

**MEETING OF THE BOARD OF DIRECTORS**  
to be held in the Seminar Room, Education Resource Centre  
on Thursday 29<sup>h</sup> September 2011 at 9am

### AGENDA

1. Welcome and apologies for absence  
  
*Apologies for absence should be conveyed to Steve Parsons, Head of Corporate Affairs, at Steve.Parsons@nhs.net*
2. Declarations of interest
3. Minutes of the meeting of the Board held on 28<sup>th</sup> July, 2011      SIP      **1**
4. Matters Arising from the minutes
5. Report of the proceedings of the Board in private session      NG      **2**
6. Questions from members of the public, related to items on the Board agenda  
  
**Items for Discussion**      **1 Hr15**
7. Red Risk Register      SIP      **3**
8. Integrated Performance Report      JO  
NS  
JaB      **4**
9. Patient Safety and Quality Report      PT/  
JO      **5**
10. Infection Control and Matrons report, Q1      JO      **6**

11.	NHSLA Progress Report	PT	7
12.	Annual Report of the Local Supervision Authority (for Midwives)	JO	8
13.	CQC planned, unannounced inspection outcomes	JO	9

**Items for Decision**

**10 mins**

14.	Class 'A' policy for approval - Trust Risk Management strategy (revised)	JO	10
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**Items for Report**

**10 mins**

15.	Chairman's Report	NG	Oral
16.	Report of the Chairman of Council	NG	Oral

**17. Exclusion of the public**

**At 11am**

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.

Dates of future meetings:

Thursday 27<sup>th</sup> October, 2011

Thursday 24<sup>th</sup> November, 2011

# Birmingham Women's

## NHS Foundation Trust

**Minutes of the meeting of the Board of Directors held in public  
On Thursday 28 July 2011 in the Seminar Room, ERC, BWH**

**PRESENT :** Professor Ian Booth (in the Chair)  
Jason Burn  
Nigel Gardner  
Jane Owen  
Steve Peak  
Robin Rison  
Marianne Skelcher  
Peter Thompson

**IN ATTENDANCE :** Estelle Carmichael (representing Neil Savage)  
Steve Parsons  
Jackie Howell (minute taking)

**APOLOGIES :** Neil Savage  
Robin Wall

### **FTP/0711/1 Welcome and Apologies**

FTP/0711/1.1 The Acting Chair welcomed Estelle Carmichael who was attending in the absence of Neil Savage. The Acting Chair also welcomed Board members and members of the public

FTP/0711/1.2 Apologies for absence were noted from Neil Savage, Director of Workforce & Organisational Development, and Robin Wall, Non Executive Director

### **FTP/0711/2 Declaration of Interests**

FTP/0711/2.1 There were no declarations of interests notified by Board members

### **FTP/0711/3 Minutes of the Previous Meeting**

FTP/0711/3.1 The minutes of the meeting held on 30<sup>th</sup> June were approved as an accurate record of proceedings subject to the following amendments:

FTP/0711/3.2 Page 4 FTP/0611/18.3 Activity Performance  
The wording of the first sentence was amended to read “ . . given the level of **referrals in gynaecology** . . “

FTP/0711/3.3 Page 5 FTP/0611/8.9 Finance Performance  
To provide clarity in respect of the context of this minute, the paragraph was amended as follows: “*Some concern was expressed with regard to the financial position of the Genetics Directorate and a Director requested that cash flow planning information was included within the financial spread sheet. However, the Board noted that this was expected to be in place by*

*month 4 as identified in the financial plan.”*

**FTP/0711/4      MATTERS ARISING**

**Report by Chief Executive**

FTP/0711/4.1      In response to a query, the Chief Executive reported that discussions with the Maternity Directorate to explore the issue relating to the West Midlands Perinatal Institute’s quarterly performance indicators would be covered later through the Integrated Performance processes.

**FTP/0711/5      Report of the Proceedings of the Board in Private Session, 30<sup>th</sup> June 2011**

FTP/0711/5.1      The Board received Enclosure 2 which outlined the items discussed at the meeting in June 2011. The Chair noted that the Board would meet in private later and would consider the minutes from the Clinical Governance and Organisational Risk & Governance Committees. It would also examine a number of Route Cause Analyses, the annual report on Aggregated Data, consider the approval of contract arrangements with commissioners for 2011-12 and receive a report from the Chief Executive on current confidential issues

**ITEMS FOR DISCUSSION**

**FTP/0711/6      Red Risk Register and Assurance Framework**

FTP/0711/6.1      The Board received Enclosure 3.

FTP/0711/6.2      The Head of Corporate Affairs presented the monthly updated risk register and reported that there had been one risk (no 137, relating to increased maternity developments from the capital scheme) added to the register during the month which related to the underachievement of planned activity targets for hospital deliveries and the adverse impact of this on the income position. It was noted that the new risk had been revised after the original red risk register had been circulated to Board members and that a revised register had subsequently been circulated reflecting the amendment. The Head of Corporate Affairs further reported that controlling actions for six of the red risks had been added during the month.

FTP/0711/6.3      The Director of Nursing, Midwifery & Operations gave an update on the new red risk (no 137) as detailed above and informed the Board that the project team had now put forward a proposal to achieve the planned increase in activity target for deliveries from January 2012 and that written confirmation of this, together with appropriate contingency plans, is awaited. For this reason, the risk has been rated as ‘high’ rather than ‘extreme’. The Chief Executive emphasised the need for the Project Team to set out clearly the milestones and timescales for the programme of actions.

FTP/0711/6.4      A Director sought assurance that the capital scheme included equipment to support the additional level of deliveries; the Director of Finance confirmed that some of the capital items had not been incorporated into the original business case but a review of the capital requirements for the planned increase in deliveries has been undertaken and about three quarters of the funding has been identified.

FTP/0711/6.5 Following a query raised about progress to resolve risk no 123 (relating to the outstanding issues with the Pharmacy SLA with UHBT) the Chief Executive reported that the issues relating to the 2010/11 finances were still not yet resolved and there is a further complication in that no resolution has been offered by UHBT with regard to providing cover for the two pharmacist posts (1 WTE) which are due to become vacant at the end of August. Negotiations with UHB to resolve these issues are ongoing.

**ACTIONS:**

**Confirm with project team undertaking maternity capital project the timescales and milestones for the project. RESPONSIBILITY- Director of Workforce and Organisational Development**

**Continue Pharmacy SLA discussions with UHB to satisfactory conclusion. RESPONSIBILITY- Executive team**

**FTP/0711/7 Amber Risk Report**

FTP/0711/7.1 The Board received Enclosure 4.

FTP/0711/7.2 The Head of Corporate Affairs presented the quarterly amber risk report. It was noted that these are subject to detailed review at either the Organisational Risk & Governance Committee or the Clinical Governance Committee, and also at Directorate level where relevant.

FTP/0711/7.3 Whilst it was acknowledged that the amber risk register is intended to provide the Board with a live 'snap shot' of current risks, it was noted that the information relating to some risks remained blank or out of date. It was agreed that the report would be updated and circulated to Board members following the meeting, in order for the data to provide assurance to the Board around corporate governance; to enhance the effectiveness of Board discussions in the future, actions would be put in place to ensure the register is updated and reviewed by the Management Board prior to presentation to future Board meetings.

FTP/0711/7.4 The risks as presented were reviewed in some detail and the following comments were noted:-

FTP/0711/7.5 *Risk No 185 – Threat to 14 day national turnaround target:* In response to a question raised about what actions are being taken in light of a lack of response from UHB, the Director of Finance reported that the Head of Informatics is currently actively pursuing this with UHB to effect a resolution. It was agreed that, should this route prove to be unproductive, then the issue will be escalated to a higher level.

FTP/0711/7.6 *Risk No 139 – Risk of babies falling from height*  
In response to question raised on what actions are being taken with regard to this risk, the Director of Nursing, Midwifery & Operations reported that only one incident had occurred in the Trust since the last full review, which had been reported to CGC. A full audit had been carried out and a range of actions had been put in place. The Director of Nursing, Midwifery & Operations agreed to validate the information and actions in the register entry

*Risk No 194: Risk of lack of availability of anaesthetic machine*

FTP/0711/7.7 A question was raised about progress made following the submission of a business case in March 2011 for a replacement machine. The Chief Executive commented that it had subsequently been established that an additional machine is available on a contingency basis and the risk should therefore have been updated on this basis. It was stressed that those responsible for updating the risks should be made aware of the need to keep these updated regularly as the information is shared at a high level with the Board as part of the Trust's governance assurance arrangements.

FTP/0711/7.8 It was agreed that the amber risk register would be updated in line with the discussions above and re-circulated to Board members

**ACTIONS:**

**Update and re-circulate the Amber Risk Register to Directors.  
RESPONSIBILITY- Head of Corporate Affairs**

**Escalate discussions with UHB re: risk 185 if necessary.**

**RESPONSIBILITY- Director of Finance and Information**

**Validate the information/ actions in respect of risk 139.**

**RESPONSIBILITY- Director of Nursing, Midwifery and Operations**

**FTP/0711/8 Presentation on Ammalife- visit to Malawi**

FTP/0711/8.1 The Chief Executive introduced Arri Coomarasamy, a consultant with the Trust and Reader in Reproductive Medicine and Gynaecology at the University of Birmingham, and President of Ammalife Charity, who was attending to make a presentation to the Board and seek support for the development of a partnership between BWH, Queen Elizabeth Hospital in Malawi and Ammalife (which would act as facilitator for the partnership). The Chief Executive reminded Directors of the visit made by a team from BWH to Queen Elizabeth in Malawi in February 2011 to establish a rapport and to identify ways of working in partnership

FTP/0711/8.2 Mr Coomarasamy gave his presentation and highlighted the key points under the following headings:-

**Aims:**

- The establish an effective, sustainable and appropriate health partnership between BWH, Queen Elizabeth Obstetrics & Gynaecology department (Malawi), Ammalife and Queen Elizabeth Hospital Management (Malawi)

**Why:**

- To enhance the national and international reputation of BWH
- To promote recruitment & retention and motivation of staff
- To provide opportunities for joint research, teaching and learning
- To enhance BWH's corporate social responsibility and contribute to health in developing countries

**Aims:**

- To provide support for the specific needs identified at Queen Elizabeth Obstetrics & Gynaecology Department in Malawi during the visit including:-
  - Clinical care
  - Estates and equipment

- Training
- Human resources

FTP/0711/8.3 It was felt that BWH has a real opportunity to make a difference and to develop a partnership that would have benefits for all parties concerned.

FTP/0711/8.4 In response to a question raised as to what he was seeking from the Board, Mr Coomarasamy suggested it would be helpful to have support for this initiative at the highest level within the Trust.

FTP/0711/8.5 There was some discussion on ways in which BWH could provide practical support and it was agreed that, in the short term, it would be sufficient for the Trust to promote support to the fundraising efforts of Ammalife, for example by offering staff the opportunity of supporting the charity via payroll giving, and to promote the charity locally. .

FTP/0711/8.6 The Board gave their full endorsement to the development and of the partnership. The Chief Executive agreed to take this forward.

**FTP/0711/9 Chief Executive's report**

FTP/0711/9.1 The Board received Enclosure 5. The Chief Executive drew the Board's attention to the following items from his report:-

- *Maternity Alliance Network:* The first meeting of the group took place on 21 July and was well attended with membership covering Trusts across the UK. A decision has been taken to re-name the group '*Women's Services Provider Alliance*' to reflect the wider perspective across obstetrics and gynaecology; and the group agreed to link up with the Foundation Trust Network via the Chair of Liverpool Women's Hospital who sits on the FTN Board. The Alliance is now looking to grow its membership and a mail shot will be sent out shortly to follow this up. In response to a question raised, the Chief Executive confirmed that the Alliance had agreed a work programme to shape policy and delivery of women's services across the UK with particular focus initially on influencing the maternity tariff, sharing benchmarking and CIP data and reviewing alternative clinical negligence insurance schemes
- *Hosted Units:* A Director referred to the expected establishment of *Public Health England* and asked about the implications of this for the Public Health Observatory, one of the Trust's hosted organisations. The Chief Executive reported that he had received confirmation from the Department of Health that funding for the Observatory would continue in its current form for the rest of the financial year at least. Details of future organisational change and funding route will follow but it is likely that by 2012/13 the funding route will start to move towards *Public Health England* and local authorities, who would take local responsibility for this area. In response to a question about whether there is a need to re-visit indemnity issues with the Department on a contingency basis, the Head of Corporate Affairs indicated that it was his current understanding that the Department would cover any additional exceptional costs resulting from a move from the current location; this would be clarified in future discussions.
- *Website:* In response to a query raised by a Director, the Chief

Executive confirmed that managerial responsibility for the development of the new website lies with the Communications Manager, Maria McLeod who reports directly to him. The current website is expensive to maintain and is not user friendly, and it was intended to launch a new web-site shortly.

**FTP/0711/10 Corporate Performance – Quarter 1**

FTP/0711/10.1 The Board received Enclosure 6. The Chief Executive presented the report and highlighted the following:-

- Out of 26 targets, 21 are rated green, 4 are rated amber and one is rated red which relates to the normal delivery rate
- Progress against objective 18 relating to CNST level 2 for Maternity and Acute standards will be updated verbally later in the meeting by the Director of Nursing, Midwifery & Operations following the informal assessment visit earlier in the week

FTP/0711/10.2 The progress against corporate objectives was discussed. In response to a question raised about the normal delivery rate, the Director of Nursing, Midwifery and Operations confirmed that the rate was showing a gradual decline and a number of actions are being taken to address this including the re-launch of *Back to Basics* training; however, she emphasised that any turnaround of the rate would not be quick. The Chief Executive commented that BWH compares favourably with the average rate across units in the West Midlands which is 65%, particularly as the Trust served a higher risk population than the average.

**FTP/0711/11 Directorate Performance – Quarter 1**

FTP/0711/11.1 The Board received Enclosure 7. The Director of Nursing, Midwifery & Operations gave a summary of the Directorates' performance including progress against objectives, highlighting the following:-

- There is an opportunity for those Directorates who are not currently achieving targets to turn the situation around during the rest of the year
- The Neonatal Directorate does not currently have any specific KPIs set by the commissioners and therefore its performance indicator is not rated. However, it does have a range of objectives to which it works and it is anticipated that a set of KPIs will be set for the Directorate next quarter based upon last year's CQUINS.
- Gynaecology Directorate is behind target on financial performance for this quarter

FTP/0711/11.2 It was noted that the Neonatal Directorate had a red indicator for progress with objectives and a question was raised as to which objectives were not being achieved. It was confirmed that the areas were: CNST Level 2 (amber); neonatal cot days and adequate payment from commissioners (amber) and pharmacy SLA (amber)

**FTP/0711/12 Integrated Performance Report – May 2011**

FTP/0711/12.1 The Board received Enclosure 8. The Director of Nursing, Midwifery & Operations highlighted a misprint in the colour indicators although all the data was correct.

*Dashboard*

- FTP/0711/12.2 The Director of Nursing, Midwifery & Operations confirmed that, although the SHA is currently indicating that the Trust has missed its referral to treatment target by 0.2 of a patient, there is confidence that the Trust has met this target and that the discrepancy is a result of the estimation techniques utilised by the SHA. There was some discussion on the view that will be taken by Monitor in respect of this and it was agreed that the route by which performance data is acquired by Monitor will be clarified.
- FTP/0711/12.3 The Acting Chair noted the increase in the DNA rate and asked when the work being undertaken by Newton Europe is likely to have an impact. The Director of Nursing, Midwifery & Operations commented that, in addition to the work being done by Newton, a separate piece of work has also been commissioned from a company which has been successful in this area within other NHS Trusts and would begin in six weeks' time.
- FTP/0711/12.4 The Acting Chair commented on helpfulness of the graphs supporting the dashboard and it was agreed that the print size of the wording within the Key should be increased for ease of reading

*Workforce:*

- FTP/0711/12.5 The Deputy Director of Workforce highlighted the following key points:-
- Contracted WTE is 1,412 and reflects a continued decrease in the last three months. A Director referred to new regulations that are being introduced that will provide agency staffing with increased rights;. the Deputy Director of Workforce reported that the biggest impact for the Trust will lie with its relationship with bank staff and that the majority of bank staff are already employed by the Trust in substantive posts. However, the potential impact of these new regulations is being reviewed
  - Agency/Bank spend is within target and has reduced by a further 0.51% during June and continues to be carefully monitored
  - Sickness absence rate has increased by approximately 0.5% in June due primarily to long term sickness. The Executive Team continues to scrutinise Directorate levels and responses.
  - Appraisal rate has decreased slightly this month due largely to the Management of Change programme that has taken place. This is approximately 4% below the year end target of 85%. This continues to be monitored carefully
  - Pay as a percentage of income remains above target at 68.70%. It was noted that this indicator has increased in month and the Chief Executive commented that this was due to the length of days in the month of June and the related drop off of Trust income
  - The number of grievances has reduced to six this month ,which related to the Management of Change process and skill mix reviews. It was acknowledged that these could take some time to conclude, particularly if they were escalated through the appeal process

*Finance*

- FTP/0711/12.5 The Director of Finance highlighted the following key points from the finance report for month 3:-
- A small deficit is recorded for month 3 resulting in a cumulative deficit at

the end of June of £47K which is £108K ahead of plan

- The position for the first quarter indicates a Financial Risk Rating of 3
- Efficiency savings at the end of June indicate £1,162K achieved which is £75K behind plan. The predicted range of CIP delivery for the year end lies between £4.9m and £5.7m. Performance against efficiency schemes is being monitored carefully, with particular focus on Gynaecology, and alternative schemes are being identified where current schemes are not being delivered

**ACTIONS:**

**Clarify the sources from which Monitor will take data re: compliance with targets. RESPONSIBILITY- Director of Nursing, Midwifery and Operations/ Head of Corporate Affairs**

**FTP/0711/13 Patient Safety and Quality Report**

FTP/0711/13.1 The Board received Enclosure 9. The Medical Director and Director of Nursing, Midwifery and Operations presented the report and the following points were noted:-

- Corrected neonatal mortality and stillbirth rates are now expressed both as a yearly rolling rate and graphically within the dashboard. In response to a query raised, the Medical Director confirmed that the rolling one year rate is only expressed as a figure and not presented graphically
- In addition, data around 'crude' stillbirths and neonatal deaths is now also included in the dashboard
- Patient feedback continues to influence the focus on projects and congratulations were extended to the Trust's volunteers who have done a fantastic job coordinating the responses from patients. This provides the Trust with data that is more meaningful than the national survey. Feedback is generally positive and there has been a significant increase in patients nominating members of staff for the monthly 'staff recognition award'.
- The number of written complaints has increased in June and the target for responding within the timeframe has not been achieved. It was noted that only one Directorate has missed the target this month and other Directorates were congratulated on their significant efforts to achieve the target. The Chief Executive reported that he had recently written to Clinical Directors emphasising the fact that, whilst complainants are generally happy with the full and open explanations provided following investigation into complaints, the Trust's reputation is somewhat marred by the length of time taken to respond to legitimate concerns. It was noted that one Directorate is offering to meet with complainants to investigate their complaints prior to responding formally in writing and this is having a positive outcome
- A Director noted that the Patient Safety Indicator for inadvertent bowel or bladder damage during gynaecological surgery reflected 4 occurrences in the first quarter of the year when the total for the previous 12 months was 6 and asked if any concern could be inferred from this. The Medical Director noted that the indicator had been amended for the current year, and now covered both bowel and bladder damage. The Chief Executive responded saying that the newly formed Women's Services Provider Alliance group has agreed this indicator will

form one of the areas for members of the Alliance to benchmark themselves against and this information will be provided when available

- A Director sought assurance that staff felt that the Board/Governor walkabout sessions were valuable; the Director of Nursing, Midwifery & Operations commented that it was generally felt that these were useful but wanted to be assured that actions were being taken in response to issues raised. It was noted that Board/Governor attendance had decreased recently and it was suggested that the notice period should be extended to allow for diary commitments. It was noted that the intention was to reduce numbers of visits in the future, as most areas have now had more than one visit.

#### **FTP/0711/14     NHSLA Progress Update**

FTP/0711/14.1 The Board received Enclosure 10. The Director of Nursing, Midwifery & Operations highlighted the key points as follows:-

- Following on from the informal visit for CNST Acute level 2 assessment on Monday 25 July 2011, the assessor had commented that the Trust's aspiration to go for Level 2 in September 2011 would be extremely ambitious and the recommendation was to postpone the assessment. The cost of delaying this is £6,322.50 per quarter
- Feedback from the informal visit on 26<sup>th</sup> July 2011 regarding CNST Maternity Level 2 assessment had been more positive and suggested that if the Trust could maintain its current level of progress, there could be optimism that Level 2 would be achieved.
- There was some discussion on the best use of the available resources for progressing with both the Acute and Maternity assessments and, in view of the feedback from assessors, it was agreed that resources should be focused on Maternity Level 2 and that the work around Acute Level 2 should be delayed until the work on Maternity Level 2 is completed

FTP/0711/14.2 The Board agreed with the recommendation to delay assessment for CNST Acute Level 2.

#### **FTP/0711/15     Outstanding Actions**

FTP/0711/15.1 The Board received Enclosure 11. The Head of Corporate Affairs presented the report and it was noted that two actions had been completed since the last report.

#### **ITEMS FOR DECISION**

#### **FTP/0711/16     Quarterly return to Monitor – Quarter 1 2011-12**

FTP/0711/16.1 The Board received Enclosure 12. The Head of Corporate Affairs presented the report and the following items were noted:-

- *Governance Declaration:* It was noted that there was confidence that the Trust had met all targets and as such that the Green target was met. It was recommended therefore that the Acting Chairman be authorised to sign Governance Declaration 1 (Compliance) on behalf of the Board and that an additional written explanation be provided to

Monitor with regard to the SHA data. This was agreed and the Acting Chairman signed the Governance Declaration 1 (Compliance) on behalf of the Board; and also approved the additional information for submission with the return.

- *Quality Declaration:* It was reported that the Trust has submitted feedback to the Care Quality Commission following its inspection visit in April but a finalised version of the CQC's report has not yet been received. The Chief Executive reported that the Executive Team are progressing well with work to provide the Board with the necessary assurance on Quality Governance Framework and were confident that the Trust will be able to declare compliance for the Quarter 2 return. A report will be circulated to the Board shortly. On this basis it was agreed that the Acting Chairman be authorised to sign Quality Declaration 2 (Compliance by Quarter 2 return) and the Acting Chairman signed this off on behalf of the Board.
- *Finance Declaration:* The Board noted the contents of the financial summary sheet giving details of the Trust's performance for Quarter 1 and Annex B providing support for Trust maintaining a rating of FRR3 for the forthcoming 12 months. It was noted that the Annual Plan submitted to Monitor reflected the Trust's expectation to have an FRR2 for the second quarter and there was some discussion on whether, based on current information, the Trust wished to declare confidence in maintaining the FFR 3 for the following 12 months; The Finance Director advised a cautious approach until the next quarter's data is available. The Board agreed therefore that for the Acting Chairman be authorised to sign Declaration 2 (lack of confidence) in maintaining FRR3 for the following 12 months. The Acting Chairman duly signed this off on behalf of the Board

**FTP/0711/17 Amendments to Class 'A' Policies**

FTP/0711/17.1 The Board received Enclosure 13. The Head of Corporate Affairs presented the report and went through the amendments to the Policy for Policies which accommodated issues identified to ensure the Trust's compliance with regard to the NHSLA Clinical Negligence for Trusts Scheme.

FTP/0711/17.2 The Board APPROVED the amendments to the Policy for Policies as notified in the report

**FTP/0711/18 Revised Trust Wide Risk Management Strategy**

FTP/0711/18.1 The Board received Enclosure 14. The Director of Nursing, Midwifery & Operations outlined the amendments which were required to be made urgently to reflect the organisational changes that had taken place within the clinical governance team and the revised frequency of the ORAG reviews. The importance of this document was emphasised as it provided the foundation for the Trust's broader risk management process.

FTP/0711/18.2 The Board APPROVED the revised Risk Management Strategy

**FTP/0711/19 Dates of Board Meetings for 2012**

FTP/0711/19.1 The Board received Enclosure 15. The following items were highlighted by the Head of Corporate Affairs:-

- The Board meeting in April 2012 would be held off-site, in the Stanley Barnes Room in the Medical School of the University of Birmingham
- It is suggested that the Board meeting in May 2012 be held on a Tuesday rather than the normal Thursday to accommodate the deadline for the annual submission to Monitor

FTP/0711/19.2 The Board APPROVED the programme of Board meeting dates for 2012 as submitted

**ITEMS OF REPORT**

**FTP/0711/20 Trust Chair's Report/  
Update from the Chairman of the Council**

FTP/0711/20.1 The Acting Chairman reported on a joint meeting earlier in the week between the Chairs and Chief Executives of BWH, UHB and BCH when there was a general discussion and update on progress with the BCH site strategy. This was a helpful meeting and was seen primarily as providing a channel of communication between the three provider Trusts.

**FTP/0711/21 Exclusion of the Public**

FTP/0711/21.1 Following the completion of the items on the public agenda the Board resolved 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 within the private discussions, publicity on which might be prejudicial to the public interest

**Date of Next Meeting**

Thursday 29<sup>th</sup> September 2011

# Birmingham Women's



NHS Foundation Trust

<b>SUBJECT :</b>	Report of the business of the Board conducted in private session
<b>REPORT BY :</b>	Nigel Gardner, Acting Chairman
<b>AUTHOR :</b>	Steve Parsons, Head of Corporate Affairs

### CONTEXT AND BACKGROUND FOR REPORT

The Standing Orders of the Board require that business considered in private session is reported into the public session as soon as possible. Given the arrangement of the Board meetings, the earliest opportunity is at the public session of the following month.

This report outlines the business considered in private at the July 2011 Board meeting, and the private meeting held on 7<sup>th</sup> September 2011.

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

*July 2011*

- The Board received minutes from Clinical Governance Committee and the Standing Finance Committee
- The Board considered 7 Root Cause Analysis reports, and was updated on other RCA's being considered and due to be reported to the Board later
- The Board further considered the annual planning process, which would lead to the annual plan submission to Monitor for the 2012-2015 period
- The Board received the annual report on emergency planning and arrangements under the Civil Contingencies Act
- Consideration was given to the developing IT strategy, with an intention to finalise a strategy during this calendar year
- The Board considered the inherent risks to the achievement of strategic objectives, as part of the Board Assurance Framework process, and also the controls and mitigations in place
- The Board considered and agreed that the Red Risk register should continue to be transparently considered in public session.
- A report from the Chief Executive on current confidential issues was received.

## ENCLOSURE 2

*7<sup>th</sup> September 2011*

- The Board considered RCA reports in respect of 9 cases.
- The Board approved entering into contract arrangements with NHS West Midlands for a Learning and Development Agreement
- The Board was updated on discussions with Birmingham Children's NHS FT
- The Audit Committee reported, and the Board considered, certain concerns regarding the effective monitoring and achievement of actions agreed by the Committee.

### **RECOMMENDATIONS**

The Board is invited to note the business transacted in the private sessions in July and on 7<sup>th</sup> September.



<b>SUBJECT :</b>	Red Risk Report and Assurance Framework- September 2011
<b>REPORT BY :</b>	Steve Parsons, Head of Corporate Affairs
<b>AUTHOR :</b>	

#### CONTEXT AND BACKGROUND FOR REPORT

As part of the Trust's risk management and mitigation processes, the Trust Board receives a report monthly update on the risks currently shown as red on the Trust's Risk Register.

The Board has requested that the following are provided within each report:

- Details of the controls currently in place in respect of each risk (shown on the attached list)
- An update on the progress made towards the mitigation of each risk since the previous report

Red Risks are subject to a monthly review by the named manager with responsibility for the risk, as set out in the Risk Management policy. Risks are more closely reviewed through ORAG or CGC, as appropriate, as set out in the Board Assurance Framework.

The information related to the controls in place has been taken directly from Datix and has been discussed by the Management Board prior to submission to the Board of Directors.

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

There are currently 7 Red Risks on the Register. During the month, two additional risks have been added:

- Risk 215, a consolidation entry relating to potential challenges in achieving CNST Level 2 accreditation
- Risk 193 (Instrument supplies) has been re-graded up to a red risk

Risk 137 (Underachievement of planned activity) has been downgraded to Amber.

## ENCLOSURE 3

During the month, the following risks have had new controlling actions recorded:

- Risk 3 (Norton Court)
- Risk 123 (Pharmacy SLA)
- Risk 136 (Midwifery staffing below National Recommendation)
- Risk 138 (Inadequate Consultant presence on delivery suite)
- Risk 193 (Instrument supplies)

### **RECOMMENDATIONS**

The Board is invited to note the Red Risks currently on the Register, and the controls in place regarding those risks.

Red Risk report, September 2011  
(as at 23rd September, 2011)

ID	Title	Controls in place	Description (Action Plan Summary)	Risk level (current)	Risk level (Target)	Adequacy of controls	Risk Type
215	Potential Failure in achieving CNST level 2	02.09.2011 Risk added by CR/MW/RW The roles and responsibilities of all staff involved are documented in a responsibility paper, and the temporary post of Audit and Guideline Midwife has been extended until September 2012. There is a project plan attached which shows the timeframes and contains a detailed overview of the current status of the evidence which has been gathered and what is still required to achieve compliance of each standard criterion. This is updated monthly by each of the standard leads. The action plan is attached based on gaps identified at visits and local self assessments. Regular meetings take place to ensure that progress is communicated to key individuals and problems highlighted and actions monitored .Commitment to regular informal visits with the assessor to ensure appropriate progress is being made.  (A seperate report is made to the Board)	To ensure regular CNST meetings To undertake risk assessment on K2 documentation Support directorates with the maintenance of the risk register.	Extreme	Moderate	U	CORP
123	Pharmacy SLA	12-9-11 Locum pharmacist now in post for 3 months. Still awaiting costing details from UHB but no invoice received for payment currently. NHS Elect initial meeting held 31/8/11. Report anticipated to Management Board in November evaluating the service and benchmarking against two other actue hospitals	UHB are not approving post critical to the SLA pharmacy SLA meeting with UHB Specialist Pharmacist now in place addressing prescribing issues monthly meetings to discuss ongoing problems	Extreme	Moderate	I	CLINI
193	lack of sufficient instruments causing potential delays and cancellations to theatre lists.	Business Case approved in full 08.08.11. Quotes and single source tender form completed. Tetra order raised for the purchase of new equipment 18.08.11. Update of progress given at Directorate meeting 24.08.11. Equipment ordered delivery expected 4-6 weeks	Submit Business Case to Exec Team Business case submitted CD raise issue with CEO Review at Directorate Meeting Reorganisation of consultant operating days	Extreme	Low	I	CLINI

Red Risk report, September 2011  
(as at 23rd September, 2011)

ID	Title	Controls in place	Description (Action Plan Summary)	Risk level (current)	Risk level (Target)	Adequacy of controls	Risk Type
3	Norton Court	16 September 2011. Risk reviewed. Electrical report received 16th September. Now being costed and prioritised with a view to actions being taken between October 2011 and March 2012	Additional controls to minimise risks associated with Norton Ct Report to ORAG Breaking down the sub risks Engage external planning specialists Appoint Healthcare Planners to develop Phase One of Estate Strategy Remedial works to the electrical systems Agree new Estate Strategy Joint Development Opportunities with BCH Agreeing next steps forward with Solicitors and Prime Organise electrical specialist to carry out wiring survey Business model required for Norton Court replacement prior to approval of Phase 2 of the Estate Strategy Fire Safety Audit	Extreme	Low	A	CORP
136	Midwifery Staffing below National Recommendation	9/9/11 Staffing meeting held 23/8/11 between Birth Centre and Delivery Suite managers with examination of the rotas. Paper being prepared for Management Board in line with release of monies for increased staffing as part of the approved Business Case for expansion to 8,000 deliveries. High % of maternity leave and sick leave continues to be above staffing allowance of 24% in total (including annual leave and study leave). CIP requirements of 3.5% sickness is not being met financially with resulting impact on budget performance.		Extreme	Moderate	A	CLINI
138	Inadequate Consultant presence on Delivery Suite	9/9/11 VAF raised for recruitment of additional consultant post for expansion to 8,000 deliveries in addition to 2 x Trust Grade posts.		Extreme	Moderate	A	CLINI

Red Risk report, September 2011  
(as at 23rd September, 2011)

ID	Title	Controls in place	Description (Action Plan Summary)	Risk level (current)	Risk level (Target)	Adequacy of controls	Risk Type
143	Unable to treat patients due to Lack of HDU facility	Patients referred back to GP with a view to sending them to peripheral hospitals or treated at peripheral hospitals with the cost recharged to BWH. Oncology patients treated elsewhere - however, cost pressure to Directorate SLA in place for treatment of Oncology patients at City Hospital SLA in place for treatment of patients at Priory Hospital Meeting held with Anaesthetists 15.07.11: Agreed that this is an elective facility only and outline of governance protocols agreed. Reviewed by Gynae DMT and Updated 19.07.11 Reviewed at Gynae Directorate meeting 27.07.11	Develop Operational Policy Seek Options to undertake treatment at alternative facility Agree Pathway for oncology patients with Cancer Centre Draft Business Case Review at Directorate Meeting develop protocol for anaesthetic assessment	Extreme	Low	A	CLINI



<b>SUBJECT :</b>	Integrated Performance Report August 2011
<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.

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

#### Cancer referral to treatment target times

There has been a breach of the 62 day target-actual performance 67% (target 79%)

#### Gynaecology referral rates

To note the continued underperformance on elective spells and over performance on referrals.

#### *Workforce*

#### Contracted WTE

This remains well *within* target. Continuing its pattern of a planned reduction, the whole time equivalence has fallen by 13.35 in the past month and 24.28 in the past three months.

#### Agency/Bank Spend as a % of directorate pay bill

At 2.30% this remains *within* target, and has reduced by 0.69% over the previous month's spend. Director level authorisation continues.

#### Sickness Absence

## ENCLOSURE 4

Sickness rates reduced by 0.37%. At 4.07% this is 0.57% above the 2011/12 target. Neonatal (6.41%), Maternity (5.32%) and Facilities (5.87%) have the highest absence rates, with Gynaecology (4.96%), Genetics (1.40%) and Corporate Management (1.56%) the lowest. Executive scrutiny of directorate absence levels continues through the in-month performance meetings.

### Appraisal

At 74.53%, appraisal rates have declined for the second month and are now 10% below the 2011/12 target of 85%. The July / August holiday period is the main rationale provided for the reduction. Director level scrutiny continues at the in-month performance meetings and line managers are being asked to ensure that staff appraisal is spread throughout the year to avoid the holiday period. Facilities rate is 91.10% while all other areas have uptake in the 70 to 75% range.

### Pay as a % of Income

At 68.45% this remains above the target of 65.83%.

### Grievances

There are 8 grievances, related to Management of Change, Skill Mix reviews and contractual matters.

### Harassment and Bullying

There are 3 reported cases being dealt with in two directorates.

### *Finance*

Please see the attached detailed Finance Report.

## **RECOMMENDATIONS**

The Board is invited to note the Trust's performance in August 2011.

**Birmingham Women's NHS foundation Trust - Trust Board Dashboard Indicators**

01-Aug Data

Month

5

Patient Activity					
	Target YTD	Actual YTD	Move	Status Vrs Target	Year End Forecast
<a href="#">Elective Spells</a>	1,503	1,293	▼		
<a href="#">Gynae Emergency Spells</a>	674	633	▼		
<a href="#">Obstetric Spells</a>	4,373	4,179	▼		
<a href="#">Outpatient New</a>	14,867	14,854	▲		
<a href="#">Outpatient Follow up</a>	23,392	24,906	▲		
<a href="#">Outpatient Procedures</a>	4,536	5,351	▲		
<a href="#">Total Deliveries</a>	3,095	3,142	▲		

Demand & Waiting Lists					
	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
<a href="#">Referral Rates - Gynae</a>	1746	1988	▼		
<a href="#">Referral Rates - Maternity</a>	2044	2133	▲		
<a href="#">Referral Rates - Genetics</a>	750	680	▼		
<a href="#">Admitted within 18 weeks</a>	90%	93.3%	▼		
<a href="#">Non-admitted within 18 weeks</a>	95%	95.7%	▲		
<a href="#">95th Percentile Admitted (weeks)</a>	23	18	▲		
<a href="#">95th Percentile Non Admitted (weeks)</a>	18.3	16	▼		

Finance					
	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
<a href="#">Year to date I&amp;E position</a>	£(258)k	£(78)k	▲		£(150)k-£(600)k
<a href="#">Year to date I&amp;E normalised</a>					
<a href="#">In month run rate</a>	£(52)k	£(24)k	▼		
<a href="#">In month run rate normalised</a>					
<a href="#">Year to date Ebitda</a>	£1,644k	£1,827k	▲		£3,950k
<a href="#">Year to date Ebitda margin</a>	4.40%	5.00%	▼		4.50%
<a href="#">Year to date CIP performance</a>	£2,166k	£1,971k	▼		£5,300k
<a href="#">CIP recurrent/non-recurrent delivery</a>	79:21	85:15	▼		87:13

Workforce					
	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
<a href="#">Contracted WTE</a>	1470.65	1388.51	▼		
<a href="#">Agency/Bank spend as a % of directorate payroll</a>	2.85%	2.30%	▼		
<a href="#">Sickness Absence Rate %</a>	3.50%	4.07%	▼		
<a href="#">Staff Turnover Rate %</a>	14.00%	14.62%	▲		
<a href="#">Employee Investigations</a>	<4 weeks	8	▲		
<a href="#">KSF - Staff groups with Job Outlines %</a>					
<a href="#">Staff Appraisal%</a>	85%	74.53%	▼		
<a href="#">Pay as a % of Trust Income</a>	64.83%	68.45%	▲		
<a href="#">Staff Grievances</a>	1	4	▼		
<a href="#">Harassment and Bullying</a>	1	3	▲		
<a href="#">NHS Staff Satisfaction</a>	72%	74%	▲		

CQC Targets					
	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
<a href="#">Cancer 2 week wait</a>	93%	95.0%	▲		
<a href="#">Cancer 1 month to treatment standard</a>	96%	100.0%	▲		
<a href="#">Cancer 1 month subsequent treatment standard</a>	94%	100.0%	▲		
<a href="#">Cancer 2 month GP urgent referral to treatment</a>	85%	67.0%	▼		
<a href="#">Cancer 2 month Cervical Screening Report RT</a>	90%	100.0%	▲		
<a href="#">Cancer 2 month from upgrade to treatment</a>	No target	100.0%	▲		
<a href="#">Cancelled Operations on day of surgery</a>	1	0	▲		
<a href="#">Cancelled Operations not admitted within 28 days</a>	0	0	▲		
<a href="#">Maternity HES data quality indicator</a>	<10%	10.9%	▼		

Efficiency					
	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
<a href="#">Theatre utilisation</a>	80%	88%	▼		
<a href="#">Outpatient DNA Rate - Gynaecology</a>		11.9%	▼		
<a href="#">Outpatient DNA Rate - Maternity</a>		8.7%	▲		
<a href="#">Outpatient DNA Rate - Neonatology</a>		11.4%	▼		
<a href="#">Outpatient DNA Rate - Genetics</a>		13.0%	▼		
<a href="#">New to Follow up ratio</a>	1.4	1.14	▼		

Birmingham Women's



NHS Foundation Trust

## **Finance Report**

**Month 5 – April 2011 to August 2011**

## 1. Overview

The Trust recorded a small deficit of £24k in Month 5, resulting in the cumulative position of a £78k deficit at the end of August, which is £181k ahead of plan and indicates a Financial Risk Rating (FRR) of 3 for the first five months.

The summary £181k variance is broken down as follows:-

- An adverse £494k income variance;
- A favourable £678k expenditure variance;
- An above plan EBITDA position of 5.0%;
- An adverse variance on depreciation of £57k;
- An adverse variance for interest received of £16k;
- A favourable variance on dividend payable of £70k.

Details of how these results compare with the previous month's performance are provided in tables 1.1 and 1.2 below.

Table 1.1 - In-month position compared to previous month

	Month 5 (11/12)		Month 4 (11/12)	
	Actual	Variance Fav/(Adv)	Actual	Variance Fav/(Adv)
	£ 000's	£ 000's	£ 000's	£ 000's
Total Income	7,626	(102) ▼	7,280	(68)
Total Operating Costs	(7,269)	131 ▲	(6,944)	75
EBITDA	358	29 ▲	336	7
EBITDA % Margin	4.7%	0.4% ▲	4.6%	0.1%
Depreciation (-)	(292)	(11) ►	(292)	(11)
Interest (+/-)	2	(4) ▲	0	(6)
Dividend (-)	(92)	14 ▼	(50)	56
Surplus / (Deficit) cfd	(24)	28 ▼	(6)	46

Table 1.2 - Year to Date position compared to previous month

	Month 5 (11/12)		Month 4 (11/12)	
	Actual	Variance Fav/(Adv)	Actual	Variance Fav/(Adv)
	£ 000's	£ 000's	£ 000's	£ 000's
Total Income	36,477	(494) ▼	28,851	(392)
Total Operating Costs	(34,649)	678 ▲	(27,381)	547
EBITDA	1,827	184 ▲	1,470	155
EBITDA % Margin	5.0%	0.6% ►	5.1%	0.6%
Depreciation (-)	(1,461)	(57) ▼	(1,169)	(46)
Interest (+/-)	15	(16) ▼	13	(12)
Dividend (-)	(459)	70 ▲	(367)	56
Surplus / (Deficit) cfd	(78)	181 ▲	(53)	153

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

When comparing the performance of Month 5 with the previous month, the main drivers for the change in the Trust's position are:

- £186k favourable movement on healthcare income – a detailed assessment of performance against individual contracts is included, with all specialties, except Gynaecology, currently over-performing. It should be noted that efficiency targets are held within the directorates under 'other income' and so performance on healthcare income and other income should be considered together;
- £298k adverse movement on other income – an element of this variance is linked to hosted organisations and R&D which have corresponding favourable expenditure variances. The balance relates to efficiency targets held within the directorates which are either being achieved as part of the healthcare income over-performance or are not being achieved at Month 5;
- £10k favourable movement on private patient income – Fertility Centre;
- £40k adverse movement on pay costs – across various directorates (see Section 3);
- £171k favourable movement on non pay costs – across various directorates (see Section 3).

### **1.1. Year End Forecast**

The target year end position is a deficit of £0.6m as per the planning submission to Monitor. The current forecast range is a deficit between £0.15m and £0.6m when taking into consideration the current income and expenditure forecasts including the known progress against the total efficiency programme.

### **1.2. Financial Risk Rating (FRR)**

The Trust's annual planning submission to Monitor for 2011/12 indicated a full year FRR rating of 2. Financial performance for the first quarter returned a financial risk rating of 3, with results for Month 5 maintaining the FRR at this level i.e. a 3.

## 2. Healthcare Income & Activity

Total income attributable to the end of August is £36.5m, which is £494k behind target.

Income for R&D and the hosted organisations shows an adverse variance but this is offset in full by favourable expenditure variances.

- Healthcare Income
  - Contract income for Maternity Services is ahead of plan, which is contributing towards the delivery of the directorate's associated efficiency target.
  - Neonatal contract income levels are ahead of plan due to increased activity with both the specialist commissioners and out-of-area.
  - Gynaecology income continues to under-perform significantly against contract.

Table 2.1 - Contract activity by speciality

		Activity to date - Month 5			Full Year Target
		Target	Actual	Variance	
Maternity	Normal spells inc. excess bed days	4,370	4,179	(191)	10,433
	Outpatients (New & Follow up)	26,019	27,975	1,956	64,087
Gynaecology	Elective spells	1,507	1,293	(214)	3,706
	Non elective spells	673	633	(40)	1,610
	Outpatients (New & Follow up)	11,585	10,977	(608)	28,530
	Outpatient procedures	4,541	5,351	810	11,181
Neonatal	Intensive Care cot days	1,042	1,136	94	2,486
	High Dependency cot days	898	1,087	189	2,146
	Special Care cot days	2,825	2,487	(338)	6,742
	Transitional Care cot days	1,451	2,101	650	3,464
Genetics	Laboratory tests	15,516	14,851	(665)	38,218
	Clinical referrals	3,030	3,454	424	7,464

- Private patient income

Private patient income at Month 5 totals £441k, which is £23k ahead of plan. Performance remains well within the Trust's private patient income cap of 2.2%.

### 3. Directorate Positions

The tables below show the combined variance positions of pay, non pay and income. As previously agreed directorate (including private patient income) and healthcare income are now combined into a single column rather than shown separately.

At Month 5 there is an adverse variance of £215k across all directorates, excluding ring fenced/hosted services.

Table 3.1 - Directorate variances from plan compared with previous month

	Cumulative position to date							
	as at Month 5				as at Month 4			
	Pay £'000	Non Pay £'000	Income £'000	Total £'000	Pay £'000	Non Pay £'000	Income £'000	Total £'000
Maternity	-68 ▼	-38 ▼	14 ▲	-92 ▼	-55	-22	6	-71
Gynaecology	114 ▲	-46 ▼	-437 ▼	-369 ▼	107	-32	-199	-124
Genetics	113 ▲	5 ▲	149 ▲	267 ▲	51	-31	103	123
Genetics - External Projects	31 ▲	82 ▲	-114 ▼	-1 ▼	27	64	-91	0
Neonatal	-29 ▲	-36 ▼	2 ▲	-63 ▲	-41	-26	-1	-68
Facilities	10 ▼	52 ▲	-19 ▼	43 ▲	20	38	-17	41
Corporate Services	-22 ▼	23 ▲	-1 ▼	0 ▲	-7	-34	35	-6
<b>TOTAL</b>	<b>149 ▲</b>	<b>42 ▲</b>	<b>-406 ▼</b>	<b>-215 ▼</b>	<b>102</b>	<b>-43</b>	<b>-164</b>	<b>-105</b>

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

Table 3.2 - Ring fenced/Hosted services variances from plan compared with previous month

	Cumulative position to date							
	as at Month 5				as at Month 4			
	Pay £'000	Non Pay £'000	Income £'000	Total £'000	Pay £'000	Non Pay £'000	Income £'000	Total £'000
Research & Development	-6	120	-114	0	2	60	-62	0
Public Health Observatory	-16	193	-177	0	-16	164	-148	0
Cancer Intelligence Unit	66	123	-189	0	54	114	-168	0
National Genetics Education & Development Centre	19	-12	-7	0	20	-12	-8	0
<b>TOTAL</b>	<b>63</b>	<b>424</b>	<b>-487</b>	<b>0</b>	<b>60</b>	<b>326</b>	<b>-386</b>	<b>0</b>

- Maternity Services

The directorate's Month 5 position is a deficit of £92k, an adverse movement of £21k when compared to Month 4. Based on Month 5 activity levels, both the contract target for the month and the additional efficiency targets for income have been achieved which is an improvement from Month 4. The pay overspend relates to bank staff expenditure and usage is being monitored closely due to the links with the directorate's efficiency schemes. The forecast year end position is a deficit which is being driven by the current non-achievement of cost reduction schemes, the main one being the sickness absence target.

- Gynaecology

The directorate's Month 5 position is a deficit of £369k inclusive of over-performance on private patients, and taking into account the performance on healthcare income contracts. The further deterioration in-month is being driven by under-achievement of contract income which has not been fully offset by decreased costs.

- Genetics

The directorate's Month 5 position is a surplus of £267k which represents an improvement from Month 4. The variances on pay, non-pay and income have all improved.

- Neonatal

The directorate's position at Month 5 is a deficit of £63k which is very similar to Month 4. Additional activity, both inside and outside the region, is driving the over-performance on healthcare income, which is offset against efficiency targets for increased activity within the directorate income plans. The pay budget is currently in deficit but has improved in the month. Non-pay expenditure is in a deficit position which has increased in Month 5. Work is currently being undertaken to analyse the link between this and increased activity but one area of significant expenditure is nitric oxide.

#### 4. Efficiency Programme

The stretch target for the 2011/12 efficiency programme totals £6.2m. The split of this target by directorate is 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 £'000		Income Generation £'000		Total £'000
Maternity	336.3	23.3%	1,108.6	76.7%	1,445
Gynaecology	176.0	15.7%	942.1	84.3%	1,118
Neonatal	178.4	18.9%	765.6	81.1%	944
Genetics	1,223.7	84.2%	229.8	15.8%	1,454
Corporate	1,165.0	88.6%	149.2	11.4%	1,314
<b>Total</b>	<b>3,079.3</b>	<b>49.1%</b>	<b>3,195.4</b>	<b>50.9%</b>	<b>6,275</b>

At the end of August, savings of £1,971k have been identified as achieved against the part year target of £2,166k (based on the stretch target) which is £195k behind plan.

Further details of how the savings have been achieved across the directorates are provided in table 4.2 below.

Table 4.2 - Current and forecast performance against target

	Months 1 to 5		Month 6 to 12		Total		
	Plan £'000	Actual £'000	Plan £'000	Forecast £'000	Plan £'000	Forecast £'000	Variance £'000
Maternity	510.2	399.8	934.7	969.9	1,445	1,370	(75)
Gynaecology	292.1	234.5	825.9	622.9	1,118	857	(261)
Neonatal	352.5	306.8	591.6	671.4	944	978	34
Genetics	567.0	567.3	886.5	917.0	1,454	1,484	31
Corporate	444.6	462.6	869.5	193.6	1,314	656	(658)
<b>Total</b>	<b>2,166</b>	<b>1,971</b>	<b>4,108</b>	<b>3,375</b>	<b>6,275</b>	<b>5,346</b>	<b>(929)</b>

Currently the predicted range for delivery based upon RAG ratings and financial implications of individual schemes is £4.9m to £5.3m.

## 5. Balance Sheet

### 5.1. Capital

The planned capital spend for the year is £3.65m as recommended within the 2011/12 annual plan, which includes the Maternity Expansion scheme. Delivery of the capital programme is managed through the Capital Development Group and capital expenditure at the end of August was £615k.

In addition to the original schemes a proposal for upgrading the IT network infrastructure is currently being prepared, for which initial estimates suggest a cost in the region of £250k. If approved, this cost will be additional to the planned capital spend for the year.

### 5.2. Cash Position

The Trust's cash balance at the end of August was £8.3m. Deferred income and accruals are recorded as £4.3m.

Table 5.2 - Cash position

	Month 5 Actual £'000	Month 4 Actual £'000
Cash held	8,311	8,624
Deferred income & accruals	4,304	4,281



### 5.3. Debtors (Receivables)

Debtors at the end of August valued £4.0m (July - £3.7m), of which £2.6m (July - £2.8m) relates to trade debtors and £1.4m (July - £0.9m) to accrued income.

The value of debts over 90 days is £425k at Month 5 (Month 4 - £402k).

### 5.4. Creditors (Payables)

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 99.6% of invoices, by value, paid within the 30 day target and by number 96.2%.

## 6. Conclusion

The Board is asked to note the Trust's financial position as at Month 5 (August 2011), which in summary is:

- In month position                      £(24)k deficit
- Year to date position                £(78)k deficit
- Year end forecast                    £(150)k - £(600)k deficit
  
- FRR as at Month 5                    3

**BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST**

**INCOME & EXPENDITURE**

**REPORTING PERIOD : - Aug 11 (Period 5)**

<b>Form F1</b>	<b>This Month</b>			<b>Year To Date</b>			<b>Full Year Forecast</b>		
	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>Income (+)</b>									
Healthcare Income	6,019	6,205	186	28,425	29,079	654	66,829	69,253	2,424
Private Patient Income	84	94	10	418	441	23	1,002	1,196	194
Other Income	1,625	1,327	(298)	8,128	6,957	(1,171)	20,278	17,093	(3,185)
<b>Total Income</b>	<b>7,728</b>	<b>7,626</b>	<b>(102)</b>	<b>36,971</b>	<b>36,477</b>	<b>(494)</b>	<b>88,110</b>	<b>87,543</b>	<b>(567)</b>
<b>Operating Costs (-)</b>									
Pay Costs	(5,010)	(5,050)	(40)	(24,401)	(24,189)	211	(58,551)	(59,125)	(574)
Non Pay Costs	(2,389)	(2,218)	171	(10,927)	(10,460)	466	(25,614)	(24,468)	1,146
<b>Total Operating Costs</b>	<b>(7,399)</b>	<b>(7,269)</b>	<b>131</b>	<b>(35,327)</b>	<b>(34,649)</b>	<b>678</b>	<b>(84,165)</b>	<b>(83,593)</b>	<b>572</b>
EBITDA	329	358	29	1,644	1,827	184	3,945	3,950	5
<b>EBITDA % Margin</b>	<b>4.3%</b>	<b>4.7%</b>	<b>0.4%</b>	<b>4.4%</b>	<b>5.0%</b>	<b>0.6%</b>	<b>4.5%</b>	<b>4.5%</b>	<b>0.0%</b>
Depreciation (-)	(281)	(292)	(11)	(1,404)	(1,461)	(57)	(3,370)	(3,507)	(137)
Interest (+/-)	6	2	(4)	31	15	(16)	75	36	(39)
Dividend (-)	(106)	(92)	14	(529)	(459)	70	(1,270)	(1,102)	168
<b>Surplus / (Deficit) Before Impairment</b>	<b>(52)</b>	<b>(24)</b>	<b>27</b>	<b>(258)</b>	<b>(78)</b>	<b>181</b>	<b>(620)</b>	<b>(623)</b>	<b>(2)</b>
Fixed Asset Impairments (-)	0	0	0	0	0	0	0	0	0
<b>Surplus / (Deficit) cfd</b>	<b>(52)</b>	<b>(24)</b>	<b>27</b>	<b>(258)</b>	<b>(78)</b>	<b>181</b>	<b>(620)</b>	<b>(623)</b>	<b>(2)</b>

# Birmingham Women's

## NHS Foundation Trust



<b>SUBJECT :</b>	Patient Safety and Quality Report
<b>REPORT BY :</b>	Peter Thompson/Jane Owen
<b>AUTHOR :</b>	Peter Thompson/Jane Owen

### 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. From April 2011 the report will also include a section on patient experience and a quality dashboard.

### 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 have now agreed the indicators for this year and this will incorporate 2 changes. These new data were published from the beginning of the new financial year.

Corrected Neonatal mortality and Stillbirth rates are now expressed both as a rolling 1 year rate and graphically with statistical process charts. We have included these graphs within the patient Quality and safety Dashboard. As not all post-mortem reports are available within a month we will continue reporting 2 months behind from this point onwards. In addition we are now reporting the 'crude' stillbirth and neonatal death rates on the dashboard.

There has been a degree of data validation taking place as production of these charts has moved into the responsibility of clinicians. Though some of the figures differ slightly from previous reports, there is no significant change.

Whilst the rolling 12 month mortality rates are remaining within their targets the adjusted neonatal mortality rates for July 2011 are above the upper control limit on the SPC charts and hence I have asked the neonatal directorate to further analyse this and will have a verbal update for the Board.

### RECOMMENDATIONS

To note and discuss the findings of the report

## Weekly Safety indicators

Please find this week's patient safety indicator results 16/09/2011.

Indicator	Number of weeks since last occurrence (start date 7/1/2010)	Number of occurrences year to date (from April 2011)
MRSA bacteraemia	20	1
Clostridium Difficile	1 year 5 weeks	0
Inadvertent bowel or bladder damage during gynaecological surgery	0	6
Unexpected returns to gynaecology theatre †	7	4
Caesarean sections for placenta praevia where the consultant anaesthetist and obstetrician were not present	16	1
Inborn babies that require therapeutic cerebral cooling for presumed peripartum hypoxia	11	6
Ventilated inborn babies below 28 weeks gestation where administration of surfactant within 1 hour of birth was not achieved	26	0
Inborn births before 25 weeks where the neonatal consultant was not present at the resuscitation when required to be present by the Trust's early care guideline	0	2
Incorrect laboratory report released by genetics laboratories	16	3

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

## 1. Mortality Rates

### Corrected Neonatal Mortality Rate

Rolling annual rate corrected for major congenital abnormalities, delivery <22 weeks gestation and birth weight <500g up to end of July 2011 is 2.6/1000. This compares to a crude neonatal death rate of 5.8/1000 for the same period.

### Adjusted Stillbirth Rates

Rolling annual rate, up to and including July 2011, corrected for major congenital abnormalities and birth weight <500g is 3.7/1000. This compares to a crude still birth rate of 4.7/1000 for the same period.

## Patient Safety Initiative

### Board and Governor's Walkabouts

Date & Time	Executive Director	Non Executive Director (NED) / Governor	Department to be Visited
Tue 11 <sup>th</sup> Oct 9.15 am	Neil Savage (Director of Workforce & Organisational Development)	Dee Nagra (Governor)	Quinton Lane Community Team
Fri 21 <sup>st</sup> Oct 10.30 am	Peter Thompson (Medical Director)		Human Resources

## Serious Incidents (SI)

Table of the occurrence of SIs in the month of July 2011

Directorate	Number of SI s May
Clinical support	0
Estates	0
Genetics	0
Gynaecology	0
Maternity	5
Neonatology	1

Table of the occurrence of SIs in the month of August 2011

Directorate	Number of SI s May
-------------	--------------------

Clinical support	0
Estates	0
Genetics	0
Gynaecology	0
Maternity	3
Neonatology	0

#### Patient Experience Report-September

At the beginning of August the volunteers started using the timetable set for them to enable feedback from all areas to be collected. As a result there has been an increase in the gynaecology patient numbers surveyed and this should continue to improve with further recruitment of volunteers. Also, the surveys have been modified to be directorate-specific which has made the reporting clearer.

Feedback has already been given to the antenatal ward and the next meeting is with Delivery Suite on 9<sup>th</sup> September. For enhanced reach a report has been prepared, to be sent to each of the directorates at the end of each month. These will be sent to the Heads of Midwifery and Nursing for each directorate for comments. The reports contain a percentage representation of the patients surveyed, their perceived level of care and a selection of the positive comments and 'improvement comments' including suggestions for improvement "quick wins".

Pagers: contact was made with the company (Qwaiting (UK) Ltd ) providing the pagers Unfortunately, due to the financial climate, they have not been able to secure enough revenue from advertisers to fund free supply. They have offered us the opportunity to buy the pagers at a reduced rate. This is being considered.

Schwartz Rounds: We are expecting a visit from the Lead at one of the pilot sites 22<sup>nd</sup> September. This will help us with the planning. There has been some difficulty getting a date for our Lead to visit a Round we expect the Rounds to start after Christmas showcasing in NNU.

Below are the patient satisfactions from July in the style of the CRT reports. Below those are the individual Clinical directorates' results for perceived level of care for August.



## Patient Satisfaction

Inpatient	February	March	April	May	June	July
Involvement in decisions about care and treatment	74%	75%	81%	71%	75.3%	79.3%
Find someone to talk to about your worries & fears	64%	72%	79%	69%	73.5%	74.3%
Understand answer to important questions asked	64%	71%	82%	67%	71.1%	74.3%
Privacy when discussing condition and treatment	74%	86%	84%	79%	83.7%	88.6%
Cleanliness of the ward or room you were in*	93%	98%	99%	99%	98.2%	96.4%

■ Excellent 80%+   
 ■ Good: 65% - 79%   
 ■ Fair: 50% - 64%   
 ■ Poor: 40% - 49%   
 ■ Very poor: Under 40%

Patient satisfaction calculated by taking the % for the top answer.  
 \* Cleanliness based on a 4 point scale, top 2 answers taken for patient satisfaction



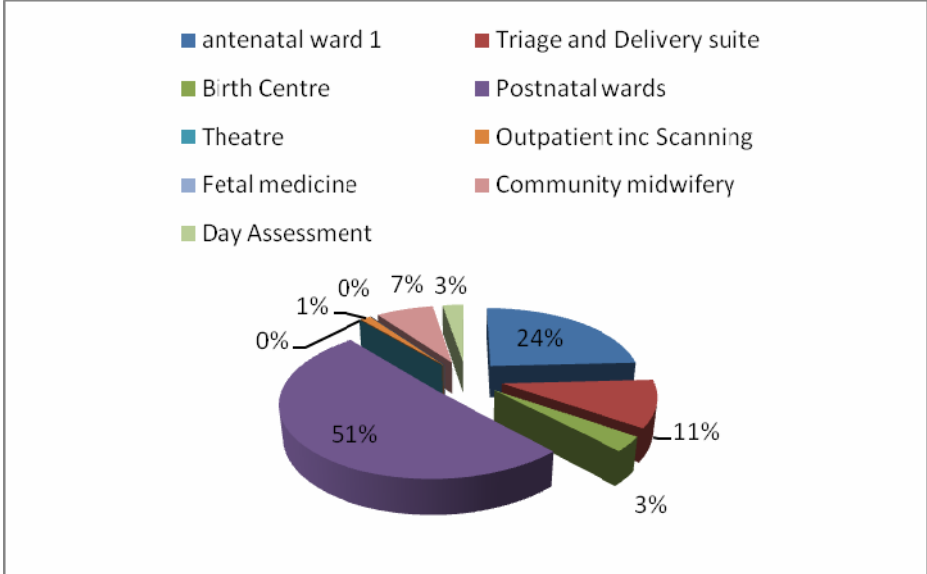
## Patient Satisfaction

Inpatient	February	March	April	May	June	July
Cleanliness of the toilets and bathrooms*	81%	90%	94%	87%	88%	89.3%
Professionals wash/clean their hands between touching patients	75%	88%	94%	89%	81.3%	91%
Treated with respect & dignity	82%	89%	95%	86%	89.2%	90.7%
Sufficient written information on benefits & risks of treatment	67%	77%	77%	69%	60.2%	76%
Overall care received	80%	87%	88%	81%	85.6%	87.9%
Recommend hospital to family or friends	73%	75%	88%	76%	72.3%	78.6%

■ Excellent 80%+   
 ■ Good: 65% - 79%   
 ■ Fair: 50% - 64%   
 ■ Poor: 40% - 49%   
 ■ Very poor: Under 40%

Patient satisfaction calculated by taking the % for the top answer.  
 \* Cleanliness based on a 4 point scale, top 2 answers taken for patient satisfaction

**Maternity results (August)**

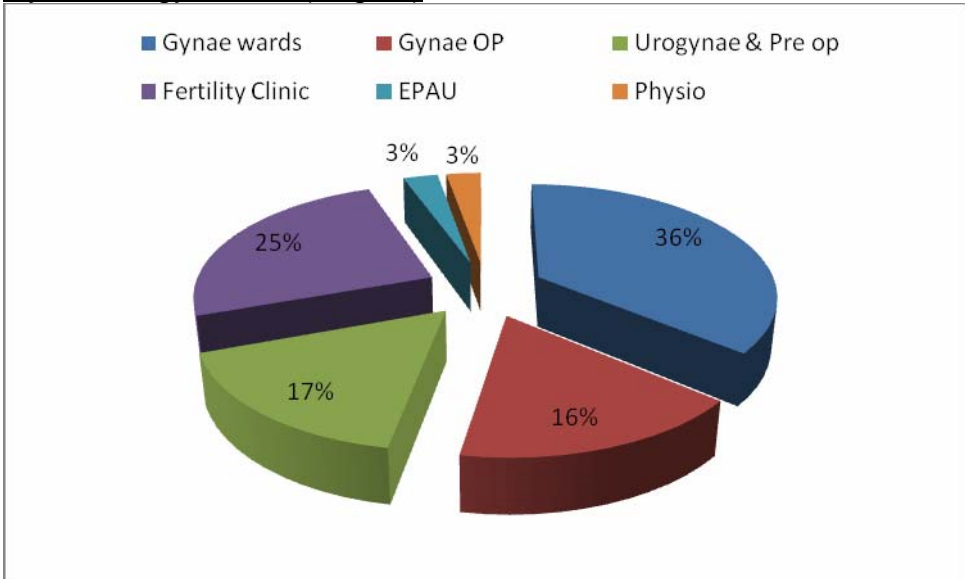


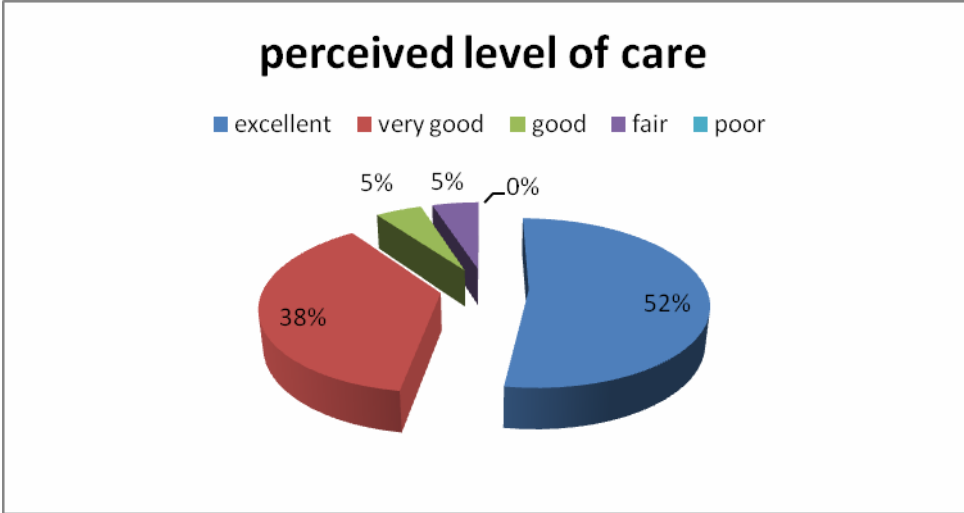
**perceived level of care**



85%  
satisfacti  
on rating

**Gynaecology results (August)**





80%  
satisfact  
ion  
rating

Neonatal Unit and Transitional Care (together due to low numbers)



94%  
satisfact  
ion  
rating

Birmingham Women's NHS foundation Trust - Trust Board Dashboard Indicators

01-Aug Data

Month

5

Clinical Quality					
	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
<a href="#">Written Complaints</a>	13	10	▲		
<a href="#">Responded to within agreed timescale</a>	80%	78%	▲		
<a href="#">MRSA Bacteramia</a>	0	0	▶		
<a href="#">Cdiff</a>	0	0	▶		
<a href="#">BreastFeeding initiated</a>	67%	64.1%	▲		
<a href="#">Smoking during pregnancy</a>	11%	9.7%	▲		
<a href="#">% of Women seen by 12 weeks</a>	90%	94.5%	▲		

Neonatal & Stillbirth rates					
	Number	Actual Month	Move	Status Vrs Target	Year End Forecast
<a href="#">Corected NNMR/1000</a>	6	9.7	▲		
Crude NNMR/1000	12	19.4	▲		
<a href="#">Stillbirth Rate - Corrected 1</a>	4	6.4	▲		
Crude Stillbirth Rate/1000	4	6.4	▲		

Clinical Quality					
	Target Year	Actual Month	Actual Year	Status Vrs Target	Year End Forecast
<a href="#">MSSA</a>	3	0	2		
<a href="#">ECOLI</a>	5	1	3		

# Birmingham Women's

## NHS Foundation Trust



<b>SUBJECT :</b>	Q1 Infection Control and Matron Reports
<b>REPORT BY :</b>	Jane Owen
<b>AUTHOR :</b>	Jim Gray, Michele Emery, Justine Jeffery, Jacky Cotton

### **CONTEXT AND BACKGROUND FOR REPORT**

Q1 Reports have been presented and discussed at the Infection Control Committee 4/08/11

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

- 1 Case of MRSA bacteraemia –previously reported to the Board.
- Compliance with hand Hygiene is encouraging
- Neonatal-results missing from transitional care. This will be rectified in Q2
- Neonatal HIA targets not met-further action taken
- Maternity-No returns from post natal area—to be rectified in Q2
- Gynaecology-excellent hand hygiene results and all HIA targets met

### **RECOMMENDATIONS**

To note the content of the reports and the progress made on infection prevention and control activities.

**Birmingham Women's NHS Foundation Trust**  
**INFECTION CONTROL REPORT TO THE CLINICAL**  
**GOVERNANCE COMMITTEE**

2011/12 Quarter 1

*Infection Control Committee*

Date of meeting since last report: Next meeting is on 4 August 2011

*Infection surveillance & audit*

Newly detected cases of colonisation or infection with MRSA Apr-Jun 2011

- Gynaecology: 5
  - All detected on elective pre-admission or admission screening
- Maternity: 2
  - One detected on routine screening
  - The other was negative on routine screening, but subsequently developed an infection: mother presumed to have been positive at a site other than nose on admission: she was the mother of the second baby described below.
- NICU: 2
  - The two cases were linked. One baby presented with bacteraemia; the other baby was the index case. The MRSA was a community-associated PVL-producing strain.
- Staff: 1
  - Student nurse on NICU detected on routine screening at time of commencing work (unrelated to the above cases)

**Mandatory MRSA bacteraemia surveillance Apr-Jun 2011**

- 1 case on NICU (post-48 hours): RCA completed.

**Mandatory GRE bacteraemia surveillance Apr-Jun 2011**

- No cases.

Mandatory MSSA bacteraemia surveillance Apr-Jun 2011

- 1 case on NICU (post-48 hours)

Mandatory E. coli bacteraemia surveillance Apr-Jun 2011

- 1 case on Delivery Suite HDU (post-48 hours)

Mandatory Clostridium difficile surveillance Jan-Mar 2011

- No cases.

*Untoward incidents*

### ***Pseudomonas aeruginosa* and sensor-operated taps on NICU (ongoing)**

All efforts to control *P. aeruginosa* in taps on NICU have been unsuccessful. A decision has been made to continue to use bacterial filters on taps to mitigate the risk. No further sensor-operated taps will be fitted anywhere in the Trust meantime.

NPSA informed of our experience, but have indicated that they do not intend to respond to either our or other reports of problems with these taps.

No new cases of acquisition of *P. aeruginosa* by babies since the last CGC report.

### **MRSA bacteraemia RCA**

RCA was undertaken on 3 May 2011. root cause identified to be transmission of MRSA from another baby who had not been adequately screened on admission. The following recommendations were made at the end of the RCA:

- Immediately following the RCA meeting the Consultant Microbiologist requested all babies on NICU and Transitional Care be re-screened for MRSA.
- To complete the screening process of staff within the Neonatal Directorate
- Grand Round handover of intensive care/long term neonates system to be reviewed, in order to formulate a plan of individualised care for all the team to follow.
- Screening policy for all admissions to be re-launched.
- Screening policy of ventilated babies to be re-launched.
- Gram negative screening process of all babies to be re-launched.
- To raise the profile of Infection Prevention & Control with particular emphasis on hand hygiene, personal protective equipment and environmental cleaning.

### **Hand Hygiene Compliance**

Monthly observational audits are undertaken in clinical areas to monitor staff compliance with the 'WHO' Five moments of hand hygiene at the point of care. Results for Quarter 1 are detailed in the tables below:

<b>Hand Hygiene Audits</b> (Green ≥ 95%, Amber 92% - 94%, Red < 92%)				
<b>Overall Results by Quarter/Month</b>	<b>Quarterly No. of Obs</b>	<b>Month</b>		
		<b>April</b>	<b>May</b>	<b>June</b>
<b>Number of Observations</b>	<b>777</b>	<b>267</b>	<b>252</b>	<b>258</b>
<b>Number Compliant</b>	<b>739</b>	<b>254</b>	<b>240</b>	<b>245</b>
<b>Number Non-Compliant</b>	<b>38</b>	<b>13</b>	<b>12</b>	<b>13</b>
<b>Average Compliance Score %</b>	<b>95</b>	<b>95</b>	<b>95</b>	<b>95</b>

<b>Hand Hygiene Audits</b> (Green ≥ 95%, Amber 92% - 94%, Red < 92%)				
Results by Directorate	Quarterly No. of Obs	Number of Obs per Directorate		
		Neonatology	Maternity	Gynaecology
Number of Observations	777	89	370	318
Number Compliant	739	84	345	310
Number Non-Compliant	38	5	25	8
Average Compliance Score %	95	94	93	97

<b>Hand Hygiene Audits</b> (Green ≥ 95%, Amber 92% - 94%, Red < 92%)				
Staff Discipline	Average Quarterly Score	Monthly Compliance Scores %		
		April	May	June
Nurses/Midwives	95	96	95	95
Medical Staff	92	94	90	90
AHP's	92	94	100	85
Others	100	100	100	100

### High Impact Interventions

Audits of the DOH High Impact Interventions are undertaken each month in clinical areas. Below is a summary of the overall results for Quarter 1. All elements of each care bundle should be performed each time an invasive device is inserted or accessed to achieve 100% compliance.

High Impact Interventions	Number of Observations In Quarter 1	Observations All elements Completed	Average Compliance Score (%)
PVC Insertion	251	181	72
PVC On-going Care	291	289	99
Overall Score for PVC Care	542	470	87
CVC Insertion	19	16	84
CVC On-going Care	26	26	100
Overall Score for CVC Care	45	42	93
Urinary Catheter Insertion	111	111	100
Urinary Catheter On-going Care	160	160	100
Overall Score for UC Care	271	271	100
Ventilator Care in NICU	105	76	72

Lowered compliance scores relate to inadequate documentation for insertion and on-going care elements. Individual Departments and Directorates are responsible for taking action locally to improve compliance scores.

### **MRSA Screening Compliance**

Screening compliance is calculated by comparing the number of admissions with the number of screens received in the laboratory. In addition snapshot audits are taken each month to match individual patient and laboratory data.

### **Gynaecology**

#### **Elective Admissions**

\* Admissions to Wards 7 & 8 Only

\*\*Also including admissions to Ward 2

<b>Month</b>	<b>Total No. of screens</b>	<b>No. of Admissions</b>	<b>Screening Compliance</b>
<b>April</b>	211	215*	98%
<b>May</b>	214	238*	90%
<b>June</b>	285	277**	>100%

#### **Emergency Admissions**

<b>Month</b>	<b>Total No. of screens</b>	<b>No. of Admissions*</b>	<b>Screening Compliance</b>
<b>April</b>	123	115	>100%
<b>May</b>	136	128	94%
<b>June</b>	137	131	>100%

### **Maternity**

<b>Month</b>	<b>Total No. of screens***</b>	<b>Total No. of C Sections</b>	<b>Screening Compliance</b>
<b>April</b>	158	143	>100%
<b>May</b>	169	160	>100%
<b>June</b>	177	177	100%

\*\*\* Will also include screens from mothers whose babies are admitted to NICU which may account for higher numbers of swabs received.

J Gray & J Suviste  
28 July 2011

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

<b>Quarterly period</b>	Q1 April-June 2011
<b>Directorate</b>	Neonatal
<b>Matron</b>	Michele Emery/Charlotte King

## 1. Infection Control Surveillance

### 1.1 Newly detected cases of colonisation or infection with MRSA

3 cases

- April - 2 cases of infection  
Mother and baby both identified during admission - baby on NICU, mother on Ward 5
- May - 1 staff member

### 1.2 Mandatory MRSA & VRE bacteraemia surveillance

April - 1 post 48 hour MRSA bacteraemia (NICU)

### 1.3 Mandatory Clostridium difficile surveillance

None

### 1.4 Mandatory E coli and MSSA bacteraemia surveillance

April - 1 post 48 hour MSSA bacteraemia (NICU)

A Root Cause Analysis Investigation was undertaken to examine circumstances leading up to and including the identification of MRSA (Methicillin Resistant Staphylococci Aureus) bacteraemia and colonisation.

As part of the investigative process all members of staff (100% compliance), including all members of the multi-disciplinary team were screened by taking nose and throat swabs. All swabs were negative.

Areas of good practice have been identified.

Recommendations around identified areas of concern have been made.

The Neonatal Intensive Unit (NICU) continued to have several patients isolated but with different micro-organisms.

The Monitoring of the automatic taps continued and PALL filters are to remain in situ. A report has been submitted to the National Patient Safety Agency and the Trust awaits a reply.

Weekly rectal swabs for the screening of gram negative organisms continues.

The screening process of all babies admitted to NICU changed in May 2011.

We are currently auditing this process.

## 2. Audit Data

<b>HAND HYGIENE AUDITS</b> (Compliance Scores - Green ≥ 95% Amber 90 – 94% Red ≤ 89%)				
Ward/Dept	April	May	June	Process used to feed back results to all ward staff
NUU	94%	91%	95%	
TC	None reported	None reported	100%	
<b>Exception Report – action undertaken for compliance scores &lt; 95%</b>				
TC: self assessment of hand hygiene to be implemented to increase compliance				

<b>Other Infection Control Audit Activity – Ward Kitchens</b> (Compliance Scores - Green ≥ 85%, Amber 76 – 84% Red ≤ 75%)			
Ward/Dept	Date	Score	Process used to feed back results to all ward staff
TC		78%	TC ward manager to create and instigate action plan. E-mail and post report on notice board. To discuss issues at team meeting
<b>Exception Report – key areas of non-compliance &amp; actions taken</b>			
<p>Areas requiring action:</p> <ul style="list-style-type: none"> <li>• Underneath the sink stained and dirty - on-going leak – <b>identified at each inspection.</b></li> <li>• Kitchen beverage trolley unclean and stained.</li> <li>• Cereals not contained within pest-proof containers.</li> <li>• Out of date and unlabelled items in the kitchen and the refrigerator - – <b>identified at previous inspections.</b></li> </ul> <p><b>NICU: This is a staff kitchen only and staff need to be mindful of labelling all food. Milk kitchen to be included in next audit</b></p>			

### 3. Patient Environment & Medical Equipment Cleanliness

<b>Quarterly Departmental Environment Audit</b>		
Ward/Dept	Date Completed	Score (%)
NICU	April 13 2011	90%
NICU	May 30 2011	91%
NICU	June 30 2011	89%
TC	No report	
TC	May 30 2011	96%
TC	No report	
<b>Exception Report</b>		
<b>Key areas of non-compliance that could not be resolved locally &amp; actions taken</b>		
NICU- Cleaning records and documentation not completed or updated. The issue of dusty trolleys continues despite enhanced education, emails and posting previous results to all staff.		
TC: Head of Nursing to investigate reasons for non completion of audits		

### Medical Equipment Cleanliness Audit

Ward/Dept	Timeframe/Result	April	May	June
NICU	Date Completed	13th	30th	30th
	Score (%)	75%	92%	77%
TC	Date Completed	Not completed	Not completed	3 <sup>rd</sup>
	Score (%)			90%
<b>Exception Report</b>				
<b>Key areas of non-compliance that could not be resolved locally &amp; actions taken</b>				
NICU: Cleaning records and documentation not completed. Dusty trolleys- medical notes/ward round trolley, breast feeding and infusion pumps.				
TC: Head of Nursing to investigate reasons for non completion of audits				

<b>Multidisciplinary Environment Inspections</b>		
Ward/Dept	Date Completed	Outcome of Inspection
NICU		i.e not deemed to be putting patients at immediate risk
TC		
<b>Exception Report</b>		
<b>Outstanding actions &amp; any non-compliance that has not been resolved</b>		
Not conducted/required this quarter		

#### Isolation Audit

Although this audit is not required for the Q1 report, due to the amount of Isolation facilities required at present on NICU this audit has been completed.

<b>Isolation Audit</b>			
Ward/Dept	Month	Score %	Outcome of Inspection
NICU	May	90%	2 staff members not compliant (One not prior to contact and the other following contact with pt environment)

#### Aseptic Technique

Although this audit is not required for the Q1 report, due to the number of indwelling devices on patients in NICU this audit has been conducted.

<b>Aseptic Audit</b>			
Ward/Dept	Month	Score %	Outcome of Inspection
NICU	June	100%	Aseptic non technique process to be implemented August with assessment of all clinical staff

#### Mattress and Pillow Audit

<b>Ward/Dept</b>	<b>Audit Undertaken (Y/N)</b>	<b>Date Completed</b>
<b>NICU</b>	<b>Yes</b>	<b>April &amp; May 2011</b>
<b>TC</b>	<b>Not required</b>	
<b>Exception Report – key issues identified &amp; actions taken</b>		
<p>NICU: During the audit process several mattresses (Incubator) were found to be faulty. There have been long delays in sourcing replacements as these come from Japan. A new supplier of a superior standard of mattresses has now been sourced. Damaged mattresses were disposed of in the correct manner</p>		

ENCLOSURE 6

4. High Impact Interventions

<b>No. 1a CVC Insertion</b>						
<b>Ward</b>	<b>Target No. obs per month</b>	<b>No. obs in Quarter</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
NICU	April-20	4	Observations not returned	100% compliance	Education & communication on an individual basis for the implementation of ANNT	
NICU	May- 20	7				
NICU	June-20	13				

<b>No. 1b CVC On-going care</b>						
<b>Ward</b>	<b>Target No. obs per month</b>	<b>No. obs In Quarter</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
NICU	April-20	10	Observations not returned	100% compliance		
NICU	May- 20	6				
NICU	June-20	13				

<b>No. 2a PVC Insertion</b>						
<b>Ward</b>	<b>Target No. obs per month</b>	<b>No. obs In Quarter</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
NICU	April-20	14	Observations not returned	Documentation continues to be an on-going problem	Education & communication on an individual basis	
NICU	May- 20	23				
NICU	June-20	29				

<b>No. 2b PVC On-going care</b>						
<b>Ward</b>	<b>Target No. obs per week/month</b>	<b>No. obs In Quarter</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
NICU	April-20	15	Observations not returned	Documentation continues to be an on-going problem	Education & communication on an individual basis	Individual emails, notice board and T Education & communication on an individual basis and Team Meetings
NICU	May- 20	19				
NICU	June-20	23				
TC	April-20	10				
TC	May- 20	14				
TC	June-20	10				

ENCLOSURE 6

<b>No. Ventilator Care ( includes ET ventilation, CPAP, SIPAP) On-going care</b>						
<b>Ward</b>	<b>Target No. obs per week/month</b>	<b>No. obs in Quarter</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
NNU	10 per month	20	Observations not returned	Documentation continues to be a problem. Support arm not utilised therefore risk of humidity draining towards baby	Education	Emails and one to one education

**Infection Prevention and Control Training**

One additional section is around compliance/uptake of Infection Prevention and Control training required by the PCT as part our commissioning contract as well as part of mandatory training for the Trust. The Neonatal Directorate has in house training for all members of nursing staff and further sessions are to be arranged for medical staff.

<b>Percentage of Staff that meet training requirement</b>		
<b>Programme 1</b> Induction of all Staff	<b>Programme 2</b> Annual Update of Permanent Clinical Staff	<b>Programme 3</b> Annual Update of Medical Staff
<b>19/23</b> <b>83%</b> 3 outstanding from NICU and one from transport team	<b>138/159</b> <b>87%</b> Not including 2 members of staff currently on maternity leave	<b>12/22</b> <b>55%</b> Clinical Director informed

Birmingham Women's   
NHS Foundation Trust

Essence of Care Audit  
June 2011

Ward Environment

Health Promotion	
Is the following information available to parents and visitors?	Percentage
Neonatal Unit Brochure	100%
Health Promotion/education resources (breastfeeding, BLISS)	100%
Control of infection	100%
Smoking Cessation	100%
Alcohol (Aquarius)	0%
Drug abuse (Frank, Addiction)	0%
Mental Health (CAMHS, Connexions)	100%
Open access for parents promoted	100%
PALS	100%
RAG rating	77%
Recommendations: Clinical Audit Lead to contact Substance Misuse Midwife for literature.	

Privacy and Dignity	
Are visitors greeted /acknowledged on arrival at ward?	100%
Upon answering the phone, do staff introduce themselves?	100%
Is care taken when using the telephone to prevent confidential information being shared?	100%
Are precautions taken to cover view of computer screens?	100%

ENCLOSURE 6

Family have access to an area that safely provides privacy?	100%
Private area provided for mothers to breastfeed or express breast milk	100%
RAG rating	100%
Recommendations:	

<b>Environment</b>	
Is the name of the nurse in charge clearly displayed	100%
Is there any form of ward orientation accessible and visible to patients i.e. ward profile/ward leaflet?	100%
RAG rating	100%
Recommendations:	

<b>Generic</b>	
Are there weighing facilities?	100%
Is there oral hygiene equipment available i.e. cotton buds/sterile water at each cot	100%
Is there personal hygiene equipment available i.e. nappies/cotton wool	100%
Fetal Medicine alert forms available for staff prior to delivery of babies with identified problems.	100%
RAG rating	100%
Recommendations:	

ENCLOSURE 6

<b>Comments</b>	
Environment improved due to signage. Clinical Audit Lead to ensure results of Essence of Care audit disseminated to all staff.	

**Case note and documentation audit**

<b>Record Keeping</b>	
Have initial assessment records been completed in black ink	100%
Consent signed in care plan	10%
Have the carers main language been identified	70%
Has baby been admitted onto badger database	90%
Do care plans and medical notes correlate	100%
Red Book available (single life long multi-agency record)	80%
RAG rating	75%
Recommendations: Discuss consent forms with Consultants and Paediatricians at Neonatal Audit group and junior Doctors teaching. Email all staff to reinforce need for documentation of first language to ensure appropriate use of interpreters.	

<b>Patient Identification</b>	
BW Number	100%
Surname	100%
Forename	40%
DOB	100%
Sex	100%
RAG rating	88%
Recommendations: None – not all parents chose a forename immediately following birth	

ENCLOSURE 6

<b>Tissue Viability</b>	
Does the patient have a care plan in place?	100%
Is there evidence the plan of care has been implemented?	90%
Is there evidence of evaluation?	90%
RAG rating	93%
Recommendations: None	

<b>Neonatal Pain</b>	
Does the patient have a care plan for identification of pain in the neonate?	0%
Is there evidence the plan of care has been implemented?	0%
Is there evidence of evaluation?	0%
RAG rating	0%
Recommendations: SWMNN pain assessment tool to be implemented. New Developmental Care Lead in post.	

<b>Safety/Safeguarding</b>	
Evidence of a family Communication record in notes	100%
Purple Family Supplement Record in Safeguarding folder	100%
Documentary evidence available on baby's future environment documented	100%
RAG rating	100%
Recommendations:	

<b>Communication</b>	
Baby's own name recorded on notes	40%
The religious affiliation of the family is assessed & documented	60%
RAG rating	50%

ENCLOSURE 6

Recommendations: Reinforce importance of good documentation on nursing admission sheet (new admission sheet devised to be approved at CIG) and when Doctors are completing Clevermed admission. Reinforce using baby's first name once it has one.

<b>Nutrition</b>	
Evidence of recorded weight on admission	90%
Evidence of nutritional needs identified daily? I.e.: mls per kg/ calorific content of TPN	100%
Is there evidence of evaluation	90%
Growth charts plotted at least once weekly.	90%
RAG rating	92%
Recommendations:	

<b>Hygiene</b>	
Does the patient have a plan of care	100%
Is there evidence the plan of care has been implemented?	100%
Documentary evidence that cares have been performed	100%
Evidence available of parents involvement in cares	60%
Parents previous experience of caring for a baby has been documented	60%
RAG rating	84%
Recommendations:	

ENCLOSURE 6

<b>Comments</b>
<p>Overall recordkeeping similar to previous quarter. Signing of consent forms is worse than previously, the new consent form is available in all admission packs and was in all sets of notes but only signed in one. Clinical Audit Lead discussed in Neonatal Audit Group, Head of Nursing and Clinical Director to discuss at Doctors teaching. Patient identification has improved. Of those babies without forenames on their labels, all had the original printed label which said either boy or girl and surname, all had a forename. Tissue viability scores are slightly worse due to poor documentation in one set of notes. Pain still an issue, but sucrose has been added to the new formulary and Developmental Care Lead is to implement the PIPP pain assessment tool from SWMNN. New Developmental Care Lead in post. Safeguarding had improved. Baby's future environment was documented for those with Safeguarding issues. Communication remains the same though use of the baby's name on notes has decreased from 90% to 40% and documentation of religion has increased from 10% to 60%. Nutrition scores have improved since the previous audit. Gender specific packs now made up by the ward clerks contain growth chart, red book and cot card – one baby did not appear to have his so did not have a growth chart. Hygiene has worsened slightly; this is due to poor documentation of parents' involvement in cares and their previous experience.</p>

<b>Uniform Audit</b>								
Correct uniform	Hair	Jewellery	Shoes	ID Badge	Tights/Socks	Make-up	Nails	General Smart Appearance
100%	100%	100%	100%	100% (42% had badge, rest had swipe only)	100%	100%	100%	100%
Recommendations:								
RAG rating				<b>100%</b>				

ENCLOSURE 6

**Action Plan Essence of Care Quarter 3 (outstanding actions)**

<b>Number</b>	<b>Recommendation</b>	<b>Action</b>	<b>By whom</b>	<b>When</b>	<b>Completed</b>
1.	Ensure all leaflets available.	Discharge liaison nurse to obtain outstanding leaflets from Safeguarding team.	Sally Lennon	January 2011	Outstanding
8.	Improve safeguarding procedures by assessing future environment.	Admission to discharge care pathway to include assessment of the home environment being formatted.	Sally Lennon	January 2011	Outstanding

**Action Plan Essence of Care Quarter 4**

<b>Number</b>	<b>Recommendation</b>	<b>Action</b>	<b>By whom</b>	<b>When</b>	<b>Completed</b>
1.	Ensure all leaflets available.	Clinical Audit Lead to obtain supply.	Julie Harcourt	July 2011	
2.	Ensure consent form completed and filed in notes.	Email to be sent to Doctors and nurses and Doctors educational supervisors to stress importance of consent form being completed.	Julie Harcourt Neonatal Consultants	July 2011	
3.	Reinforce need to document main language to ensure interpreters are used appropriately.	Raise issues of poor documentation on training days and staff induction. Email to Doctors and nurses.	Neonatal Consultants Diana Young Sandra Wright Julie Harcourt	Ongoing	Ongoing
4.	SWMNN pain assessment tool to be implemented.	New Sucrose guideline approved by SWMNN to be ratified. New Developmental Care Lead in post	Sue Meads	July 2011	

ENCLOSURE 6

5.	Reinforce importance of good documentation on nursing admission sheet and when Doctors are completing Clevermed admission.	Raise issues of poor documentation on training days and staff induction. Email to Doctors and nurses. Stress importance of using baby's first name and documenting parent's religion.	Neonatal Consultants Diana Young Sandra Wright Julie Harcourt	Ongoing	Ongoing
6.	Promote involving parents in cares early, even if only containment holding and document.	Bliss pilot audit initiated including looking at parent experience and promotion of family centred care. NICU to be involved in accreditation scheme for Bliss Baby Charter.	Julie Harcourt	Ongoing	Ongoing education.

**Transitional care**

<b>Health Promotion</b>	
Is the following information available to parents and visitors?	Percentage
Transitional Care Brochure	100%
Health Promotion/education resources (breastfeeding, BLISS)	100%
Control of infection	100%
Smoking Cessation	0%
Alcohol (Aquarius)	0%
Drug abuse (Frank, Addiction)	0%
Mental Health (CAMHS, Connexions)	0%
Postnatal exercises/Continence	100%
PALS	100%
RAG rating	65%
<p>Recommendations: Email sent to H Gray who is sourcing Leaflets /Posters for alcohol/drug misuse. New TC Brochure under review at present. New posters on ward regarding tolerance of behaviour towards staff now evident.</p>	

<b>Privacy and Dignity</b>	
Are visitors greeted /acknowledged on arrival at ward?	100%
Upon answering the phone, does staff introduce themselves?	100%
Is care taken when using the telephone to prevent confidential information being shared?	
Are precautions taken to cover view of computer screens?	100%
Family have access to an area that safely provides privacy?	100%
Is the privacy and dignity of patients maintained during direct care and in handover.	100%
RAG rating	95%
<p>Recommendations: Some difficulties noted when we have babies in the nursery and then babies arrive for intravenous antibiotics, this is difficult due to the small space we have. To be discussed at ward meeting.</p>	

<b>Environment</b>	
Is the name of the Midwife in charge clearly displayed	0%
Is there any form of ward orientation accessible and visible to patients i.e. ward profile/ward leaflet?	100%
RAG rating	50%
<p>Recommendations: Midwife in charge is not displayed – sign to be displayed with shift leader’s name visible. It is not at all clear for patients who they are speaking to as all uniforms are the same and we do not have name badges – this issue yet again brought up by mums on TC.</p>	

<b>Generic</b>	
Are there weighing facilities?	100%
Are inappropriate activities at meal times, such as cleaning and routine activities curtailed for example as in the protected meal times initiative?	100%

Is there personal hygiene equipment available i.e. nappies/cotton wool/ sanitary towels	100%
Are procedures in place to ascertain presence, and to identify misuse of alcohol and drugs?	100%
RAG rating	100%
Recommendations: None	

<b>Comments</b>
Parents are made aware that they will need to provide cotton wool and nappies on arrival to TC, may be this needs to be incorporated onto visiting policy leaflet? NAS mums are made aware on arrival to the ward of expected standard of behaviour towards staff/ appropriate care for baby, this continues.

### Case note and documentation audit

<b>Record Keeping</b>	
Have initial assessment records been completed in black ink	100%
Consent signed in care plan	60%
Have the carers main language been identified	90%
Has baby been admitted onto badger database	95%
Do care plans and medical notes correlate	95%
Red Book available (single life long multi-agency record)	90%
RAG rating	80%
Recommendations: Red books need to be given out on admission, all staff to be aware of this/ discuss at ward meeting. Consent forms done on NNU not all our babies have been there so this is an issue. Verbal consent for procedures obtained and documented on TC in babies notes, this must be done every time e.g. when taking blood, this needs to be reinforced to all staff.	
<b>Patient Identification</b>	
BW Number	100%
NHS Number	95%
Surname	100%
Forename	60%
DOB	100%
Sex	100%
RAG rating	80%
Recommendations: Fore names to be updated on discharge on patient notes.	

<b>Tissue Viability</b>	
Does the patient have a care plan in place?	100%
Is there evidence the plan of care has been implemented?	100%
Is there evidence of evaluation?	100%
RAG rating	100%
Recommendations:	

<b>Neonatal Pain</b>	
Does the patient have a care plan for identification of pain in the	0%

neonate?	
Is there evidence the plan of care has been implemented?	0%
Is there evidence of evaluation?	0%
RAG rating	0%
Recommendations: We need to look at this as a ward; education and training may be needed as on reviewing practice this seems to be done ad hoc with heel prick tests. Discuss at ward meeting. To liaise with Band 7 Developmental Care Lead.	

<b>Safety/Safeguarding</b>	
Evidence of a family Communication record in notes	70%
Purple Family Supplement Record in Safeguarding folder	100%
Documentary evidence available on baby's future environment documented	0%
RAG rating	56%
Recommendations: Addresses checked prior to discharge/ environment difficult to assess. To devise means to do this in conjunction with Neonatal Discharge Liaison Nurse. Not all TC babies have a communication record documentation in mums white postnatal notes or medical notes, as these babies may not have come from NICU.	

<b>Communication</b>	
Baby's own name recorded on notes	70%
Parents first language recorded in notes	70%
The religious affiliation of the family is assessed & documented	70%
RAG rating	70%
Recommendations: Update babies' forenames on discharge/encourage all staff to do this. Encourage religious support from pastoral staff/allow access to ward.	

<b>Nutrition</b>	
Evidence of recorded weight on admission	95%
Evidence of nutritional needs identified daily? I.e.: mls per kg	100%
Is there evidence of evaluation	100%
Growth charts plotted at least once weekly.	80%
RAG rating	85%
Recommendations: Ensure growth charts are in the notes and plotted weekly, the white growth charts are updated by nursing staff, however the medical charts in the babies notes are not being done by the doctors along with head circumference and lengths. Plan: Discuss at ward meeting.	

<b>Hygiene</b>	
Does the patient have a plan of care	100%
Is there evidence the plan of care has been implemented?	100%
Documentary evidence that cares have been performed	100%
Evidence available of parents involvement in cares	95%
Parents previous experience of caring for a baby has been documented	85%
RAG rating	90%

Recommendations: Ensure all parent craft is documented CLEARLY in the mothers white postnatal notes and on the discharge pathway, this is still being missed at times.

### Comments

Parents need to be told prior to admission if coming to TC that they need to provide cotton wool, nappies, and will be asked to bring in their own bottles if bottle feeding.

### Bladder and Bowel Care

The Guidelines for Bladder Care and the Prevention of Urinary Retention & Bladder Damage Post Delivery have been followed	100%
There is evidence of assessment in the postnatal record	100%
Patient's who have sustained a 3 <sup>rd</sup> or 4 <sup>th</sup> degree tear	100%
There is evidence of referral to the OASIS clinic	100%
RAG rating	100%
Recommendations: NICE guidelines observed. Documentation recorded in white maternal notes or yellow postnatal record in medical notes.	

### Care Environment

The patient feels that staff are consistently approachable, courteous, trustworthy, friendly, responsive to their needs and supportive of their rights	100%
There is sufficient storage for the patient's belongings	100%
The patient has been informed of what they should expect to see and do in relation to infection control measures and is empowered to challenge staff where there are poor hygiene practices	90%
The patient knows who is looking after them	100%
Staff respond to the patient's requests for assistance in a timely and willing manner	100%
RAG rating	100%
Recommendations: Staff introduce themselves on taking over care. Need to ensure patients able to reach buzzer system if needed, and aware of its use.	

### Communication

The woman has communication needs	90%
The appropriate measures have been taken to provide effective communication i.e. interpreting service, sign language	100%
Straightforward language is used when communicating with people and carers	95%
Explicit or expressed valid consent is sought from individual people for care to be provided	100%
Patients and carers know who to contact first if they have any questions regarding care	100%
RAG rating	95%
Recommendations: Mostly all communication needs met/ not always documented clearly in notes.	

<b>Food and Drink</b>	
The level of assistance required is assessed on every occasion that food and drink is served	100%
The patient requires a plan of care for food and drink	N/A
There evidence that the plan has been implemented	
RAG rating	100%
Recommendations: All patients assessed able to care for own hydration and nutrition.	

<b>Prevention and Management of Pain</b>	
Pain observed regularly along with other vital physiological measurements (that is, pain is one of the 'vital signs')	100%
Patients are offered the opportunity to manage their pain, and/or its impact on their lives, to an acceptable level	100%
RAG rating	100%
Recommendations: Part of MEWS chart assessment/analgesia offered with regular drug rounds	

<b>Personal Hygiene</b>	
The patient needs assistance with her personal hygiene needs	N/A
Care and assistance with personal hygiene is provided according to the patients' needs?	N/A
RAG rating	
Recommendations: All patients self-caring that were assessed.	

<b>Prevention and Management of Pressure Ulcers</b>	
The patient has risk factors for pressure ulcers	N/A
There is evidence that all relevant staff are involved in planning, implementation, evaluation and revision of advice and care, for example, dietician, nurse, doctor, occupational therapist, physiotherapist, tissue viability nurse etc	N/A
RAG rating	
Recommendations: All patients assessed mobile not at risk of pressure ulcers.	

<b>Promoting Health and Well-being</b>	
The patient knows where to find leaflets/information on ward	100%
The patient knows where to find the health information and advice office for advocacy services	100%
RAG rating	100%
Recommendations: Leaflets out on the ward, accessible to all patients.	

<b>Record Keeping</b>	
The patient can access her records	100%
Care records are comprehensive, accurate, clear and free from	100%

unauthorised abbreviation	
The patient's confidentiality is respected according to Caldicott principles	100%
The hand held antenatal notes, birth notes and postnatal notes are all available in the medical notes	100%
RAG rating	100%
Recommendations: Mums all have access to own white postnatal notes, kept at end of bed.	

<b>Respect and Dignity</b>	
The patient is addressed as they wish and is spoken to using their preferred name. This information is documented	100%
Privacy is maintained effectively, for example, using curtains, screens	100%
Personal boundaries are identified and communicated to staff, for example, by using the patient's own language	100%
RAG rating	100%
Recommendations: Privacy as on any ward sometimes a little difficult, especially around the desk area. Day to day sometimes left? Where may be seen/ use of day to day under review at present/ possibility of patient board with doors under review.	

<b>Safety</b>	
The patient was oriented to the care environment taking into account their feelings, concerns, abilities, skills and cognitive level?	100%
The patient has experienced continuity of care and staff (where possible)	80%
Family history, social context and significant events prior to, and since, admission and/or treatment, are ascertained, recorded and shared as appropriate, for example, with colleagues or police (as appropriate)	100%
RAG rating	95%
Recommendations: Continuity difficult due to long shifts/nights, it is aimed for when allocating patients at morning handover.	

<b>Self Care</b>	
Mental health issues have been identified	N/A
There is evidence of a Family Supplemental Record (FSR)	100%
There is evidence of a plan of care as identified by their risk	100%
There is evidence of Specialist Midwife involvement	100%
There evidence of ongoing assessment	100%
Options of care delivery are discussed and the patient's choices and preferences obtained, respected and met (where appropriate)	85%
Consistent information is provided by staff	100%
Patients and carers know how to access services and resources, for example, by using the Citizen's Advice Bureau, NHS Direct etc	80%
RAG rating	95%

Recommendations: No patient in assessed group had mental health issues.  
FSR remains present in all notes when needed.

**Comments**

In this audit it has been highlighted by the mothers on the ward that they are unsure who they are talking to as our uniforms are the same. Email sent to Head of Nursing who is looking into this.  
Parents from the NICU need to be told that they will have to provide cotton wool and nappies when they come up to us.

Uniform Audit								
Correct uniform	Hair	Jewellery	Shoes	ID Badg e	Tights/Sock s	Make-up	Nails	General Smart Appearance
100%	100 %	100%	100 %	0%	100%	100 %	100 %	100%
Recommendations: All staff noted to be bare below the elbow!!								
RAG rating							<b>100%</b>	

**Comments**

All staff issued with ID card. Not many staff with name badges as no funds in budget for this. Email sent and responded to by M.Emery  
Day to day board needs review as is left uncovered with patient details evident/ to discuss at next ward meeting.

## Action Plan Essence of Care Quarter 1

<b>Number</b>	<b>Recommendation</b>	<b>Action</b>	<b>By whom</b>	<b>W</b>
1.	Transitional Care leaflets needed	Review update	Sian Woodhouse	June
2.	Source leaflets for alcohol/drug misuse/mental health	Heather Gray has been emailed/ Awaiting response.	H Grey	Jun
3.	Name badges for staff	Email M Emery	S Bunch-Taylor	Jun
4.	Day to day board	Discuss at ward meeting	S Bunch-Taylor	Next Mee
5.	Documentation- Ensure all staff document consent for procedures	Audit ongoing	S Bunch-Taylor	Next quar
6.	Documentation – Ensure all staff document parent craft	Audit ongoing	S Bunch-Taylor/Sally Lennon	M Qu
7.	Plotting of babies' weight.	Discuss at ward meeting	All Staff	Next Mee
8.	Cotton wool and nappies needed to be provided by parents when admitted to TC	Discuss at ward meeting/ email NICU Staff	All Staff	July

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

<b>Quarterly period</b>	April – June 2011
<b>Directorate</b>	Maternity
<b>Matron</b>	Justine Jeffery

## 1. Infection Control Surveillance

### 1.1 Newly detected cases of colonisation or infection with MRSA

2 cases of colonisation identified via admission screening, both on Ward 4

- April - 1case
- June - 1 case

### 1.2 Mandatory MRSA & VRE bacteraemia surveillance

None

### 1.3 Mandatory Clostridium difficile surveillance

None

### 1.4 Mandatory E coli and MSSA bacteraemia surveillance

- June - 1 Post 48 hour E.coli bacteraemia ( Delivery Suite HDU)

## 2. Audit Data

<b>HAND HYGIENE AUDITS</b>				
(Compliance Scores - Green ≥ 95% Amber 90 – 94% Red ≤ 89%)				
Ward/Dept	April	May	June	Process used to feed back results to all ward staff
Ward 1	90%	75%	75%	Team meeting and newsletter
Ward 3	95%	95%	90%	Team meeting/display
Ward 4	90%	100%	95%	Team meeting/display
Delivery Suite	100%	100%	90%	Targeted teaching/display
Birth Centre	100%	100%	100%	Email/display
Radiology	100%	100%	88.9%	
<b>Exception Report – action undertaken for compliance scores &lt; 95%</b>				
<p><b>Ward 1</b> The main non-compliance is following contact with the patients' environment, and is across all staff groups. Staff reminded at the time.</p> <p><b>Ward 3&amp;4</b> Compliance overall good although some reductions in this quarter.</p>				

**Delivery Suite**

Awareness training effective-disappointing that results not maintained throughout the quarter.

<b>Other Infection Control Audit Activity – Ward Kitchens (Compliance Scores - Green ≥ 85%, Amber 76 – 84% Red ≤ 75%)</b>			
<b>Ward</b>	<b>Month</b>	<b>Score</b>	<b>Process used to feed back results to all ward staff</b>
1	June	81%	Team meeting
3	June	81%	Team meeting
4	June	93%	Team meeting
DS	June	73%	Team meeting
Birth Centre	June	81%	Team meeting
<b>Exception Report – key areas of non-compliance &amp; actions taken</b>			
<p>Disappointing quarter as most scores are down from previous quarter. There are common themes in all areas:            Dusty/dirty shelves and drawers            Unlabelled food.            Expired food.            Ice machine not visibly clean.            Staff not wearing appropriate apron for preparing food for patients.            Outstanding actions from previous audit-issues with availability of estates dept known.            Ward managers tasked to complete actions-local inspections recommended.</p>			

**5. Patient Environment & Medical Equipment Cleanliness**

<b>Quarterly Environment Audit</b>		
<b>Ward/Dept</b>	<b>Audit Completed (Y/N)</b>	<b>Score</b>
Ward One	09.05.2011	93%
Ward Three	02.05.2011	97%
Ward Four	02.05.2011	96%
Delivery Suite	19.05.2011	85%
Birth Centre	15.06.2011	93%
Radiology		
<b>Exception Report</b>		
<b>Key areas of non-compliance that could not be resolved locally &amp; actions taken</b>		
<p><b>Ward 1</b>            Apron dispenser in dirty utility was broken, reported to Estates and replaced.            Equipment Cleaning Documentation not completed, staff reminded.</p> <p><b>Ward 3&amp;4</b>            Chairs sent for recovering. PPE equipment holders ordered for outside each missing area.</p> <p><b>Birth Centre</b></p>		

Extra shelving installed in linen cupboards in rooms 18, 20, 21-equipment no longer being stored on floor.

Estates contacted re repair of sealant on floor edges in rooms 19 and 20 and wet room flooring repair in bathroom of room 20, requisition no 131529. They have reviewed it and stated that it is not a problem, however bathroom wet room flooring in room has actually peeled away leaving large gaps.

#### Delivery Suite

Some ongoing environmental issues e.g. dusty vents and some wall damage, work stations also dusty and mixed storage noted on one occasion. Estates notified of issues. Chairs in garden room recovered.

Medical Equipment Cleanliness Audit				
		April	May	June
<b>Ward 1</b>	Audit Completed (Y/N)	<b>11.04.11</b>	<b>09.05.2011</b>	<b>13.06.2011</b>
	Score (%)	<b>100%</b>	<b>97%</b>	<b>97.6%</b>
<b>Ward 3</b>	Audit Completed (Y/N)	<b>04.04.2011</b>	<b>02.05.2011</b>	<b>01.06.2011</b>
	Score (%)	<b>90%</b>	<b>86%</b>	<b>92%</b>
<b>Ward 4</b>	Audit Completed (Y/N)	<b>04.04.2011</b>	<b>02.05.2011</b>	<b>01.06.2011</b>
	Score (%)	<b>88%</b>	<b>76%</b>	<b>92%</b>
<b>Delivery Suite</b>	Audit Completed(Y/N)	<b>13.04.2011</b>	<b>19.05.2011</b>	<b>20.06.2011</b>
	Score (%)	<b>90%</b>	<b>90%</b>	<b>88%</b>
<b>Birth Centre</b>	Audit Completed(Y/N)	<b>10.04.2011</b>		<b>15.06.2011</b>
	Score (%)	<b>100%</b>		<b>96%</b>
<b>Radiology</b>	Audit Completed(Y/N)			
	Score (%)			
Exception Report				
Key areas of non-compliance that could not be resolved locally & actions taken				
<b>Ward 1</b>				
Good compliance noted for quarter				
<b>Ward 3&amp;4</b>				
Role responsibilities regarding cleaning schedule now defined by Manager to ensure consistency of cleanliness.				
<b>Delivery Suite</b>				
Roles and responsibilities clarified as some concerns raised by staff regarding completion of cleaning schedule as issues noted with dust on top of machines. VAF for band 1s completed.				
<b>Birth Centre</b>				
Good results-no results available le for May as sickness/AL-ward manager aware to allocate task.				

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#### 4. Multidisciplinary Environment Inspections

Ward/Dept	Date Completed	Outcome of Inspection i.e. not deemed to be putting patients at immediate risk
Delivery Suite	7 <sup>th</sup> April 2011	Not deemed to be putting patients at immediate risk
Day Assessment	5 <sup>th</sup> May 2011	Not deemed to be putting patients at immediate risk
Antenatal Clinic	5 <sup>th</sup> May 2011	Not deemed to be putting patients at immediate risk
<b>Exception Report Outstanding actions &amp; any non-compliance that has not been resolved</b>		

#### 5. Mattress and Pillow Audit

Ward	Audit Undertaken (Y/N)	Date
Ward 1	Yes	09.05.2011
Ward 3/4	Yes	01.06.2011
Delivery Suite	Yes	19.05.2011
Birth Centre	Yes	15.06.2011
<b>Exception Report – key issues identified &amp; actions taken</b>		
<p><b>Ward 1</b> 2 mattresses replaced.</p> <p><b>Ward 3&amp;4</b> 4 mattresses put on data base as marks/stains on inside of mattress, 1 cover changed. No new mattresses available, so unable to remove from use. 6 pillows removed as torn covers or had blood or meconium on inside of them.</p> <p><b>Delivery Suite</b> 3 mattresses showing signs of wear-2 full sets of mattresses ordered and 2 new covers</p> <p><b>Birth Centre</b> 2 base covers ordered. No other issues noted.</p>		

**6. MRSA screening compliance****Overall Compliance**

(Includes all Elective & Emergency C Sections and all swabs received by Microbiology)

Month	Total No: Screens received	Number of C Sections	Screening Compliance
April	158	143	100%
May	169	160	100%
June	177	177	100%

**Elective C Sections**

Month	Total No: Screens received *	Number of C Sections	Screening Compliance
April	56	57	98%
May	57	62	92%
June	53	57	93%

\*Swabs received from Ward 1 & MOP

**Emergency C Sections**

Month	Total No: Screens received **	Number of C Sections	Screening Compliance
April	102	86	> 100%
May	112	98	> 100%
June	124	120	> 100%

\*\*Swabs received from Ward 3, Ward 4, HDU & DS

**7. Infection Prevention and Control Training**

	<b>Programme 1</b> Induction All Staff	<b>Programme 2</b> Annual Update Permanent Clinical Staff	<b>Programme 3</b> Annual Update Medical Staff	<b>Programme 4</b> Management of Inoculation Injuries Delivery Suite Shift Leaders
Percentage of staff that meet training requirement				

ENCLOSURE 6

8. High Impact Interventions

<b>No. 2a PVC Insertion</b>						
<b>Ward</b>	<b>Target No. obs per month</b>	<b>No. obs in month</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
Ward 1	5	4/5	Not many venflons inserted	PPE an documentation	Midwives asked to observe drs and remind them	Infection Control Board
Ward 3	5	8	Not many venflons inserted	Medical staff not filling in pvcs,33% compliance	Midwives asked to observe drs and remind them	Infection Control Board
Ward 4	5	13	Not many venflons inserted	Medical staff not filling in pvcs 50% compliance	Midwives asked to observe medical staff-forms provided and still compliance not met.	Infection Control Board
DS	20	30		PPE and documentation	Communication meeting. Lead Consultant aware. Lead Anaesthetist informed	Infection Control Board
DS-HDU CVCs		1		100% compliance		

<b>No. 2b PVC On-going care</b>						
<b>Ward</b>	<b>Target No. obs per week/month</b>	<b>No. obs In month</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
Ward 1	5/20	8/10	Not many venflons inserted	Poor documentation although improved in last quarter. All women had care plans.		Infection Control Board/verbal
Ward 3	5/20	40		2 venflons left in too long with no clinical indication,1 venflon not flushed. Compliance improved over	Midwives reminded to remove pvcs promptly and flush venflon once a shift	Infection Control Board/verbal

ENCLOSURE 6

				quarter		
Ward 4	5/20	40		100% compliance		Infection Control Board/verbal
DS - HDU	5/20	40		Documentation	Further awareness raising.K2 to improve documentation.	Infection Control Board/verbal
DS HDU CVCs		1		100% compliance		Infection Control Board/verbal

**No. 6a Urinary Catheter Care - Insertion**

Ward	Target No. obs per month	No. obs in Quarter	Reason Target not met	Areas of Non-compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
DS	20	60	100% compliance	Self assessed		Team meeting
DS - HDU	5		Inserted prior to admission.			Team meeting

**No. 6b Urinary Catheter Care – On-going care**

Ward	Target No. obs per week/month	No. obs in month	Reason Target not met	Areas of Non-Compliance identified	Action Taken in response to non-compliance	Process used to feedback results to clinical staff
Ward 3	5/20	60		100% compliance		Team meeting
Ward 4	5/20	60		100% compliance		Team meeting
DS - HDU	5/20	45		Good compliance, improvement needed in documenting all care	To be included on K2	Team meeting

ENCLOSURE 6

**Essence of Care Audit****DATE**

Thursday, 07 July 2011

**Ward Environment**

<b>Nutrition</b>	<b>Ward 1</b>	<b>PNF</b>
Patient has recorded weight and BMI in HHN	100%	<b>No Report this quarter</b>
If risk identified, e.g. BMI<18 >30 has an individual care plan been developed?	no	
If risk identified, has individual care plan been followed?		
RAG rating		
<p>Recommendations:</p> <p>2 had a BMI Greater than 30 (32 and 24)            These were highlighted on the VTE assessment            GTT guidelines have only just been changed to BMI greater than 30 and these women were due to deliver.            Manual Handling care plans were not required for these ladies as their weight was below 110 kg</p>		

<b>Bladder and Bowel Care</b>		
	<b>Ward 1</b>	<b>PNF</b>
Has the 1 <sup>st</sup> void been recorded	NA	
If urinary problems identified was a fluid balance commenced?		
Was 3 <sup>rd</sup> or 4 <sup>th</sup> Degree tear sustained? If yes, has a referral been made to the OASIS Clinic	NA	
RAG rating		
Recommendations: None		

<b>Pressure Ulcers</b>		
	<b>Ward 1</b>	<b>PNF</b>
Did the woman have an epidural, spinal or general anaesthetic? If yes,	NA	
Evidence of assessment in Recovery?		
Evidence of evaluation?		
Please complete the personal & oral section below		
RAG rating	NA	
Recommendations: None		

<b>Personal &amp; Oral Hygiene</b>		
	<b>Ward 1</b>	<b>PNF</b>
Personal hygiene needs assessed on admission	NA	
Patients with personal hygiene needs have individualised care plan		
Documented evidence of oral hygiene assessment		
RAG rating		
Recommendations: None		

<b>Communication</b> <i>(information can be found in the Pregnancy Hand Held Notes)</i>		
	<b>Ward 1</b>	<b>PNF</b>
Documented assessment of communication needs	yes	
If communication needs identified, evidence of documented plan of care.	yes	
If yes, care plan directs use of interpreters	yes	
If yes, care plan directs use of visual aids	no	
If yes, care plan directs use of speech & language therapists	no	
RAG rating		
Recommendations: There were 2 ladies who needed interpreters and the hand held notes identified this		

Lifestyle / Self Care		
	Ward 1	PNF
Evidence of lifestyle assessment on admission (includes smoking, alcohol intake) (HHN's)	yes	
Evidence of ongoing lifestyle assessment (HHN's) e.g. Drug use, Alcohol, DV, Mental Health, FGM	yes	
If a Family Supplementary Section is in notes is the information up to date?	yes	
Evidence of consultation with patient/carer regarding self-care	NA	
If health risk regarding lifestyle identified, evidence of documented plan of care.	yes	
RAG rating		
<p>Recommendations: None</p> <p><b>One patient had been referred for smoking cessation support . The others were non smokers</b></p> <p><b>One patient had a history of drug abuse and there was a record of support from the Specialist Midwife as well as a plan of care</b></p> <p><b>All women were self caring</b></p>		

Record Keeping		
	Ward 1	PNF
Documented evidence of involvement of patients in their plan of care	yes	
Documented evidence of discussion with carers regarding their plan of care	NA	
Observation chart present	yes	
Observation chart contains name and hosp. number	yes	
Each entry is timed	yes	
Each entry is dated	yes	
Fluid balance chart present	NA	
Fluid balance chart contains name and hosp. number	NA	
Each entry is legible	NA	
Each entry is timed	NA	
Total columns completed accurately	NA	
RAG rating		
<p>Recommendations: None</p> <p>There is evidence from most of the notes of the inpatients that their care has been discussed with them and their views sought. Preferences for birth in the HHN have not been completed.</p>		

<b>Safety</b>		
	<b>Ward 1</b>	<b>PNF</b>
Initial social assessment documented (HHN's)	yes	
Falls assessment been completed (PN notes)	NA	
If patient identified with mental health needs risk, documentary evidence that psychiatric Team informed (page 3 HHN's)	yes	
If risk identified, and referral to the appropriate specialist teams i.e. safeguarding team	yes	
Evidence of a care plan	yes	
RAG rating		
<p>Recommendations: None            One patient had a history of psychiatric problems and she had been seen by the psychiatric team who had made a plan of care.</p>		

<b>Health Promotion</b>		
<b>Is the following information available to patients and visitors?</b>	<b>Ward 1</b>	<b>PNF</b>
Pelvic floor exercises	yes	
Mental health(CAMHS, Connexions, Samaritans)	yes	
Smoking Cessation	yes	
Alcohol (Aquarius)	yes	
Health promotion / education resources	yes	
Bladder and Bowel care	yes	
Drug addiction guidance	yes	
Patient information accessible and visible	yes	
PALS	yes	
RAG rating		
<p>Recommendations: None            All information available from the Health Shop if not available on the ward</p>		

<b>Environment</b>		
	<b>Ward 1</b>	<b>PNF</b>
Ward profile available and visible to patients	yes	
Appropriate weighing facilities (scales)	yes	
Appropriate Patient handling Equipment	yes	
Ward has supply of soap	yes	
Ward has supply of toothpaste	yes	
Ward has supply of toothbrushes	Yes	
Ward has supply of combs	yes	
Ward has slide sheets	yes	
Authorised abbreviation list on ward or in notes	yes	
RAG rating		
<p>Recommendations: None</p> <p>Most patients supply their own personal hygiene items An emergency supply is available when necessary</p>		

<b>Uniform Audit</b>		
	<b>Ward 1</b>	<b>PNF</b>
Correct uniform (no scrubs)	yes	
Trust/NHS lanyard	yes	
Hair off collar	yes	
Jewellery	No	
Shoes	yes	
ID badge	<b>yes</b>	
Tights/socks	<b>yes</b>	
Make up	<b>yes</b>	
Nails	<b>yes</b>	
General appearance	<b>good</b>	
RAG rating		
<p>Recommendations: All staff on duty wearing appropriate uniform. One staff member was wearing a gold chain and was requested to remove it.</p>		

<b>Privacy, Dignity and Respect</b>		
	<b>Ward 1</b>	<b>PNF</b>
Are visitors greeted /acknowledged on arrival at ward?	yes	
Upon answering the phone, do staff introduce themselves?	sometimes	
Care taken when using telephone to prevent confidential information being shared	yes	
Precautions taken to cover computer screen	yes	
Room available for private consultation with patients/relatives	<b>yes</b>	
RAG rating		
<p>Recommendations:</p> <p>Most staff identify themselves when answering the phone. Some just give the name of dept-recommended to give their name and position</p> <p>The computer screen is turned away from the patient area</p> <p>Visitors greeted by the ward clerk or midwives when they ring the door bell as well as when approaching the main desk.</p>		

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

<b>Quarterly period</b>	April - June 2011
<b>Directorate</b>	Gynaecology
<b>Matron</b>	Jacky Cotton

### 3. Infection Control Surveillance

#### 1.5 Newly detected cases of colonisation or infection with MRSA

5 cases of colonisation

- April - 2 cases (Ward 8 via admission swabs)
- May - 1 case (Ward 8 via admission swab)
- June - 2 cases (Ward 8, Ward 2 via admission swabs)

#### 1.6 Mandatory MRSA & VRE bacteraemia surveillance

None

#### 1.7 Mandatory Clostridium difficile surveillance

None

#### 1.8 Mandatory E coli and MSSA bacteraemia surveillance

None

### 4. Audit Data

<b>HAND HYGIENE AUDITS</b> (Compliance Scores - Green $\geq$ 95% Amber 90 – 94% Red $\leq$ 89%)				
Ward/Dept	April	May	June	Process used to feed back results to all ward staff
Ward 7	90%	95%	95%	Graphs on display Discussed at ward meetings
Ward 8	95%	95%	100%	Graphs on display Discussed at ward meetings
Theatres	100%	100%	100%	Graphs on display Discussed at team meetings
<b>Exception Report – action undertaken for compliance scores &lt; 95%</b>				
Great improvement noted in results for compliance on Ward 7.				

<b>Other Infection Control Audit Activity – Ward Kitchens</b> (Compliance Scores - Green $\geq$ 85%, Amber 76 – 84% Red $\leq$ 75%)			
Ward/Dept	Date	Score	Process used to feed back results to all ward staff
7	6.6.11	93%	Discussed at ward meetings
8	6.6.11	93%	Discussed at ward meetings
<b>Exception Report – key areas of non-compliance &amp; actions taken</b>			
<b>Ward 7</b>			
<ul style="list-style-type: none"> <li>• Stains to flooring around dishwasher – still evident but improved.</li> <li>• Debris evident in corners &amp; inaccessible areas – under dishwasher.</li> <li>• No refrigerator temperature recordings since 3rd June (3 days – no recordings).</li> <li>• Holes in IPS panel above handwashing basin - needs filling in.</li> </ul> Required action taken by Ward Manager with housekeepers and Estates.			
<b>Ward 8</b>			
<ul style="list-style-type: none"> <li>• The daily temperature chart is only completed on a morning no evidence of completion for PM.</li> </ul>			

- Cupboard under the sink unclean and stained.
  - Debris evident in corners & inaccessible areas – under dishwasher.
  - Stains to flooring around dishwasher – still evident but improved.
- Required action taken by Ward Manager with housekeepers

## 6. Patient Environment & Medical Equipment Cleanliness

Quarterly Departmental Environment Audit		
Ward/Dept	Date Completed	Score (%)
Ward 7	1.6.11	97.7%
Ward 8	1.6.11	95%
Colposcopy	27.4.11	100%
Hysteroscopy	3.5.11	100%
Fertility Centre	17.6.11	85%
Urogynaecology/preop assessment	23.6.11	98%
GOPD	23.6.11	97.3%
EPAU	23.6.11	95.5%
Physio	27.5.11	100%
Theatres	23.4.11	95.5%
Exception Report		
Key areas of non-compliance that could not be resolved locally & actions taken		
<p><b>GOPD:</b> 2 walls still requiring paint touch up. Estates informed. Ripped couch sent for repair</p> <p><b>Fertility Centre</b> – Some wall areas requiring repair and repainting. Estates informed.</p>		

Medical Equipment Cleanliness Audit				
Ward/Dept	Timeframe/Result	April	May	June
Ward 7	Date Completed	29.4.11	16.5.11	13.6.11
	Score (%)	100%	100%	100%
Ward 8	Date Completed	23.4.11	31.5.11	27.6.11
	Score (%)	100%	100%	97.5%
Colposcopy	Date Completed	27.4.11	18.5.11	21.6.11
	Score (%)	100%	96%	96%
Hysteroscopy	Date Completed	27.4.11	4.5.11	21.6.11
	Score (%)	100%	100%	100%
Fertility Centre	Date Completed	29.4.11	**5.11	17.6.11
	Score (%)	96.1%	88%	92.5%
Urogynaecology/preop assessment	Date Completed	26.4.11	26.5.11	23.6.11
	Score (%)	100%	100%	100%
GOPD	Date Completed	28.4.11	2.5.11	3.6.11
	Score (%)	100%	100%	100%
EPAU	Date Completed	23.4.11	24.5.11	23.6.11
	Score (%)	100%	100%	100%
Theatres	Date Completed	April	May 11	June 11
	Score (%)	100%	100%	100%
Physio	Date Completed	28.4.11	27.5.11	30.6.11
	Score (%)	100%	100%	100%
Exception Report				
Key areas of non-compliance that could not be resolved locally & actions taken				
<p>Urogynaecology: Still waiting for noticeboard to be put up</p> <p>Fertility Centre: Blinds in nonclinical rooms need replacement. Fans on bimonthly</p>				

cleaning contract with Estates. Requires to be done more frequently. Stained ceiling tiles in reception area have been replaced. but department feel that whole ceiling area requires replacement to improve aesthetic appearance of reception. Funding not currently available.

<b>Multidisciplinary Environment Inspections</b>		
<b>Ward/Dept</b>	<b>Date Completed</b>	<b>Outcome of Inspection</b> i.e not deemed to be putting patients at immediate risk
Ward 7	Not undertaken this quarter	For taskforce inspection 7.7.11
Ward 8	Not undertaken this quarter	For taskforce inspection 7.7.11
Colposcopy / Hysteroscopy	Not undertaken this quarter	For taskforce inspection 7.7.11
Fertility Centre	Not undertaken this quarter	-
Urogynaecology/preop assessment	Not undertaken this quarter	-
GOPD	Not undertaken this quarter	-
EPAU	5.5.11	not deemed to be putting patients at immediate risk.
Theatres	Not undertaken this quarter	-
Physio	Not undertaken this quarter	For taskforce inspection 7.7.11
<b>Exception Report</b>		
<b>Outstanding actions &amp; any non-compliance that has not been resolved</b>		
<b>Action plans produced for all areas.</b> Issues raised on EPAU taskforce visit already identified through other audits and actions in place.		

#### 4. MRSA Screening Compliance in Gynaecology

##### Overall Compliance

(Includes Elective & Emergency Admissions and all swabs received by Microbiology)

<b>Month</b>	<b>Total No: Screens received</b>	<b>Number of Admissions</b>	<b>Screening Compliance</b>
<b>April</b>	<b>334</b>	<b>379 incl Wd 2 330 excl Wd 2</b>	<b>88% &gt;100%</b>
<b>May</b>	<b>343</b>	<b>423 incl Wd 2 374 excl Wd 2</b>	<b>81% 92%</b>
<b>June</b>	<b>422</b>	<b>408</b>	<b>&gt;100%</b>

##### Elective Admissions

Month	Total No: Screens received *	Number of Admissions	Screening Compliance
April	211	264 incl Wd 2 215 excl Wd 2	80% 98%
May	214	287 incl Wd 2 238 excl Wd 2	75% 90%
June	285	277	>100%

\*Swabs received from Ward 2 & GOPD, Colp & Hysteroscopy

#### Emergency Admissions

Month	Total No: Screens received **	Number of Admissions	Screening Compliance
April	123	115	>100%
May	128	136	94%
June	137	131	>100%

\*\* received from Ward 7, 8

#### 5. Mattress and Pillow Audit

Mattress Audit		
Ward/Dept	Audit Undertaken (Y/N)	Date Completed
7	Y	27.4.11
8	Y	27.4.11
2 (ECG bed)	Y	27.4.11
Pillow Audit		
7	Y	28.4.11
8	Y	28.4.11
2 (ECG bed)	Y	28.4.11
Exception Report – key issues identified & actions taken		
Auditors checked all mattresses on list regardless of location.		
1 mattress out of 50 audited required replacing as the cover was damaged and there was some evidence of bottoming out.		
2/74 pillows replaced		

Quarterly meetings being held with Head of Nursing, Ward & Departmental Managers and infection control link nurses to discuss elements of role and audit requirements.

**Last meeting held on 15<sup>th</sup> July.**

ENCLOSURE 6

6. High Impact Interventions

<b>No. 2a PVC Insertion</b>						
<b>Ward</b>	<b>Target No. obs per month</b>	<b>No. obs in Quarter</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
8	5	April = 5 May = 5 Jun = 5	N/A	All elements 100% except for April – PPE 80% May & June - PPE & Documentation 90%	Staff reminded of required standards of practice.	Ward meetings.
EPAU	10	April = 10 May = 10 Jun = 10	N/A	All elements 100% except for April – PPE 80% Documentation 90%	Staff reminded of required standards of practice.	Ward meetings
Fertility Centre	10	April = 10 May = 10 Jun = 10	N/A	All elements 100% except for April – Hand Hygiene 80% PPE 80% Previous improvement maintained	Staff reminded of required standards of practice. PVC inserted for short period only so no form required but insertion and removal to be documented in patient care plan.	Department Meeting
Theatres	20	April = 20 May = 20 Jun = 20	N/A	All elements 100% except for April & May :- Hand Hygiene 80% PPE 80%	Staff reminded of required standards of practice.	Department Meeting
<b>No. 2b PVC On-going care</b>						
<b>Ward</b>	<b>Target No. obs per month</b>	<b>No. obs in Quarter</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
8	20	April = 20 May = 20 Jun = 20	N/A	100% compliant in all areas for all 3 months in Quarter 1	None required	Ward meetings

ENCLOSURE 6

<b>No. 6a Urinary Catheter Care - Insertion</b>						
<b>Ward</b>	<b>Target No. obs per month</b>	<b>No. obs in Quarter</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
Urogynae		April = 15 May = 21 Jun = 20	N/A	100% compliant in all areas for all 3 months in Quarter 1	None required	Department Meeting
Theatres		April = 20 May = 20 Jun = 20	N/A	100% compliant in all areas for 2 months of data submitted in Quarter 1	None required	Department Meeting
8	5	April = 10 May = 10 Jun = 7	N/A	100% compliant in all areas for all 3 months in Quarter 1	None required	Ward meetings
<b>No. 6b Urinary Catheter Care – On-going care</b>						
<b>Ward</b>	<b>Target No. obs per month</b>	<b>No. obs in Quarter</b>	<b>Reason Target not met</b>	<b>Areas of Non-Compliance identified</b>	<b>Action Taken in response to non-compliance</b>	<b>Process used to feedback results to clinical staff</b>
8	20	April = 10 May = 10 Jun = 20	Ward manager reminding staff constantly.	None 100% compliant in all areas for all 3 months of Quarter 1	None required	Ward meetings

## ENCLOSURE 6

### Essence of Care Audit

**Overall RAG ratings for each section:**

<b>Red</b>	=	<b>&lt;60%</b>
<b>Amber</b>	=	<b>60-85%</b>
<b>Green</b>	=	<b>&gt;85%</b>

Unfortunately this audit was not undertaken in Quarter 1.

This was due to confusion caused by the Head of Nursing on the Directorate Infection Control Audit Results template. It indicated that this was required in Quarter 2 and Quarter 4. Mistake was not discovered until beginning of July.

Situation discussed and clarified with Ward Managers. The audit will be carried out in Quarters 2, 3, and 4.

# Birmingham Women's



NHS Foundation Trust

<b>SUBJECT :</b>	NHSLA Risk Management Standards Project
<b>REPORT BY :</b>	Jane Owen, Director of Nursing, Midwifery and Operations
<b>AUTHOR :</b>	Michelle Walsh, Quality and Compliance Manager

## CONTEXT AND BACKGROUND FOR REPORT

This report aims to demonstrate progress made towards compliance with the NHSLA Risk Management Standards for Acute Trusts and the CNST Clinical Risk Management Standards for Maternity Services.

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

### NHSLA Acute Standards

An informal assessment was carried out with the NHSLA assessor on 25<sup>th</sup> July 2011. The feedback from this visit concluded that 'the evidence does not appear to indicate that the organisation is ready for a Level 2 assessment'.

Following discussion at the NHSLA Leads meeting and Clinical Governance Committee, it is proposed that the Trust aim for a Level 2 assessment of the Acute Standards in November 2012, with a 12 month assessment period of 1<sup>st</sup> Oct 2011 – 30<sup>th</sup> Sept 2012.

### CNST Maternity Standards

An informal assessment was carried out with the NHSLA assessor on 27<sup>th</sup> July 2011. The feedback from this visit concluded that 'Overall, the evidence presented was to a high standard and it is clear that a lot of work has gone into preparation for the assessment. A number of areas need more work in order for the Trust to achieve full compliance'.

The Trust has currently self-assessed 6 criteria as non-compliant over the full 12-month period. Work is continuing to maintain evidence in the final quarter of the assessment period, with a focus on improving the evidence collected for some criteria self-assessed as bordering on compliance.

## RECOMMENDATIONS

To note the content of this report and to agree the postponement of the Level 2 Acute Standards assessment to November 2012.

## **NHSLA Risk Management Standards Project – September 2011**

### **1. Acute Risk Management Standards**

#### **1.1 Level 1**

The following policies have been updated in response to feedback from the NHSLA assessor: South West Midlands Neonatal Network Consent Policy, Clinical Audit Procedure and the Gynaecology RASAP (Responding to Acutely Sick Adult Patients) Guideline.

The following policies are still to be amended and approved: Risk Management Policy, Consent Policy, Slips, Trips and Falls Policy and Neonatal Resuscitation Procedure.

#### **1.2 Level 2**

An informal assessment was carried out with the NHSLA assessor on 25<sup>th</sup> July 2011. The feedback from this visit concluded that 'the evidence does not appear to indicate that the organisation is ready for a Level 2 assessment'. Improvements are needed in the quality of minute-taking and ensuring meeting agendas are set correctly, following up and completing action plans as a result of audits and national guidance gap analyses, and ensuring non-attendance at mandatory training is followed up in accordance with the Trust Mandatory and Statutory Training Policy.

A detailed presentation was given to all standard leads and directorate representatives about the acute standards.

Standards 1 and 5 – Directorate meeting reporting schedules and template minutes have been developed to prompt directorates to ensure all relevant items (risks, audits, national guidance, action plans) are discussed at the frequency described in relevant Trust policies.

Standard 2 – The Training, Education and Development Group has set up a 'task and finish group' to review the Training Policy, including Training Needs Analysis and to develop a number of tools to support staff and managers to manage attendance at mandatory training. Each member of staff will be issued with a template of mandatory training requirements specific to their role and department, to enable them to easily identify what training is required of them and when they are next due to attend. Work is also being carried out to ensure the OLM reports issued to managers are accurate, up to date and in a meaningful format to enable line managers to easily follow up any staff who are out of date with their training requirements.

Standard 4 – Clinical paperwork, such as the manual handling forms, and discharge paperwork have been updated and are currently with the printers to be implemented for 1<sup>st</sup> October 2011.

In response to feedback from the assessor, the provisional assessment for September 2011 has been cancelled. The assessor recommended an assessment in 12 months. The latest date for assessment is 2 years from date of the last formal assessment, which was 22<sup>nd</sup> November 2010.

Following discussion at the NHSLA Leads meeting and Clinical Governance Committee, it is proposed that the Trust aim for a Level 2 assessment of the Acute Standards in November 2012, with a 12 month assessment period of 1<sup>st</sup> Oct 2011 – 30<sup>th</sup> Sept 2012.

The full project plan has been updated and is available on the U:Drive for information, <U:\NHSLA Standards\NHSLA Project Plan - Acute.xls>. The overview is attached.

### **1.3 Level 3**

Directorate audit programmes were approved at the Clinical Governance Committee, subject to the inclusion of audits for the departments new to the Directorate.

### **1.4 Financial Implications**

The cost per quarter for delaying a Level 2 Assessment is £6,322.50.

## **2. Maternity Clinical Risk Management Standards**

### **2.1 Level 1**

All amendments to guidelines following the level 1 assessment and the informal visit on 27<sup>th</sup> July 2011 have been completed, with the exception of: Caesarean Section, Postnatal Care, Antenatal Screening, Handover and Transfer of Care, Raised BMI and Oxytocin.

### **2.2 Level 2**

An informal assessment was carried out with the NHSLA assessor on 27<sup>th</sup> July 2011. The feedback from this visit concluded that 'Overall, the evidence presented was to a high standard and it is clear that a lot of work has gone into preparation for the assessment. A number of areas need more work in order for the Trust to achieve full compliance'.

The Trust has currently self-assessed 6 criteria as non-compliant over the full 12-month period. Work is continuing to maintain evidence in the final quarter of the assessment period, with a focus on improving the evidence collected for some criteria self-assessed as bordering on compliance.

Another informal visit has been confirmed with the assessor for 19<sup>th</sup> October 2011. This visit will focus primarily of evidence collected for Standards 1 and 4.

A dedicated room on Ward 6 has been identified and refurbished for use by the CNST project team to review casenotes and undertake audits. This will provide a more suitable environment for the validation and preparation of casenotes.

The K2 IT system was implemented in July 2011. It has been monitored during August 2011 to identify any unforeseen consequences in relation to evidence required for the CNST assessment. Some areas of compliance have been identified, that were previously non-compliant using paper documentation. However, 2 criteria have also been identified as now non-compliant that were previously compliant. The K2 screens are being reviewed, but in the interim staff have been asked to temporarily revert back to a paper partogram until the problem has been resolved.

The project plan has been updated and is available on the U:Drive for information, <U:\NHSLA Standards\NHSLA Project Plan - Maternity.xls>. The overview is attached.

### **2.3 Level 3**

All NHSLA audits have been allocated and progress is monitored monthly; however, many audit results are still below 75%.

Learning from audits is being shared with staff through a variety of methods, such as posters, emails, verbal reports at key meetings and PROMPT training. Best practice is often reiterated with staff during clinical shifts if any non-compliance is identified.

### **2.4 Financial Implications**

The cost per quarter for delaying a Level 2 Assessment is £153,176.50.

**Project:** NHSLA/CNST Risk Management Standards

Red = not on target, Yellow = in progress but not complete, Green = complete

MILESTONES	Responsibility	Sep-10	Oct-10	Nov-10
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# Birmingham Women's



NHS Foundation Trust

<b>SUBJECT :</b>	LSA report of the Audit of Supervision of Midwives within the Trust
<b>REPORT BY :</b>	Jane Owen
<b>AUTHOR :</b>	Barbara Kuypers The Local Supervising Authority (LSA) Midwifery Officer

## CONTEXT AND BACKGROUND FOR REPORT

The LSAMO conducts a yearly audit of Supervision of Midwives within all trusts providing maternity care in the West Midlands. This is part of her remit in producing the report for the Nursing and Midwifery Council, as outlined in the NMC, Midwives Rules and Standards. (Rule 16.)

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

Supervisors were asked to self assess and present how the 5 standards set by the LSA were being met by supervisors at the Trust, and how the recommendations from previous audits had been met.

Supervisors were also asked to demonstrate and present, two of the visions highlighted in the recent document Midwifery 2020.

Vision 7 **“Responding to women’s experiences of care will drive quality improvements and this will result in an increased focus on social models on care with women and families at the very heart of midwifery and maternity care”** (Midwifery 2020)

Vision 10 **“All midwives recognise that their learning continues after graduation They have access to relevant, timely continuing professional education and will have sufficient time to take part in this education”**

Attached is the report with the commendations and recommendations made by Barbara Kuypers LSAMO and the visiting audit team. (Midwifery 2020)

## RECOMMENDATIONS

To note the content of the report and good practice points.



### The Women's for LSA Visit

LSA Audit Report for: The Women's  
Date of Audit Visit: 12<sup>th</sup> April 2011  
Audit Team: Barbara Kuypers  
Sue Lees  
Paula East

Attachments to the Report:

#### **Arrangements for the Day**

All of the Audit Team received information ahead of the visit along with directions etc.

The audit was held in the Education and Resource Centre which was an appropriate venue providing time away from service and allows for adequate parking.

The pre-visit report on meeting the 5 National Standards was well written, informative and good references to new developments within Supervision.

The Trust Chief Executive, along with the Board Chair and other members of the Trust Exec Team and Trust Governors attended various presentations and the feedback session.

The day was very well planned with clear objectives indicated for the Team.

1:

**Please complete and return the LSA Self Assessment Tabulate and return to the LSA Office at least 1 week ahead of your Audit Visit. Please insert your actions in meeting any recommendations from previous 2009 & 2010 LSA Visits on the final page of the Template. You will be asked to present your key accomplishments as part of the Audit.**

The group have evolved a great deal over the last 2 years working towards meeting recommendations from previous Audit Visits.

The team has grown in number creating an extensive portfolio of expertise amongst the group.

Jane Owen presented actions following the previous Audit Visits and referred to previous audit findings using the survey results and graphics to demonstrate improved processes and interface with supervision.

2009-10

- They accessed pints of view from users in relation to softening the MLU which has recently been redecorated with some soft furnishing additions. which meets the requirements of the Infection Control guidance's
- The group self audited access to a supervisor of midwives in an emergency and met the optimum standard of 15 m minutes.. Access is gained via the switchboard which has a listing of SoM contact details.
- There has been explorations with drop in sessions which was not well responded to, however, the creation of a link supervisors for respective clinical areas and specialities has proved much more successful and is now part of day to day currency.
- The SoM Newsletter was well received by the midwives with a specific request to keep this method of communication to tall staff.

2010-2011

- The group decided to introduce a review of record keeping to be integral to the Annual Review and invited each midwife to bring 2 sets of notes, one of their own records and one of a colleagues. This has proved beneficial for highlighting good practice (or omissions) in record keeping.
- The Trust has recently invested in the Normality Project enabling 40 midwives and 20 supervisors to attend the Back to Basics Training. This will continue with Train the Trainers cascade as part of the Mandatory Training.
- Also utilised Di Garland to enhance the learning around the use of water in labour and pool births.
- The group also decided to explore with the midwives who had been involved in untoward events how supported they were by their Supervisors and by the model of supervision itself. 78% felt they had been very well supported by their Named Supervisor following such events.

**2.**

***Responding to women's experiences of care will drive quality improvements and this will result in an increased focus on social models of care with women and families' needs at the very heart of midwifery and maternity care. (Vision 7 of Midwifery 2020 & Standard 1 of the LSA Standards of Supervision of Midwives)***

Please present a case where supervision of midwives have assisted women in achieving their birth choices and the role of supervision in assisting midwives in responding to extra-ordinary requests from women with regard to their birth intentions. You may wish to include the midwives involved with the case in this part of the presentation.

Independent Midwives Amanda Garside and Claire Jarrett were invited to join Angela and Paula in presenting a case. The Trust had booked the woman for care and in addition, the woman had booked the Independent Midwives to support her in achieving a Home Birth despite the history of 4 previous C/S.

The case demonstrated the working in partnership between the woman and her family, the independent midwives and the supervisors at the Trust. The significance of trust and honesty in sharing information amongst all of the parties and to support the premise that enables the woman to feel that she ultimately was making her own decisions with regard to her care.

- They all met to discuss the woman's expectations for herself
- Notes and records of the agreed plans placed in the notes and disseminated amongst all staff.
- The obstetricians were also aware and indicated cautious support.
- Communications during the women's labour.
- Escalation Plans and Contact details with West Midlands Ambulance etc.
- Midwives acted as advocates once the woman transferred to hospital care.

The audit team were impressed with the openness and cohesiveness amongst all of the people involved with this case and agreed that the situation described was woman focussed and is a good example to share with other IMs and SoMs at other Forums within the sector and the LSA.

**3.**

***All midwives will recognise that their learning continues after graduation. They will have access to relevant, timely continuing professional education and will have sufficient time to take part in this education. (Vision 10 of Midwifery 2020 & Standard 3 of the LSA Standards of Supervision of Midwives)***

Please present to the Audit Team the supporting role that Supervisor of Midwives have in:

- supporting pre-registration student learning
- supporting the pre-ceptorship package for newly qualified or appointed midwives at your Trust.

### **Students**

Students are introduced to Supervision of Midwives as part of their curricula and meet with a SoM in year 2 of their programme.

A number of the Tutors at BCU are Supervisors of Midwives and so access to support is often via the university.

There is no allocation of a SoM to a Cohort but a Named Supervisor allocated in year 3, earlier in the 18 month programme.

There are no formal sessions for Supervisors to meet with students on their own in their clinical learning environment.

SoMs are part of the Health Care Quality Group and also the Professional Specialty Group and so inform the curricula development and learning packs.

### **Newly Qualified.**

The Practice and Development Midwife presented the pathway for newly qualified and appointed midwives to the Trust.

The Pre-ceptorship Pack has been reviewed and is now a generic pack for both gynaecology and maternity

The pack is self directed for the practitioner who should be assisted by her Named Pre-ceptor. The pack assists the midwives in demonstrating their skills acquisition and is integral to the Band 5 – 6 gateway.

The pack includes assessment and learning packages for aseptic technique and drug administration and other clinical skills sets. There are some pages for reflection.

The new pack may also incorporate the principles of Flying Start in order to achieve the objective of Midwifery 2020.

The Audit team will wish to meet:

- a group of student midwives
- a group of newly qualified midwives in their first period of registration.

**Students**

2 Students attended who were in their final year of their training.

They confirmed the process of being introduced to Supervision and that they now have a Named Supervisor of Midwives as they work toward their qualification.

Both students knew how to access a SoM via the switchboard

**Newly Qualified**

2 Midwives attended who were in their first year of registration.

One had begun in rotation in the community and was pleased that this was how she had begun to consolidate her learning. She was currently in the Post Natal Ward. She did know her Named Preceptor and so was having shift leads sign off her document. She had accessed her Supervisor more recently following witnessing an untoward event which she had found very beneficial.

The second midwife had begun her rotation on the MLU and again found this to be an appropriate location to consolidate. She had utilised her Preceptor who worked alongside her in the same clinical area but she had not accessed her Supervisor at all other than submitting her ITP.

Both Midwives felt that the Pre-ceptorship Pack should have sections for discussions with their Named Supervisor of Midwives as they being their rotations and at various points of their first year of practice.

### **Commendations**

- **The whole days was exceptionally well planned and showcased developments and very good examples of supervision.**
- **The group clearly have worked steadily in response to previous audit findings and have assured themselves and the LSA with regard to how supervision is viewed by midwives in practice at the Trust.**
- **There is a good recognition of Supervision by the Trust Exec Team who supported the event.**
- **Very good use of the LSA previous reports and surveys in order to demonstrate progress against particular SoM Standards.**
- **The group chose an excellent case which exemplified effective team working and recognition of the need to respond respectively to women's choices and expectations for their birth plans.**
- **A good example of interface with midwives who do not work within the NHS culture and still have a very good rapport and successful outcome.**
- **Opportunistic reflection on how supportive SoMs were to respective midwives following untoward events.**
- **Success full promotion and recruitment of new Supervisor of Midwives to raise the ratio etc.**

### **Recommendations**

- **To continue with strategic development and vision for the team and to present successes at Board level and other external Forums.**
- **To develop a Portfolio of cases where SoMs have provided guidance for midwives attending women with complex birth plans for future reflection and teaching.**
- **To integrate Supervision into the Pre-ceptorship Pack and ensure the principle of the pack is about skills acquisition rather than re-assessment.**
- **To introduce sections for reflection and discussions with the Named SoM at the beginning and at midway and end of the first year of practice.**
- **To continue with Away Days.**

Barbara Kuypers  
Local Supervising Authority Midwifery Officer  
NHS West Midlands

ENCLOSURE 8

**ACTION PLAN**

NO	ACTION	WHO	WHEN	ON GOING	COMPLETE
1	<ul style="list-style-type: none"> <li>To continue with strategic development and vision for the team and to present successes at Board level and other external Forums.</li> </ul>	All		In progress	
2	<ul style="list-style-type: none"> <li>To develop a Portfolio of cases where SoMs have provided guidance for midwives attending women with complex birth plans for future reflection and teaching.</li> </ul>	All	Continuously		Folder on G drive contains previous cases Where SOM have provided guidance to MWs attending women with complex birth plans.
3	<p><b>To integrate Supervision into the Pre-ceptorship Pack and ensure the principle of the pack is about skills acquisition rather than re-assessment</b></p> <ul style="list-style-type: none"> <li>To introduce sections for reflection and discussions with the Named SoM at the beginning and at midway and end of the first year of practice.</li> </ul>	Wendy Burt Sue Smithson		Completed may 2011	
4	<ul style="list-style-type: none"> <li>To continue with Away Days.</li> </ul>	Contact Supervisor	13 <sup>th</sup> April 2011 23rd Nov 2011		completed
5					

ENCLOSURE 8

# Birmingham Women's

## NHS Foundation Trust



<b>SUBJECT :</b>	Care Quality Commission (CQC) Final report on review of Compliance.
<b>REPORT BY :</b>	Jane Owen
<b>AUTHOR :</b>	Jane Owen

### CONTEXT AND BACKGROUND FOR REPORT

The board will be aware that the trust had a planned, unannounced inspection in April this year. This was to review compliance against the essential standards of quality and safety. The draft report was received at the end of June and the trust returned comments on factual accuracy on 11<sup>th</sup> July. The final report was received 22.08.11, and a copy is appended.

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

The report gives many examples of very positive feedback. As well as interviewing staff and patients, CQC asked other organisations about any information they had that indicated whether or not the hospital was compliant with the essential standards. These organisations were:

- Monitor, the independent regulator of NHS foundation trusts;
- NHS West Midlands, the local strategic health authority;
- NHS South Birmingham, the lead commissioner of the service;
- Birmingham Local Involvement Network, an independent network of people and groups working together to improve health and social care;
- Health and Adults Overview and Scrutiny Committee, a Birmingham City Council committee that scrutinises health and adult social care within the city;
- Birmingham Safeguarding Children Board;
- Birmingham Safeguarding Adults Board.

#### The overall results was:

"We found that Birmingham Women's NHS Foundation Trust was not fully meeting one essential standard. Improvements were needed". The concern was classed as minor- people are safe but not always experiencing the outcomes relating to the standard. The trust has submitted an action plan to achieve compliance. This will be monitored both internally and monitored by CQC,

The minor concern was related to regulation 23 outcome 14 (supporting workers)

**How the regulation is not being met:**

People received care from staff who received training relevant to their jobs and annual appraisals. However, the trust was not able to demonstrate that staff had received all the training they needed to carry out their roles. Midwives and some other staff had supervision sessions but many other staff did not have specific time to talk through issues about their role or the people they provide care to.

In addition, the trust has implemented improvement actions to ensure compliance is maintained regarding regulation 14, outcome 5 nutrition ( temperature of food served to patients) and regulation 19 outcome 17 complaints (timely responses)

**RECOMMENDATIONS**

To note the content of the report and the good practice points and that the action plans will be monitored by CGC and ORAG.

# Review of compliance

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

<b>Region:</b>	West Midlands
<b>Location address:</b>	Metchley Park Road Edgbaston Birmingham West Midlands B15 2TG
<b>Type of service:</b>	Acute services Community healthcare services Ambulance services
<b>Publication date:</b>	September 2011
<b>Overview of the service:</b>	Birmingham Women's NHS Foundation Trust operates from Birmingham Women's Hospital and provides specialist healthcare for women and their families in South Birmingham and the West Midlands. The hospital was established in 1968 and is one of two in the country which specialises in providing care for women and their families. The trust provides gynaecological, maternity and neonatal care as

	<p>well as a comprehensive genetics service. It also has an assisted conception unit. The trust has 149 adult beds, 34 neonatal intensive care cots and 11 transitional care cots, making a total of 45 cots, and looks after 50,000 patients a year, carries out 3,000 operations and delivers more than 7,000 babies.</p>
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# Summary of our findings for the essential standards of quality and safety

## What we found overall

**We found that Birmingham Women's NHS Foundation Trust was not fully meeting one essential standard. Improvements were needed.**

The summary below describes why we carried out the review, what we found and any action required.

### Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

### How we carried out this review

We reviewed all the information we held about this hospital and we looked at the information the trust published on its website, which included information presented at the monthly meetings of its board of directors.

We asked other organisations about any information they had that indicated whether or not the hospital was compliant with the essential standards. These organisations were:

- Monitor, the independent regulator of NHS foundation trusts;
- NHS West Midlands, the local strategic health authority;
- NHS South Birmingham, the lead commissioner of the service;
- Birmingham Local Involvement Network, an independent network of people and groups working together to improve health and social care;
- Health and Adults Overview and Scrutiny Committee, a Birmingham City Council committee that scrutinises health and adult social care within the city;
- Birmingham Safeguarding Children Board;
- Birmingham Safeguarding Adults Board.

We asked the hospital's managers for information that showed us how the hospital met four of the essential standards (outcomes 2, 6, 9, 11) and they sent us this information within the timescale we set.

We carried out an unannounced visit on 13 April 2011. During the visit, we observed how people were being cared for, talked with people who used the service, talked with staff and managers, checked the trust's records, and looked at records of people who used services and staff. We visited outpatient and inpatient areas in the maternity and gynaecology services, including the ante-natal ward (ward 1), the delivery suite, the neonatal unit, the uro-gynaecology outpatient department (ward 2) and a gynaecology ward (ward 8). We visited the clinical genetics outpatient department and talked with the community midwifery team leaders. We also talked about the termination of pregnancy service and the neonatal transport team.

## **What people told us**

People who used the service told us that staff explained their care, treatment and support choices to them and involved them in their care. People told us that the "staff are very knowledgeable. They explain things clearly and give me plenty of chances to ask questions", "I never feel rushed, it is always very calm, they are not rushing you out at the end of an appointment". They said that the staff were "very helpful, kind and approachable" and that "the privacy on the ward is fine, they close the curtains if we need to be private". They told us that medicines to relieve pain were available when they needed them and they were effective.

Some people told us they had to wait for their outpatient appointments, "This clinic usually runs about an hour late. People never tell you why, there is no communication from the front desk. That would make it much better really".

People gave us mixed views about the food. They said they had a choice of food and some people told us that the food was tasty, "I love it". However, not everyone liked the food. One person said "the food was OK. Put it like this, I was never left hungry. It was edible". Several people in the gynaecology ward we visited told us that the food was "lukewarm".

Nearly everyone we spoke to told us that they thought the hospital was clean and they had no concerns about cleanliness. "Cleanliness has always been fine. There has never been a problem with this clinic or other parts of the hospital I have been in". "The cleaners come and Hoover every day" and "the nurses are backwards and forwards to the sinks washing their hands all the time".

Most people told us they had not had a reason to complain. One person said "I have never had a problem. They have been so good to me". People's views on the trust were generally summed up in these two comments: "staff here have a lot of specialist knowledge. I come regularly, and find it excellent", "I feel we are very lucky in Birmingham to have this specialist hospital. Friends I speak to, who don't live locally, don't get the same services we get here".

## **What we found about the standards we reviewed and how well Birmingham Women's NHS Foundation Trust was meeting them**

### **Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run**

People had their privacy, dignity and independence respected. They had their care, treatment and support choices explained to them and were involved in making decisions. Information was provided in a range of ways to make sure people could understand and be involved in their care and treatment. They had their views and experiences taken into account in the way the service was provided and delivered.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

### **Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it**

Staff explained the benefits and risks, and alternatives to, the tests and treatments that were being suggested and people consented to them before they were done.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

### **Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights**

People experienced effective, safe and appropriate care, treatment and support that met their needs.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

### **Outcome 5: Food and drink should meet people's individual dietary needs**

People had a choice of food and were able to obtain food outside mealtimes if necessary. People with special diets were able to get the food they needed. The food on one ward was sometimes "lukewarm" when it was served.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

### **Outcome 6: People should get safe and coordinated care when they move between different services**

The trust co-operated with other providers to make sure that people received safe and co-ordinated care, treatment and support when more than one service was involved in a person's care.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

**Outcome 7: People should be protected from abuse and staff should respect their human rights**

Staff knew what to do if they suspected that someone was at risk of abuse and responded appropriately if they suspected that abuse had occurred or was at risk of occurring.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

**Outcome 8: People should be cared for in a clean environment and protected from the risk of infection**

People were protected against identifiable risks of acquiring a health care associated infection because of the effective operation of systems and the maintenance of good standards of cleanliness and hygiene. This indicated that the trust was complying with the Department of Health's Code of Practice on the prevention and control of infections.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

**Outcome 9: People should be given the medicines they need when they need them, and in a safe way**

People received their medicines at the right times and in a safe way.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

**Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare**

The hospital provided a safe and well-maintained environment for the delivery of care and treatment.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

**Outcome 11: People should be safe from harm from unsafe or unsuitable equipment**

The trust managed its equipment to make sure that the right equipment was available to meet the needs of the people who use its services.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

**Outcome 12: People should be cared for by staff who are properly qualified and able to do their job**

The trust carried out relevant checks when staff were employed, to make sure they were fit and physically and mentally able to do their job.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

**Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs**

People's needs were met by sufficient numbers of staff. The trust monitored areas where there may not be enough staff or where changes were being made to the numbers and types of staff.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

**Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

People received care from staff who received training relevant to their jobs and annual appraisals. However, the trust was not able to demonstrate that staff had received all the training they needed to carry out their roles. Midwives and some other staff had supervision sessions but many other staff did not have specific time to talk through issues about their role or the people they provide care to.

- Overall, we found that improvements were needed for this essential standard.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

The trust had systems to monitor the quality and safety of services people receive and to identify and manage risks to people's health and welfare, making improvements where required. The trust made much of the information about the quality and safety of its services available to people who use services and others.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

**Outcome 17: People should have their complaints listened to and acted on properly**

The trust had systems in place to investigate and respond to comments and complaints but responses were not always made in a timely manner.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

**Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential**

The trust kept records about the people who use the service, the staff who work there and how the hospital is managed. The trust stored these records securely and made sure they remained confidential.

- Overall, we found that Birmingham Women's NHS Foundation Trust was meeting this essential standard.

### **Action we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

**What we found**  
for each essential standard of quality  
and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

# Outcome 1: Respecting and involving people who use services

## What the outcome says

This is what people who use services should expect.

People who use services:

- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 1: Respecting and involving people who use services

### Our findings

**What people who use the service experienced and told us**  
We asked people who used the service about how well staff explained their care, treatment and support choices to them. People told us that the “staff are very knowledgeable. They explain things clearly and give me plenty of chances to ask questions”, “I never feel rushed, it is always very calm, they are not rushing you out at the end of an appointment”, “they checked and double checked I knew what was going on”. One person told us “my next consultant’s appointment is for information gathering, so that I am involved in the decision about what kind of delivery to have”.

People gave us mixed views about being kept waiting for outpatient appointments and being kept informed about delays. Some people said they were not kept waiting “and staff tell me if there is a delay” but several people told us that certain clinics always run late. “This clinic usually runs about an hour late. People never tell you why, there is no communication from the front desk. That would make it much better really”.

Some people told us that staff did not rush them during their outpatient

appointments but this also meant that sometimes the clinics ran late and they had to wait a long time when they arrived for their appointments. They appreciated the extra time when they were in the appointments but they were concerned about the delays if they had to go back to work and if they would be charged extra for car parking. We asked the trust's managers about this. They said that clinic staff had notes explaining that the clinic had over-run, that they could give to people, to give to the car park attendants so they would not be charged extra, although it was not clear how people would know about this system.

We talked with some people who told us that they had attended their first appointment, hoping to get more information about their condition, but instead they had been asked a lot of questions and had had some tests. They were hoping that they would get the information at their second appointment.

Most people told us that the staff were "very helpful, kind and approachable" but a couple of people had had experiences of staff who were less approachable. One person said staff in one area "didn't smile. They weren't reassuring at all" and another said that she left one appointment in which the staff "didn't give me eye contact, didn't speak clearly" feeling angry and upset. She said she telephoned and arrangements were made so that she would not see that person again.

We saw staff making people feel welcome, treating them with respect and protecting their privacy. We saw reception staff greeting people on arrival in a friendly, helpful and supportive way and we saw staff offering help to a person who arrived with a guide dog. We saw staff taking people into private rooms and switching signs from 'vacant' to 'engaged'. We were directed away from people who had just had bad news.

One person told us "the privacy on the ward is fine, they close the curtains if we need to be private". Another told us "I have been examined by both male and female staff. They have all been very professional, and made me feel as comfortable and relaxed as possible".

We saw notice boards in several areas with notices and leaflets about conditions, treatments and support services.

### **Other evidence**

Staff told us that they had a lot of information that they gave to people before they had operations, including general information about the operations, not eating or drinking before an operation, pain control, and information for visitors. They told us that they talked through the information with people and wrote in any extra information.

We also saw a number of leaflets for people, several of which included information in other languages. Staff in the uro-gynaecology service told us that they had compact discs (CDs) with information on them in a variety of languages that they give to people.

We found that about half of the people who used the trust's services reported their ethnic origin as different from 'white'. We looked at the ways in which the trust supported people who were not able to communicate in English. Staff told us they

tried not to use family members to interpret and female interpreters were used as far as possible. The trust employed link workers who spoke other languages and who were trained to provide some types of support such as breastfeeding and who were also able to help interpret. A local interpreting service provided interpreters for appointments in the hospital and the community. Staff could also access interpreters over the telephone if necessary and each ward and clinical department had telephones specifically for this. Staff were not able to use the telephone everywhere that people had treatment in the uro-gynaecology department but in the delivery suite, staff told us the telephones were mobile so they could be taken in to the delivery rooms. Staff told us there were sometimes delays in getting interpreters for languages that were not spoken by many people in the area. There was also sometimes a problem with unfamiliar medical words, which staff then needed to explain to the interpreters.

Some of the community midwives could use British Sign Language (BSL) and had been able to support pregnant women who were deaf. They commented that it might be useful to have more colleagues who could use BSL.

We asked staff about how they made sure that people's privacy and dignity were respected. They told us "I see them in private", "all doors are closed", "there is a buzzer they can ring to let us know they are ready", "I ensure curtains are drawn and people are covered", "I always pull the curtains round, and try and put people at their ease, reassure them all the time. We always ask if they mind if students are in with them". The community midwives told us that they suggest people draw the curtains when they see them in their homes, if the rooms in which they are examining them are overlooked by neighbours.

Some staff told us they looked in people's records so they knew why they were there, which helped when introducing themselves as they were not always getting good news. They also gave us an example of not being involved if the person was someone they knew. Other staff said things like "I ensure the patient understands what is being done".

We saw other examples of how the trust protected people's privacy and dignity. The antenatal outpatient department was laid out so that urine samples could be handed through a hatch from the toilet area or left in a cupboard for collection, so people did not need to carry samples out of the toilet area. The maternity unit gave women two hospital gowns so that they could wear one on top of the other, the other way around, to cover any gaps.

The trust had a number of different ways in which it asked people about their views and experiences of the service. The trust reported it had started to collect patient feedback in a more structured way in February 2011. This included an online survey, text message survey and hand held computer tablet survey. During our visit, we saw posters and leaflets which invited people to send their answers to five questions about their appointment by text message. The chief executive presented the first results of this feedback to the March 2011 board of directors' meeting. One of the questions they asked outpatients in February 2011 was about how far people were involved in decisions about their care. Nearly 80% said they were definitely involved, and nearly 20% said they were involved to some extent. 2% said they were not involved.

**Our judgement**

People had their privacy, dignity and independence respected. They had their care, treatment and support choices explained to them and were involved in making decisions. Information was provided in a range of ways to make sure people could understand and be involved in their care and treatment. They had their views and experiences taken into account in the way the service was provided and delivered.

# Outcome 2: Consent to care and treatment

## What the outcome says

This is what people who use services should expect.

People who use services:

- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 2: Consent to care and treatment

### Our findings

**What people who use the service experienced and told us**  
We talked with several people who were going to have operations and they all said they had been made aware of the operation that they were going to have, the benefits and the risks of the operation and of other options that were available. One person told us “I have agreed to all of the treatment that I have had”.

We saw signed consent forms in the clinical records that we looked at.

**Other evidence**  
Before visiting the trust, we asked the managers for information that showed the trust made sure that people gave their consent before they were examined or had any tests or treatment. The trust described how it obtained and acted in line with consent from the people who used its services. This included having policies and procedures, providing training to staff and giving people verbal and written information. People were asked to sign consent forms for some things, especially operations.

The trust also told us that it had senior staff who looked at all people who might not

have the capacity to consent. There were specific forms for these people and detailed plans were written if necessary.

We talked with staff about how they made sure that people understood what tests and treatments were being suggested, why they were being done and what the benefits, risks and alternatives were. They told us “if people refuse, it is usually because they are scared. We try and talk to them and reassure them” and they gave us some good examples of how they helped people understand the implications of their decisions. Community midwives told us that if they were very concerned about a situation, they would discuss it with their supervisor. Staff told us that if people declined treatment after it had been fully discussed with them, they respected those decisions.

We found that the trust had made arrangements with another organisation to use their patient information leaflets, which explained about some common procedures, why they were done, the benefits and the risks. There were links on the trust’s website to these leaflets but a few had also been put on the website and were now out of date.

### **Our judgement**

Staff explained the benefits and risks, and alternatives to, the tests and treatments that were being suggested and people consented to them before they were done.

# Outcome 4: Care and welfare of people who use services

## What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 4: Care and welfare of people who use services

### Our findings

**What people who use the service experienced and told us**  
Most people talked positively about the care they had. They spoke well of staff and told us “the staff on the ward are brilliant”, “they have told me why the baby needs a drip. The consultant kept me informed all the time”, “the midwives take the time to speak to me. One has just come to me to let me know that she has just spoken to the doctor and I may be able to go home tomorrow. They communicate with me well”, “I almost fainted when I had my first blood test this morning. The midwives were very good to me”.

People said “staff here have a lot of specialist knowledge. I come regularly, and find it excellent“, “I feel we are very lucky in Birmingham to have this specialist hospital. Friends I speak to, who don’t live locally, don’t get the same services we get here”.

We heard a nurse talking with a new mother while helping her feed her baby and heard her explain everything in a calm and positive way.

One person talked about the trust’s ability to be flexible and said she had been referred as an emergency and asked to go in straight away but “that wasn’t convenient, so I made this appointment which is more suitable”.

One person had concerns about a delay in being seen and said “I wish I had been

seen more promptly in first appointment. It may have meant I didn't get as ill as I did" and another had concerns about staff awareness of 'the whole picture', and told us that she saw a nurse who was not aware of what a doctor had talked with her about.

We saw posters offering people access to chaplains, a chapel, multi faith prayer rooms, counselling services and bereavement services.

### **Other evidence**

The community midwives told us that each GP surgery had a named midwife who looked after all the pregnant women from that surgery, so the women were usually seen by the same midwife throughout their pregnancies. They tried to make sure that women were seen by no more than two different midwives after they had had their babies.

Several staff such as community and specialist midwives told us that they gave people their mobile telephone numbers so that they could contact them if they needed to.

We found that people who had to be transferred to the ante-natal ward did not have to wait very long. We saw one person who had to wait for triage before being admitted to the ante-natal ward because the doctor who had been due to see her had been called away for an emergency but staff explained this to her.

We looked at some people's maternity records, to see if staff were assessing people to identify their needs and if there were plans to meet those needs. Staff told us that pregnant women kept their own case notes and were asked to bring them to all their appointments. We saw that, if it seemed as if there might be difficulties during the birth, the doctors would develop a care plan beforehand, in the ante-natal clinic. The community midwives told us about the sorts of things they would discuss with women who planned to give birth at home, including what would happen if an emergency arose. It was easy to follow what had happened in the files. We saw that people had been assessed to see if they needed help with moving or if they were at risk of deep vein thrombosis. We saw that maternal early warning score (MEWS) sheets had been completed and 'vital signs' had been recorded. We also looked at some records for new born babies and saw that plans had been written to make sure they were kept warm and clean and fed enough. We saw records of the care they had been given, what they had drunk and their weight, as well as records of communications with the parents.

We looked at some people's gynaecology records and found that they followed the journey of the person from outpatients to inpatients. People had been assessed on admission to hospital and individual plans had been written for their care. Everyone had been assessed to see if they needed help with moving and few people did. People had also been assessed to see if they needed catheters, if they were at risk of deep vein thrombosis and for pain. Observations of 'vital signs' had been done at the identified intervals. The forms that needed to be in the files were there and it was easy to follow issues through in the files.

We looked at some information that gave an indication of the quality and safety of the treatment and care that people who used the trust's services experienced. We

found that directors routinely reported information about this to the monthly meeting of the board of directors. The commissioner of the service and Monitor both told us that the trust sent them information about its performance against a range of performance indicators, many of which were about people's treatment and care and included the information that was reported to the board of directors.

This information included details about how long people waited after they had been referred to the trust by their family doctor. In February 2011, the chief executive reported that people waited for less than 18 weeks to be seen and for their treatment to begin. People who may have cancer were seen within two weeks of referral and if cancer was found, treatment was started within two months of seeing their family doctor.

The trust also reported on the percentage of non-emergency operations cancelled at short notice for non-clinical reasons, as a percentage of non-emergency admissions. There were no such cancellations for nine months of the 2010/11 year and fewer than 0.5% for the whole year, with all women being offered another date within 28 days for their operation.

The medical director routinely reported on patient safety issues. In February 2011, he reported that the 12 month rolling average for still birth and neonatal death rates had been declining. He also reported on nine specific patient safety indicators which had been identified by the trust's clinicians as being significant. The number of times these incidents occurred appeared to be low, but the medical director told us that they had been unable to compare their performance against that of other services as this information was not available nationally.

The commissioner of the service had identified a number of priorities for the trust that would indicate people were receiving timely and effective care. The commissioner asked the trust to make sure that over 70% of pregnant women had seen a midwife before the tenth week of their pregnancy and that over 90% had seen a midwife by the end of the twelfth week. The percentages fluctuated during the 2010/11 year but by the end of the year, the trust had achieved 62% of women being seen before the tenth week and nearly 90% of women being seen by the end of the twelfth week.

The commissioner also asked the trust to make sure that over 90% of pregnant women who smoked were referred to the local stop smoking service and that fewer than 12% of women smoked at the time they gave birth. By the end of February 2011, 93% of women were referred to the stop smoking service. However, although about 10% of women smoked at the time they gave birth at the end of June, this rose to 13% at the end of September and December 2010 and about 12% at the end of March 2011.

They also asked that over 67% of women had begun breastfeeding and this figure was achieved at the end of each quarter of the 2010/11 year.

Finally, there is an NHS framework that enables commissioners to reward excellence by linking the achievement of local quality improvement goals to payment (commissioning for quality and innovation, or CQUIN). The commissioner's report of the trust's performance for October to December 2010 rated their progress

as 'green', with the trust being on track to achieve all eight of the CQUIN indicator areas.

**Our judgement**

People experienced effective, safe and appropriate care, treatment and support that met their needs.

# Outcome 5: Meeting nutritional needs

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are supported to have adequate nutrition and hydration.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 5: Meeting nutritional needs

### Our findings

**What people who use the service experienced and told us**  
People told us that they had a choice of food. “You go up to the trolley at 12 midday and choose what you want.”

People gave us mixed views about the food. Some people told us that the food was tasty, “I love it”. Not everyone liked the food. One person said “the food was OK. Put it like this, I was never left hungry. It was edible”. Several people in the gynaecology ward we visited told us that the food was “lukewarm”.

One person told us that “staff here go the extra mile”. She had had a low appetite and staff had asked her if she fancied anything. She had asked for something that was not available in the ward and staff got it for her while she was asleep. She woke up and found it on her table with a little note saying “enjoy”.

**Other evidence**  
We found that food was readily available. We saw vending machines and free water dispensers around the hospital and there was a coffee shop and a dining room that people could use. Staff told us that volunteers brought a trolley to an outpatient department four times a day. We saw that cereal and bread for toast and sandwiches was available on the wards. Staff told us the kitchen staff were very good and catered for individual requests.

On the ante-natal ward, staff told us that dieticians and kitchen staff would come to talk with people about their diets and preferences, so that people with special diets were able to get the food they needed. People could order alternatives such as jacket potatoes or omelettes, if they did not want what was available. People could have food brought in for them but there were no facilities on the ward for heating food up.

On the gynaecology ward, staff told us that everyone over the age of 80 was screened to see if they were at risk of malnutrition, with a widely used tool called the Malnutrition Universal Screening Tool (MUST). This was also used on people under 80 if staff assessed it was needed.

We saw menus on display on the gynaecology ward we visited. The menus had a variety of choices and were repeated every four weeks. The ward had a dining room and staff told us they encouraged people to eat their meals there, when they were able to. Staff told us the kitchen staff were very good and catered for individual requests. The food we saw looked appetising.

We talked with some catering staff who told us that they freshly cooked all the food each day and they used the same food and standards for people who used the service, visitors and staff.

Several people on the gynaecology ward we visited told us that the food was "lukewarm". We asked the trust's managers about this. They told us the hospital had recently had new food trolleys, the trolleys usually arrived on the wards shortly after they had left the kitchen and the service on the ward was quick. They told us they would look into this. They asked the people on the ward about the food temperature for five days shortly after our visit and sent us the results, with the records of the food temperature for those days. Everybody rated the temperature as 'average' for three out of the nine meals but the temperature records for those meals showed the temperatures for the main dishes at the beginning of the service were similar to or higher than the temperatures for the main dishes on other days. The managers told us they would like the food to be between 70°C to 75°C at the start of the service but only a third of the main dishes were recorded as being in that range.

Some people talked about the length of time from when they were not able to eat or drink before an operation to when they were able to have a proper meal again. They told us it could be a long time, if their surgery was late in day or they were late back on ward. There would be a light supper and breakfast, with the next main meal at lunch time. We talked with the ward manager about this, who explained that they try to discourage people from eating too heavily after operations for clinical issues relating to the site of surgery, the possibility of nausea, and of further surgery in event of an emergency. The trust's managers also told us that they had recently changed their 'nil by mouth' practice so that people who were due to have operations in the afternoon were able to have breakfast so they were without food and drink for a shorter period of time.

Staff in the gynaecological outpatient clinic were aware if people had to wait for transport to take them home or if they had diabetes and offered them drinks and sandwiches. There was also a sign in the department saying that staff would be happy to get drinks of water.

Patient Environment Action Teams (PEAT) were established in 2000 to conduct annual assessments of food, cleanliness, infection control and the patient environment in inpatient healthcare sites in England. We looked at the trust's 2010 PEAT scores for food and food services and found that one out of five was 'much better than expected' and four were 'similar to expected'.

The chair of the Birmingham Health and Adults Overview and Scrutiny Committee commented to us that she had received many representations about nutrition at another trust but no issues had been raised with her about nutrition at Birmingham Women's Hospital.

**Our judgement**

People had a choice of food and were able to obtain food outside mealtimes if necessary. People with special diets were able to get the food they needed. The food on one ward was sometimes "lukewarm" when it was served.

# Outcome 6: Cooperating with other providers

## What the outcome says

This is what people who use services should expect.

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 6: Cooperating with other providers

### Our findings

**What people who use the service experienced and told us**  
One person gave us an example of communication between services, explaining that she had a urine infection the last time she came to the clinic. “The hospital communicated with my GP about this and my GP contacted me so that I started antibiotics. There is good communication”.

We saw leaflets about other services and support groups for people who used the service in the hospital.

**Other evidence**  
Before visiting the trust, we asked the managers for information that showed the trust co-operated with other services. The trust described how it co-ordinated care, treatment and support. This included having policies which were supported by specific guidance or procedures. They told us that pregnant women carried their own antenatal and postnatal notes and were advised to take them to any health care appointment. They passed on information within the hospital between shifts verbally and to other hospitals by copying clinical records and sending them with a letter of handover. The trust ran some joint clinics with other specialists in areas such as diabetes and mental health. They also employed specific staff to co-ordinate transfer and discharge from some specialist services. Correspondence and discharge information were routinely sent to people and their family doctors. We

saw copies of discharge letters in the clinical records that we looked at.

The community midwives told us that they use the multi-agency common assessment framework (CAF) for children when this was needed. The safeguarding team had begun providing the administrative support for this which they had found very helpful.

One of the community midwifery team leaders told us that she had monthly meetings with other colleagues involved in the local children's centre which were useful for sharing information.

The director of nursing's report on safeguarding children during 2010 outlined an audit that had been done on liaison between maternity and health visitor services, in conjunction with the health visiting service. The auditors looked at 50 sets of records and found that 25% showed evidence of communication between professionals, although there was anecdotal evidence of information being shared between them.

We found that another local specialist trust employed a nurse specialist who trained the trust's neonatal unit staff about the care that babies needed after operations.

In conjunction with Ofsted, we looked at the arrangements for safeguarding children and the looked after children's services in Birmingham in the summer of 2010. We found that there were a number of areas where evidence of effective partnership working was seen. Midwives working with teenage parents in children's centres in South Birmingham were working well with partner agencies and reported an increased use of the common assessment framework (CAF) for children. Effective action taken following serious case reviews demonstrated learning and had led to improvements in the timeliness and level of information sharing between health visitors and midwives. This had resulted in earlier targeted interventions by both midwives and health visitors and better tracking of vulnerable young women across South Birmingham and the city as a whole. We also found that midwives reported good links with the looked after children's health team but with no clear impact other than some sharing of information.

In the information the trust sent us before we visited it, it told us that it had identified the ways in which information was transferred to other organisations and made sure that this was done securely.

In the information the trust sent us before we visited it, it told us that its role in a major incident would be to provide aid to other services. It had an emergency planning lead in post who participated in monthly local health resilience forum meetings, and an emergency planning group which met quarterly. It also took part in a major incident exercise that was held in the West Midlands in May 2010. It was working with another trust based on the same site on emergency site evacuation plans.

The commissioner of the service told us that the trust "was easy to work with" and regularly attended the meetings it was invited to attend. Equally, the trust routinely invited the commissioner to attend some of its meetings.

**Our judgement**

The trust co-operated with other providers to make sure that people received safe and co-ordinated care, treatment and support when more than one service was involved in a person's care.

# Outcome 7: Safeguarding people who use services from abuse

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 7: Safeguarding people who use services from abuse

### Our findings

**What people who use the service experienced and told us**  
We saw posters and leaflets around the hospital about safeguarding children and vulnerable adults and what to do about abuse. We also saw posters and leaflets aimed at people who were victims of domestic violence.

**Other evidence**  
The trust had a dedicated safeguarding team and we found that they were well known throughout the trust.

The trust's managers told us that everybody was given information about safeguarding in the form of a leaflet and that some groups of staff had additional training. Several staff told us they had not had formal training about safeguarding but everyone we spoke to knew that if they had any concerns about children or vulnerable adults, they would speak to their manager or the safeguarding team. The community midwifery team leaders said that some of their teams managed a lot of child protection issues and they and their staff were very well supported in safeguarding children.

One member of staff gave us an example of when concerns were picked up by a consultant. We saw an example of staff raising concerns with the safeguarding team in some of the clinical records we looked at.

We found that the trust reviewed and reported on its arrangements for safeguarding children and vulnerable adults. The director of nursing reported on the trust's safeguarding activity during 2010 to the February 2011 board of directors' meeting. She outlined the trust's arrangements for safeguarding people in these two groups and some of the safeguarding activity that had taken place through the year. The report on safeguarding children also outlined some audits that had been done. One audit looked at whether or not midwives routinely asked women about domestic abuse and the auditors found that this had been done in nine out of 28 (32%) cases. Another audit looked at whether or not referrals to the local authority met the local procedures. The auditors found almost 100% compliance, with evidence of good record keeping and information sharing in all 12 of the cases.

A business manager wrote to us on behalf of the Birmingham Safeguarding Children Board to say that the trust was an active member of the board. The board had reviewed each member organisation's safeguarding quality assurance systems in March 2010 and told us that the trust had provided a comprehensive response, detailing the arrangements in place within the trust, which included quantifying the learning after training, supervision and audit of practice. The board reviewed all child deaths and oversaw serious case reviews into the deaths or serious injury of children subject to child abuse. The trust had contributed to seven serious case reviews. As part of the Ofsted evaluation process for serious case reviews, its reviews were assessed, with the most recent evaluation judged as 'good'.

### **Our judgement**

Staff knew what to do if they suspected that someone was at risk of abuse and respond appropriately if they suspected that abuse had occurred or was at risk of occurring.

# Outcome 8: Cleanliness and infection control

## What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

## What we found

<b>Our judgement</b>
<b>The provider is compliant</b> with outcome 8: Cleanliness and infection control

<b>Our findings</b>
<p><b>What people who use the service experienced and told us</b> People told us that they thought the hospital was clean and they had no concerns about cleanliness. “Cleanliness has always been fine. There has never been a problem with this clinic or other parts of the hospital I have been in”. “The cleaners come and Hoover every day.” They said they saw staff washing their hands (“the nurses are backwards and forwards to the sinks washing their hands all the time”), although one person said “I have never seen a doctor wash their hands before they examine me. I assume they do?”.</p> <p>One person told us about a dirty toilet area in reception but when we looked at it, we saw that it was heavily used but was acceptable.</p> <p><b>Other evidence</b> We found that all the areas we visited looked clean and tidy. We saw hand cleansing gel in outpatient and inpatient areas. Staff told us they thought the hospital was clean and that staff kept their hands clean and the community midwifery team leaders told us they all had hand gel and gloves and aprons.</p> <p>We found that wards had some single rooms which could be used for people with infections. We saw that one person had an infection and ‘barrier nursing’ was being used. Staff entering her single room used hand cleansing gel and wore disposable apron and gloves, which they took off when they left the room. They also used the hand cleansing gel again.</p>

Staff told us about a incident in which a person who used the service was identified as having an infection and the staff who had cared for her were followed up immediately, to see if they had caught it as well.

The trust's managers spoke highly of the housekeeping staff, describing them as "brilliant" and "committed". They told us they were allocated to specific clinical areas and felt part of those teams. They said that the housekeeping staff were proud of the cleanliness standards and raised issues with the clinical staff, including if they thought they were not following the rules. Many of them had worked at the hospital for many years and they had adapted and changed as necessary over the years. They gave us a copy of the room cleaning checklist that was used in the birth centre and delivery suite, which set out the cleaning tasks and identified who was responsible for which ones. The cleaning tasks included taking the bed apart and thoroughly cleaning it and checking the mattress for any damage. They told us the room cleaning took about 30 minutes. They also gave us a copy of the checklist to use for cleaning rooms in which someone had been isolated or had had an infectious illness. This identified the cleaning solution to be used and specified that new cloths should be used for each area and disposed of in specific clinical waste bags.

We looked at the trust's 2010 PEAT scores for cleanliness and infection control and found that eight out of eighteen were 'much better than expected' and ten were 'similar to expected'.

We found that other organisations had also looked at the trust's cleanliness. The commissioner of the service told us that it had visited the hospital unannounced on 12 November 2010 and looked at four clinical areas. It found that the hospital was working hard to maintain good infection prevention and control standards, it was clean and not cluttered and staff had a positive approach to infection prevention and control. Cleaning schedules were displayed and the cleaning trolleys were well organised. There were good hand hygiene facilities and staff were 'bare below the elbows'. The commissioner made three recommendations for action and the hospital responded positively and quickly to these. The local authority had awarded the hospital's main and ward kitchens four out of five 'H's ('very good') under its 'H' for Hygiene scheme in May 2010.

We saw some notice boards with a lot of information about cleanliness and infection control, including cleaning records, showing that identified cleaning was being done, and the results of audits. However, the results of the audits tended to be simple graphs which were not readily understandable. Some additional explanation of what was being audited, how the audit had been done and what the results meant would have made them more meaningful to people who were not familiar with them.

We found that the trust monitored and reported on its compliance with infection prevention and control. The director of nursing reported on this in detail to the February 2011 board of directors' meeting. The report included information about audits that had taken place throughout the hospital over three months (October to December 2010). The results were generally good. Inspectors found concerns in two areas but they re-visited them after two weeks and found that improvements had been made. The report also outlined the difficulty that the neonatal unit was

having with bacteria in its new automatic taps. The trust's managers told us that they had taken steps to reduce the risks while they investigated this with the tap manufacturers and had followed guidance provided by the Department of Health. They had fitted filters to the taps and staff were using hand hygiene gel after they had washed their hands. In addition, babies were being washed in bottled water.

We found that the trust had not had any cases of Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia since June 2003 and had had one case of *Clostridium difficile* infection during 2010/11, with no cases for several years before then. The trust investigated the case of *Clostridium difficile* and identified actions to improve the prescribing of antibiotics. Since our visit, the trust has informed us of one case of MRSA bacteraemia.

The commissioner of the service told us that the trust always invited it to attend its infection prevention and control committee meetings and that communication outside the meetings was good so that they did not have any surprises at the meetings.

#### **Our judgement**

People were protected against identifiable risks of acquiring a health care associated infection because of the effective operation of systems and the maintenance of good standards of cleanliness and hygiene. This indicated that the trust was complying with the Department of Health's Code of Practice on the prevention and control of infections.

# Outcome 9: Management of medicines

## What the outcome says

This is what people who use services should expect.

People who use services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 9: Management of medicines

### Our findings

**What people who use the service experienced and told us**  
People told us that medicines to relieve pain were available when they needed them and they were effective. They said “pain relief has been fine”.

**Other evidence**  
Before visiting the trust, we asked the managers for information that showed the trust managed medicines safely. The trust described how it made sure medicines were given appropriately. This included having policies and procedures, providing training to staff, daily reviews of prescription charts by pharmacists, monitoring and auditing practice. It told us its pharmacy service was provided by another trust based on the same site. Staff reported 146 incidents relating to medicines during 2010/11, none of which were serious, and all of which were discussed at its drugs and therapeutics committee. It told us it reviewed alerts relating to medicines and gave examples of how it had checked to see if particular medicines were in stock and how it had improved its practice to make sure that other medicines were used safely.

We found that people’s initial prescriptions were checked against the medicines they were taking before they came into hospital by the pharmacists. The trust’s managers also told us that the pharmacists talked with people on the ante-natal and

gynaecology wards about how they were taking their regular medicines and gave them advice if they found that they were not taking them correctly.

We looked at some records of the medicines people had been prescribed and given and found that all the medicines had been recorded as given. We saw an example of a doctor having been asked to review a person and the medicines she had been prescribed after a blood test showed that something had changed, which had happened very quickly.

We asked people in the hospital if they were able to give themselves their own medicines. People told us that they could, if they were on regular medicines before they came into hospital, but there were no keys to the bedside lockers. On one ward, people told us they were keeping their medicines in their lockers but they had to ask the nurses to open the lockers with the 'master' key so they were not in full control of their medicines. On another ward, people told us they were keeping their medicines in their bags so they were not being stored safely. We asked the trust's managers about this. They looked into this and told us that on one ward, the problem seemed to be that some keys had gone missing and had been found and they had arranged for spare copies of all the keys. They had ordered replacement and spare keys for the lockers on the other ward.

The trust's managers also told us that women were able to give themselves medicines to relieve pain after a caesarean section.

We saw that staff administering medicines were wearing disposable aprons.

We saw that resuscitation equipment and drugs in one clinical area had been frequently checked to make sure it was complete and 'in date'.

The community midwifery team leaders told us that they were able to ask GPs to prescribe people medicines if they needed them. They were also able to administer certain medicines for home births.

When we went into one clinical area, we noticed an ampoule of vitamin K which was not secure at the midwives' station. This was still there when we left the unit. We told the trust's managers about this and they made sure that the ampoule had been taken away.

### **Our judgement**

People received their medicines at the right times and in a safe way.

# Outcome 10: Safety and suitability of premises

## What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 10: Safety and suitability of premises

### Our findings

**What people who use the service experienced and told us**  
We saw that there was a voice activated appointment system for phlebotomy. People who used the service took a ticket and then their number was called electronically for people who had poor eye sight and displayed on a screen for people who had a hearing impairment.

We saw one person arrive in a motorised scooter who had to get out of it to push a button to open the door and move a sign that was in her way. She told us that this was ok and that she chose not to bring a carer or ask for help.

We saw that the neonatal unit had padded flooring so that the babies were not disturbed by noise.

**Other evidence**  
We found that the hospital looked bright and it was a pleasant environment. The wards had a mixture of bays with several beds in them and single rooms. The gynaecology ward had a day room that was also used as a dining room so people were able to leave their bedsides and talk with others.

The neonatal service had moved into a new centre in September 2010 and had a parents' lounge, kitchen area and quiet room, as well as some rooms in a building adjacent to the hospital in which parents could stay overnight. The neonatal

transport team had its own entrance to the hospital.

We found that the maternity and neonatal wards had good security. People could only get in after having asked via an intercom and there were signs reminding people not to let other people follow them in. Babies had 'tags' on them which set off alarms if they were taken out of the area without the 'tags' having been switched off. The trust's managers told us that the alarms went off frequently but people told them they appreciated this level of security.

The antenatal outpatient department was laid out so that urine samples could be handed through a hatch from the toilet area or left in a cupboard for collection, so people did not need to carry samples out of the toilet area.

Some consulting rooms in the gynaecology outpatient department had doors that linked them and some staff said they thought people who used the service sometimes worried that people might come through them unexpectedly. They also said that people could sometimes hear voices from the next room.

The clinical genetics outpatient department was located in a building adjacent to the hospital that had been converted from staff accommodation. It was clean and tidy and had recently had new flooring but was not very welcoming. Other non-clinical services were also based in this building. The chief executive reported to the February 2011 board of directors meeting that a group of staff was looking at ways of improving the reception area in the building and that staff would be cleaning, painting and decorating the area over one weekend in May 2011. The trust's managers told us they were developing plans to improve or replace the building.

The trust's managers told us that the trust employed its own maintenance team which had a planned programme of maintenance work and also responded when things needed to be repaired. They told us there was a 'hot line' telephone number that staff could use and maintenance staff were on call 24 hours a day. Clinical staff told us that the maintenance staff responded quickly if anything needed to be repaired. We did not see anywhere that was not in good repair.

We found that a fire door propped open with a cardboard box and another door tied open. We told the trust's managers about this and they made sure that the doors were closed.

The trust's managers told us that how fire alarms were responded to had changed, in order to reduce the number of unnecessary calls to the fire service. When the fire alarm sounded, a designated member of staff investigated the cause of the alarm. If it was caused by a fire or if the staff member did not respond within three minutes, an emergency call was made to the fire service.

We saw several storage areas which were tidy, with items stored off the floor.

The trust's managers told us that the car parks on the site had won awards for their security and that staff were available to escort trust staff to their cars if necessary.

We looked at the trust's 2010 PEAT scores for issues relating to the premises and found that all 15 were 'much better than expected'.

The trust's managers told us that they had recently installed a new 'energy centre' at the hospital and this was resulting in significantly lower heating and power bills.

**Our judgement**

The hospital provided a safe and well-maintained environment for the delivery of care and treatment.

# Outcome 11: Safety, availability and suitability of equipment

## What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

## What we found

<b>Our judgement</b>
<b>The provider is compliant</b> with outcome 11: Safety, availability and suitability of equipment

<b>Our findings</b>
<p><b>What people who use the service experienced and told us</b> We did not talk with people who used the service about the safety, availability or suitability of equipment</p> <p><b>Other evidence</b> Before visiting the trust, we asked the managers for information that showed the trust had enough equipment and maintained it properly. The trust described its arrangements for maintaining and using equipment correctly, which included having policies and recording information about equipment on specific databases. It told us it serviced equipment in line with the manufacturers' recommendations and said that a check on the delivery suite and neonatal unit in September 2010 had found that all the equipment checked had been serviced within the last 12 months. We saw a hoist in an outpatient department that had a service sticker on it and we saw a person checking all the fire extinguishers, with an extensive plan that showed him where they all were.</p> <p>The trust told us that each directorate reviewed its equipment each year to see if it needed any extra or replacement equipment. It told us that the neonatal unit had ordered extra 'vital signs' monitors through this process.</p>

We asked staff if they had the equipment they needed to care for people and they told us that they did, although one community midwifery team had to share scales which they 'booked' out. In the information it sent us before we visited it, the trust told us it had bought electric beds that meant that people could adjust them for their own comfort. The trust's managers told us that they had plans to replace all the remaining non-electric beds. There were long entonox hoses in the birth centre and telemetry monitoring systems in the delivery suite so that people who needed to use this equipment could remain mobile.

We looked at the neonatal transport team, which collects and transfers new born babies from 16 hospitals within the West Midlands, including Birmingham Women's Hospital. It also transports babies to hospitals outside the West Midlands region if necessary. We found that this team had four transport units and staff told us that there were no issues about equipment not being available. We saw that the babies' incubators in the neonatal unit had been kept covered so that the environment mimicked the womb.

Staff told us that the trust had equipment that could be lent to people who needed it, such as equipment for pregnant women to use to monitor their blood pressure all the time. In the information it sent us before we visited it, the trust gave examples of how people were shown how to use equipment they needed before taking it home.

Staff told us they knew how to use the equipment they needed. One person told us about a midwife who had recently started who did not know how to use a particular syringe driver. She did not use it until she had been shown how to by other members of staff. In the information it sent us before we visited it, the trust told us that each directorate had identified which staff needed to be able to use what equipment and the method and frequency of the training they required, based on the risk to people who used services if it was not used correctly. The directorates kept their own records of training and were working to improve the number of staff who had 'up-to-date' training.

Staff told us that two different departments maintain equipment (the medical physics and the estates departments), depending upon the equipment, but anyone could contact either of them, which meant that people did not have to wait for a specific member of staff to be available to ask for repairs. Staff told us that the service was good and, if equipment was needed urgently, both departments responded quickly. The community midwives told us that they brought their equipment into the hospital so that the medical physics department could check it each year. We did not see any 'out of order' equipment during our visit.

In the information it sent us before we visited it, the trust told us staff reported incidents relating to equipment and it gave an example of a serious incident that had taken place in 2010/11 which had been investigated and reported to the Medicines and Healthcare products Regulatory Agency (MHRA). The trust had been told that the manufacturer had improved the design of the equipment as a result of the investigation.

The trust told us it had procedures in place to act on guidance and alerts relating to equipment issued by manufacturers or other organisations. It told us it reviewed alerts and gave an example of how it had recently checked to see if portable syringe

drivers met new standards and had planned to replace the current syringe drivers with new and additional ones.

The trust reported that one of its seven highest ('red') risks related to analysis machines that were failing to process histology samples reliably. The trust had put controls in place to address the risks and judged these as 'inadequate'. The risk would continue to be reported to the board of directors each month until its actions had reduced the level of risk.

**Our judgement**

The trust managed its equipment to make sure that the right equipment was available to meet the needs of the people who use its services.

# Outcome 12: Requirements relating to workers

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 12: Requirements relating to workers

### Our findings

**What people who use the service experienced and told us**  
We did not talk with people who used the service about the recruitment of staff.

**Other evidence**  
We looked at the files of five staff who had recently started work in the trust. We found that they had photographs of them and information about checks on criminal convictions, references, qualifications and health. The trust’s managers told us that the West Midlands Deanery had a lead role in the recruitment of doctors in training and some of the information was held by the deanery rather than the trust.

One person who had recently started working in the trust said it had checked her identity through driving licences or passports, had obtained a check on whether she had any criminal convictions or not and two references, and had checked her health through an occupational health service. Staff we talked with were aware that a check on criminal convictions would be done every three years. One person who had worked in the hospital for about three years told us that this check had “been done twice”.

One member of staff told us that she had worked in one area until her physical fitness meant that she was not able to. She did a course that helped her regain her confidence and update her skills and returned to work in a different area.

We found that the director of nursing reported to the February 2011 board of directors' meeting that about 80% of staff had a 'current' check on criminal convictions. For staff whose job specifically included safeguarding children and vulnerable adults, about 95% of staff working in the neonatal service and about 90% of staff working in the maternity service had a 'current' check. The trust was aiming to achieve 100% for all staff.

**Our judgement**

The trust carried out relevant checks when staff were employed, to make sure they were fit and physically and mentally able to do their job.

# Outcome 13: Staffing

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 13: Staffing

### Our findings

**What people who use the service experienced and told us**  
People told us that midwives were very supportive and did not rush them when talking with them. People told us “the midwife has been with me constantly, one to one care” and “it has been very quiet and relaxed in here. They have been doing my observations, asking me if I want tea or something to eat. The staff are lovely. Really lovely”.

People said things like “they are brilliant, they answer any questions. They are really friendly and helpful”, “staff are very helpful, kind and approachable”.

One person told us she had used the call bell once and staff had responded straight away.

**Other evidence**  
During our visit, we saw a lot of staff about and we found that staff did not appear to be overly rushed and call bells were not sounding for unacceptable lengths of time.

Staff working in outpatient areas told us that all people were chaperoned whilst intimate examinations were being undertaken. Staff on the delivery suite told us that, when women are in established labour, they get one to one care from a midwife.

Most staff we talked with said they thought that there were enough staff, although some areas could do with more and sometimes there were delays. One member of staff said “I think that we are busy, there is a quick turnover of patients and a lot of complex patients. If everyone works well there are not delays and the staffing levels are ok”.

Staff working in outpatient areas told us that, if colleagues were off work unexpectedly, they would cover their clinics as far as possible amongst themselves. One member of staff told us “I feel that we are a very good team as we all know our job roles. We can step in for each other as everyone is trained to do the same job”. Sometimes the clinics had to be cancelled, for example, if they were at a different site. They did not use ‘bank’ or agency staff, especially for specialist areas.

We found that the clinical areas had a mix of staff who had different roles, some of whom worked part-time. Clinicians were supported by assistants who did such tasks as checking blood pressure and taking blood for tests. Some staff also specialised in specific areas, such as diabetes, and the maternity service ran both consultant-led and midwife-led diabetic clinics.

The local supervising authority (LSA) midwifery officer (who has a leadership role across all the trusts in the strategic health authority area) published an annual report on midwifery and the supervision of midwives’ activities, which included comparative information about staffing levels in 2009/10. The trust’s midwife to birth ratio was 1:28.7, which was better than the ratio of 1:32 for the whole region (range from 1:25.3 to 1:38.67). The trust’s ratio had improved since 2007/08, when it had been 1:34.3 (1:36.8 for the whole region).

At the end of March 2011, the trust reported that three of the trust’s seven highest (‘red’) risks related to staffing levels. The midwife to birth ratio was below the nationally recommended ratio of 1:28, there were not enough consultants to provide the recommended consultant presence on the delivery suite and there were not enough ‘middle grade’ doctors to cover the neonatal unit. The trust had put controls in place to address the risks and judged these as ‘adequate’ for the first two of the risks and ‘uncertain’ for the third. The risks would continue to be reported to the board of directors each month until its actions had reduced the level of risk. At the end of June 2011, the trust reported that new actions had been recorded to control the risks relating to the midwifery staffing levels and the presence of consultants on the delivery suite and that the risk related to the ‘middle grade’ doctors had been reduced to ‘amber’ as cover on the neonatal unit was now also being provided by advanced neonatal nurse practitioners.

The trust’s managers told us that they were going through a period of organisational change in which the numbers and types of staff were being changed in some areas. They said that they had looked at the proposed changes to make sure that patients would still be cared for safely. They also said that they were keeping the changes under review.

### **Our judgement**

People’s needs were met by sufficient numbers of staff. The trust monitored areas where there may not be enough staff or where changes were being made to the

numbers and types of staff.

# Outcome 14: Supporting workers

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by competent staff.

## What we found

### Our judgement

**There are minor concerns**  
with outcome 14: Supporting workers

### Our findings

**What people who use the service experienced and told us**  
We did not talk with people who used the service about the training or support of staff.

**Other evidence**  
We talked with some staff who had started recently. They told us that they had had a two week induction which had included 'shadowing' a colleague. Their colleagues had been very helpful. Their induction had left them feeling confident about what they had to do.

The trust's managers gave us a copy of the one day corporate induction programme, which showed that staff had sessions on a range of issues including resuscitation, infection control, risk and health and safety management, handling patient concerns, and keeping information confidential. One member of staff who had attended it recently described it as "really good". They also gave us a copy of the induction programmes for the junior doctors, which showed that their first three days in the trust were spent learning about clinical and management issues and included both talks and the opportunities to improve their skills.

Staff told us that they had had their annual appraisal. We found that the chief executive reported to the February 2011 board of directors' meeting that 70% of staff had had an appraisal and that the trust's managers were expecting to achieve

their target of 80% by the end of March 2011. At the end of June, the trust reported that 81% of staff had had an appraisal.

Staff told us that they got enough training to do their jobs and they had regular training updates in a variety of topics, such as ante-natal screening, neonatal resuscitation, breast feeding, infection control, patient handling, conflict resolution and fire procedures. A neonatal unit service manager told us that they had two rooms for training and an excellent staff education programme, including a nurse specialist from another local specialist trust who trained staff about the care that babies needed after operations. Staff had scenario based training, such as practising administering medicines, so they had the skills and confidence to do it in a real situation.

We found that the director of workforce and organisational development reported on training during 2010 to the February 2011 board of directors' meeting. He explained that the trust had looked at some different ways of providing training, such as web-based induction training for junior doctors. He also reported on the percentage of staff trained against 48 training programmes identified as statutory and mandatory training. Some of this training was provided by issuing staff with leaflets. 13 programmes had been completed by over 80% of the staff that needed them and these included induction into the trust, awareness about both dignity and respect, and equality and diversity, safeguarding children and vulnerable adults, and infection prevention and hand hygiene. 18 programmes were reported as completed by fewer than 50% of the staff that needed them and these included health and safety awareness and risk management awareness.

The director of workforce told us that the trust had made other improvements to the arrangements for training, which included a review of staff training needs and improvements to the recording and monitoring of attendance at training. He explained that, where training courses were administered centrally by the human resources team, attendance was recorded on the trust's electronic staff record system. There had been a less systematic process for courses that were administered by specific trainers, who kept their own records. This meant that there had been under-reporting of attendance on some statutory and mandatory training. This was being addressed and was steadily improving, with a view to being resolved by the end of June 2011.

At the end of June 2011, the trust reported again on the percentage of staff trained against the 48 statutory and mandatory training programmes. This showed that a larger percentage of the staff that needed them had been trained in 34 (71%) of the programmes. The programmes that had been completed by over 80% of the staff that needed them had gone up from 13 to 16. The programmes that had been completed by fewer than 50% of the staff that needed them had gone down from 18 to 14.

We asked staff about the supervision and support they received. The midwives told us they all had a midwifery supervisor and met with them at least annually. They told us that, if they had any concerns during the year, they would contact their supervisors.

The LSA midwifery officer's most recent annual report on midwifery and the

supervision of midwives' activities included comparative information about supervisors in 2009/10. The authority said that it aimed for a ratio of 1:12 as an optimal standard. The report found that the trust's supervisor to midwife ratio was 1:20, which was worse than the ratio of 1:13.6 for the whole region (range from 1:6.9 to 1:20). The trust's managers told us that they were aiming for a ratio of 1:15 and had been recruiting more midwives to become supervisors. In spite of this higher ratio, the supervisors had met with all the midwives they supervised at least once in the previous year.

The director of nursing's report on safeguarding children during 2010 identified that certain lead professionals did not receive any formal professional support or supervision from the organisation whose responsibility it was to provide it. However, they had an informal, mutual support arrangement with another local specialist trust. Staff managing complex child protection cases and safeguarding co-ordinators had access to supervision.

Some other staff told us that they had supervision sessions with their managers, particularly when they were new to their job, but most did not. The trust's managers told us that newly qualified nurses worked in different areas for a year with mentors and supervisors, who assessed their competence. They told us that they did not have a formal policy on supervision. They had various arrangements to supervise and support staff, including supervision by the people in charge of each shift and by trainers, team meetings, and reviews after incidents. Clinical supervision in gynaecology had been a 'mixed success' and where staff had found it useful, they had continued with it.

Staff told us that they felt that they worked well as a team and that they received good support from their managers. They said that they felt confident to put forward any suggestions or concerns they had about the service to their managers, who were approachable and helpful, "(they are) very good at listening to suggestions down here". Staff told us they had regular team meetings. Several staff said "it's a really nice place to work".

We found that the trust had been running a Listening Into Action programme since the summer of 2010, aimed at improving staff engagement and involvement, so they felt able to make a difference. The chief executive reported to the February 2011 board of directors' meeting that the profile of the events held as part of the programme had risen and that staff were beginning to see themselves as being able to provide solutions to problems and to feel they had a role to play in resolving issues. More than 150 staff were actively engaged in the two most recent groups.

Staff told us that they were currently going through significant organisational change prompted by a reduction in funding to the trust, which was being implemented by their managers, who were the people they would usually go to for support. There were concerns about the changes and staff told us that although they felt able to raise questions, they were not necessarily getting responses. The trust's managers told us that they had originally held open sessions for staff on the changes and why they were needed and were going to hold further sessions on the current position. It was not possible to answer all the questions staff had as movements in one area could have an effect on movements in another. The human resources team were holding sessions for staff who were likely to experience significant change.

The trust's managers said that they had a 'whistleblowing' policy. They were occasionally asked for a copy but staff could also see it on the trust's intranet. They told us there had been no 'whistleblowing' reports in 2010.

Each year, we co-ordinate a staff survey throughout the NHS. We published the results of the survey undertaken towards the end of 2010 in March 2011. For the trust, 16% of the 38 key findings were 'better than average', 31% were 'average' and 53% were 'worse than average'. However, 32% of the key findings that could be compared with the findings from the year before had improved significantly, showing that staff thought things were improving.

### **Our judgement**

People received care from staff who received training relevant to their jobs and annual appraisals. However, the trust was not able to demonstrate that staff had received all the training they needed to carry out their roles. Midwives and some other staff had supervision sessions but many other staff did not have specific time to talk through issues about their role or the people they provide care to.

# Outcome 16: Assessing and monitoring the quality of service provision

## What the outcome says

This is what people who use services should expect.

People who use services:

- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 16: Assessing and monitoring the quality of service provision

### Our findings

**What people who use the service experienced and told us**  
We did not talk with people who used the service about the way the service was monitored.

**Other evidence**  
We found that the trust had a long history of assessing and monitoring the quality of its services. It had published an annual clinical report each year since 1973, which was also externally assessed. It had also published an annual report and accounts since 2002/03 and annual quality accounts since 2008/09.

We found that the directors routinely reported information about quality and safety to the monthly meeting of the board of directors, as outlined in our findings for outcome 4. Some of this information was reported to the part of the meeting held in public and published on the trust's website, while some of it, such as reports on investigations into serious incidents, was reported to the private part of the meeting. The medical director told us that the latest information about the nine patient safety indicators was e mailed to all staff within the trust, as well as to some others such as non-executive directors and commissioners, every Friday in a way that made it easy for people to read them quickly.

The commissioner of the service and Monitor both told us that the trust sent them information about its performance against a range of performance indicators, many of which related to quality and safety and included the information that was reported to the board of directors.

We found that the trust had a committee structure that included a clinical governance committee and an organisational risk and governance committee. Each directorate had a clinical improvement group, reporting to the clinical governance committee. There were reporting schedules for both the clinical governance and the organisational risk and governance committees, setting out when specific quality and safety issues would be reviewed. Other groups looked at specific quality and safety issues in more detail and reported to either the clinical governance committee or the organisational risk and governance committee. The theatre users group, for example, looked at the cases of women returning to gynaecology operating theatres unexpectedly as well as any trends relating to specific operations or surgeons or if any indicators were higher than published rates. The infection control committee looked at the quarterly reports about infection prevention and control from each clinical directorate.

The medical director and the director of nursing told us about how they were assured that they, and the board of directors, were aware of what was happening within the clinical services. They explained that the trust was relatively small, that the medical director continued to work within the clinical services as an obstetrician, and that the director of nursing had worked at the trust for a long time and was very approachable. She also managed the complaints department and saw all the complaints that the trust received. They explained that they had introduced executive 'walkabouts' about a year ago, in which each executive director visited one area each month, often accompanied by either a non-executive director or a governor. These gave staff an opportunity to talk with them about any issues of concern. The reports of these visits were discussed by the executive directors at their weekly meetings and then reported to the board of directors meetings, with an outline of any action that had been taken. The directors told us that some improvements that had been introduced as a result of these 'walkabouts' included a transport service for the collection of specimens and improvements to the medical records department environment.

We found that the trust checked and audited various aspects of its work. Each of the clinical directorates had a programme that identified the audits it planned to complete during 2010/11. The trust published information about the national audits and confidential enquiries in which it participated in its quality accounts for 2009/10 and it reported on the local audits that had been done in that year. It also outlined the actions that it had taken in response to both national and local audits. During our visit, we saw results of checks and audits throughout the hospital. These included checks that resuscitation equipment was complete and 'in date' and audits of cleanliness. We saw some results that were displayed as graphs on notice boards but without any explanation so, although they were 95% or 100% and so seemed to be good, it was not immediately clear what they meant. Staff told us that they had found that the 'journey' for patients in the ante-natal clinic was too long when they did an audit of it and so they made changes. Some service managers told us that their time was divided between working as clinicians and managers but the management time was not always enough for all the things they had to do.

The commissioner of the service told us that the trust had a positive approach to the quality and safety of its services and gave an example of managers being given some feedback about problems and responding by thinking about how they could improve the service.

We found that the several of the trust's laboratories were accredited under the external clinical pathology accreditation system.

We found that the trust had been assessed by the NHS Litigation Authority against its risk management standards for both acute and maternity services in the winter of 2010/11. It had achieved level 1 (meaning that the processes for managing risks had been described and documented) with 100% compliance for the acute standards and 98% compliance for the maternity standards.

We found that the trust had a register of its risks and that the head of corporate affairs reported information about the highest ('red') risks to the monthly meeting of the board of directors. The March report identified seven 'red' risks and noted that one previously 'red' risk had been re-graded to a lower level, showing that the risk register was being actively reviewed and revised. Controls and additional action were outlined for all seven 'red' risks, although the controls for three of the risks were rated as 'adequate', 'inadequate' for another three and 'uncertain' for one.

Staff told us that they knew how to report an incident, if one took place. The trust's managers told us there were local and directorate incident managers who managed incidents within their areas and a trust risk manager who liaised with them and reviewed incidents. Serious incidents were investigated so that the 'root causes' of the incident were identified and the reports of the investigations were presented to the clinical governance committee, the board of directors and the commissioner of the service. Staff told us that they did not always get feedback about the incidents that they reported. We asked the trust's managers about this and they said staff did not always get feedback on individual incidents, but they circulated quarterly reports and newsletters on the main trends and changes that had been made as a result of incidents. Incidents were also discussed in annual reports that were widely circulated. They also said that some specific issues were taken up by the midwifery supervisors with the midwives they supervised.

We found that the trust had reported incidents to the national reporting and learning service run by the National Patient Safety Agency (NPSA) for a number of years. It had a comparatively low number of incidents per 100 admissions. We asked the trust's managers about this and they looked into it. They told us that some patient safety incidents had been reported within the trust but had not been sent on to the NPSA and that they had corrected this. Since April 2010, we received information about the most serious patient safety incidents at the trust from the NPSA. There were about six each month and the reports included information about the trust's investigation into the incidents.

The commissioner of the service told us that the trust reported serious incidents requiring investigation to them and always invited them to attend meetings held to investigate serious incidents and identify the 'root causes' of the incidents. They told us that these meetings were professional and thorough.

**Our judgement**

The trust had systems to monitor the quality and safety of services people receive and to identify and manage risks to people's health and welfare, making improvements where required. The trust made much of the information about the quality and safety of its services available to people who use services and others.

# Outcome 17: Complaints

## What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

## What we found

<b>Our judgement</b>
<b>The provider is compliant</b> with outcome 17: Complaints

<b>Our findings</b>
<p><b>What people who use the service experienced and told us</b></p> <p>We asked people who used the service about complaints and most of them told us they had not had a reason to complain. One person said “I have never had a problem. They have been so good to me”. Another person said “I have never had the need to complain about anything. I am sure if I did I could find out from notice boards or the internet”.</p> <p>Some people told us that they had to wait a long time for their appointments but that “there is no point in complaining. They can’t help being late, it is because they care about people and don’t rush you”.</p> <p><b>Other evidence</b></p> <p>We saw leaflets in the hospital that told people about the Patient Advice and Liaison Service (PALS), which could help sort out problems, and how to make a complaint. The trust also published information about PALS and complaints on its website. It stated that it would learn from people’s experience and take action to prevent the same experience from happening again. It also stated that making a complaint would not affect current or future treatment. The website also had information about the local Independent Complaints and Advocacy Service (ICAS) which could support people through the complaints process.</p>

We asked staff about complaints. They told us that they would try to resolve complaints themselves if possible or they would refer the person to their manager or to PALS or give them information about how to make a complaint. One member of staff who worked in an outpatient area told us that “if a patient has been waiting long I introduce myself and I apologise for the waiting time. I ask them if they want to talk to a member of staff or if they want a PALS leaflet”.

The service managers we spoke to were confident about addressing informal complaints or referring more formal issues to PALS or the complaints manager.

The commissioner of the service told us that the trust’s organisation of PALS had recently changed and it was possibly less effective than before. The trust’s managers told us that one of the things that had changed was that complex concerns were now always dealt with as formal complaints.

The director of nursing reported information about responding to complaints to the monthly meeting of the board of directors. The trust aimed to respond to 80% of complaints on time and its performance fluctuated during the 2010/11 year.

She also reported on complaints and PALS contacts every three months to the clinical governance committee and gave us a copy of a report on PALS and complaints for October to December 2010. The trust had received 114 complaints in 2009/10 and 107 from April to December 2010, which was an increase on the same period in 2009. The report included detail about meetings that had been held with people who had not been satisfied with the trust’s initial response and said that five of the six had appeared satisfied with the outcome as a result of the meeting. It also identified improvements that were to be made as a result of complaints.

The reports that the clinical directorates compiled each quarter for the clinical governance committee included summary information about the complaints that had been received and the improvements made.

Information about complaints and improvements was also published in the annual clinical report and the annual report for 2009/10, and so was available to people who used services and the general public.

We found that the parliamentary and health service ombudsman had received 13 complaints about the trust in 2009/10. The ombudsman assessed all the complaints it received and did not take any further action in relation to any of them.

### **Our judgement**

The trust had systems in place to investigate and respond to comments and complaints but responses were not always made in a timely manner.

# Outcome 21: Records

## What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 21: Records

### Our findings

**What people who use the service experienced and told us**  
Some pregnant women told us that staff “write everything in the big file and the green notes” and “I have not seen a care plan but everything is recorded in my green notes. They go everywhere with me”.

Other people told us “my records have always been available, when I have come to the clinic”.

**Other evidence**  
Staff told us that pregnant women kept their own case notes (their ‘green notes’) and were asked to bring them to all their appointments. The community midwives then recorded information in them. They also recorded information into the family doctor computer systems. The trust also had a set of clinical records for each pregnant woman. These were used for filing blood tests etc during the pregnancy but the community midwives also recorded sensitive information in them, such as information about concerns for the safety of the woman or the baby. The advantages of pregnant women keeping their own case notes included that they and all the health professionals they saw had access to information about their pregnancy. The disadvantages included that the midwives and the trust did not have

access to this information for monitoring progress, auditing practice or investigating complaints.

Staff told us that they were able to find the information they needed in the clinical records and the files we looked at were well ordered and up-to-date.

We looked at some clinical records in the special care baby unit and saw that records of 'vital signs' observations such as temperature and blood pressure were kept at the end of the cot so they were readily available but the main clinical records were kept out of the way, under the incubator, so they were nearby but could not be read by people passing by.

We saw a 'whiteboard' that folded so that information about particular people was kept hidden from people passing by.

We saw a lot of clinical records in the outpatient departments and on the wards but they were not unattended by staff. The clinical records for the ante-natal clinic were stored in the clinic reception area, which was kept locked out of 'office hours' and staffed by two people when open. The medical records department was on the ground floor and was kept secure.

The human resources team kept the medical staff files but all other staff files were kept by the departments in which the staff worked.

The strategic health authority told us about an incident in which a camera card containing photographic images had been mislaid. The trust's managers told us that they had made changes that would mean that cards should not be mislaid again, written to all the families concerned and reported it to the organisations they thought it should be reported to.

We were able to find a lot of information about the trust from its website. We asked the trust's managers for information about various things and they were generally able to produce these within the timescale we set. They were not able to produce accurate information about the numbers of staff who had attended some training courses, as described in outcome 14 but they told us this was being addressed and was steadily improving, with a view to being resolved by the end of June 2011.

### **Our judgement**

The trust kept records about the people who use the service, the staff who work there and how the hospital is managed. The trust stored these records securely and made sure they remained confidential.

## Action

we have asked the provider to take

### Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Diagnostic or screening procedures	14	5 (Meeting nutritional needs)
Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p><b>Why we have concerns:</b> People had a choice of food and were able to obtain food outside mealtimes if necessary. People with special diets were able to get the food they needed. The food on one ward was sometimes “lukewarm” when it was served.</p>	
Diagnostic or screening procedures	19	17 (Complaints)
Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p><b>Why we have concerns:</b> The trust had systems in place to investigate and respond to comments and complaints but responses were not always made in a timely manner.</p>	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

# Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Diagnostic or screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	23	14 (Supporting workers)
<p><b>How the regulation is not being met:</b>            People received care from staff who received training relevant to their jobs and annual appraisals. However, the trust was not able to demonstrate that staff had received all the training they needed to carry out their roles. Midwives and some other staff had supervision sessions but many other staff did not have specific time to talk through issues about their role or the people they provide care to.</p>		

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

# What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.


## Information for the reader

<b>Document purpose</b>	Review of compliance report
<b>Author</b>	Care Quality Commission
<b>Audience</b>	The general public
<b>Further copies from</b>	03000 616161 / <a href="http://www.cqc.org.uk">www.cqc.org.uk</a>
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## Care Quality Commission

<b>Website</b>	<a href="http://www.cqc.org.uk">www.cqc.org.uk</a>
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<b>Postal address</b>	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA

**ACTIONS TO MAINTAIN COMPLIANCE WITH OUTCOME 5 (CATERING)**

	COMMENT	ACTION	WHO	WHEN	COMPLETE	AUDIT
	To ensure that food temperatures are within the safe parameters and acceptable to patients.	<ul style="list-style-type: none"> <li>Undertake temperature monitoring on Ward 8.</li> <li>Review findings.</li> </ul>	P.C.	1 week from 28 <sup>th</sup> June 2011. 6 <sup>th</sup> July 2011	Completed – results attached.   \\stanmore\userhome\OBSCP\Jar	
		<ul style="list-style-type: none"> <li>Undertake patient satisfaction survey across all wards.</li> <li>Produce summary report.</li> </ul>	P.C.	First 2 weeks in July 2011.  By end of July 2011.	New system introduced for bed bound patients, patient see order form <a href="G:\Facilities\PAM\Lunch Menu patients.doc">G:\Facilities\PAM\Lunch Menu patients.doc</a>  New survey deferred to w/c 5.9.11 to allow impact of new system  Report on Patient survey results to produced mid September	
		<ul style="list-style-type: none"> <li>Continue current process of random temperature checks across all wards at the point of service.</li> </ul>	P.C.	Ongoing	On going	

**ACTIONS TO ACHIEVE COMPLIANCE (14)**

	<b>COMMENT</b>	<b>ACTION</b>	<b>WHO</b>	<b>WHEN</b>	<b>COMPLETE</b>	<b>AUDIT</b>
	The Organisational Risk and Governance Committee to receive quarterly monitoring on training update.	Most recent quarterly compliance update was reported to the committee on 11 August 2011.	Director and Deputy Director of Workforce & OD	11 <sup>th</sup> August 2011	11 <sup>th</sup> August 2011, next report due in three months' time	
	Consulted staff side unions about a new policy on incremental pay linking it to satisfactory attendance, appraisal and training uptake. Rejected by the Unions but formally approved by the Trust in June. This will be key to driving further improvements in the coming year.	To implement incremental pay policy linked to attendance, appraisal and training uptake.	Director of Workforce & OD	Being implemented in October 2011, subject to reported Staff Side / Trades Unions Dispute		
	National requirements for the Information Governance Toolkit training by 30 <sup>th</sup> June, activity focussed on ensuring uptake in this area in the months of April to June 2011.	<p>1. Plan to provide a new campaign proposal for (a) Risk Management and (b) Health and Safety training.</p> <p>2. Continue to monitor uptake at the Directorate Performance Meetings as well as the quarterly Organisational Risk and Governance Committee.</p>	<p>Director of Workforce &amp; OD with Risk Manager</p> <p>Director of Workforce &amp; OD</p>	<p>(a) Health and Safety – 30<sup>th</sup> September 2011 and (b) Risk 31<sup>st</sup> October 2011.</p> <p>Quarterly</p>		

	Achieve target of 85% appraisal target within 2011/12	<p>1. Report to Board of Directors on a monthly basis through Workforce metric dashboard. Executives to monitor with Directorate Management Teams at monthly Performance meetings</p> <p>2. Review Trust appraisal policy paperwork to incorporate explicit prompts for managers to use appraisal process to review compliance with Mandatory and Statutory training.</p>	<p>Director of Workforce &amp; OD</p> <p>Senior HR Manager</p>	<p>On-going monthly</p> <p>End October 11</p>		
	Not all clinical areas are covered by structures that explicitly include scheduled opportunities for staff to discuss issues about their role or the people they provide care, treatment and support to. Information does not identify how supervision arrangements are monitored and reviewed	Develop Trust wide clinical supervision guidelines/policy	Senior Nurse Education & Professional Development	End December 11		
	Midwives and some other staff had supervision sessions but many other staff did not have specifically allocated sessions to talk through issues about their role and the people they provide care to.	<p>1. Midwifery supervision and other clinical supervision sessions already in place are to continue.</p> <p>2. The Gynaecology Directorate and Maternity</p>	<p>Supervisors of Midwives and other ward managers</p> <p>All ward managers and</p>	<p>On going</p> <p>To commence in October</p>	<p>On going</p> <p>On going</p>	<p>Staff feedback</p>

	<p>Directorate are to include clinical supervision as part of their team meetings. Staff will be able to talk about practice issues and or difficult cases and receive supervision and support. Minutes will be kept of these meetings.</p> <p>3. The Neonatal Directorate is to commence Clinical Supervision sessions for staff, where possible the Clinical Psychologist will also be invited to attend these meetings. The sessions will be divided by nursing band in order to address issues particularly pertinent to that group of nurses. These meetings will be minuted.</p> <p>4. The Neonatal Directorate will continue to hold multidisciplinary 'debrief' meetings following a difficult incident or case. Anonymous notes are taken at these meetings.</p> <p>5. 'Schwartz Rounds' supported by the Kings Fund and the Trust are to be piloted in the Neonatal</p>	<p>team leaders to be led by the Head of Nursing for Gynaecology and the Head of Midwifery</p> <p>Led by the Head of Neonatal Nursing</p> <p>Lead clinician</p> <p>Patient Experience Lead, Neonatal Clinical Director</p>	<p>2011.</p> <p>To commence in October 2011. Each band will have a formal session four times per year. However individually requested 1:1 sessions will continue.</p> <p>On going as required.</p> <p>December/January 2011/12</p>	<p>On going</p> <p>On going</p> <p>On going</p>	<p>questionnaires and the staff survey.</p> <p>Staff feedback questionnaires and the staff survey.</p>
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		Directorate if successful these will be rolled out across the organisation.				
	Information provided about attendance on mandatory training programmes does not provide assurance that all staff are receiving appropriate training.	<p>1. Appraisal policy review mentioned above will provide assurance</p> <p>2. Establish task and finish group from TED members to review and revise monitoring systems/follow for DNA's in line with Mandatory &amp; Statutory training policy</p> <p>3. Develop and publicise simple Mandatory &amp; Statutory training requirement templates for staff roles</p> <p>4 Introduce National Learning Management System (NLMS) as an additional training resource across the Trust</p>	<p>Senior HR Manager</p> <p>Senior Nurse Education &amp; Professional Development / Senior HR Manager</p> <p>Training Leads / Senior Nurse Education &amp; Professional Development / Senior HR Manager</p> <p>Project group - Director of Workforce, Deputy Director, Senior HR Manager, Workforce Information Officer &amp; General Manager Genetics</p>	<p>End October 11</p> <p>Commence 31<sup>st</sup> August and complete end December 11</p> <p>End Dec 11</p> <p>Commence w/c 22<sup>nd</sup> Aug 11 - end March 2012</p>	<p>Commenced</p> <p>Commenced</p> <p>Commenced</p>	

		5 Monitor attendance reports via TED and report /quarterly to ORAG	Director of Workforce & OD (ORAG), Senior HR Manager (TED)	End Oct 11		
		6. Review Study Leave Policy & learning contracts	Senior HR Manager	End Dec 11		

**ACTIONS TO MAINTAIN COMPLIANCE WITH OUTCOME 17 (COMPLAINTS)**

	<b>COMMENT</b>	<b>ACTION</b>	<b>WHO</b>	<b>WHEN</b>	<b>COMPLETE</b>	<b>AUDIT</b>
	All patients who raise concerns should have their complaint investigated and responded to in a timely manner.	<ul style="list-style-type: none"> <li>The investigator should call the complainant from the outset and agree a date.</li> </ul>	Directorate Managers	Within 5 working days of receiving the complaint	Gynaecology and NNU comply Maternity do not always comply	Logged on Datix and available for Auditors
		<ul style="list-style-type: none"> <li>Directorates to set realistic and acceptable timescales.</li> </ul>	Directorate Managers	On a case by case basis and provided to complainant within 5 days of receiving complaint	All directorates supply response dates, but these are not always achieved	Logged on Datix and available for Auditors
		<ul style="list-style-type: none"> <li>If a Directorate cannot meet the deadline they need to provide detailed reasons to be put in the holding letter.</li> </ul>	Directorate Managers/Complaints Department	Reasons for delay provided by Directorate and sent in holding letter or given by telephone by Complaints Department when it becomes evident response date will not be achieved		Logged on Datix and available for Auditors
	Directorates have a target to achieve response times on time in a minimum of 80% of cases.	<ul style="list-style-type: none"> <li>To monitor monthly.</li> </ul>	Complaints Department	Weekly update reminders sent and Monthly - monitoring	Ongoing monitoring on a Monthly and &	Logged on Datix and available for Auditors

		<ul style="list-style-type: none"><li>• Report to Clinical Governance Committee and Board of Directors quarterly.</li></ul>	JO	Quarterly	Quarterly basis – reported to Management Board and Clinical Governance Committee	
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# Birmingham Women's

## NHS Foundation Trust



<b>SUBJECT :</b>	Revised Trust Risk Management Strategy
<b>REPORT BY :</b>	Jane Owen
<b>AUTHOR :</b>	Coralie Rogers

### **CONTEXT AND BACKGROUND FOR REPORT**

The Trust-wide Risk Management Strategy has been amended as part of a scheduled annual review.

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

The major changes of the document include

- Some definitions and role responsibilities updated for clarity
- Inclusion of the role of the Quality and Effectiveness manager
- The frequency for review of this policy has been changed from annual to triennial

### **RECOMMENDATIONS**

To note and approve the changes



# Trust-wide Risk Management Strategy

Policy category and number:	A RM4
Version:	8.1
Name of approving committee:	Board of Directors
Ratified by:	Board of Directors
Date ratified:	29 <sup>th</sup> July 2010
Date issued:	29 <sup>th</sup> July 2010
Review date:	29 <sup>th</sup> July 2012
Name of Lead Officer	Peter Thompson
Name of originator/author:	Coralie Rogers
Job title of author:	Acting Risk Manager
Target audience:	Trust-wide

## Version Control

Version	Date	Author	Status	Description of Amendment
1.0	February 2003	Diane Halliley, Risk Manager	Archived	
2.0	October 2004	Diane Halliley, Risk Manager	Archived	
3.0	October 2006	Diane Halliley, Risk Manager	Archived	
4.0	October 2007	Malcolm Bowcock, Clinical Effectiveness Manager	Archived	
5.0	January 2009	Cath Roper, Risk Manager	Archived	
6.0	August 2009	Cath Roper, Risk Manager and Michelle Walsh, Clinical Effectiveness Facilitator	Archived	
7.0	29 <sup>th</sup> July 2010	Jane Owen, Director of Nursing, Midwifery and Operations and Michelle Walsh, Clinical Effectiveness Facilitator	Approved	
8.0	1 <sup>st</sup> July 2011	Coralie Rogers Acting Trust Risk Manager	Approved	Reflecting ORAG changes
<b>8.1</b>	1 <sup>st</sup> September 2011	Coralie Rogers Acting Trust Risk Manager	Draft	Updated structure Removed business continuity section – for inclusion in separate policy. Updated some definitions

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## **1. Introduction**

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

## **2. Objectives**

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

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

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

## **3. Policy Scope**

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

It is recognised that risk management encompasses more than the reporting of incidents and the strategy outlines management arrangements for the identification, assessment, treatment and monitoring of all risk, whether clinical or non-clinical.

## 4. Indemnity Statement

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

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

## 5. Document Definitions

### 5.1 Risk

Can be defined as uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. These may be

#### 5.1.1 Clinical risks

A risk which arises directly from the delivery on healthcare, and directly impacts on patients.

#### 5.1.2 Non-clinical

Those risks where the potential for or impact of the risk does not directly impact on the care that the patient is receiving.

#### 5.1.3 Risk subtype

Risks may be further subcategorised from either of the above types into the following sub-types

- Clinical
- Compliance with national or professional standards
- Infection control
- Health and safety (including fire and security)
- Information Governance
- Financial
- Reputation
- Organisational
- Operational
- Strategic

### 5.2 Risk Management

is the process for

- the identification of those risks which may have (proactive) or have already had (reactive) adverse effects on the quality, safety and effectiveness of care and service delivery,
- the assessment and evaluation of those risks and positive action to eliminate or reduce them

### **5.3 Risk Assessment**

Risk assessment is a systematic and effective way of identifying risks and determining the most cost effective means to maintain, minimise or remove them. It encompasses the processes of risk analysis and risk evaluation

### **5.4 Inherent Risk**

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

### **5.5 Residual Risk**

The exposure arising from a specific risk after effective action has been taken to manage it.

### **5.6 Risk Appetite**

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

### **5.7 Control**

Is any action, originating within the organisation, taken to manage risk.

### **5.8 Risk Profile**

Is the documented and prioritised overall assessment of the range of specific risks faced by the organisation.

### **5.9 Assurance**

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

## **6. Duties and Responsibilities**

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

The following have specific roles in the risk management system:

### **6.1 Board of Directors**

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

### **6.2 Chief Executive**

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

- Continuously demonstrating personal commitment and support for the promotion of risk management and an open and fair culture
- Ensuring that a risk management structure is in place to encompass all elements of risk and that a reporting framework is in operation to enable the Board of Directors to be assured that the risks, in accordance with agreed quality of service and the risks associated with the organisation, are effectively managed

- Ensuring that Executive Directors are assigned responsibilities for the management of clinical and non-clinical risks
- Overseeing the handling and monitoring of complaints and litigation claims arising from direct patient care.

### **6.3 Executive Directors**

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

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

### **6.4 Non-Executive Directors**

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

### **6.5 Medical Director**

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

- Responsibility for delivering clinical governance in the Trust
- Chair of Clinical Governance Committee
- Lead of the Clinical Governance Directorate
- As part of the Executive Team, conducts and receives feedback from Executive Walk Rounds (with exception of their own directorate) for presentation to the Board of Directors.
- Lead Executive Director with responsibility for Maternity Services at Board of Director level:
  - Meets monthly with the Maternity Services Clinical Director through CGC and Management Board
  - Attends Maternity Services Directorate Consultant Obstetricians meeting monthly
  - As chair of CGC, receives Maternity Directorate QI reports, reviews

the Maternity Directorate risk register and receives escalated risks, including newly designated red clinical risks

- Ensuring that systems are in place to provide an educated, skilled and competent medical staff workforce within the Trust
- Managing the strategic development and implementation of clinical risk management and clinical governance
- Meeting the clinical risk management conditions of the NHS Litigation Authority
- Ensuring the development of the Health and Social Care Regulations, monitored by the Care Quality Commission
- Responsible for advising on legislation and guidance
- Responsible for bringing all red risks to the attention of the Chief Executive
- Participate in the reporting to external organisations of red risks / serious incidents where appropriate.
- Ensuring root cause analyses are carried out where required and in the case of serious incidents, that an executive director leads the process.

### **6.6 Director of Nursing, Midwifery and Operations**

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

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

### **6.7 Director of Workforce and Organisational Development**

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

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

### **6.8 Director of Finance**

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

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## **6.9 Trust Risk Manager**

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

## **6.10 Lead Clinician for Clinical Risk (Trust Wide)**

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

## **6.11 Quality and Clinical Effectiveness manager**

- Project manages processes for participation in external assessment for CNST Maternity Risk Management Standards
- Is a member of the Clinical Governance Committee

## **6.12 Directorate Responsibilities**

Each Clinical Director is responsible for the implementation of risk management within their directorate, supported by other professional staff with Clinical Governance / Risk Management responsibilities. These responsibilities are defined in the individual job descriptions and in the local Directorate Risk Management Strategy. In addition, other policies referred to in this document specify roles and responsibilities for risk assessment, managing the risk register and dealing with incidents, complaints and claims. Local risk management strategies include:

- Maternity Directorate Risk Management Strategy
- Gynaecology Directorate Risk Management Strategy
- Genetics and Laboratories Services Risk Management Strategy
- Neonatal Directorate Risk Management Strategy

## **7. Procedures**

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

### **7.1 Risk Prevention**

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

### **7.2 Reporting, Investigating and Learning from Incidents, Complaints and Claims**

All staff have a duty to adhere to the principles of the following policies:

- Incident Reporting and Investigation Policy
- Managing Patient Concerns, Complaints and Compliments Policy and Procedure
- Claims Handling Policies and Procedures
- Aggregating Data and Sharing Learning from Incidents, Complaints and Claims Policy
- Being Open. Policy to be Followed When Patients Come to Harm.

### **7.3 Risk Identification**

This is the process of identifying what has happened or could happen, why and how, as described in the Trust Risk Management Policy. Once a risk has been identified, it should be assessed.

### **7.4 Risk Assessment**

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

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

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

### **7.5 Recording and management of Risks**

The Risk Management Policy describes the process of how risks are treated and controlled, and the method by which the risk register is populated and reviewed throughout the Trust.

Risks are also subject to an in-depth review by the two board sub-committees responsible for risk CGC and ORAG, and by the Board of Directors, as described in section 7.9.1 of this strategy.

## **7.6 Escalation of Risk Issues**

All assessors of risk should attempt to take immediate action to reduce newly identified risks. Where a newly identified risk is evaluated as high or extreme, or where it cannot be considered adequately controlled, then the risk must be immediately escalated to the line manager, or 'out of hours' to the operational manager via hospital cover. This process also applies to existing risks where the rating or control changes following an incident.

The full process for immediate escalation of risk is described in The Risk Management Policy

## **7.7 Business Continuity Management**

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

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

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

## **7.8 Action Planning**

Risks, incidents, complaints and claims should all have action plans to identify next steps, responsibilities and time scales. Implementation of action plans should be monitored via local directorate groups and lessons learned shared in the quarterly quality indicator (QQI) reports. Trust-wide action plans should be monitored by the appropriate Trust-wide group or committee.

The directorate management teams have responsibility for ensuring staff are aware of the actions identified within their specific area of work.

## **7.9 Monitoring and Reviewing Risk**

### **7.9.1 Internal monitoring**

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

All directorates are expected to:

- Report incidents (Incident Reporting and Investigation Policy)
- Listen and respond to patient concerns and complaints (Managing Patient Concerns, Complaints and Compliments Policy and Procedure)
- Manage clinical and non-clinical claims (Claims Handling Policies and Procedures)
- Investigate all incidents, complaints and claims

- Review all of the above for common trends (Aggregating Data and Sharing Learning from Incidents, Complaints and Claims Policy)
- Undertake proactive and reactive risk assessments (The Risk Management Policy)
- Populate and review the risk register, ensuring that controls are put in place to minimise risks and that residual risks are escalated to the appropriate levels (The Risk Management Policy)
- Produce action plans where a change in practice is identified as a result of any of the above.

Directorates Risk Management Strategies should describe the local processes in place to implement, review and monitor all of the above. A Directorate Risk Management Strategy template is available on the Trust Intranet, which contains the minimum data requirements relating to risk management processes.

The Trust will monitor the above through the Clinical Governance Committee and the Organisation Risk and Governance Committee, which are the two sub-committees of the Board of Directors with responsibility for risk.

The Clinical Governance Committee has primary responsibility for risks within the clinical work of the Trust, as set out in their terms of reference. CGC will monitor implementation of this strategy by consideration, discussion and overview of the following:

- Quarterly Quality Indicator reports from the Directorates regarding numbers, types, details and trends of clinical and non clinical incidents, complaints, and claims.
- Quarterly Trust-wide Clinical Incident Reports produced by the Risk Manager
- Quarterly Trust-wide Clinical and Non-clinical Complaints Reports produced by the Complaints Manager
- Quarterly Trust-wide Clinical Claims Reports produced by the Head of Legal Services
- Monthly review of selected clinical risks on the Risk Register, examining the Directorates risk registers in rotation in line with the CGC reporting schedule
- Monthly review of any newly designated red clinical risks
- Annual risk assessment of corporate objectives
- Considering reports of RCAs undertaken in the directorates

The Organisational Risk and Governance Committee has primary responsibility for risks that affect the corporate and non-clinical work of the Trust, as set out in their terms of reference. ORAG will monitor implementation of this strategy by consideration, discussion and overview of the following:

- Quarterly Trust-wide Non-clinical Incident Reports produced by the Risk Manager
- Six-monthly Trust-wide Non-clinical Claims Reports produced by the Head of Legal Services
- Six-monthly Trust-wide Non-clinical Complaints Reports produced by the Complaints Manager
- Review of corporate red risks on the Risk Register at each meeting
- Review of corporate amber risks on the Risk Register at every second meeting
- Annual risk assessment of corporate objectives.

The Board of Directors will have an overview of the Trust's risks by receiving the following reports:

- Monthly Review of Red Risks on the Risk Register
- Quarterly Review of amber risks on the risk register
- Annual report on concerns raised at work from the audit committee
- Quarterly Progress against the Corporate Objectives
- Monthly Integrated Performance Report / Dashboard
- Monthly Patient Safety Reports
- Annual Review of Clinical and Non-clinical Incidents, Complaints and Claims
- Minutes of CGC and ORAG
- QCI Reports
- Annual audit of CGC and ORAG terms of reference
- Assurance from Internal and External Audit
- Compliance levels with National Standards, including Monitor and the Care Quality Commission
- Compliance levels with the NHSLA Risk Management Standards
- Annual Review of the Board Assurance Framework
- Annual Statement on Internal Control
- Feedback from executive walk rounds

### **7.9.2 External Monitoring**

This is undertaken by the NHS Litigation Authority (NHSLA) through the Clinical Negligence Scheme for Trusts (CNST) Maternity Standards assessments and the NHSLA Risk Management Standards for Acute Trusts assessments. All staff must be familiar with, and comply with the NHSLA Risk Management Standards for Acute Trusts and proactively work towards compliance with Level 3 status. In addition where applicable, staff must actively work to achieve the requirements of CNST Maternity Standards at Level 3.

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

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

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

## **7.10 Support for Staff**

### **7.10.1 Communication**

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

All Trust policies and procedures are developed following the Trusts 'Policy for the Development, Distribution and Maintenance of Trust Policies and Procedural Documents' and are available to all staff via the intranet.

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### 7.10.2 Training

Risk management awareness training is provided to staff as identified in the Trust Training Needs Analysis within the Trust Mandatory and Statutory Training Policy.

The Trust Mandatory and Statutory Training Policy also states how training requirements are identified using information from incidents, complaints, claims, risk assessments, the risk register and audits.

### 7.10.3 Support for staff involved in serious adverse clinical events

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

## 8. Review, Monitoring, and Revision Arrangements

All Trust policies / guidelines will be monitored for compliance in one of three ways:

- **Review** is normally proactive and designed to evaluate the effectiveness of systems and processes;
- **Audit** is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria;
- **Continuous Audits** are repeated audit cycles to ensure new controls can be identified and tested as they arise.

Where deficiencies have been identified through any of the above, there must be evidence that recommendations and action plans have been developed and changes implemented.

The frequency and detail of the monitoring process is described in the table below:

Monitoring	Method	Frequency	Lead	Reporting to
Update Strategy	Review	Every three years	Risk Manager	Board of Directors
Risk management reporting processes as listed in section 7.9.1 of this strategy	Review agenda, minutes & papers of Directorate and/or CIG, CGC, ORAG and BoD	Annual	Risk Manager	Board of Directors

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

Monitoring of the quality of specific risk management processes will be detailed in policies and procedures listed in section 9 of this strategy.

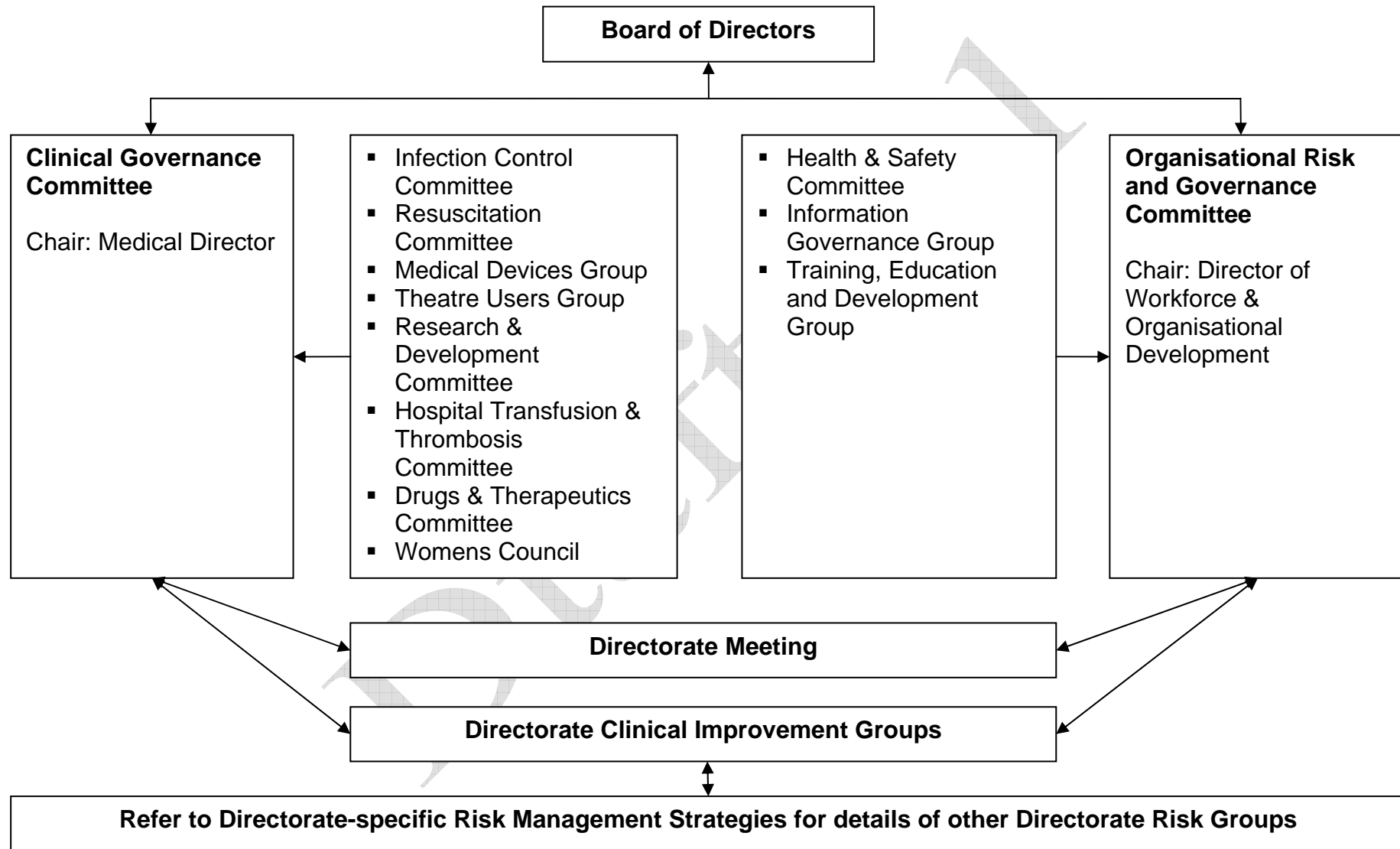
## 9. Associated Documents

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

## 10. References

- Risk Management in the NHS. NHS Executive 1994
- HSC 1998/ 113 A First Class Service. Quality in the new NHS
- HSC 1999/ 065 Clinical Governance. Quality in the new NHS.
- Clinical Risk Management for Obstetricians and Gynaecologists - Clinical Governance Advice No 2 . RCOG January 2001
- NHSLA Risk Management Standards for Acute Trusts Standards January 2010. NHS Litigation Authority
- The Orange Book, Management of Risk - Principles and Concepts. October 2004. HM Treasury
- Risk Management Strategy 2008-2010. University Hospitals Birmingham NHS Foundation Trust 2008
- Standards Australia (1999) *Risk Management AS/NZS 4360: 1999*
- NPSA, January 2008, A Risk Matrix for Risk Managers

## Appendix A – Trust Risk Management Structure



## Appendix B – Plan for Dissemination of Procedural Documents

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

<b>Title of document:</b>	Trust Risk Management Strategy		
<b>Date finalised:</b>	29 <sup>th</sup> July 2010	<b>Dissemination lead: Print name and contact details</b>	Jenna McGlinchey Ext 2695
<b>Previous document already being used?</b>	Yes		
<b>If yes, in what format and where?</b>	Intranet		
<b>Proposed action to retrieve out-of-date copies of the document:</b>	Archive previous version and replace with version 7.		
<b>To be disseminated to:</b>	<b>How will it be disseminated, who will do it and when?</b>	<b>Paper or Electronic</b>	<b>Comments</b>
All Staff	Intranet	E	

### Dissemination Record to be used once document is approved.

<b>Date put on register / library of procedural documents</b>	29 <sup>th</sup> July 2010	<b>Date due to be reviewed</b>	29 <sup>th</sup> July 2011	
<b>Disseminated to: (either directly or via meetings, etc)</b>	<b>Format (i.e. paper or electronic)</b>	<b>Date Disseminated</b>	<b>No. of Copies Sent</b>	<b>Contact Details / Comments</b>
Trust Wide	Electronic	29 <sup>th</sup> July 2010	0	Staff informed updated copy available on the intranet

## Appendix C – Equality Impact Assessment Tool

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

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

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

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

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

## Appendix D – Policy Checklist

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

	Title of document being reviewed:	Yes/No/Unsure	Comments
<b>7.</b>	<b>Approval</b>		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
<b>8.</b>	<b>Document Control</b>		
	Has a version control sheet been placed at the front of document, and been filled out correctly?	Yes	
<b>9.</b>	<b>Process to Monitor Compliance and Effectiveness</b>		
	Is there a plan to review or audit compliance with the document?	Yes	
<b>10</b>	<b>Review Date</b>		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
<b>11</b>	<b>Equality Assessment</b>		
	Has an equality impact assessment been carried out?	Yes	
<b>Individual Approval</b>			
If you are happy to approve this document, please sign and date it below, and put the document onto the DMS for final approval			
Name	Peter Thompson	Date	29 <sup>th</sup> July 2010
Signature			
<b>Committee Approval</b>			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Steve Peak	Date	29 <sup>th</sup> July 2010
Signature			