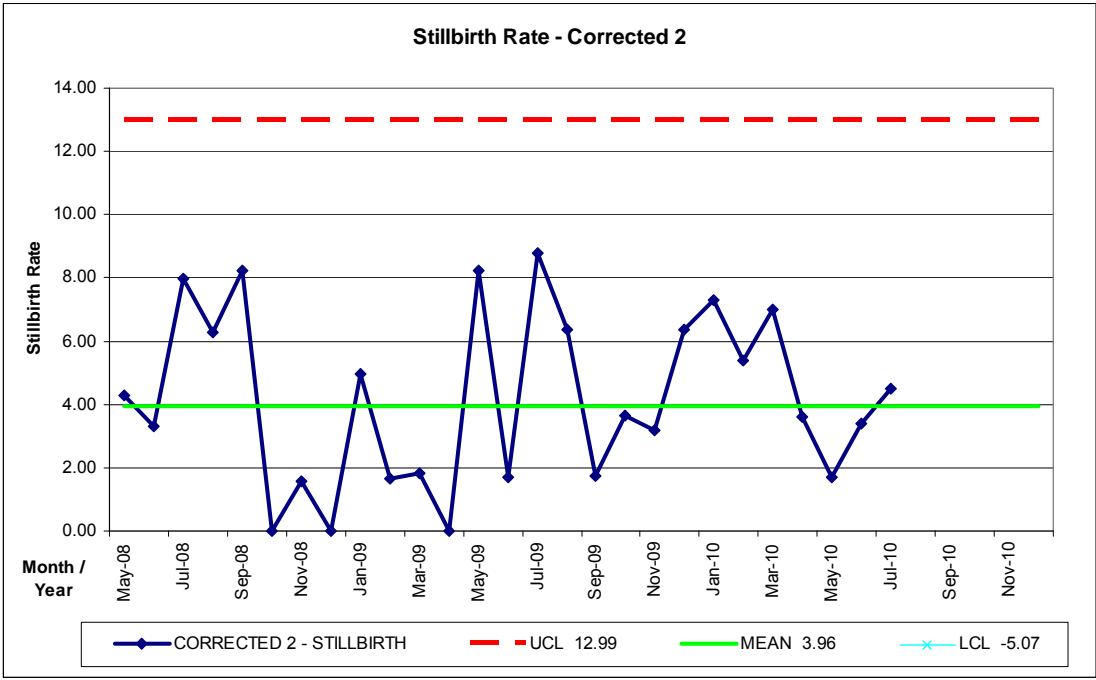
UCL = Upper control limit  
LCL = Lower control limit

Corrected Stillbirth Rates

Rolling annual rate corrected for lethal congenital abnormalities and birth weight <500g is 4.3/1000.



Rolling annual rate corrected for lethal congenital abnormalities, birth weight <500g and intrauterine transfers is 4.3/1000.



## Patient Safety Initiative

### Board and Governor's Walkabouts

To date as a combined Board and Members' Council Team we have scheduled the following areas of the hospital for visits in October.

<b>Date &amp; Time</b>	<b>Executive Director</b>	<b>Non Executive Director (NED) / Governor</b>	<b>Department to be Visited</b>	<b>Named Contact / Venue</b>
<b>Mon 6<sup>th</sup> Sept 2.00 pm</b>	Jason Burn (Director of Finance & Informatics)	Frank Gough (Governor)	West Midlands Public Health Observatory (WMPHO)	<b>John Kemm / Julia Clark</b> <i>(WMPHO, Vincent Drive, B15 2SQ)</i>
<b>Fri 17<sup>th</sup> Sept 9.00 am</b>	Peter Thompson (Medical Director)	Robin Rison (NED) Kay Fuller (Governor)	Quinton Lane Community Midwifery Team	<b>Judith Dickens</b> <i>(Quinton Lane Care Centre, Quinton Lane, Quinton B32 2TR)</i>
<b>Thu 23<sup>rd</sup> Sept 9.00 am</b>	Jane Owen (Director of Nursing & Midwifery)	Helen Hemberg (Chair) Sarah Francis (Governor)	Charlotte Road Community Midwifery Team	<b>Jackie Poyner</b> <i>(Allens Croft Childrens Centre, Allens Croft Road, Kings Heath, B14 6RP)</i>  <i>(JP to pick up at 9 am from FOH)</i>
<b>Thu 23<sup>rd</sup> Sept 9.30 am</b>	Neil Savage (Director of Workforce & OD)	Nigel Gardner (NED) Sandy Buchan (Governor)	Sparkhill Community Midwifery Team	<b>Bev Stewart</b> <i>(Greet Health Centre, 50 Percy Road, B11 3NG)</i>
<b>Mon 27<sup>th</sup> Sept 2.00 pm</b>	Steve Peak (Chief Executive)	Lorraine Groves (Governor)	Milk Bank	<b>Anne Hemmings / Jenny Harris</b> <i>(Lower Ground Floor)</i>

### Surgical Safety Check list

Questionnaire 98% response. Conducted Feb/March 2010

Participated in WebEx

## Key Themes

- All Trusts are implementing the Surgical Safety Checklist.
- 33% are taking a five step approach including briefings and debriefings as well as the Checklist
- 32% performing briefings alongside the Checklist
- **33% implementing Checklist only: BWH position**
- 45% started implementation with one list or theatre and rolled out the Checklist slowly
- **30% began with a few theatres at a time; BWH position**
- 25% implemented Checklist in all theatres at once

Factors that were found to be helpful in implementation. Ideas that were used at BWH are identified by a ✓

- clinical champions / early adopters (76%) ✓
- enthusiasm of nurses in theatres (75%)
- engagement from clinicians (62%) ✓
- applying the Checklist in one area first (57%) ✓
- *Patient Safety First* campaign and similar initiatives (39%) ✓
- executive leadership (37%) ✓
- using rapid improvement cycles such as PDSA (24%)
- leadership walkrounds (14%) ✓
- safety incident or never event (22%)

Since then we have:

1. Rolled out to elective Obstetrics
2. Included briefings at beginning of lists
3. Some lists have debriefs at end
4. Started checklist in ACU theatres

## Serious Untoward Incidents (SUI)

Table of the occurrence of SUIs in the month of July 2010.

Directorate	Number of SUI s this month
Clinical support	0
Genetics	0
Gynaecology	0
Maternity	2
Neonatology	0

\* includes 1 incident occurring on 8/3/10 which was escalated to become a SUI in May. Summary from form below:

Table of the occurrence of SUIs in the month of August 2010.

<b>Directorate</b>	<b>Number of SUI s this month</b>
Clinical support	0
Genetics	1
Gynaecology	0
Maternity	0
Neonatology	1

PJ Thompson  
Medical Director



**Birmingham Women's**   
NHS Foundation Trust

<b>Subject:</b>	<b>"Facing the Future Head-on"</b>
<b>Report by:</b>	Steve Peak, Chief Executive
<b>Author:</b>	Neil Savage, Director of Workforce & Organisational Development

### Context and background for report

This report provides a summary of progress with "Facing the Future Head-On" and the key organisational development priorities.

### Key issues for Board's consideration and decision:

The keys issues for the Board to consider are the progress reports for the following Themes:

- Staff engagement – Listening into Action
- Service improvement via lean methodologies – Productive Ward, Pathology & ANC
- Service Line Reporting / Management
- Staff Reward and Recognition - Staff Recognition Scheme and Long Service Awards. This section includes recommendations for the future of the scheme
- Leadership and Management Development – Leadership Academy

### Recommendations:

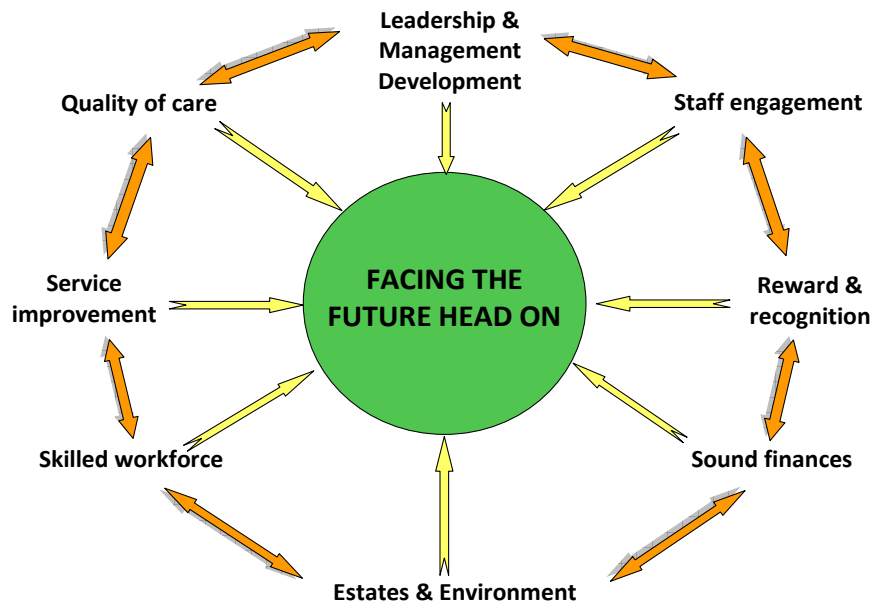
The Board of Directors is asked to NOTE the progress to date on the above themes. It is also asked to DEBATE and APPROVE the direction of travel suggested for a future staff reward scheme highlighted in section 5.

## Facing the Future Head On

### 1. INTRODUCTION

- 1.1 This report provides a progress update on the development of key aspects of the Trust's agreed Organisational Development priorities, summarised below:

### Organisational Development Priorities



### 2. Staff Engagement

- 2.1 Vicki Davies, Staff Engagement Facilitator has now completed her induction and is project managing Listening into Action (LiA) for the Trust over the next 10 months. Her post is funded from ring fenced monies provided by West Midlands Strategic Health Authority.
- 2.2 The LiA Sponsorship Group, which includes leaders and engagement champions from across the hospital, continues to meet on a fortnightly basis. The group has agreed the Phase One actions for implementing improved staff involvement and engagement through the LiA toolkit. All Sponsorship Group members now have access to the web-based tool-kit and are uploading examples of LiA in practice on to a central database.
- 2.3 The formal launch and five "Chief Executive's conversation" events are running throughout this month. Four successful and well attended sessions have been held to date with the concluding one taking place on the 27<sup>th</sup> September 2010. If there is a real demand for additional sessions, time permitting, consideration may be given to putting some more on.

- 2.4 An initial pre-LiA staff pulse check has been completed by a random sample of staff. This is attached as Appendix 1 and includes benchmarking against the most recent Staff Survey. Further pulse checks will be carried out during and after the implementation of the methodology. The pulse checks will be one of a number of methods used to measure improvements in engagement.
- 2.5 The central aims the Trust wishes to achieve from implementing Listening into Action includes:
- To create and nurture a culture whereby teams feel that the opportunity for engagement and involvement is high and they feel empowered to make a difference
  - To ensure that there is a common understanding of the breadth of challenges facing the organisation
  - To involve teams in our work around strategy review and formulation
  - To provide support to our leaders so they feel more confident to engage their teams in service change and improvement
  - To demonstrably improve reported staff perception of engagement with managers and the support they receive from their immediate managers
- 2.6 Up to ten top improvement themes will be selected out of the staff conversations. Some of the common themes raised to date include communications, information technology, visitor policies, reward and recognition, bureaucracy, procurement, staffing policies and sickness absence management. Small task and finish groups of key stakeholders will then work through and deliver measurable improvements for these chosen themes. A variety of communication methods will be used to better engage staff and ensure improvements are well publicised.

### **3. Service Improvement via lean methodologies**

#### **3.1 Productive Ward**

- 3.1.1 A sizeable end of project report is attached as Appendix 2. The report demonstrates the broad range of productivity and efficiency successes from the pilot and wider implementation of the methodology.
- 3.1.2 Over the past year Productive Ward has been piloted and implemented in key areas. Developed by the NHS Institute the methodology was developed as a structured service improvement system which had been tried and tested across the NHS on wards, theatres, mental health and community teams. The methodology used throughout at this Trust has focussed on improving key activities at ward level. The organisation has successfully implemented the foundation and other modules have been successfully implemented on the chosen wards.
- 3.1.3 The Trust's experience of implementing Productive Ward within the hospital is that it has brought demonstrable benefits for patients, staff and the Trust, particularly in terms of experience, safety and efficiency. It is evident from the implementation that the methodology contributed to and continues to contribute to the wider objectives of the Trust and other improvement initiatives. The methodology aims to empower staff and bring about cultural change, improved productivity and delivering higher quality patient care. This aim has largely been achieved. As such there is a good fit with the Trust's strategic aims on quality, staff engagement and sound finances. Further details of benefits are contained in the report.

- 3.1.4 The Trust is now determining how best to progress wider implementation into the future.. Due to central funding for this project, Noureen Wasique, the Project Manager, has had her contract extended for another two months to enable her to deliver key Productive benefits more widely across Post Natal and Delivery Suite. Persistent and sustainable success of Productive Ward requires ongoing commitment and support from the Directorate Heads and Ward Managers. Noureen is helping to support the start of longer term adoption.
- 3.1.5 Finally, the following project recommendations are being taken forwards or explored at this time:
- Wards to continue to implement further process modules
  - Standardised colour coding to be adhered to
  - New storage to be ordered for Wards 3 & 4
  - New storage to be ordered for Transitional Care
  - Knowing How We are Doing module and patient status boards along with trolleys ordered for the Neonatal Unit
  - Patient Status at a Glance coloured magnets ordered for use in all the ward areas.
  - Medifilms ordered for all the items/equipment across the Trust on single supply link.

### **3.2 NHS Improvements Pilot - Histopathology**

- 3.2.1 Tervinder Sokhi and the wider Histopathology team are to be congratulated on their persistent performance on this service improvement pilot. They continue to perform exceptionally well in comparison with both the national benchmarks and with the other participating NHS pilot sites:
- University College London (UCL)
  - North Middlesex
  - Musgrove Park
  - Leeds
  - Whipps Cross
  - North Tees & Hartlepool
  - North West London (Northwick Park)
  - Derby Hospitals NHS Foundation Trust
- 3.2.2 There are currently 7 improvement sub-projects being undertaken by the team and the improvements in Turnaround times remain sustained as at end of August 2010:
- 99.2% of work reported in 7 days (against 88.3% baseline & national target of 95%).
  - 68% of work reported in 3 days (against 41% baseline & national target of 50%)
- 3.2.3 Staff continue to have productive 5–10 minute daily “issues meeting” to discuss and solve problems from the previous day. A Comprehensive Visual Management Control Board is now in operation in the main laboratory. However, due to staff shortages over the summer period some of the laboratory based projects have not progressed as far as the team would have wished.
- 3.2.4 The team will be attending the National Histopathology Service Improvements Meeting this November in London. The purpose of the national meeting is to showcase and share pilot progress and knowledge for the following key areas:
- The delivery of timely and more responsive services for patients and users
  - Supporting and achieving the 31/62-day cancer pathways
  - Improving the effectiveness of MDT meetings
  - Delivering improvements in quality, safety and productivity

- Encouraging clinical leadership in improvement methodology
- Supporting change in service user pathways
- Using Lean principles to improve work flow
- Pioneering pathology clinical dashboards

Breakout sessions will explore some of the following lean service improvement themes including:

- Flow in the laboratory and office
- Quantifying waste
- Pooled reporting
- Improving quality and productivity
- Paperless reporting
- Communication, user involvement and staff engagement
- Transportation
- Overcoming inertia
- Improving safety through zero tolerance on non-conformities and discrepancies

### **3.3 LEAN projects supported by NHS Elect**

3.3.1 The main project being supported by NHS Elect over the past two months has been the Ante-natal Clinic Service Improvement project.

3.3.2 A half-day “deep-dive” event was held in August, the purpose of which was to involve key staff in methodically identifying blocks and priorities for action to enable rapid improvements.

3.3.3 The main themes identified from the workshop covered 2 key areas, (1) Demand and capacity and (2) Communications, both internal and external. A steering board was agreed consisting of Jane Owen, Neil Savage, Jo Naylor-Smith, Jo McHugo, Ellen Knox, Chris Jones, Damon Harris and Michaela Revel-Maton. The board has met and is in the process of supporting the following work streams:

- A review of the Radiology escalation plan
- A review of the current sonographer skill mix and capacity
- A data collection of demand and associated performance data to enable a better operational understanding and decision making
- A review of payments receipt for non-pregnant patients who attend the clinic for an clinical opinion
- A review of the maternity information published on the intranet
- The creation of a short patient information leaflet on the journey through clinic so as patients are clearer about what will happen during their appointment and expectations are better managed

3.3.4 The Clinical Genetics Lean project team has met twice with NHS Elect to scope the development of a waiting list process to manage capacity and demand. The access policy is being reviewed after which appropriate operational and clinical changes will be made. The project is expected to complete on schedule.

3.3.5 The Laboratory Genetics Lean project team have been working with Duncan Fleming and NHS Elect to process map the project. The Directorate has now installed Visio software to enable the project team to extend and manipulate the pathways. An evaluation study to track referral (time process steps and dead time) and identify bottlenecks has been completed and will be reviewed shortly to inform the next steps.

- 3.3.6 The Glucose Tolerance Testing lean project is near completion. This is aimed at improving the systems for glucose tolerance testing for women with possible gestational diabetes. The project has remapped work processes to deliver more capacity and efficiency. This has successfully brought down waiting lists. A new patient pathway and associated protocol is being finalised. Coupled with changes in staffing skill mix, subject to commissioner agreement, the team expect to be able to offer up a service for up to an additional 17 patients each week from November. Selton Smith will be presenting an end of project report in November.

## **4. Service Line Reporting & Management**

- 4.1 Roger Smith commenced in mid-June as project manager for Service Line Reporting (SLR). Good progress has been made in line with the project plan. He has gathered financial information, modelling information and agreed a project plan for the implementation of SLR. To date he has met with key clinicians and managers, subsequently reviewing hierarchy and account structures within the financial ledger system, in order to complete a feasibility assessment for translation into a workable SLR.
- 4.2 In liaison with the Finance team he has also identified software solutions to produce service line reports and organised demonstrations by suitable suppliers. A tender specification is being issued this week with a turnaround date of 15<sup>th</sup> October. His current focus is on finalising a mock service line report for Gynaecology. Mock reports for other areas are on track for late October. He is also gathering best practice and learning from other organisations who have already implemented SLR. Based on current progress, SLR is fully expected to be in place by February in line with the project plan.

## **5. Reward & Recognition**

### **5.1 Staff Recognition Scheme**

- 5.1.1 The Trust's Staff Recognition Scheme is being reviewed with a view to increasing the level of regular and annual awards given to staff. Recommendations for a new Staff Recognition Scheme will be brought back to the Board in September. The current scheme categories are highlighted below:

#### **1. Outstanding individual contribution to the Trust**

This award is for an unsung hero, where a member of staff provides a service that does not always receive the recognition they deserve.

#### **2. Best practice award – Clinical / Service Development**

This award is for an individual or team who demonstrate(s) outstanding and exemplary clinical practice.

#### **3. Best practice award – Improving Working Lives (IWL)**

This award is for an individual or team who have significantly added value to the Trust and their colleagues by their actions. Typically evidence is sought for improved staff satisfaction or morale as a result of a particular change to working practices etc.

#### **4. Most improved team**

This award is for a team which demonstrates significant improvement in areas such as morale and productivity.

5.1.2 As a result of the staff survey, alongside staff and managerial feedback, recommendations are being finalised for a broader and more mainstreamed scheme. The following suggested categories have been put forward by a range of managers and staff:

- Patient Champion of the Year
- Staff Champion of the Year
- Excellence Award (for clinical or support services improvement)
- External Partnership Champion of the Year
- Safety Champion of the Year
- Infection Control Champion of the Year
- Mentor of the Year
- Placement of the Year
- Student of the Year
- Regional or National Recognition Award (to reward regional or national roles)

Alternative suggestions from the LiA conversations will also be added to the final recommendations which will be taken to the JNC Staff Committee for debate and approval in October.

5.1.3 It is proposed that an annual award event will be held in November each year with the expanded categories. A certificate and choice of gift vouchers worth £200 each will be awarded for each category. Further funding is available as a result of a recent legacy to staff.

5.1.4 In addition to the annual award ceremony, a monthly award has been suggested for peer nominated Individual or Team of the Month. A reward of gift tokens (e.g. £50 for an individual or £100 for a team) would be presented by an Executive Director at the work place. Awards will be published in Women's Progress which could have new specific section to communicate the awards and other achievements.

5.1.5 The proposed new formal scheme will be supported by additional focus on recognition including:

- Ongoing recognition for good news - e.g. good patient, cleanliness or catering survey results would mean the team would receive gift tokens or subsidy for a meal
- Letters of thanks received from patients and relatives will be hand delivered to the area in question by an Executive Director to say thank you to those named
- Two staff celebration parties will be organised each year to recognise the organisational success, one at Christmas/New Year and one in springtime.

## **5.2 Long Service Awards**

5.2.1 The Trust's Annual Long Service Awards Ceremony took place at the end of June 2010. Over 100 staff with combined NHS service of more than 2100 years received certificates and awards. The long service categories and format of the award event work well. Alternative award badge options are being explored for next year.

## **6. Leadership & Management Development**

6.1 Steve Peak, Marianne Skelcher, Neil Savage and Estelle Carmichael met on the 28<sup>th</sup> of July to scope key themes and options for a proposed programme. A new leadership and management development programme is now being planned for delivery in 2011.

6.2 It is envisaged that the programme will be mandatory for all the Trust's leaders. Initial thoughts are that the programme will run for all Band 8s, 9s, Clinical Directors and some key Band 7 staff.

6.3 The programme will have five key elements to its:

- A pre-programme 360° assessment using the NHS Institute Leadership Qualities Framework (LQF).
- Resulting Cohort and Personal Development Plans
- Masterclasses. These will be put together following the initial assessment of needs through the 360° and may include inspirational speakers on key aspects of leadership, leadership theory, NLP tools for leaders, Finance masterclass, strategy master class etc.
- Coaching & Mentoring to be provided to participants.
- Individual Projects in support of personal development needs and Trust strategy
- Review with post programme assessment

## **7. Recommendations**

7.1 The Board of Directors is asked to NOTE the progress to date on the above themes. It is also asked to DEBATE and make recommendations on the outline proposals for an extended Staff Recognition Scheme and the Leadership Academy.

## Pulse Check Results Summary – August 2010

Listening into Action Pulse Check	Pulse 08/10 %	Staff Survey 09 %
<b>My manager gives me clear feedback on my work</b>		
Strongly agree	17	13
Agree	45	40
Neither agree or disagree	19	25
Disagree	13	15
Strongly disagree	6	6
<b>I am involved in deciding on changes introduced that affect my work/team/department</b>		
Strongly agree	18	9
Agree	33	37
Neither agree or disagree	24	22
Disagree	18	24
Strongly disagree	7	7
<b>BWH encourages me to report errors, near misses or incidents</b>		
Strongly agree	36	16
Agree	46	66
Neither agree or disagree	14	15
Disagree	2	2
Strongly disagree	1	0
<b>BWH's directors and senior managers are visible and approachable</b>		
Strongly agree	8	N/A
Agree	30	N/A
Neither agree or disagree	31	N/A
Disagree	22	N/A
Strongly disagree	8	N/A
<b>BWH communicates clearly with me about what it is trying to achieve</b>		
Strongly agree	8	4
Agree	42	43
Neither agree or disagree	33	34
Disagree	12	14
Strongly disagree	4	4
<b>If a friend or relative needed treatment, I would be happy with the standard of care provided by BWH</b>		
Strongly agree	29	18
Agree	48	61
Neither agree or disagree	17	17
Disagree	4	3
Strongly disagree	5	1
<b>I believe BWH values my work</b>		
Strongly agree	7	4
Agree	38	26
Neither agree or disagree	28	40
Disagree	17	20
Strongly disagree	8	10
<b>In the last 12 months, I have had an appraisal or KSF development review</b>		
Yes	71	62
No	27	38
<b>I feel that day to day communication across BWH is effective</b>		
Strongly agree	5	2
Agree	35	23
Neither agree or disagree	33	33
Disagree	19	29
Strongly disagree	7	13
<b>We are given feedback about changed made in response to reported errors, near misses and incidents</b>		
Strongly agree	6	4
Agree	38	36
Neither agree or disagree	19	34
Disagree	25	21
Strongly disagree	11	6



### Productive Ward-End of Project Report

<b>Report to:</b>	Project Board
<b>Report of:</b>	Noureen Wasique - Productive Ward Project Manager
<b>Subject:</b>	End of Project Report
<b>Date:</b>	20 August 2010
<b>Purpose:</b>	To provide the end of project report to the Project Board
<b>Recommendation:</b>	The Project Board is asked to: <ul style="list-style-type: none"><li>• <b>Note</b> the progress made</li></ul>

### Releasing Time to Care – The Productive Ward

#### 1. Introduction

This report informs the Project Board of progress made in the implementation of the Releasing Time to Care – The Productive Ward initiative at the Birmingham Women's NHS Foundation Trust.

#### 2. Background

The Productive Ward is a national initiative designed by the NHS Institute for Innovation and Improvement. The aim is to help teams review the way that key activities are undertaken on wards in order to remove waste and release time to provide more direct patient care. It is a systematic approach, based on Lean service improvement principles, to improving the reliability, safety and efficiency of care to improve the experience of both staff and patients.

The Productive Ward programme draws on principles of 'Lean thinking' (Lean) to help tackle previously neglected everyday issues facing frontline NHS staff. Lean aims to reduce activities that do not add value. In the case of health care this could mean releasing more staff time for work that actually meets patient needs. The programme is distinctive in that it provides tools specifically created to engage frontline staff in the initiation and implementation of service improvement at ward level.

The explicit promise of 'The Productive Ward: *Releasing time to care*' is framed to appeal both to service managers and ward staff: it suggests that there is room for efficiencies in organisational systems and that staff can take a lead in improving the delivery of patient care.

**Liberating The NHS** White paper published by the DH in July 2010 states: The existing Quality, Innovation, Productivity and Prevention (QIPP) initiative will continue with even greater urgency, but with a stronger focus on general practice leadership. The QIPP initiative is identifying how efficiencies can be driven and services redesigned to achieve the twin aims of improved quality and efficiency. Work has started on implementing what is required, for example by improving care for stroke patients, the "**productive ward programme**", increased self-care and the use of new technologies for people with long-term conditions.

The paper **Confidence in Caring**, A framework for best practice published by the Department of Health in September 2007 states that it can be used in conjunction with initiatives like The productive ward as the confidence creators' relate to the Productive Ward in these areas. To provide

- calm, clean, safe environment;
- a positive, friendly culture;
- good team-working and good relationships;
- well-managed care with efficient delivery; and
- personalised care for and about every patient

### **Strategic context**

The Productive Ward complies with and provides evidence for 17 of the CQC Core Standards.

### **Organisational Objectives**

The Productive Ward project provides an opportunity for the Trust to improve the quality of ward systems. It also provides cost savings through reduction in staff sick leave.

### **Promoting Equality & Diversity**

All staff and service users on inpatient wards are encouraged to participate in leadership activities through the Productive Ward project, promoting the leadership skills of the diverse workforce and service user population by providing regular feedback.

### **Patient & Public Involvement**

The project includes input from service users and carers on the wards. Quality measures are displayed in public ward areas to promote interest and involvement from visitors to the ward.

### **Resource Implications**

The Strategic Health Authority provided funding to the Birmingham Women's NHS Foundation Trust for a period of one year to implement the

Productive ward programme.

### **Assessment of Organisational Learning**

A key element to the Productive Ward process is the opportunity for wards to learn from each other as they develop local initiatives. The process ensures that there are opportunities for creative thinking at ward level and then the platform to cross fertilise if an idea is developed in one place that may be of benefit elsewhere.

### **Changing the Way Staff Think**

The vision is to 'change the way that staff think', to allow them to use skills to improve services. It is also intended to make the Productive Ward part of mainstream service improvement activity, linked to the delivery of Trust objectives, by delivering service key organisational change through the Productive Wards.

### **Staff Empowered to Change**

Ward staff feel more empowered to suggest and make improvements as a result of participating in the programme.

- 2.1. The Productive Ward has eleven modules focussed on key activities at ward level. Three foundation modules underpin the other eight process modules. The foundation modules are:
  - Knowing how we are doing – (understanding and using measurement to drive improvement).
  - Well organised ward – (being able to find things first time, every time).
  - Patient status at a glance – (using the patient white board to aid communication and shift handovers).
- 2.2. The eight other modules focus on the key activities and include: medicines, admissions and discharge, shift handover, meals, nursing procedures, patient hygiene, patient observations and ward rounds.

### **3. Outcomes/Benefits realisation**

Implementation of the Productive Ward programme results in the following benefits.

- **Improved efficiency of care.**
- **Improved patient experience.**
- **Improved patient safety and reliability of care.**
- **Improved staff well-being.**

### **4. Implementation at the Birmingham Women's NHS Foundation Trust**

- 4.1. Productive Ward implementation began at the Women's Hospital in September 2009.
- 4.2. In September 2009 robust Project Plan was developed by the Project

- Manager and approved by the Project Board.
- 4.3. The Project is steered by the Project Board on a monthly basis chaired by Jane Owen, Director of Nursing & Midwifery.
  - 4.4. Implementation began on one “showcase ward”, Ward 8 in September 2009 following Ward 7 in November 2009 with a period of detailed planning and training. In February Project was rolled out in ward 1 and the roll out commenced on the Neonatal unit in March. The Project was then rolled out to Ward 3, Ward 4 and more specialised areas such as Delivery Suite and the Birth Centre.
  - 4.5. Productive Ward implementation training was regularly conducted by the Project Manager. Training includes a detailed introduction to the Productive Ward programme and how to utilise lean methodology in the Healthcare environment. In-house training has been developed and delivered by the Project Manager for staff from roll-out wards. It is vital that every member of staff from each participating ward attend training sessions. The sessions are being conducted on a regular basis to involve each and every member of staff, which is very important for the successful completion and sustainability of the initiative.

At the beginning of March 2010 a comprehensive Productive Ward Briefing document was distributed widely by the Project Manager amongst staff in each of the areas. The purpose of this briefing is to provide a sound awareness of the programme and the benefits it can achieve in terms of releasing more time to provide quality care for patients. The documentation also aims at engaging staff more fully in these potential opportunities and generally gaining wider buy-in.

## **5. Foundation Modules**

### **5.1. Knowing How We are Doing module**

It is essential that ward staff know how well they are doing against a key set of metrics and are able to use the information to determine what action to be taken to improve. As part of Productive Ward, participating wards develop and display baseline data for key measures. These key measures then act as Key Performance Indicators (KPI's), which when displayed raise staff awareness of performance and creates an impetus for change. In addition, these metrics are used to measure progress within the programme and its outcomes.

**High Impact Actions** – Wards now display information of their progress on a series of key performance indicators or “measures”.

### **5.2. Well Organised Ward module**

This module is based on Lean principles of creating the right environment to work in, that is not only safe, clean and tidy but is one in which practice is standardised and sustained. It results in rapid change that is visible to everyone. Wards focus on the 5S principles. By adjusting their stock levels, these wards continue to reduce non-pay costs. This results in savings from reduced wastage from items expiring for use.

5S principles are:

1. Sort
2. Set

3. Shine
4. Standardise
5. Sustain

Well organised wards mean faster and more accurate access to equipment –easier for staff whether they are familiar or unfamiliar with the ward, and releasing more time for direct care.

#### **Improvements in cleanliness and infection control**

Reduced stock, re-organisation of materials and provision of additional storage has had a positive impact on the wards ability to keep clean both patient and non patient areas. Work to remove or have better storage of inappropriate stock improves infection control compliance with audit standards.

#### **Improvements in stock control**

Work achieved in the Well Organised Ward module provides a further opportunity for wards to review and reduce their stock levels. This includes better systems for ward staff ordering non supplies controlled items resulting in less time spent by nursing staff ordering stock.

### **5.3 Patient Status At a Glance module**

This module focuses on the use of visual management to show important patient information so that it can be updated regularly, seen at a glance and used more effectively by those who need it, resulting in fewer interruptions to staff. Studies have shown that nurses are interrupted once in every six minutes. (Ref. NHS Institute for innovation and Improvement) Most of these interruptions are from multi-professional team members and relatives, who were looking for information about location or discharge status of a patient.

## **6. Analysis of progress**

Productive Ward was initially rolled out in Gynaecology Directorate, then to the Maternity and Neonatal Directorates. Ward 8 being chosen as the show case ward. It is now delivering measurable benefits. For example, the total staff time saved on Ward 8 is 9% and the numbers of interruptions have fallen by 67% during 12 hours activity follow. These savings have enabled more time to be released to provide quality care for patients and associated tasks.

During the implementation a significant Trust-wide safety and quality improvement has been started. With this, a universal standardised colour coding system has been put into place, meaning that clinical items will have the same colour coding irrespective of the area they are being used in. This improves staff experience and reduces the risk of clinical errors. (Copy attached as Appendix 1)

All the wards have now developed and displayed ward vision for their areas on their Measures Board to remind staff of core values and principles. (Copy attached)

### **6.1. Gynaecology Directorate**

### 6.1.1 Ward 8

#### **Knowing How we Are Doing KHWD) module**

This module is now completed and benefits being evaluated

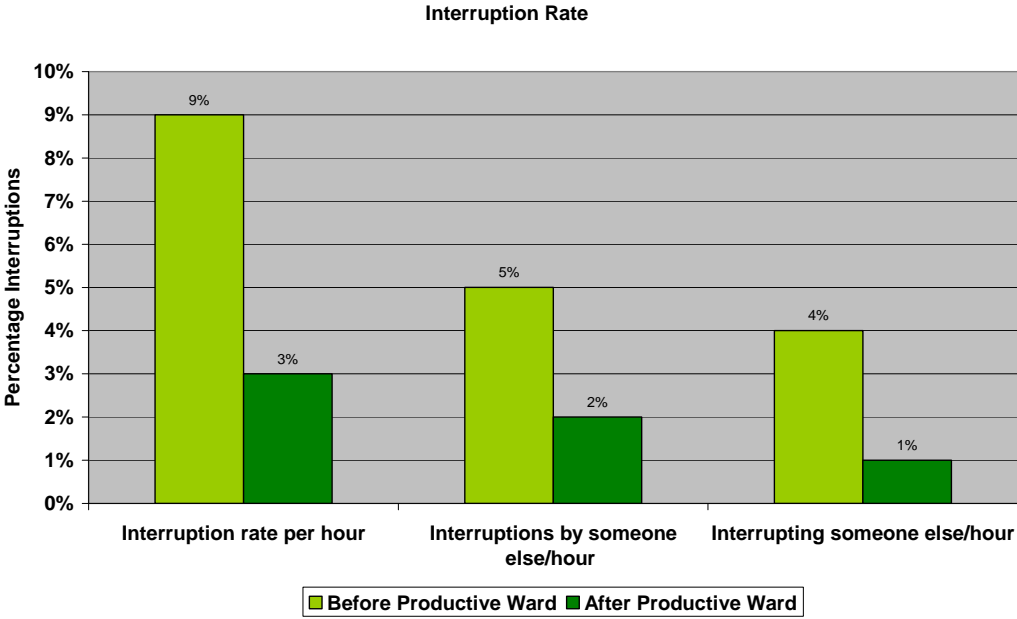
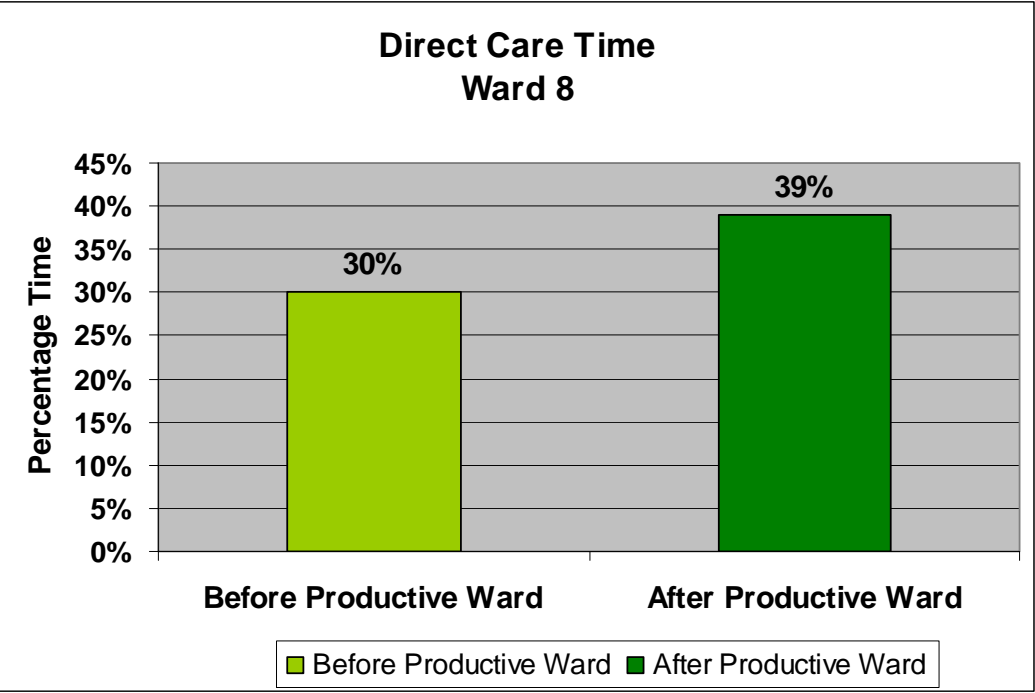
With the progression of the Productive Ward, there is a measures board located in a prominent position on the ward which displays the agreed measures. Ward vision has been developed and displayed on the board.

Initial activity follow conducted on ward 8 showed 30% of the time was spent in direct care whereas now the direct care time has risen to 39%. Total time saved on Ward 8 is 9% and the number of interruptions has fallen by 67% during 12hours activity follow.

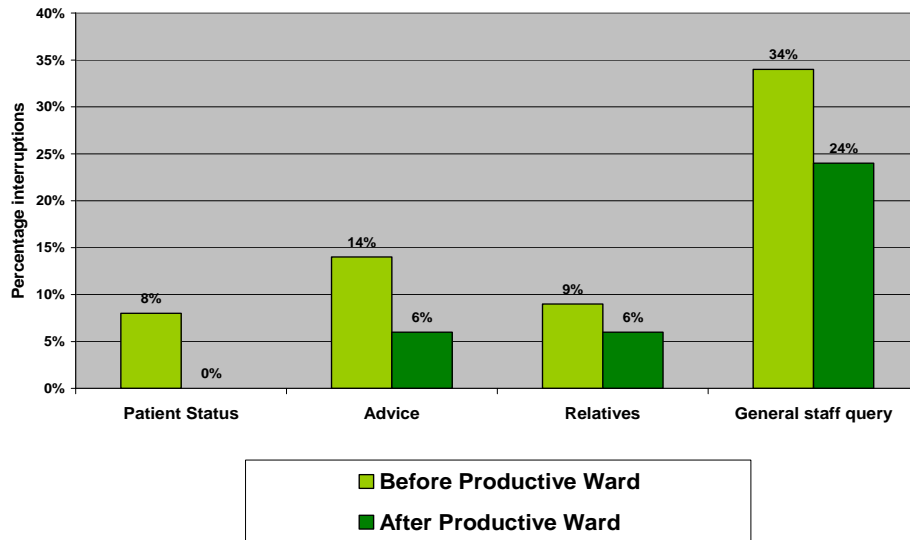
To improve patient satisfaction, patient survey questionnaire was designed and feedback collected to focus on the areas of concern. It was important to have reflection on the quality, safety and dignity of the care delivered. Questionnaire attached as Appendix 3.

#### **Measures Board on Ward 8**

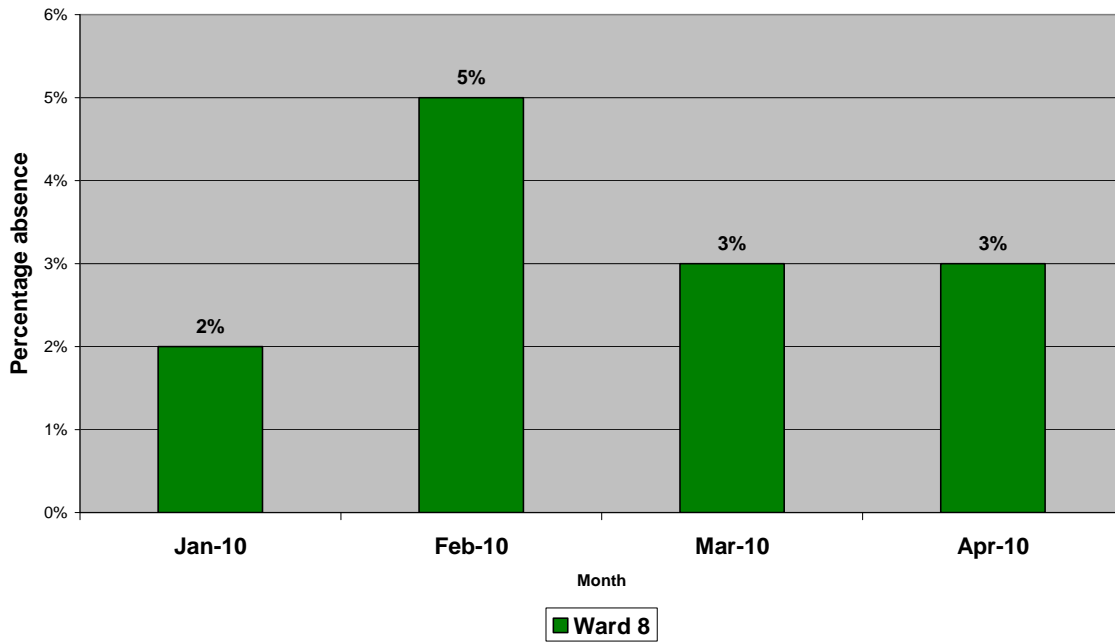




### Interruption Summary



### Staff Unplanned absence



### Well Organised Ward (WOW) module

This module is now completed and benefits being evaluated. All the areas have been organised using the 5S approach. Labelling of the items using standardised colour coding has been done.

### Picture before Productive Ward



**Pictures after Productive Ward**



**6.1.2 Ward 7**

### **Cost saving**

By re adjusting the stock levels on Ward 7, an amount of £893.00 was saved.

### **Time saving**

By moving a stock of fluids to the clean room, total time saved is 4 shifts a year.

**Picture before Productive Ward**



**Picture after Productive Ward**



### **Patient Status at a Glance (PSAG) module**

PSAG board is in place and the staffs have starting using it using symbols, taking into consideration patient confidentiality. This will also be used in Shift Handovers. Copy of symbols used are attached as Appendix 2

### **PSAG board on ward 8**



### **Patient Observation Module:**

This module is now completed and benefits being evaluated.

This module increases the standard of Patient observations carried out by ward teams. Ensuring they are accurate and that appropriate action is taken with the results. There were no specified standards or guidelines to record Patient Observations so the audit result was 70%. By videoing staff on the ward going about their usual daily routine to record Patient observations, it was easier to identify where time and effort was being wasted and how they could make changes.

Now with the progression of the Productive ward programme, the standards are formulated for recording Patient observations, and have shown huge progress. Now the audit score has risen to 93%. Standards for Patient observations are attached as Appendix 4.

## **Shift Handovers (SH) module**

Shift Handovers module is under progress on Ward 8. After successful Implementation of this module time wasted during handovers will be saved.

Moreover the information handed over would be more appropriate, easier to remember and easier to understand. It would be made easier with the help of the patient status board. Timing would be recorded to see how much time is spent in handovers. The staff is collecting information as to what other areas are doing with regards to handovers and see what they can do to make improvements.

### **6.2. Maternity Directorate**

#### **6.2.1 Ward 1**

##### **KHWD module**

With the progression of the Productive Ward, there is a measures board located in a prominent position on the ward which displays the agreed measures. Ward vision has been developed and displayed on the board.

In Ward 1 the rate of checking Resuscitation equipment has increased immensely. By displaying the rate of checking Resuscitation equipment on Safety crosses on the KHWD measures board, raised staff awareness and has shown progress. The rate of checking Resus equipment has risen from 57% 83%.

They are also displaying data for mothers delivering babies on ward. There is a huge progress in this regard as there are no cases this month.

Issues arising from the patient survey were about involving patients in decisions about care and treatment, patients being bothered by noise at night from hospital staff and staff passing different information to patients. These issues were discussed with the ward manager and were also suggested to discuss with the members of staff to improve patient satisfaction.

##### **WOW module**

This module is now completed and benefits being evaluated. Standardised colour coded labelling has been completed.

The Well Organised Ward (WOW) module has dramatically reduced the time staff spent running around looking for things or interrupting each other. They have also placed pictures of the items which are inside the cupboards for better visual management.

##### **Picture before Productive Ward**



### **Pictures after Productive Ward**



Shelving units are in place. Wall pockets have been ordered for patient notes as a lot of time is currently wasted in looking for the clip boards which get lost in transferring the patients.

One of the store rooms in Ward 1 was occupied with old record diaries dating back to 1929. Those will soon be moved to another appropriate place so that room can be used for CTG Monitors and other equipment.

It was discussed with infection control nurse specialist to have medifilms on floor for the equipments on the wards. medifilms are stickers placed on

floor, having the pictures of the items placed on them. They are excellent for visual management. One medifilm for blood pressure machine has been ordered to test its suitability with regards to infection control issues. After it is tested then more would be ordered for all the areas across the Trust.

### **PSAG module & SH module**

PSAG board has been delivered. Layout of the PSAG board is under discussion and all the members of staff are involved in the process. Discussions around Shift Handovers are also being done.

## **6.2.3 Ward 3 & 4**

### **KHWD module**

Activity follow has been conducted which shows 46% Direct care time and 23 interruptions in 6 hours. The baselines are displayed for the following measures

- Staff sickness absence
- Uniform compliance
- Unattended babies on beds
- Visiting Times compliance
- Resuscitation equipment checking

### **WOW module**

It was decided that that the ward would focus on the 5S principles to simplify their work place. 5S work was carried out on the store rooms. All the store rooms have been sorted and are much more organised and systematic then before.

Reduced stock, re-organisation of materials and provision of additional storage has a positive impact on the wards ability to keep clean both patient and non patient areas.

### **Pictures before Productive Ward**



**Picture after Productive Ward**



#### **6.2.4. Delivery Suite**

##### **KHWD module**

Board location and layout has been decided and the board has been delivered.

It has been decided that the baselines would be displayed for the following measures on the safety crosses

- Staff sickness absence
- Resuscitation equipment checking

## WOW module

There are two store rooms on the Delivery Suite. Only one of the rooms was used as a store room. It was suggested by the Project Manager that both the rooms could be re organised in such a manner that these rooms could be standardised and used regularly. The staff would save a lot of time, which they are currently wasting in walking long way to the front store room. This change process has been conducted as the new storage has been placed in the back room and the items have been moved and labelled using standardised colour coding.

### Picture before Productive Ward



### Picture after Productive Ward



Moreover one of the issues faced is with the drugs and supplies. Project Manager has escalated the issue to the Clinical support Department and has advised the Ward managers to make a list of items with specific issues so that this can be addressed and resolved. Incident reports are now sent to the Clinical Support Department. The time wasted would be saved and the staff on the wards will become more productive.

### 6.2.5. Birth Centre

Completed

#### WOW module

The store room on the Birth centre has been sorted using the 5S approach. The room looks much cleaner than before. Standardised colour coding has been used to label the items.

**Picture before Productive ward**



**Picture after Productive ward**



### **6.3. Neonatal Directorate**

#### **6.3.1 Neonatal Unit**

Productive ward programme has been rolled out to the Neonatal Unit. Productive Ward Newsletter has been populated and distributed regularly in the Neonatal Unit.

A group has been formed to start looking at all the documentation on NNU. Parent questionnaires have been given to Parent support lead nurse. Staff ideas and vision board is in place.

#### **KHWD module**

The Activity follow was conducted on the Neonatal unit which shows 52% of time was spent in Direct care and there were 24 interruptions during 6 hour activity follow. Location of KHWD measures board in the new unit is under discussion.

#### **WOW module**

Work is under progress in the Neonatal unit. To start with the baby trolleys are being 5Sd. Audits of storage trolleys and medications is done, which would lead to cost saving.

#### **PSAG module & SH module**

Layout of the PSAG board is under discussion and all the members of staff are involved in the process. Discussions around Shift Handovers are also done.

#### **6.3.2. Transitional Care**

Productive ward programme has been rolled out to the Transitional care. Module box set has been handed over to the ward manager. Briefing notes have been distributed among all the members of staff.

Activity follow was conducted for 6 hours which shows 38% Direct care time and 29 interruptions.

#### **WOW module**

The store rooms on the Transitional care need to be 5Sd. Items would be labelled using colour coding for better visual management.

### **7. Conclusion**

The Productive Ward is a structured service improvement system launched by the NHS Institute that is focussed on improving key activities at ward level. The Trust has piloted the Productive Ward and has successfully implemented the foundation modules and other relevant modules on these wards. Results are very positive with ward leads and staff reporting high levels of satisfaction.

Delivery of the Productive Ward initiative at the Birmingham Women's

Hospital has shown real benefits for the patients and staff both in terms of experience and safety. It is evident from this report that the work being carried out within this programme contributed to the objectives of the Trust and other improvement initiatives. Importantly, the approach taken in implementing the Productive Ward at BWFT is based on empowering staff which will bring cultural change within the organisation, underpinning productivity, efficiency and delivering high quality patient care.

## 8 Recommendations

If the Productive Ward programme is progressed in the future, this initiative will continue to identify inefficiencies and changes that have resulted in time being released for re-investment in patient care. Sustainable success of this initiative requires ongoing commitment and support from the Directorate Heads and Ward Managers.

Based on the analysis of the programme the following recommendations are suggested for consideration in future.

- Wards should continue to implement further process modules as these will bring greater benefits to patient care and to the Trust.
- Standardised colour coding is adhered to
- New storage is ordered for Ward 3 & Ward 4
- New storage is ordered for Transitional care
- KHWD and patient status boards along with trolleys are ordered for the Neonatal unit
- Coloured magnets for the PSAG are ordered for all the areas. It is highly recommended that every area uses them.
- Medifilms ordered for all the items/equipment across the Trust on the following link <http://www.medifilm.co.uk/contact.html>



Module	Hyperlink to module guides and resources
KHWAD	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
WOW	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
PSAG	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
Handover	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
Meals	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
Medicines	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
Pt Observations	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
Admissions and Discharges	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
Nursing Procedures	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
Patient Hygiene	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
Ward Round	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>
Toolkit	<a href="http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf">http://www.institute.nhs.uk/index.php?option=com_joomcart&amp;Itemid=194&amp;main_page=document_product_inf</a>

Appendix 1:

**STANDARDISED COLOUR CODING FOR ITEMS ACROSS THE TRUST**

Oxygen masks Oxygen tubing Nasal specs Nebulisers Pocket mask
Dressing packs Dressings Norma sol Gloves Sterile gloves Stitch removal packs
IVI giving sets Fluids Venflons Phlebotomy Syringes Needles Cotton wool Tape
Catheters Catheter bags Banano catheters Speculums VE pack Delivery pack Flip flow valve
Toiletries Sanitary pads Cloths

Appendix 2:



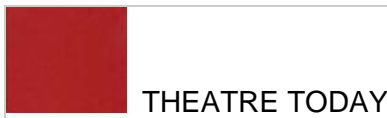
**BOOKED ADMISSION**



**DISCHARGE HOME**



**EMERGENCY ADMISSION**



**THEATRE TODAY**



**NIL BY MOUTH**



**GYNAE ULTRASOUND SCAN**



**EPAU ULTRASOUND SCAN**



**TRIAL WITHOUT CATHETER**



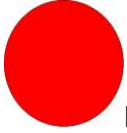
**SUPRAPUBIC CATHETER**



**CATHETER**



**NO KNOWN DRUG ALLERGIES**



**KNOWN DRUG ALLERGIES**



**TABLETS TO TAKE OUT**



# Patient Survey

Please answer the following questions by ticking **ONE** box using a pen. If you make a mistake, simply put a line through your previous answer and choose another response.

**Which Ward or Department were you treated in?**

Ward 7

Ward 8

**Do you feel you have been treated with respect and dignity throughout your hospital stay?**

Yes, always

Yes, sometimes

No

**Were you given enough privacy when discussing your personal details, condition or treatment and whilst being examined or treated?**

Yes, always

Yes, sometimes

No

**Were you involved as much as you wanted to be in decisions about your care and treatment?**

Yes, definitely

Yes, to some extent

No

**Were you given enough information, including the benefits and risks of your treatment?**

Yes

Yes, to some extent

No

Not enough

**Have you been seen by a Doctor, from your Consultants team, every day during your Admission?**

- Yes  No

**In your opinion, how clean was the hospital room, ward you were in?**

- Very clean  Fairly clean  
 Not very clean  Not at all clean

**How clean were the toilets and bathroom that you used in hospital?**

- Very clean  Fairly clean  
 Not very clean  Not at all clean

**As far as you know, did staff wash or clean their hands between touching patients?**

- Yes, always  Yes, sometimes  
 No  don't know/can't remember

**How would you rate the hospital food?**

- Very good  Good  
 Fair  Poor  
 I did not have any hospital food

**Were you offered a choice of food?**

- Yes, always  Yes, sometimes  
 No  Not Applicable

**If you answered NO to the above question, in which meals choice was not offered?**

- Breakfast  Lunch  
 Suppertime

**Were any mealtimes interrupted by Doctors round? If so which one**

- Breakfast  Lunch  
 Suppertime

**When staff are talking can you overhear confidential information about other patients?**

Yes, always

Yes, sometimes

No

**Were you on any regular medication when you came into hospital?**

Yes

No

**If yes, was this given to you at the times you usually take it?**

Yes

No

**If you have been commenced on any new medication whilst in hospital, has this been explained to you?**

Yes

No

**Were you given sufficient written or printed information to help you?**

Yes

No

**Did you find written information easy to understand?**

Yes

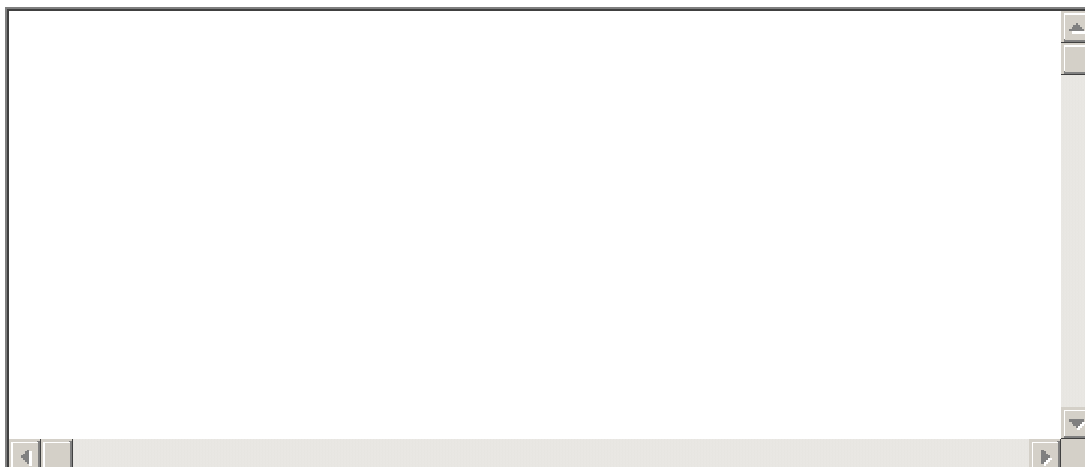
No

**Would you recommend this hospital to a family member/friend?**

Yes

No

**Please use this comments box for any other points that you would like to raise.**



Appendix 4:

**Ward 7 & 8 Standards for Inpatient Observations**

**All gynaecology inpatients should undergo observations in a timely manner appropriate to their condition or procedure.**

All patient observations on admission to include respirations IF patient has a pre existing medical condition e.g. asthma, copd etc. If unsure check with nurse in charge.

Frequency of observations to be documented on patients chart and on white board at nurse's station.

**All surgery with a PCA on return to ward**

Half hourly BP pulse respirations x 3

Hourly bp pulse respirations x3

4 hourly bp pulse, temperature, respirations until pca discontinued

The above should also include pain score, ponv, and sedation score and PV loss.

Checking of PCA machine should be documented at least 4 hourly.

Post op observations should continue to the set routine regardless of the time the patient returned to the ward.

**All major surgery post op recovery**

Observations to be completed as above.

**Intermediate surgery (not day case)**

To include laparoscopic cystectomy, oophrectomy, salpingectomy, excision of endometriosis and adhesiolysis.

Half hourly for 2, hourly for 2, then four hourly

**Day surgery**

On return to ward, 2 hours later or on discharge.

**Ectopic pregnancy (confirmed/unconfirmed)**

4 hourly unless indicated otherwise

**Medical management of miscarriage**

Four hourly unless indicated otherwise

**Ovarian hyper stimulation syndrome (OHSS)**

Four hourly. Also include weight, girth and bloods daily.

**Bladder retraining**

Daily unless otherwise indicated

**Blood transfusion**

Baseline

15 minutes after commencing and when unit is finished.

**Hyperemesis**

On admission to include lying and standing BP and weight.  
Four hourly if has postural hypotension, otherwise BD.

**PV bleed /abdominal pain**

Four hourly.

**Fluid balance charts**

Robinson/redivac drainage to be charted daily, unless indicated more frequently.  
Ensure that it is documented whether drain has been emptied or not.  
Catheter drainage charted 6 hourly  
Input to be updated with observation round.

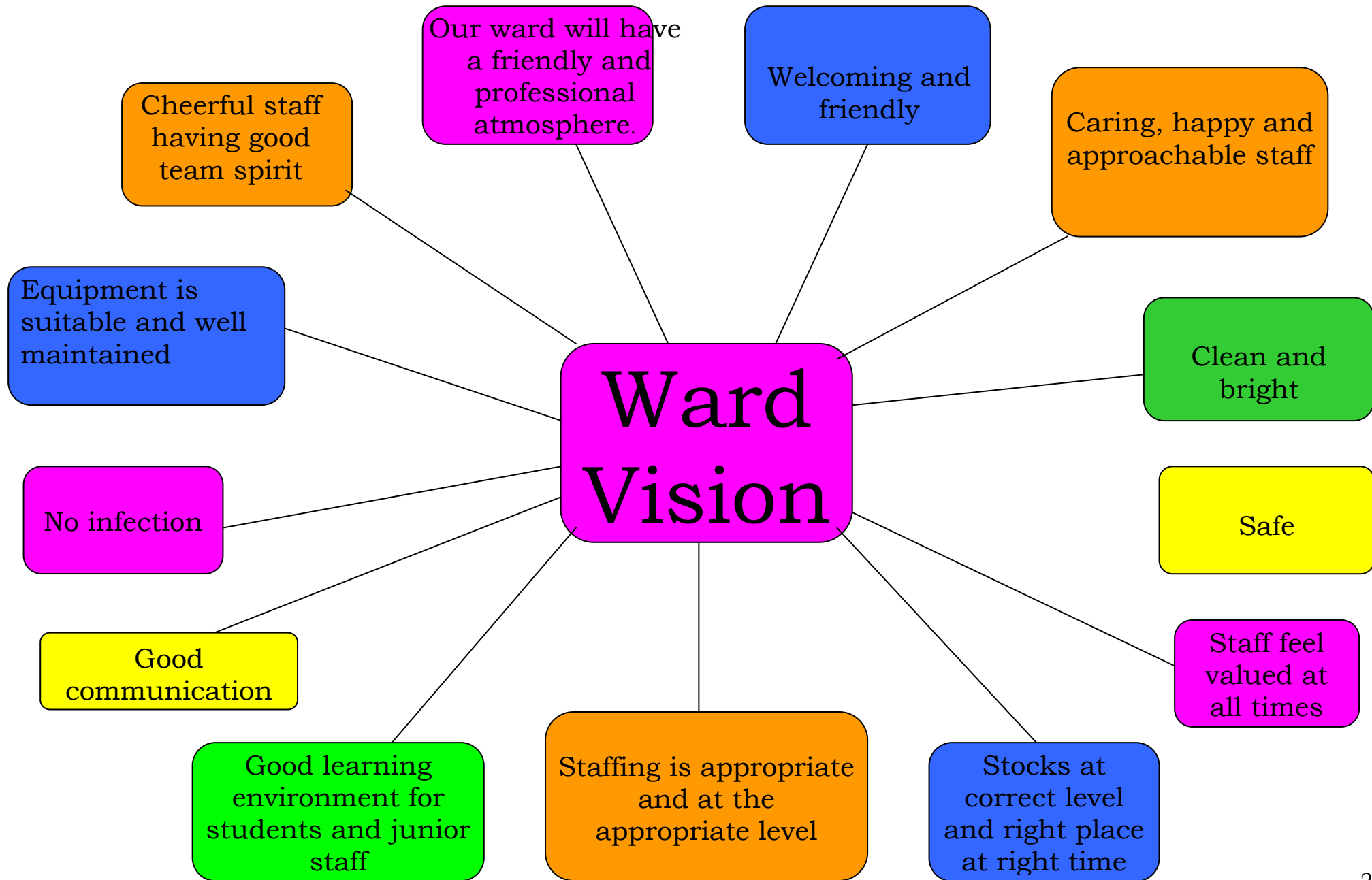
**Standard times to agree**

**4 hourly = 02.00, 06.00, 10.00, 14.00, 18.00, 22.00**

**QDS = 6.00, 12.00, 18.00, 22.00**

**Bd= 06.00, 18.00**

**Daily 10.00am**



# Birmingham Women's

NHS Foundation Trust

<b>SUBJECT:</b>	Cancer Waiting Times Performance Report
<b>REPORT BY:</b>	Jane Owen, Director of Nursing, Midwifery and Operations
<b>AUTHOR:</b>	Jane Bennett, Cancer Manager Delreita Bernard, General Manager.

## CONTEXT AND BACKGROUND FOR REPORT

This report highlights performance in relation to the Cancer Waiting Times Standards for August 2010 and progress against the Action Plan 2010/11

### Executive Summary

The delivery of the six cancer waiting standards is a key national target. Due to the small number of patients who receive treatment for their cancer diagnosis, the delivery of the standards is challenging as it is based upon percentage of patients treated within the required timescales.

Consequently one breach of the standard, in percentage terms, can make a significant difference as to whether the standard is delivered. Equally challenging is the need to manage potentially complex pathways between 2 or 3 providers of care.

#### **All Cancer Standard Waiting Times (CWT) standards have been achieved in August for the fourth consecutive month.**

The Year to Date position against all standards continues to improve. The 62 day referral to treatment standard is now 84.2% against a standard of 85% and the 31 day diagnosis to treatment standard is at 94.1% against a standard of 96%.

All standards are on course to achieve Q2 performance apart from the 31 day diagnosis to treatment as the Trust will be required to treat at least 8 patients against this standard to achieve 96%. A request to City Hospital for reallocation of a breach which occurred in April has verbally been refused on the grounds that the delay was due to clinical reasons and not administration. We are awaiting a written response before pursuing this further.

Priorities during August have been focused preparation of documents required for the Cancer Peer Review, scheduled for Monday 22<sup>nd</sup> November. However, progress against the Action Plan continues, where the only outstanding action is the development and agreement of the cervical pathway timelines, planned for October.

As we progress, the next challenge for the Trust is the management of patients with a high BMI that cannot be treated at BWH as an HDU facility is required. This will be incorporated into the Oncology MDT Work Programme for 2010/2011.

**RECOMMENDATIONS:**

The Board is asked to note :

- Performance against the CWT standards August 2010 and year to date progress.
- Progress against the CWT Standards Action plan 2010/11
- To note forthcoming Peer Review.

## 1.0 Introduction

The Department of Health set the operational standards in 2009/2010 around Cancer Waiting Times by identifying the expected rate of exceptions to the target for each tumour type. The proportions of patients treated under each tumour type were then applied to produce an overall percentage.

The standards are as below:

<b>Cancer Waiting Times Standards 2009/10</b>	
2 week wait Referral Received to date 1st seen (14 day standard)	<b>93%</b>
Referral Received to treatment (62 day standard)	<b>85%</b>
Cervical Screening 62 day standard	<b>90%</b>
Upgrade to 62 day standard (No national target set)	No target set
Diagnosis to Treatment (31 day standard)	<b>96%</b>
Subsequent treatments (31 day standard)	<b>94%</b>

The numbers of patients treated by each specialist trust for each tumour type in the first quarter of 2009/10 were examined and compared with the national average. It was found that Birmingham Women's NHS Foundation Trust treated more than the national average proportion of patients with tumour types, with a higher level of exceptions than the average of 15% against the Referral received to Treatment 62 day standard.

## 2.0 Performance August 2010/2011

	Target	August 2010	Year to date	Variance on previous month	Total Patients August 2010	Total Patients YTD
<b>2ww Referral Recd to date 1st seen (14 day standard)</b>	<b>93%</b>	97.3%	97.0%	+0.2%	73	295
<b>Referral Recd to treatment (62 day standard)</b>	<b>85%</b>	100%	84.2%	+ 5.6%	1.5*	9.5
<b>***Cervical Screening 62 day standard</b>	<b>90%</b>	100%	100%	-	0.5	4.0
<b>**Upgrade to 62 day standard</b>	No target set	100%	100%	-	1.5**	6.5
<b>Diagnosis to Treatment (31 day standard)</b>	<b>96%</b>	100%	94.1%	+ 1.2%	4	17
<b>Subsequent treatments (31 day standard)</b>	<b>94%</b>	100%	100%	-	1	3

\* 62 day Referral to treatment standard:

- 3 shared patients with City (1.5)

\*\*62 day Upgrade to treatment standard:

- 1 shared patient with University Hospital of North Staffordshire (0.5)
- 2 shared patients with City (1)

## 2.1 Standards not achieved - Year to Date

- 62 day referral to treatment standard – 84.2% achieved against 85% target: A total of 8 patients treated within the standard, 1.5 breaches year to date. (Therefore a total of 9.5 patients treated against this standard April-August).

***Subject to no further breaches, this target will be achieved for Q2.***

- 31 day diagnosis to treatment standard- 94.1% achieved against a 96% standard: This under performance relates to 1 patient. A total of 16 patients treated within the standard set, one patient breached the standard in April, (therefore a total of 17 patients treated against this standard April-August)

*A further 8 patients need to be treated within the standard set for this standard to be achieved.*

## 3.0 Tracking

The number of patients who were referred for an outpatient appointment under the urgent referral system for suspected cancer during August 2010 = 73

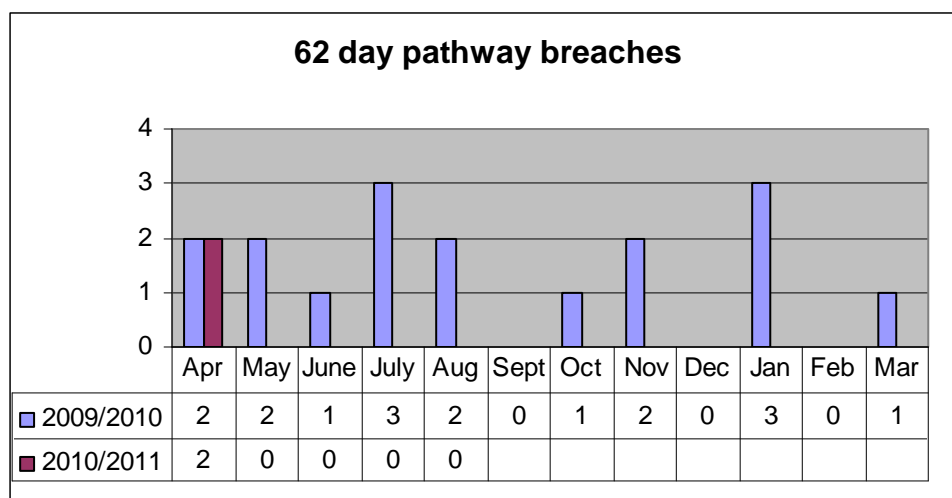
The number of patients who were tracked from a cervical screening report during August 2010 = 20

Therefore, a total of 93 patients were tracked by the Oncology department during August.

## 4.0 Breaches of the standards and analysis

There were 2 breaches on the 2ww Referral Received to date 1st seen (14 day standard) in the period, both were as a result of patient choice.

No further breaches to report for August 2010.



## 4.1 Breach Review

No breaches to review for the month of August.

Informal notification from the Cancer Manager at City Hospital has been received refusing the breach reallocation request for the April breach. A formal reply will follow.

## **5.0 Progress against Cancer Waiting Times Action Plan : June 2010**

The Cancer Operational Team, which comprises of the Lead Consultant for Oncology, Clinical Nurse Specialist for Oncology, PMB Pathway Lead Nurse, Cancer Data Manager and Directorate General Manager meet on a fortnightly basis to discuss:

- Cancer Waiting Times Action Plan
- Peer Review
- Patient Tracking
- Patient pathways
- Monthly Performance against targets
- Breach review
- Staffing resource planning

### **5.1 Operational Effectiveness**

The Cancer Waiting Times Policy and an associated Escalation Policy has been agreed by the Operational Team.

The Escalation policy is to be forwarded to the Director of Nursing and Midwifery for approval.

The Oncology Administrative team is now enabled to sustain effective patient tracking processes, MDT operational support and management support to the Unit MDT.

Much work is being undertaken within the department to prepare the documents which are required as part of the peer review process i.e.

- Oncology Multidisciplinary Team (MDT) Annual Report,
- Updated MDT Operational Policy
- Work Programme for 2010/2011.

The Peer Review visit will be held on Monday 22<sup>nd</sup> November.

Live MDT has been scoped and is to be piloted on Monday 27<sup>th</sup> September.

### **5.2 Operational Capacity**

A nurse-led clinic has been implemented in August, which will increase the capacity to see oncology patients, and allow more qualitative time for those patients needing to see the Clinical Nurse Specialist.

### **5.3 Effective Pathway Design**

All pathways have now been completed with the exception of the cervical pathway.

A shortened pathway has been agreed at a multi-disciplinary meeting in July which is to commence in September. Performance against the new pathway will be closely monitored and a review will take place after the three month period.

#### **5.4 Robust Data and Information and Administrative Systems**

The Data Validation Policy has now been agreed with Informatics Department.

The Informatics Department have commenced monthly validation of data uploaded to Open Exeter with effect from August.( i.e. June data, as data is uploaded 2 months after the end of the period into Open Exeter.)

The Informatics Manager has now been trained to undertake upload to Open Exeter in the absence of the Oncology Data Manager.

##### **Outstanding Actions**

- Informatics Manager to explore uploading of data into Somerset Database from Lorenzo to reduce the manual input required into the system.
- Informatics Manager to review options to enable the Informatics Department to submit monthly Cancer Performance Data, data requiring validation would be forwarded to the Oncology Data Manager.

## 5.5 Cancer Waiting Times Action Plan 2010/11 : Monitoring Template

<b>Operational Effectiveness: Develop the Operational Policy for Cancer Waiting Standards so as to Clearly identify responsibilities for cancer tracking team.</b>		
Actions	Due	Progress
Draft Policy skeleton	Apr-10	Completed May 2010
Draft policy	May-10	Completed Jun 2010
Policy to be approved by Gynae Oncology Locality Group	Jun-10	Circulated to all members for consultation.
Policy to be approved by Gynae Directorate	Jul-10	Formatting amendments required prior to submission to Gynae Directorate for final ratification on 27/9/10
<b>Operational Capacity - Ensure the Trust has appropriate Resources and Sufficient Capacity to deliver the Cancer Waiting Times Standards</b>		
Actions	Due	Progress
Appoint MDT Co-ordinator	Jun-10	In post as at 05.07.10
Review Potential for Clinical Nurse Specialist led clinics	Sep-10	Nurse-led clinic commenced 02.08.10
Review Clinical Nurse Specialist Capacity	Dec-10	
Monitor notice periods for clinical annual leave, manage in such a way as not to impact on patient care	Ongoing	
Scope provision for an Anaesthetic Review Clinic (to be added to action plan)	Dec 2010	
<b>Effective Pathway Design - effective pathways deliver quality and timely care to patients throughout their cancer journey.</b>		
Actions	Due	Progress
Complete review of Cancer Pathways	Jul-10	Endometrial Pathways completed; discussed & agreed at Gynae Operational meeting 11.06.10. Vulval and Ovarian pathway completed in draft, to be discussed at Operational meeting 16.07.10. Cervix pathway to be completed. For completion in October
Share results with Clinical Teams	Aug - 10	Endometrial Pathways shared at June Gynae Oncology Locality (GOL Meeting). All pathways to be discussed at Aug Gynae Oncology Locality Meeting. Deferred to September meeting.
Redesign/review Clinical Pathways	Sept - 10	Meeting held to Post Menopausal Bleed pathway June 2010, pathway reviewed.
Agree Standard Pathways	Oct - 10	Standard time lines revised for a shortened PMB pathway to be trialled Sept – Dec 2010.
Audit against Agreed Cancer Pathways	Jan-11	
<b>Robust Data and Information and Administrative Systems : Information systems must be complete and robust to guarantee delivery of the standard of care</b>		
Actions	Due	Progress
Develop clear protocols to support data capture with clarity about which individuals own and revise it.	Aug-10	Data Validation Policy Agreed Aug 2010 Informatics Department commenced validation procedures for data uploaded to Open Exeter – Aug 2010
Single user for Somerset Upload: General Manager to be trained to upload monthly data on National database.	Jul -10	Informatics Manager trained to upload data from Somerset into Open Exeter- Aug 2010
Implement Live Multi Disciplinary Team system - live recording of outcomes at the weekly Multi-disciplinary meeting.	Sep-10	Live MDT to be piloted Monday 27 <sup>th</sup> September



## Birmingham Women's



NHS Foundation Trust

<b>SUBJECT :</b>	Chairman's Report, September 2010
<b>REPORT BY :</b>	Helen Hemberg, Trust Chair
<b>AUTHOR :</b>	

### CONTEXT AND BACKGROUND FOR REPORT

This report updates the Board on the activities of the Chairman during the month, and also seeks approval for matters relating to the Board such as appointments to Committees and future meeting arrangements.

### KEY ISSUES FOR BOARD OF DIRECTORS' CONSIDERATION AND DECISION

- Following his appointment to the Board, the question of appointing Mr Wall to committees arises. His appointments are required to be made by the Board (SO 5.1.6)
- Following discussion between the Chairman and Mr Wall, the Board is recommended to appoint Mr Wall to the Audit, BIOG, ORAG and Remuneration Committees
- The current Terms of Reference for ORAG only provide for one NED appointment, and so changes will be necessary. These will come forward to the Board at next month's meeting as part of the annual review.
- Following discussion between all parties, it has been agreed that the appointment to BIOG should be to replace Marianne Skelcher, who has agreed to go onto the Equality and Diversity Committee

The Board has previously agreed that there should not be a formal meeting of the Board in the December slot (16<sup>th</sup> December). However, following discussions with Directors, agreement is sought to hold a Board meeting on that date if it is felt necessary given the progress of the Trust towards meeting its objectives.

Recent meetings and activities include:

- Meeting with Prof Michael West at Aston Business School
- Board planning seminar
- Meeting Richard Bacon, partner of our new external auditors PWC
- Meeting of Chairs/CEOs of BCH and ROH
- Conference on White Paper implications
- Meeting with Chair of UHB, Sir Albert Bore

## ENCLOSURE 8

- Attended Maternity Services Liaison committee
- Meeting with Jenni Ord, Chair of Solihull Care Trust
- Meeting with Councillor Gaved (Governor)
- Meeting with Steve McCabe MP
- SHA Chairs regular meeting

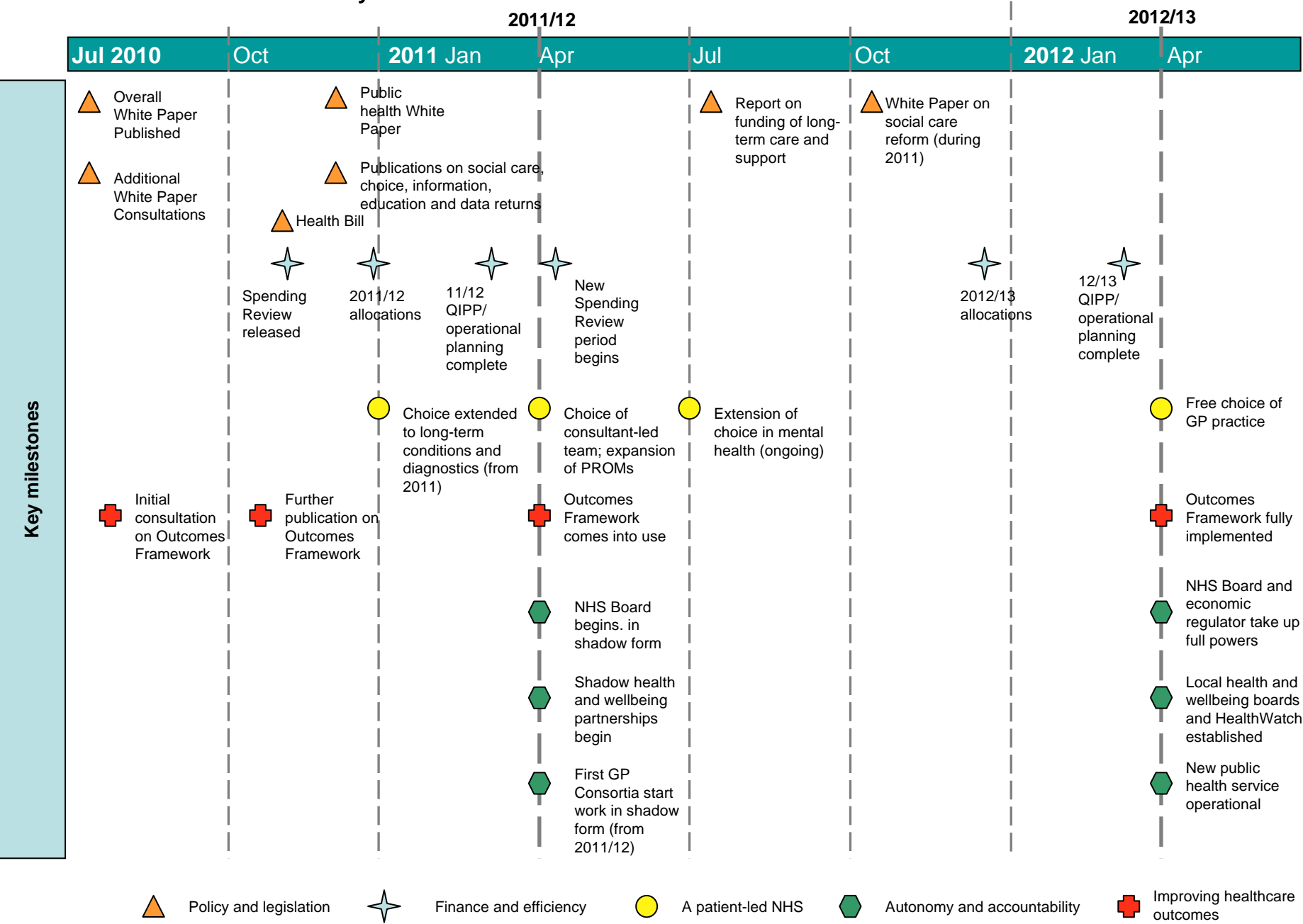
Additionally, attached to this paper is a provisional timetable for the implementation of the White paper recommendations.

### RECOMMENDATIONS

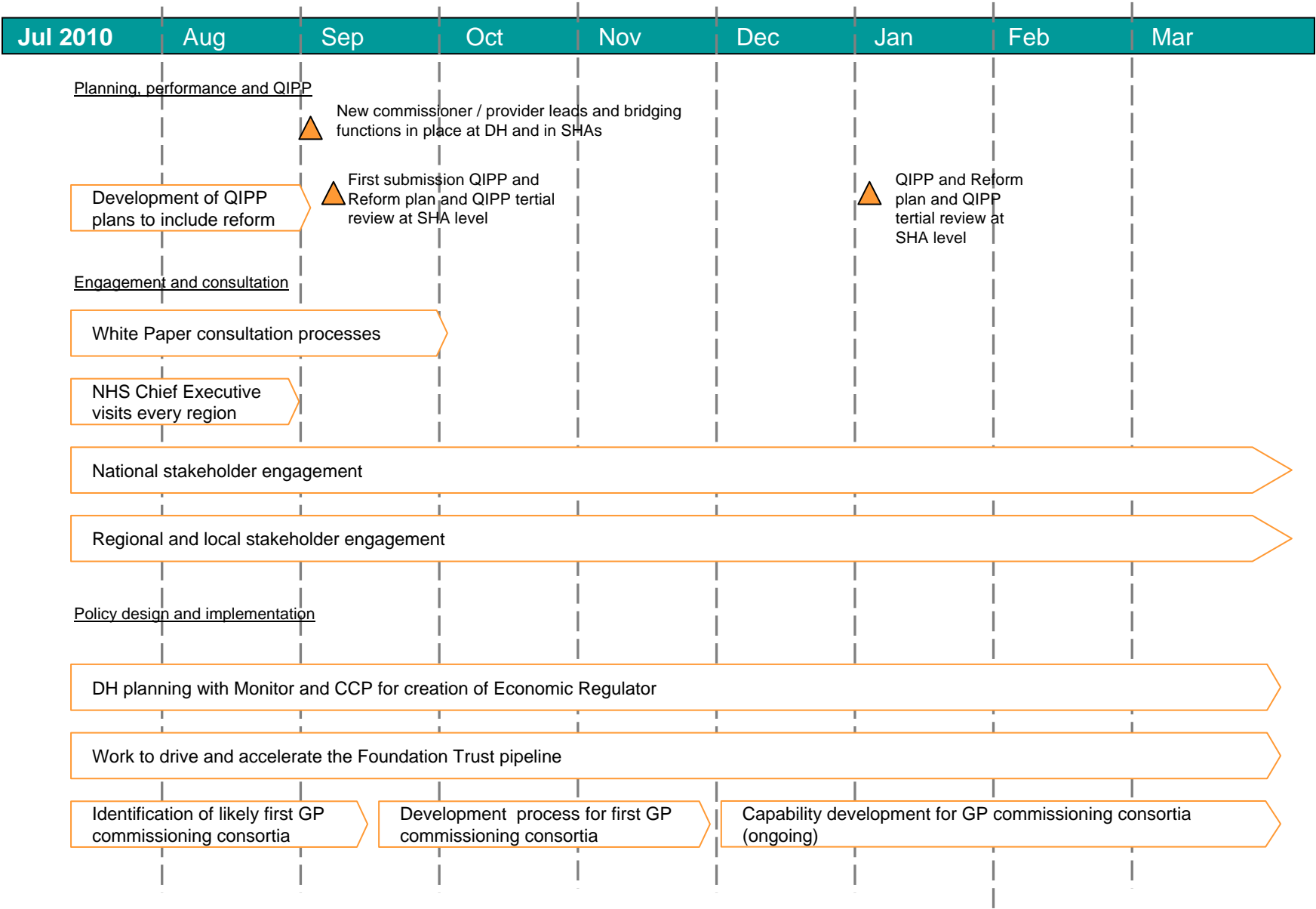
The Board is invited to agree:

- a. That Mr Robin Wall be appointed to the following Committees of the Board:
  - Audit Committee
  - Business Investment and Opportunities Committee (replacing Marianne Skelcher)
  - Organisational Risk and Governance Committee
  - Remuneration Committee
- b. That Marianne Skelcher be appointed to the Equality and Diversity Committee
- c. That the Secretary be authorised to convene a meeting of the Board on 16<sup>th</sup> December 2010 if considered necessary

# Provisional overall timeline: July 2010 - June 2012



# Early engagement and action timeline: July 2010 – Mar 2011



# Birmingham Women's



NHS Foundation Trust

<b>SUBJECT:</b>	Chief Executive's Monthly Report – PUBLIC (September 2010)
<b>REPORT BY:</b>	Steve Peak
<b>AUTHOR:</b>	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 :

- Lorenzo IT Implementation - Update
- Capital Schemes – Update
- Development of the sperm donor service - Update
- Appointments
- National Pathology week
- Trust Strategy
- Improving the collection and presentation of patient experience information – Update on achieving project outcomes

## RECOMMENDATIONS

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

## **1. Lorenzo IT Implementation - Update**

To report that the Trust has agreed to postpone the go-live date for the Lorenzo care management system from the 4<sup>th</sup> October to the 1<sup>st</sup> November.

The reason for the postponement is to provide our teams with more experience of using the live test system ahead of go-live. The latest user testing and feedback has demonstrated that we must do this to give greater confidence in adopting the new system.

## **2. Capital Schemes - Update**

### **• Neonatal Unit**

The new unit and link corridor were handed over in early July and became fully operational on the 8<sup>th</sup> September following the safe transfer of the babies from the old unit. Many teams worked very hard on the day, I have written to teams to say thank you. Equally the outpatient team moved in late July very successfully.

The opening produced a great deal of very positive media coverage. BBC Midlands Today were on site on the day. There were also key pieces on Heart FM and Radio WM as well as Shine FM. Our story appeared on the BBC News Website for Birmingham and NHS Local featured a piece on it's news site. The Birmingham Mail will look to do an article about one of the first babies admitted to the unit.

The official opening is being planned for October/November with details to follow.

### **• Mortuary Refurbishment**

The £540,000 mortuary scheme to satisfy regulatory requirements, to improve the working environment and bereavement facilities has been completed and became operational on the 9<sup>th</sup> September.

The facility will be subject to an inspection by the Human Tissue Authority in November to confirm compliance. The official opening is planned for early November.

### **• Maternity scheme**

Design consultants have been appointed to work with the Maternity Directorate and Estates Team to deliver a full business case for Board consideration in October. The scheme will deliver improved induction of labour, triage and day assessment facilities as well as improved facilities for

the fetal medicine team. The scheme will allow the organisation to increase the number of deliveries per annum to 8000 with the commensurate increases in staffing groups required.

- **Ambulatory care facility – Gynaecology**

Initial scoping work is underway to explore the development of an ambulatory care facility for gynaecology. This facility will reflect the growing move of service provision to an outpatient/short stay setting and where possible bring together services that have similar environment and building needs. The plan is to use existing estate to create the facility.

- **Other significant works**

Upgrades to the main lifts have commenced. This will completely replace the existing lift cars and external fascia. The scheme will deliver improvements to both the look and feel of the lifts, increase reliability and reduce energy usage. The scheme will take 26 weeks to complete.

An upgrade to the Housekeepers' female changing facility is under way and an upgrade to the catering team's changing facility will begin in October/November.

### **3 Development of the sperm donor service - Update**

The bullet points below outline the progress made in relation to the signed off business case approved by the Board of Directors in June:

- The two new members of staff (1 administrator and one scientist) are in post
- A local attitude survey has been carried out, as a result of which a set of recruitment messages and a brand have been finalised
- Local surveys have also been used to generate press material with a view to a formal launch in October
- Two meetings have now been held with the National Gamete Donation Trust, who have confirmed that our strategy fits with national objectives, and have expressed a desire to collaborate with us as they believe our messages are more appropriate than those of other recruitment centres
- We will be participating in Freshers' week events in various colleges across the city, as well as targeting campuses more broadly from the start of term
- We are currently assessing other outreach and advertising opportunities across the city
- Information has been sent to 30 prospective donors since the beginning of September, and 9 of these have begun the screening process
- The project is predicted to at least cover costs in the first year of activity

#### 4. **Appointments**

I am delighted to confirm the following appointments:

- Consultant Neonatologist & lead for Neonatal Transport - Dr Alex Philpott
- Consultant Clinical Geneticist - Dr Nicola Cooper
- Consultant Neonatologist - Dr Manobi Borooah
- Clinical Director for Genetics – Dr Cyril Chapman

#### 5. **National Pathology Week - (1<sup>st</sup> – 7<sup>th</sup> November)**

Our Communications team is working with Dr Phil Cox, Consultant Perinatal Pathologist, to organise a number of events for National Pathology Week. Events being planned include a symposium on site for our health partners on 3<sup>rd</sup> November and an event for local GCSE and 6<sup>th</sup> form students.

We are also planning the official opening of the new Mortuary at this time.

#### 6. **Trust Strategy**

Attached to this report is an outline plan for the next stage of our strategy formulation. Thus far we have undertaken the initial analysis phase and have held the CEO conversations where views from our teams have been sought on what needs to change and how.

The next stage is to consider what the analysis points to in terms of potential strategic options open to services and the Trust. The attached plan highlights the involvement of members and governors, our directorate teams and ultimately the Board of Directors in firming up the strategies we will pursue.



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#### 7. **Improving the collection and presentation of patient experience information – Update on achieving project outcomes**

Catherine Bishop has been appointed as Patient Experience Project Lead. Catherine currently works as a nurse in Renal Genetics and will take up post on the 11<sup>th</sup> October 2010.

She brings a wealth of experience including an advanced communication course and a Masters thesis on investigating patients' views.

Catherine's first task will be to review all current data collection systems, rationalise them and recommend a system to ensure maximum user engagement and delivery of measurable service improvements and measurable increased level of patient engagement.

Throughout the project Catherine will provide feedback on the outcomes from the project to key Committees and Groups and she will communicate the project progress to the Board and the Professional Heads of Service.

#### **8. Medical Revalidation - Responsible Officer update**

Medical revalidation was first discussed by the Board in March 2010. At that time the timetable for the introduction of medical revalidation required that each Trust appoint a Responsible Officer by 1<sup>st</sup> October 2010. Since then the timetable has moved on and it is now a legal requirement for all organisations to appoint a responsible officer before 1<sup>st</sup> January when The Medical Profession (Responsible Officers) Regulations 2010 comes into force.

Duties of the Responsible officer;

The Responsible Officer will

- ensure that those doctors who provide care continue to be safe;
- ensure doctors are properly supported and managed in sustaining and, where necessary, raising their professional standards;
- for the very small minority of doctors who fall short of the high professional standards expected, ensure that there are fair and effective local systems to identify them and ensure appropriate remedial, performance or regulatory action to safeguard patients; and
- increase public and professional confidence in the regulation of doctors

Duties of Health Care Organisations

All designated healthcare organisations (Regulation 4 & Schedule of designated bodies) will be required to nominate or appoint, resource and support a responsible officer. In the NHS in England this will be a senior licensed doctor, usually sitting on the Board. In NHS Scotland this will be a Health Board Medical Director who is an executive member of the Board. In NHS Wales this will be a Local Health Board or NHS Trust Medical Director.

Each designated body will normally have only one responsible officer. He or she may assign some aspects of the wider role to an assistant medical director or other medical manager as an “associate” to the responsible officer. However, the decision-making of the responsible officer, and recommendations made, are the statutory responsibility of the responsible officer

Organisations will need to make decisions as to how best to deliver the additional duties of the responsible officer on top of those already carried out by the Medical Director. This may necessitate some restructuring and strengthening of the organisation’s medical management infrastructure but this will vary according to existing arrangements that are in place and gaps that need to be filled. The Board should also note that there is a requirement

under the Regulations to provide sufficient funding and other resource to discharge the responsible officer's role.

A paper will be presented to a future Board of Directors setting out a formal proposal to introduce the Responsible Officer role.

## Birmingham Women's



NHS Foundation Trust

<b>SUBJECT :</b>	Updated Register of Director's Interests
<b>REPORT BY :</b>	Steve Parsons, Head of Corporate Affairs
<b>AUTHOR :</b>	Steve Parsons, Head of Corporate Affairs

### CONTEXT AND BACKGROUND FOR REPORT

The Standing Orders of the Board of Directors (Standing Order 7) lays out requirements for Directors to register their interests, and gives definitions.

During the summer, the Secretariat circulated the Board to ensure that all interests had been identified, enclosing a copy of the Standing Order. All Directors were requested to make a return (including a 'nil return' where appropriate).

Following his appointment to the Board, Mr Robin Wall was also invited to complete a declaration in a similar way.

### KEY ISSUES FOR BOARD OF DIRECTORS' CONSIDERATION AND DECISION

- The returns submitted by Directors are as on the attached sheet

### RECOMMENDATIONS

The Board is invited to note the current interests of Directors as declared on the Register.

## Birmingham Women's NHS Foundation Trust

### Register of Director's Interests (See Standing Order 7)

Director	Interests Declared
Ian Booth	Nil declaration
Jason Burn	Nil declaration
Nigel Gardner	Nil declaration
Helen Hemberg	Nil declaration
Jane Owen	Nil declaration
Steve Peak	Director, NHS Elect
Robin Rison	Director, Kelmscott Consulting Ltd Director, Waypoint Advisory Ltd (dormant)
Neil Savage	Nil declaration
Marianne Skelcher	Principal -Skelcher Associates –(OD consultancy and coaching) Group Vice Chair- East Thames Group (Housing association) Non Executive Chair, Progress Care Solutions (provides residential and foster care to children and young adults) NED, PDA Ltd, (training and development company) Senior Associate, Central Consultancy & Training, (HR consultancy and training company – housing and social care sectors) Senior Consultant, GCC, (Organisation development consultancy) Associate, DRC, (training and coaching company) Interim HR/OD Director, Islamic Relief Worldwide, (International Non-Governmental Organisation) Non-Executive Director, People Development Associates Ltd
Peter Thompson	Minority shareholder and private practice undertaken through Health Harmonie Ltd.
Robin Wall	Nil declaration