

# Birmingham Women's



NHS Foundation Trust

## PUBLIC SESSION

MEETING OF THE BOARD OF DIRECTORS  
to be held in the Seminar Room, Birmingham Women's Hospital  
on Thursday 24<sup>th</sup> September 2009 at 11 am

## AGENDA

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**1 Welcome and apologies**

Apologies should be sent to Jackie Howell at  
jackie.howell@bwhct.nhs.uk, tel 0121 627 2601

**2 Questions from the public on matters relating to the agenda**

**3 Declarations of interest**

Directors are asked to declare any interests relating to any of the  
items on the agenda

**4 Minutes of the meeting held on 27<sup>th</sup> August 2009**

To APPROVE the minutes of the meeting held on 27 August  
2009

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**5 Matters arising from the minutes of the meeting held on 27  
August 2009 (where not covered by agenda items)**

**6 Trust Chair's report**

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**7 Meeting of Board in private session**

To NOTE that representatives of the press and other members  
of the public were excluded from an earlier session of the  
meeting having regard to the confidential nature of the business  
which was transacted, publicity on which would be prejudicial to  
the public interest.

**8 Report by the Chief Executive**



SP


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**PATIENT EXPERIENCE AND IMPROVING CLINICAL  
PERFORMANCE**



9	<b>Red Risk Register and Assurance Framework</b> To CONSIDER the Red Risk Register and Assurance Framework	SIP	3	 J:\BOARD OF DIRECTORS\2009\I- !  J:\BOARD OF DIRECTORS\2009\I- !
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10	<b>Safeguarding Children and the Care Quality Commission Review</b>	JO	4	 J:\BOARD OF DIRECTORS\2009\I- !
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11	<b>Mid-Staffs- Monitor internal audit report and response</b>	SP	5	 J:\BOARD OF DIRECTORS\2009\I- !  J:\BOARD OF DIRECTORS\2009\I- !  J:\BOARD OF DIRECTORS\2009\I- !
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12	<b>Inpatient Survey</b>	JO	6	 J:\BOARD OF DIRECTORS\2009\I- !
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**ASSURANCE**

13	<b>Review of state of readiness for pandemic influenza</b>	JO	7	 J:\BOARD OF DIRECTORS\2009\I- !  J:\BOARD OF DIRECTORS\2009\I- !
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**ORGANISATIONAL PERFORMANCE**

14	<b>Integrated Performance Report</b> To CONSIDER the report	JO JaB	8	
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15 **Planning Process**

SP

**ORAL**

**MEMBERS' COUNCIL MATTERS**

16 **Report from Members' Council Chair**  
*- Members' Council, 21<sup>st</sup> September 2009*

IB

**Oral**

17 **CLASS 'A' TRUST POLICIES FOR APPROVAL**

18 **SEALING REGISTER**

SIP

**9**



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**Dates of next meetings**

Thursday 29<sup>th</sup> October 2009  
Thursday 26<sup>th</sup> November 2009  
Thursday 17<sup>th</sup> December 2009

# Birmingham Women's



## NHS Foundation Trust

**Unconfirmed Minutes of the  
MEETING OF THE FOUNDATION TRUST BOARD  
HELD IN PUBLIC  
in the Seminar Room, Birmingham Women's Hospital,  
on Thursday 27 August 2009**

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

### ACTION

**FTP/0809/1 WELCOME AND APOLOGIES**

FTP/0809/1.1 No apologies for absence were received.

**FTP/0809/2 QUESTIONS FROM THE PUBLIC ON MATTERS  
RELATING TO THE AGENDA**

FTP/0809/2.1 No questions relating to the business of the meeting were asked by the members of the public attending.

**FTP/0809/3 DECLARATIONS OF INTEREST**

FTP/0809/3.1 No interests were declared in any item on the agenda for the meeting.

**FTP/0809/4 MINUTES OF MEETING HELD ON 30 JULY 2009**

FTP/0809/4.1 The minutes of the meeting held on 30<sup>th</sup> July 2009 were approved with the following amendments:

- 10.2, the record of mandatory training was kept for NHSLA purposes rather than re-validation
- 13.2, the restatement was of accruals and also budget phasing

# ENCLOSURE 1

- 13.3, CQIN should read CQUIN

## **FTP/0809/5                    MATTERS ARISING FROM THE MINUTES OF THE MEETING HELD ON 30 JULY 2009**

### HCC Action Plans

FTP/0809/5.1                    Jane Owen presented the action plans, which would be taken forward by the Clinical Governance Committee; she clarified that references to 'All' were to the Board as a whole.

FTP/0809/5.2                    The Board noted that the Executive team were currently establishing walkabouts within the organisation, and that Non-Executive Directors and Governors would be invited to become involved at appropriate stages in the development of the process. **Execs**

## **FTP/089/6                    TRUST CHAIR'S REPORT**

FTP/0709/6.1                    Prof Booth drew the following matters to the Board's attention:

### Chairman appointment

FTP/0809/6.2                    A timetable for the appointment process had been circulated, subject to the formal approval of the Appointments Committee. This was also subject to the number of applications received, but anticipated a final decision by Members' Council in early October. **Council**

### Higher Education Innovation Clusters

FTP/0809/6.3                    Work was proceeding on this area, with a small group (including Mr Savage) working to draft the answers to the Pre-Qualification Questionnaire. This was to be submitted by 1<sup>st</sup> September and feedback was expected in mid-October.

## **FTP/0809/7                    MEETING OF THE BOARD IN PRIVATE SESSION**

FTP/0809/7.1                    The Chairman reported that, in a private session held earlier, the Board had considered the following matters:

- A possible opportunity to develop services by an acquisition
- A report that reviewed private patient income in general and a strategy for the Assisted Conception Unit in the Trust
- A review of the smoking policy, which had determined that the current policy should be retained

## **FTP/0809/8                    ENCLOSED REPORT BY THE CHIEF EXECUTIVE**

# ENCLOSURE 1

FTP/0809/8.1 The Chief Executive presented Enclosure 3, and drew the following items to the Board's attention:

## Directors' Expenses

FTP/0809/8.2 As reported to the previous meeting, arrangements had been made to publish the expenses of the Directors on-line on a monthly basis, with a publication of earlier figures from the end of August. The publication would be broken down into the four categories in the paper.

SP

## National Clinical Excellence Awards

FTP/0809/8.3 Three Trust consultants had been given awards under the national scheme:

- Dr Cox (Pathology)- Bronze Award renewed for 5 years
- Mr Thompson (Obstetrics & Gynaecology)- Bronze Award
- Dr Cole (Genetics)- Silver Award

These were nationally-recognised markers of quality, and the Trust 'punched above its weight' in the number of awards held by its staff.

FTP/0809/8.4 The Chief Executive's report was **NOTED** with thanks.

## **PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE**

### **FTP/0809/9 Red Risk Register and Assurance Framework**

FTP/0809/9.1 The Head of Corporate Affairs presented Enclosure 4, noting that no further red risks had been identified in the month. The status of risk 89 (Haematology accreditation) had now been revised to Adequate for controls.

FTP/0809/9.2 It was noted that concerns had been expressed by the Clinical Governance Committee regarding completion of audits: this was to be reviewed and an appropriate entry made in the Register for the next report.

JO

FTP/0809/9.3 The Board **noted** the Red Risk Report.

### **FTP/0809/10 MATRONS REPORTS, QUARTER ONE**

FTP/0809/10.1 Jane Owen presented Enclosure 5, noting that the reports had been considered by both the Infection Control Committee and the Clinical Governance Committee. There was some variation in quality, and the relevant directorates were looking to improve. A key

# ENCLOSURE 1

message was that the targets on hand hygiene needed further work and improvement. A change in physical environment had assisted the Neo-Natal Unit, but issues relating to the environment and temperature control had been identified and were being addressed.

FTP/0809/10.2 The following comments were made:

NS

- NNU required high temperatures for clinical reasons, and technical solutions were being explored
- The 'yes or no' approach to the assessment, combined with a lack of appreciation that some activities were within the definition of patient contact (for example, transporting patient notes in the vicinity of the patient), contributed to the failure to meet targets
- In response to a question, it was confirmed that the surveys were a snapshot of the position, and there could be significant variation between them
- The evidence indicated that, as a generalisation, medics and students performed less well nationally on these surveys. Within the Trust, there was improvement in the high-dependency areas
- It was noted that a lot of progress had been made over time in this area, although it was also acknowledged that it needed to be taken forward

FTP/0809/10.3 The Board **noted** the Matron's Reports.

## FTP/0809/11 **INFECTION CONTROL REPORT, QUARTER 1**

FTP/0809/11.1 Jane Owen presented Enclosure 6, which had also been considered by the Infection Control Committee and the Clinical Governance Committee.

FTP/0809/11.2 The following points were noted:

CGC

- The mattress audits were being reviewed for robustness
- A new consultant microbiologist had been appointed by the Children's Hospital, and was available to the Trust
- The Infection Control Nurse's duties had been re-arranged so that she was leading on Women's Hospital issues, although she continued to have contact with the Children's Hospital to ensure a full level of experience was available
- It was suggested that the report should adopt a positive tone about dealing with MRSA colonisations detected as part of our screening processes, as the Trust was successful with these; this would be reviewed
- The recent CQC visit had been successful with no

JO

# ENCLOSURE 1

areas for action being identified

FTP/0809/11.3 The Board **noted** the Infection Control report.

## **FTP/0809/12 MONITOR ASSESSMENT OF THE TRUST'S BUSINESS PLAN**

FTP/0809/12.1 Jason Burn presented Enclosure 7, noting that this was the official Monitor response to the Annual Plan (the 3-year plan document) submitted to them by the Trust. The response had been informed by discussions held with Monitor, particularly at a formal meeting held in June 2009.

FTP/0809/12.2 The response was in line with expectations; the Board's attention was drawn to the change in Financial Risk Rating from 4 to 3, which was caused by an amendment to the underlying calculation introduced by Monitor after the submission date. The financial plans had been rated as prudent, but Monitor had noted (in accordance with its general view) that they could be too cautious for the expected economic retrenchment in the NHS. The Board's attention was drawn to the comments in relation to CIP's; it was suggested that the Monitor approach did not fully reflect that the Trust had already discounted for the expected 3% efficiency gain that was expected to be applied within the tariff.

FTP/0809/12.3 The following points were made in discussion:

- Some concern was expressed that Monitor were signalling an over-reliance on the CIP's delivering; it was confirmed that the Operating Framework assumed CIP's of 3½% to 4%, but this was before allowing for any reduction for efficiency that was built into tariff. If this approach had been followed, the Trust's CIP's would have been in the region of 4% to 5%.
- The effect of proposals for the local health economy had been identified in the report, and it was noted that this linked back to Monitor's view that the surplus indicated was modest.
- There was a need to focus strongly on income generation in the next planning round
- The Board noted the effect of the Trust's planned capital investments (particularly the NNU) on the Financial Risk Rating

FTP/0809/12.4 The Board **noted** the Monitor feedback on the Annual Plan.

**Execs**

## **ORGANISATIONAL PERFORMANCE**

## **FTP/0809/13 INTEGRATED PERFORMANCE REPORT**

# ENCLOSURE 1

## Operations

FTP/0709/13.1

Jane Owen referred to the Dashboard (Enclosure 8), and noted that there had been some teething issues with the production of the new style information agreed at the last Board. She drew the Board's attention to the following points:

- The Gynaecology and Genetics referrals were increasing
- There were continuing issues relating to meeting the timetable for complaints, despite the move to negotiating timetables for individual cases. It was also expected that there would be an increase formal complaints, as new guidance indicated that PALS matters not resolved within 24 hours were to be treated as formal complaints **JO**
- After the discussion at the previous Board, the data for neo-natal deaths and stillbirths was being collated and refined **JO/ PT**
- Cancer targets had now been split further, which would be reflected in the August dashboard. There were continuing issues about meeting the targets, given the small numbers of cancer patients seen and the reliance on other providers to give treatment **Execs**
- It was expected that the Trust would be in full compliance with the 13-week Referral to Treatment target by the end of August.

FTP/0809/13.2

A question was asked as to whether the timetables for responding to complaints were realistic: it was reported that it was variable between directorates, but some seemed generous but were not being met. The complexity of some complaints needed to be taken into account; however, the Trust needed to learn how to perform better.

## *Workforce*

FTP/0809/13.3

Neil Savage referred to the workforce section of the dashboard, noting that certain of the figures were not accurate and that a revised version was available. He mentioned the following points:

- The spend on Agency and Bank staff, and the sickness absence rate, was above the expected rate; this was believed to reflect viral illness as well as seasonal changes
- A recent report on NHS sickness absence was noted, and it was suggested that the service's policies on matters such as infection control (48 hours wait before return to work) made a greater level of sickness absence inevitable

# ENCLOSURE 1

- A revision to the Attendance Management policy was being prepared, which was expected to increase the involvement of the Occupational Health service in absence cases **NS**
- There had been a slight improvement in KSF and PDR figures; this would remain a focus **NS**
- There had been no grievances in July; one case of harassment or bullying was under consideration for the month
- The NHS Staff Survey would be forthcoming shortly, and it was intended to improve from the 70% rating achieved in the previous exercise
- Pay as a percentage of income had moved as a result of extra work and the incremental drift under Agenda for Change; it would be necessary to review this more closely against the budget **NS/ JaB**

## *Finance Report*

FTP/0809/13.4

Jason Burn presented his report, and drew the Board's attention to the following items:

- The Trust continued to perform ahead of plan
- The year-end forecast for Clinical Support was (£255k), but other processes were being reviewed and this figure might be revised downwards **JaB**
- Only £14k of the CIP's were classified red, with a further £298k at amber and £2,268k at green
- The recurrent/ non-recurrent split indicated on the dashboard was to be further reviewed, as it was possible that Directorates were being too cautious in classifying items as no-recurrent **JaB**
- Following a review, the aged debts over 90 days had been significantly reduced: there would be a continued focus on these
- The costs of the refurbishment of the Mortuary (required to retain the HTA licence) were currently at £140k over the initial estimate; a final figure was not currently available. **Execs**

FTP/0809/13.5

The following comments were made:

- In respect of non-pay, concern was expressed that directorates could get used to exceeding budgets and not see any issues with this: it was necessary to keep control of this area high on the agenda **Execs**
- It was confirmed that the downside scenario planning was required to be submitted to Monitor by the end of September, and would be presented to the September Board. **JaB**

FTP/0809/13.6

The Board **noted** the Integrated Performance Report.

# ENCLOSURE 1

## FTP/0809/14 IFRS: RESTATEMENT OF STATUTORY ACCOUNTS FOR 2008-2009

FTP/0809/14.1 Jason Burn presented Enclosure T1, reminding the Board that this was part of the transition process to full IFRS reporting in the accounts for the year ending 31<sup>st</sup> March 2010. Monitor required the Board to submit figures supported by the declaration set out in the enclosure, amended if appropriate to identify any areas of material uncertainty; no such areas had been identified. KPMG would be on-site to undertake the external audit review on 7<sup>th</sup> September, and it was anticipated that the October Board would be invited to make the final declaration and submission in the transition process.

FTP/0809/14.2 It was noted that the valuation issues identified by the Auditors in the ISO 260 report (the management letter) had now been addressed as part of the transition work.

FTP/0809/14.3 The following points were noted:

- The 2008-2009 surplus was reduced by £246k, including a reduction in the carrying value of Norton Court which had no related revaluation reserve
- Tax-payers equity reduced by £9.37 million, mostly relating to the Board's previous decision to remove the value of land from the balance sheet
- Holiday pay provision had been restated at £315k, reflecting IFRS requirements to provide for holiday untaken at the balance sheet date

In response to a question, it was confirmed that the only potential issue would be the treatment of land, which could impact on the Trust's permitted borrowing limits.

FTP/0809/14.4 The Board:

- **Noted** the accounts prepared under IFRS conventions at 1<sup>st</sup> April 2009;
- **Approved** making the statement on these accounts set out in the paper, and **authorised** the Deputy Chairman to sign the statement on behalf of the Board; and **IB**
- **Authorised** the accounts to be submitted to Monitor. **JaB**

## MEMBERS' COUNCIL MATTERS

### FTP/0809/15 REPORT OF THE MEMBERS' COUNCIL CHAIR

FTP/0809/15.1 The Chairman advised that no items fell to be reported under this heading.

# ENCLOSURE 1

**FTP/0809/16 TRUST POLICIES**

FTP/0809/16.1 The Board **approved** the following policies:

- Disputes Policy
- Equal Opportunities in Employment policy

**FTP/0809/17 SIX-MONTHLY UPDATE FROM THE NATIONAL GENETICS EDUCATION AND DEVELOPMENT CENTRE**

FTP/0809/17.1 The Board **noted** the update, and the Chairman congratulated the Centre on achieving a further five years of funding from the Department of Health.

**FTP/0809/18 SEALING REPORT**

FTP/0809/18.1 The Board **noted** the Sealing Report (Enclosure 12).

**Dates of next meetings**

Thursday 24<sup>th</sup> September 2009

Thursday 29<sup>th</sup> October 2009

Thursday 26<sup>th</sup> November 2009

Thursday 17<sup>th</sup> December 2009

# Birmingham Women's



NHS Foundation Trust

<b>SUBJECT:</b>	Chief Executive's Monthly Report – PUBLIC (September 2009)
<b>REPORT BY:</b>	Steve Peak
<b>AUTHOR:</b>	Steve Peak

## CONTEXT AND BACKGROUND FOR REPORT

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

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

The paper updates the Board on :

- Visit from Changzhou Women & Children Health Care Hospital
- Consultant appointments
- Recruiting volunteers
- Annual Health Check 2008/09
- Neonatal Unit Development Guaranteed Maximum Price (GMP)
- ITV Filming – Neonatal Unit
- Patient Safety First campaign

## RECOMMENDATIONS

- The Board is asked to consider and note the Chief Executive's update for the month of September 2009

### **1.0 Visit from Changzhou Women & Children Health Care Hospital**

To confirm that the Trust welcomed visitors from Changzhou City Women & Children Health Care Hospital which is situated within the Jiangsu province in China. The team of visitors included the CEO and clinical/managerial representation. We provided them with a tour of the hospital's departments and wards before a question and answer session with members of the Trust's executive and Governor team.

The Changzhou delegation have asked us to consider a more permanent link to Birmingham Women's NHSFT to explore matters of mutual interest. I would welcome the thoughts of Board members on this potential.

### **2.0 Consultant appointments**

I am pleased to report that we have appointed Dr Beata Hargitai to the post of Consultant perinatal pathologist. Dr Hargitai trained in Hungary and is currently a locum Consultant. She joins a team of three existing Consultants.

### **3.0 Recruiting volunteers**

I am pleased to report that plans to recruit increased numbers of volunteers to work alongside teams across the Trust are advancing quickly. The volunteers will be adding value to core roles to improve the patient experience and support wards and departments where appropriate. The volunteers will be trained and will have their own uniform to identify them to patients and visitors alike.

### **4.0 Annual Health Check 2008/09**

To report that the Care Quality Commission Annual Health Check results will be known to the Trust on the 13<sup>th</sup> October and published on the 15<sup>th</sup> October. Initial results against the Standards for Better Health measurements that form part of the assessment have been published and members of the Executive team are currently reviewing those results.

### **5.0 Neonatal Unit Development Guaranteed Maximum Price (GMP)**

At the time of writing the project Board for the Neonatal Development has yet to receive confirmation of the GMP for this very important scheme. However early draft figures are favourable with confirmation expected to be received ahead of the Board. A final figure will therefore be provided on the day of the Board meeting.

## **6.0 ITV Filming**

During September, the neonatal unit took part in filming with ITV's 'Tonight' programme. The focus was on premature babies and highlighting the care for extreme premature babies. It featured interviews with parents on the unit with babies born at 23/24 weeks as well as some filming with Dr Imogen Morgan talking to programme host, actress Kym Marsh. The Trust was chosen for the focus, thanks to Baby Lifeline president Judy Ledger who has been instrumental in raising funds and donating vital kit to both Maternity and the Neonatal Unit. Judy has also been interviewed for the programme and we are hoping for some publicity for the Tiny babies Big Appeal.

The transmission date has not been set but it is likely to be aired towards the end of October.

## **7.0 Patient Safety First Campaign**

To report that we have signed up as an organisation to the nationally led 'Patient Safety First' campaign. The campaign covers the vast majority of NHS providers and focuses upon the implementation of five key interventions:

- Leadership for safety
- Reducing harm from deterioration
- Reducing harm in critical care
- Reducing harm in perioperative care
- Reducing harm from high-risk medicines

I will bring a paper to the October Board that sets out the challenges in delivering the campaign's key aims, in the mean time more details are available at [www.patientsafetyfirst.nhs.uk](http://www.patientsafetyfirst.nhs.uk).



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

### CONTEXT AND BACKGROUND FOR REPORT

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

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

One new Red Risk has been identified this month, related to the CCL Maternity Information System (ID 100). This has been assessed as Adequate assurance.

The Red Risk on the Loss of Mortuary Services (ID 97) has been re-assessed from Adequate to Uncertain Assurance

The Red Risk on Delivery of Category 1 caesarean sections within 30 minutes (ID 10) has been re-assessed from Adequate to Inadequate assurance.

The previously reported risk relating to Haematology CPA Accreditation (ID 89) has been removed from the risk register following review.

### RECOMMENDATIONS

The Board is invited to:

- a. **NOTE** the Red Risk Register and Assurance Framework.

## CURRENT RED RISKS

ID	Title	Opened	Review date	Risk Type	Risk Subtype	Adequacy of controls	Manager
3	Norton Court	14-Oct-2008	1-May-2009	Corporate	Multi	I	Pam Cooper
54	DATIX and risk management records	2-Mar-2009	8-Sep-2009	Corporate	Multi	A	Peter Thompson
92	Ability to maintain delivery of a radiology service to the Trust	8-May-2009	25-Sep-09	Clinical	Multi	A	Cathy Garlick
100	CCL Maternity Information System	7-Aug-2009	30-Sep-2009	Clinical	Compliance	A	Cathy Garlick
97	Loss mortuary services	9-Jun-2009	8-Sep-2009	Clinical	operational	U	Cathy Garlick
98	Risk to Trust services from Pandemic Flu	3-Jul-2006	05-Oct-2009	Corporate	Organisational	U	Steve Peak
4	Trust not being able to function as a Perinatal Centre	1-Jul-2005	3-Jan-2011	Clinical	Clinical	A	Michele Emery
8	Neonatal Unit capacity	1-Mar-2005	31-Aug-2009	Clinical	Clinical	A	Michele Emery
9	Lack of midwifery staff	12-Oct-2006	30-Sep-2009	Clinical	Clinical	A	Jenny Henry
10	Delivery of category 1 caesarean section within 30 minutes	28-Aug-2007	1-Sep-2009	Clinical	Multi	I	Cathy Garlick
83	Not meeting cancer waiting times - Gynaecology	12-Mar-2009	9-Sep-2009	Corporate	Multi	I	Masoud afnan

<b>SUBJECT:</b>	Safeguarding Children
<b>REPORT BY:</b>	Jane Owen – Director of Nursing and Midwifery
<b>AUTHOR:</b>	Elaine Giles – Lead Nurse/Midwife for Safeguarding Children and Vulnerable Adults. Mike Hocking – Named Doctor for Child Protection.

### CONTEXT AND BACKGROUND FOR REPORT

The DH has requested Chief Executives and their Boards assess their own position against the findings of the Care Quality Commission “Safeguarding Children: review of arrangements in the NHS for safeguarding children” and assure themselves that best practice and statutory requirements are being followed.

This report is to provide assurance to the Board of Directors on the arrangements in place within the trust to enable the board to publish a statement of compliance. This declaration will help to support core standard declarations which will be required by the CQC in November.

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

- The trust is on plan to achieve Criminal records bureau (CRB ) before the target of March 2011
- Child protection policies and systems are up to date and robust, including a process for following up children who miss outpatient appointments and a system for flagging children for whom there are safeguarding concerns
- All eligible staff have undertaken and are up to date with safeguarding training at level 1.
- The Trust has named professionals who are clear about their role and have sufficient time and support to undertake it.
- There is a Board level Executive Director Lead for Safeguarding, the Board reviews Safeguarding across the organisation at least once a year and has robust audit programmes to assure it that safeguarding systems and processes are working.

### RECOMMENDATIONS:

- The Board is asked to discuss and note the contents of the report and agree ongoing annual updates to the Board by the Lead for Safeguarding and Named Doctor.
- The Board is asked to consider the funding arrangements for safeguarding training.
- The Board are asked to agree that the trust should publish a statement of compliance both on the trust web site and note this fact to Monitor.

## 1.0 Brief Introduction

At the request of the Secretary of State, on 16<sup>th</sup> July 2009 the Care Quality Commission (CQC) published their initial findings from a review of safeguarding children in the NHS, [Review of Safeguarding Children](#)

This followed a detailed online survey of 392 NHS Trusts which the Trust took part in.

Within 12 months NHS organisations will be required to register their services with CQC and part of the requirements for registration will be effective arrangements for the Safeguarding and protection of children.

This report identifies how Birmingham Women's Foundation Trust compares to the findings of this report and other related reports.

## 2.0 Background

In February 2009 Lord Laming published his progress report into child protection in England. The report reviewed the progress made since the Victoria Climbié Inquiry in 2003 and the subsequent Children Act in 2004. [The Protection of Children in England.](#)

In the autumn 2009 the CQC will publish the findings in full from individual Trusts.

## 3.0 Key Issues from the CQC Report

The CQC, Department of Health & Monitor have identified that as a minimum Boards should assure themselves of the following:

### 3.1 'Their organisation meets statutory requirements in relation to Criminal Records Bureau check'.

- Recruitment procedures follow the NHS Employers Safer Recruitment guidance (March, 2008). [Occupational Health Checks](#). The aim is to ensure that all BWFT staff have in place a 'disclosure' check by 31<sup>st</sup> December 2011. All staff will then be subject to a three-yearly re-checking process.
- An action plan previously agreed by the Board of Directors is in place for arrangements in respect of retrospective CRB checks for all Trust employees, prioritising those who have regular access to children. The current programme completes 80-100 CRB checks each month and is on target to deliver 100% compliance by March 2010. This is one year ahead of the date set in the regulations and the board should be assured that the target will be achieved. Our current status is shown in the table below.

Directorate	Total staff	Total CRB'd	Percentage
Clinical Support	154	104	67.5%
Corporate Management	182	56	30.7%
Corporate Facilities	146	96	65.7%
Genetics	254	154	60.6%
Gynaecology	194	127	65.5%
Maternity Services	455	174	38.2%
Neonatal	160	127	79.4%
<b>Trust Total</b>	<b>1545</b>	<b>838</b>	<b>54.2%</b>

### **3.2 'Child protection policies and systems are up to date and robust, including a process for following up children who miss outpatient appointments and a system for flagging children for whom there are safeguarding concerns'.**

- The Trust child protection policy is currently up to date and due for review and updating in September 2009. They reflect Birmingham Safeguarding Board (BSCB) Procedures.
- There is ongoing work being done to develop situation specific policies.
- Safeguarding policies are available electronically and a 'hard copy' is available in the Safeguarding Office. Where to locate policies is incorporated into the safeguarding children training programme and updates are also sent out by email.

#### **Children who miss outpatient appointments**

- A policy is in place for children who miss outpatient appointments. However, this needs to be more robust and is in the process of being updated by the Named Doctor.

#### **Safeguarding alerts**

- When children/unborn babies are known to have Safeguarding concerns systems are in place to highlight this within the hospital records. 'Alerts' are distributed by email to managers to share with their teams. Following risk-assessment this information may also be shared with appropriate professionals and agencies outside the Trust.

#### **Safeguarding systems and arrangements**

- The Lead Nurse/ Midwife is supported by the Named Doctor and a Specialist Safeguarding Nurse/Midwife who are available to provide professional guidance and support to all staff on a day to day basis. Advice is provided on sharing information and the need to refer to outside agencies and professionals and management of individual cases and record keeping. Although there are no formal arrangements for 24 hour advice, the Safeguarding Team will provide an on-call service if there are known complex cases within the Trust. Staff can also access advice via the local authority emergency duty team.
- Additional support is available from the Safeguarding Team. This consists of specialist midwives in domestic abuse & mental health, teenage pregnancy and substance misuse.
- The Safeguarding Team attend departmental meetings as required to undertake case discussions and update teams regarding changes in service.
- A team of Link Safeguarding nurses and midwives have been introduced into clinical areas and meet with the Lead or Specialist Nurse/ Midwife quarterly. The purpose is for the Link professionals to be 'champions' for Safeguarding Children within their teams and provide additional front-line support and advice.
- New local & national guidance and articles are distributed via email to relevant professionals.
- The Safeguarding Team will be producing a quarterly e-bulletin from September 2009 to update staff working with children and families on current issues.

- A Safeguarding working group has been developed and meet bi-monthly.

### **Support and supervision**

- Safeguarding Supervision was found to be inadequate in the four London trusts involved in the Baby P case. Although Trust staff have easy access to support and advice, there are no formal safeguarding supervision arrangements. However, the Trust is currently working on plans to enhance supervision further, supported by a new Safeguarding Supervision Policy which is in the consultation stage.

### **Information sharing/ interagency partnerships**

- The Lead Nurse/Midwife and Named Doctor attend the Health Professionals Advisory Group (sub-group of BSCB)
- The Lead Nurse/ Midwife attends South Birmingham Forum (sub-group of BSCB) bi-monthly and also provides inter-agency training on Serious Case Reviews on behalf of the forum.
- Appropriate staff attend Multi Agency Child Protection Conferences where risks to the child / unborn are assessed and a plan is put in place to ensure the child is protected from harm.

### **3.3 'All eligible staff have undertaken and are up to date with safeguarding training at level 1. The new e-learning package on the e-Learning for Healthcare system and the National Learning Management (ESR) system offers an additional resource to support this. In addition, a review of other training arrangements should be completed within 6 months, taking account of emerging messages from the national review of safeguarding training'.**

- BWHFT has an existing Safeguarding Training Strategy which is reviewed and updated annually. The training programme is aligned to the professional competencies set out in the Intercollegiate Document (2006). [Intercollegiate doc.](#)
- The CQC review of NHS arrangements for Safeguarding Children and Young People raised serious concerns about how it's staff accessed training. The report recommended that a new national e-Learning package be implemented across the health community. [Electronic Staff Record - Safeguarding Children and Young People](#) . Unfortunately, the Trust is some way off implementing the National Learning Management System (NLMS), therefore the training package cannot be used. It is a recommendation that this should be addressed as soon as possible as this would clearly be a considerable resource saving.
- Current level 2 and level 3 training is provided in line with the Intercollegiate Document.
- Staff have access to multi-agency training provided by BSCB.
- Training is available on substance & alcohol misuse, mental health, teenage pregnancy and domestic abuse, serious case reviews and Common Assessment Framework (CAF). This is provided either 'in-house' or by outside agencies. However, this is dependant on the 'good will' of outside agencies as funding is not available.

- A record is kept of all training attended by staff and is audited against the existing Training Strategy.
- Currently, there is no budget for training provided by the Safeguarding Team. This restricts the current demand for training around Safeguarding issues for all Trust staff. In order to be able to continue to meet the training needs it is recommended that a budget is made available to the team for this purpose.

### **3.4 'Designated and/ or named professionals are clear about their role and have sufficient time and support to undertake it'.**

- The Named professionals have job descriptions which clearly outline their respective roles and responsibilities.
- Both posts have dedicated time to undertake the role.

### **3.5 'There is a Board level Executive Director Lead for Safeguarding, the Board reviews Safeguarding across the organisation at least once a year and has robust audit programmes to assure it that safeguarding systems and processes are working'.**

- The Board receive an annual Safeguarding Children report and annual report of Internal Management reviews (IMR) and Serious Case Reviews (SCR). It is a recommendation that the Board receive an annual presentation from the Lead Nurse/ Midwife and/ or Named Doctor.
- Jane Owen is the Executive safeguarding lead and 'Safeguarding Champion'.
- The Lead Nurse/Midwife and Named Doctor meet quarterly with the Executive Lead/ Safeguarding Champion.
- Safeguarding is a standard agenda item at Clinical Governance meetings.

### **Audit**

- Audits are currently in progress on information sharing, training and, following an Internal Management Review into a child death, cannabis use.
- Audits have been completed on the number of children who do not attend outpatient appointments and teenage pregnancy.
- A 2 year audit plan is currently being developed.

### **4.0 Conclusion**

Lord Laming's report 'The Protection of Children in England: A Progress Report' and the Care Quality Commission 'Review of the involvement and action taken by health bodies in relation to the case of Baby P' were highly critical of health services in contributing to the death of Baby Peter. However, BWFT can be confident that it is providing the services that are required to Safeguard the children within its care. Whilst at the same time, the Trust should not be complacent and must continue to monitor and review its Safeguarding arrangements

# Birmingham Women's

## NHS Foundation Trust



<b>SUBJECT :</b>	Mid-Staffs- Monitor internal audit report and response
<b>REPORT BY :</b>	Steve Peak, Chief Executive
<b>AUTHOR :</b>	Steve Parsons, Head of Corporate Affairs

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

Arising from the Healthcare Commission report into Mid-Staffordshire NHS Foundation Trust, and the subsequent suite of enquiry reports, Monitor commissioned an investigation of its own processes from its internal auditors, KPMG.

Monitor has accepted all recommendations in the report and has published both the KPMG report and its response. Copies of these documents are attached.

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

The following key issues arise from Monitor's response and intended actions:

- An additional quality 'bar', above current Compliance Framework targets and national standards, may be introduced
- Monitor may seek evidence of the Board's strategic leadership and monitoring of CIP targets, including clinical governance monitoring and the approval of clinicians for the CIP's proposed
- Quality metrics may, over time, replace national targets as governance indicators
- Evaluation of clinical governance may be included in the standard Monitor compliance process (subject to cost/ benefit analysis)
- Guidance on including clinical governance risks in the annual business planning round will be revised, and rating of clinical quality and governance risk may be included
- Additional self-certifications on clinical quality and governance will be considered in the Annual Report and Accounts process, together with audit requirements on the internal and external auditors
- Monitor intend to develop regular contact with (i) Medical Directors (ii) Nursing Directors (iii) Chairs of Clinical Governance Committees (iv)

# ENCLOSURE 5

Ref

## Heads of Risk Management

- Monitor intends to increase its engagement with Governors, including developing training and undertaking to write to Governors directly in cases of concern. The Board will be aware that Monitor has required Trusts to advise of a nominated 'Lead Governor', elected by Members' Council, for direct communication.

## RECOMMENDATIONS

The Board is invited to:

- a. **Note** the Monitor internal audit report, and the response of Monitor senior management; and
- b. **Note** the possible changes in approach from Monitor in consequence



ADVISORY

# Learning and Implications from Mid Staffordshire NHS Foundation Trust

Monitor – Independent Regulator of NHS Foundation Trusts

Final Report dated 5 August 2009

INTERNAL AUDIT, RISK AND COMPLIANCE SERVICES

# Contents

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2. Executive summary
3. Key findings and recommendations

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- A. Glossary of terms
- B. Staff interviewed and documents examined
- C. Summary chronology
- D. Mid Staffs stakeholder information flows at Assessment

Report Status	
Preliminary findings presented to Board	27 May 2009
Draft report discussed at Board:	29 July 2009
Final report issued:	5 August 2009

Distribution for action:	Distribution for information:
Dr William Moyes, Executive Chairman Adrian Masters, Strategy Director Stephen Hay, Chief Operating Officer Rebecca Gray, Director of Public Affairs and Communications Miranda Carter, Assessment Director Edward Lavelle, Regulatory Operations Director Kate Moore, Director of Legal Services	Jan Quirke, Secretary to the Board

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# 1. Introduction and scope

## Background

Monitor commissioned KPMG to conduct a 4 to 6 week 'lessons learnt' exercise based on the events relating to Mid Staffordshire NHS Foundation Trust (Mid Staffs) during the period 1 October 2007 to 30 April 2009. The purpose of the exercise was to identify where existing processes across Assessment and Compliance could be improved, identifying learning and recommendations to improve processes. This included consideration of compliance actions identified following the notification of a review by the Healthcare Commission's (HCC's) investigation at Mid Staffs in 2008.

## Scope of services

This exercise covered the domains of quality and clinical governance, but not legal constitution or financial viability, except where issues in these areas were material to the questions of quality and clinical governance (defined in Appendix A). During the exercise, we reviewed a small sample of similar Assessment and Compliance cases to provide useful comparison and validation of learning.

## Approach

At a high level, the key steps in this review included:

- A kick off meeting to finalise the proposed approach, agree documentation to review, participants and project communication (Appendix B);
- Early meetings with Monitor's Assessment and Compliance staff who worked directly on Mid Staffs and key senior individuals at Monitor to sketch out the high level chronology and lessons learnt to date so that the review did not just focus on known learning but also built on existing knowledge;
- A review of certain documentation to identify the issues to explore;
- Building the timeline showing the chronology of events over the specified time period and identifying the interdependencies between the streams of activity in Assessment and Compliance (outlined in Appendix C);
- Development of a 'stakeholder map' highlighting information flows between Mid Staffs, Monitor and the key stakeholders including the HCC, National Patient Safety Agency (NPSA), Strategic Health Authority (SHA), Primary Care

Trust (PCT) and Department of Health (DH) (provided in Appendix D);

- Identification of any additional information required and issues to explore in specific interviews;
- Drawing on a range of KPMG specialists on our advisory panel, with knowledge of the sector, to analyse the chronology, challenge the issues identified, confirm areas to explore further in interviews. We also used our KPMG advisory panel to help identify recommendations for change at an early stage;
- Undertaking interviews with key individuals to investigate specific issues and identify areas to explore further and develop recommendations;
- Development of our preliminary report presentation based on the issues and recommendations identified to date;
- Using our advisory panel of KPMG specialists to challenge the initial findings and recommendations and content of the preliminary report presentation issued prior to the Monitor Board meeting in May 2009;
- Reviewing the preliminary report presentation with the Project Sponsor and other senior management stakeholders, prior to issue for first Board meeting on 27 May 2009;
- Presentation of the preliminary findings to the Monitor Board in May;
- Scheduling additional interviews to gain further information to supplement lessons learnt and recommendations;
- Holding a workshop with Monitor's Senior Management following the May 2009 Board meeting to challenge and refine recommendations;
- Conducting further analysis in order to finalise recommendations;
- Close out meetings with senior management to discuss and confirm Monitor's management response to the findings;
- Presentation to the Monitor Board in July 2009; and
- Finalisation and issue of the report.

## 2. Executive summary

In summarising our findings and recommendations we think it is important to understand the context within which Monitor operates.

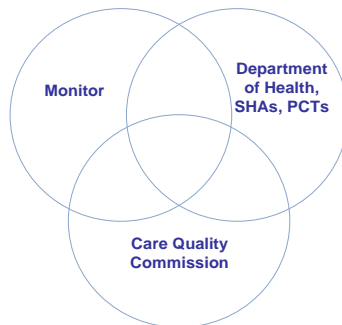
### Stakeholder responsibilities for quality and clinical governance

During the period under review the primary stakeholder relationships that Monitor maintained were with the DH, the HCC (now the Care Quality Commission (CQC)) and the SHAs and PCTs associated with Foundation Trusts (FTs) and Foundation Trust applicants.

The working relationships in place are crucial in handling the complexity of the responsibilities across the NHS system for evaluating and monitoring quality of performance at a detailed level and then evaluating and monitoring management performance in clinical governance as a result.

The precise nature of responsibilities, particularly where individual bodies' responsibilities intersect or overlap has evolved and is not entirely clear, which can give rise to confusion and uncertainty. In the case of Monitor's role in authorising and monitoring compliance for FTs the structure is broadly as shown below in Figure 1.

**Figure 1 – NHS high level inter-relationships**



### Responsibilities for quality and clinical governance

The DH is responsible for strategy, policy and funding. This is delivered through the SHAs at regional level and the PCTs for commissioning services. Monitor is responsible for authorising NHS Trusts to become FTs and then monitoring their

compliance with their terms of authorisation. It is also responsible for interventions based on significant breaches of the authorisation conditions. The CQC is responsible for overseeing the quality of service delivery within the NHS.

Whereas at the highest level these roles and responsibilities are relatively simple, we believe that they are more complex at a detailed operational level. It is not until they are addressed at a level of detail and stress tested, in the event of marginal performance by an FT applicant or FT, that one can be sure that the system itself has no significant gaps, cracks or uncertainties. It may equally be that more than one stakeholder takes responsibility for certain activity, which can be just as confusing in such a complex environment.

### Recent history

When Monitor was established in 2004 the quality threshold for FTs was clear; only Trusts with a 3 star rating from CHI (superseded by HCC annual review) were supported by the Secretary of State for referral to Monitor. This provided a clear benchmark. Subsequently, this basis changed. From 1 April 2006 star ratings were replaced by the HCC's Annual Health Check ratings (Weak, Fair, Good, Excellent) which include the DH's Targets and National Core Standards.

While targets and standards are important indicators, they do not provide a full picture of quality, and other factors need to be considered to develop a holistic picture of quality performance. Although the HCC Annual Health Check includes a review of clinical governance within the Standards for Better Health, ratings are self certified by the Trust Board annually and supported by periodic risk based spot checks by the HCC. Additionally the Health Overview and Scrutiny Committee, SHA and Local Involvement Networks (LINKs) are asked to comment on the Annual Health Check.

From 2008/09, FTs are required to publish Quality Accounts, summarising their quality aspirations and supporting clinical quality indicators. In 2009/10, all NHS organisations will be required to publish Quality Accounts, with supporting clinical quality data. However, there is recognition from the Audit Commission's 2009 publication 'Taking it on Trust' that the quality of clinical data is not as reliable as would be expected, therefore raising questions on the level of assurance needed over data quality.

## 2. Executive summary (continued)

Following publication by Dr Foster, SMRs also appear to have become recognised within the NHS as an important indicator of clinical quality performance, although we have not sought to obtain the DH's view of their status. Nevertheless, whereas it was clear in 2004 what constituted the threshold for quality, it is now less clear what set of factors is regarded as the key data set for evaluating quality performance at an aspiring FT.

We are not clear how the mutual responsibilities of the various stakeholders involved in the evaluation of quality and clinical governance relate inter-se. This is applicable at Assessment, within Compliance and in the event of escalation of an Issue Trust to Intervention. Furthermore, we are not clear what constitutes the threshold for an acceptable level of quality performance and clinical governance for an NHS Trust to be accepted as an FT. Accordingly, we are unclear what level of work ought or needs to be performed by Monitor, in conjunction with its stakeholders, to ensure that the aspiring Trust has achieved an acceptable level of quality performance and is capable of continuing to do so.

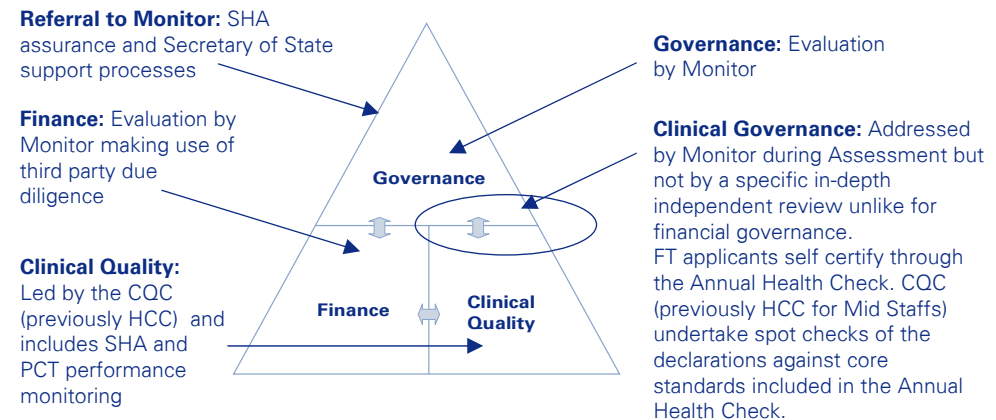
The types of question we have asked include:

- What is Monitor's regulatory role in relation to clinical governance?
- What is the CQC's role in relation to clinical governance?
- How much of Monitor's role is addressed by what the CQC does on clinical governance?
- Is there a gap between Monitor's role and what the CQC can assure?
- How, when and where does the gap arise?
- How might the gap be covered off?
- Who would discharge the work required to fill the gap?

At a high level the analysis of responsibilities at Assessment appears to be broadly as set out in Figure 2 on this page which also summarises the stakeholders involved for Mid Staffs. There are considerable differences in the depth and breadth of activity amongst the stakeholders with regard to assurance over quality and clinical governance versus that for financial governance.

Monitor will not receive a high degree of assurance over quality performance (the quality of underlying data) and clinical governance effectiveness at Assessment and subsequently in Compliance until the potential gaps, overlaps and uncertainties in roles, responsibilities and ways of working across the stakeholders have been resolved.

**Figure 2 – Trust level external oversight activities at Assessment**



### Clinical Governance/Clinical Quality

By clinical governance we mean the way a Trust organises itself to manage and monitor clinical performance, plan and manage continuous improvement, identify performance that is below standard and then investigating and taking appropriate management action (See Appendix A). Clinical governance is not the same as clinical quality. For example, it is possible for a Trust to achieve the DH's Targets and National core Standards but to have poor clinical governance. If a Trust has a good level of clinical governance, that does not, in itself, guarantee that the DH's targets and National core Standards will be achieved; they are complementary. Greater clarity is required about the relationship between the two topics, stakeholders' mutual responsibilities and how Monitor can make best use of its resources to focus on the most relevant aspects in discharging its role.

## 2. Executive summary (continued)

### Analysis and summary

While the quality threshold on Assessment may have been clear at one time, it is now much less clear:

- What constitutes the threshold for clinical governance on Assessment and subsequently through Compliance; and
- What scope of review should be used by Monitor in the context of quality and clinical governance.

In order to identify the main learning and implications from this audit we have gone back to first principles and asked a series of questions about Monitor's role in relation to quality and clinical governance. The end result of the line of thought that we have followed has been a broader question: Should Monitor focus more time and attention on clinical governance at Assessment and then subsequently during Compliance?

We believe that there are some areas where Monitor should place more focus; for example, on clinical governance as a part of the Assessment process and then subsequently through Compliance.

In making this statement, we are also cognisant of the:

- Hampton Principles for regulation and the need for Monitor to operate in a proportionate and risk based manner; and
- Need for Monitor to operate within the existing NHS stakeholder framework. That is, certain changes might only be feasible if made by mutual consent amongst the stakeholders.

More specifically, we recognise that there are recommendations where further analysis will be required to assess the feasibility, practicality and cost benefit of further work. Certain of our recommendations can only be implemented successfully with the co-operation of the other key stakeholders in the NHS regulatory system. Accordingly, the actions arising from those recommendations require a broader dialogue amongst the stakeholders to ensure that they are based on a mutual understanding/agreement and aligned to cover their respective roles and responsibilities. We have indicated in our recommendations where such collaboration is required to achieve the desired objective.

The structure of the body of this report is based round the findings and recommendations under three primary headings: Assessment, Compliance and Intervention. Following these headings we have included a further section dealing with structural matters that are largely a matter for implementation i.e. how the primary findings might be addressed. This section is broken into internal matters, relating to Monitor's management; and external matters, how it interacts with the stakeholder community.

While the primary focus of this report has been to identify learning arising directly from Mid Staffs, other matters that have come to our attention are addressed. For example, there are no findings, arising from Mid Staffs that related to the Compliance process, per se. This is because the Trust moved almost directly from Assessment to being an Issue Trust, which places it in Monitor's Intervention process. In our recommendations we have suggested that the principles identified in Assessment should be taken and the implications considered for Compliance as well to ensure consistency in approach and to give Monitor a sound basis for identifying the risk of non compliance in an FT at the earliest opportunity.

We have not just taken a backward look at events. We have also considered the potential implications for Monitor looking forward based on the understanding that we have gained from the detailed work. Accordingly, we have also made some recommendations that we believe would help Monitor to continue to develop. In doing so we have noted certain objectives already included in the Corporate Plan 2009-2012.

We have also considered a wide range of potential developments and activity for Monitor in response to its role and the findings. Certain of these have been discounted as being outside Monitor's span of responsibility. For example, we believe that the development by Monitor of a detailed analysis of clinical indicators to help identify potentially poor performance in clinical areas would be outside the scope of its role and also conflict with the roles of the CQC and of PCTs.

## 2. Executive summary (continued)

### Summary findings

In the following paragraphs we provide a high level picture of the findings and recommendations in each section of the report.

#### Assessment

It is now less clear than it was what is regarded as the acceptable standard or threshold for Trusts aspiring to Foundation Trust (FT) status for quality and clinical governance. This impacts the potential nature and level of work required of Monitor on Assessment.

We believe that Monitor should work with its partners to redefine the standards for quality and clinical governance for use on Assessment and subsequently. Monitor should then perform more specific and focused work as a part of Assessment on clinical governance at aspiring FTs to address those areas requiring additional assurance not covered by the other stakeholders.

#### Compliance

While the internal audit findings do not impact Monitor's Compliance systems directly, there will be a need to consider whatever standards may be defined for quality and clinical governance as a part of future Compliance activity in order to maintain the same standard after authorisation. Following the work on Assessment, Monitor will also need to agree with its stakeholders what the new threshold for quality and clinical governance means under Compliance, how their mutual roles fit together and contribute to effective monitoring of FTs' performance and what information needs to flow between them.

Changes that we recommend include a range of measures designed to increase the level of evidence and assurance that Monitor should seek regarding the performance of individual FTs. The matters we raise represent a menu from which Monitor will need to adopt a number depending upon the circumstances, their feasibility and the relative cost benefit. The intention behind these recommendations is to reduce the risk of failing to detect non compliance at an early stage.

### Intervention

When Monitor detects significant non compliance in performance at an FT it becomes an Issue Trust; such FTs are escalated and the intensity of regulatory activity increased through the intervention system.

Through the audit we have identified some administrative matters that we believe should be addressed, relatively simply. We are also aware of changes to intervention processes that have continued as a part of Monitor's natural development during the last 18 months. There are also objectives cited in the Corporate Plan 2009-2012 relating to Governors which we believe need to be progressed as they are consistent with our findings.

#### Structural matters

In addressing the specific recommendations made in relation to Assessment, Compliance and Intervention there are a number of related matters that will need to be considered.

#### Management Capacity

Monitor has continued to develop and strengthen its senior management team since its creation. The activities required of Monitor in relation to Mid Staffs were handled within its regular management capacity.

We believe that Monitor should engage clinical management skills to assist the existing management team in addressing the actions envisaged by this report. As a part of the actions being developed, we expect Monitor to define what skills and competencies might be required to best address its continuing needs. Depending upon the outcome we would expect a decision to be made regarding the need for clinical management skills as an integral part of the management structures, whether in Assessment, Compliance or elsewhere. Such skills would be expected to help Monitor discharge its role and not to take over roles encompassed by the CQC and the PCTs.

## 2. Executive summary (continued)

### **Stakeholder relationships**

In developing its view of clinical governance Monitor will need to use its key stakeholder relationships to ensure that there is a mutual understanding and agreement of any position reached. This should include confirming the basis of Monitor's role in relation to clinical governance, the threshold determined for Assessment and the nature of the assurances available from stakeholders in support of the elements of the overall structure for which they may be responsible.

While a positive set of assurances is obtained during Assessment, Compliance is based on negative assurances and it is, accordingly, more difficult to identify non compliance. Agreement amongst the stakeholders of their mutual roles within the overall framework will be vital if the effectiveness of the broader regulatory system is to be maintained. This should include mutually agreeing the practicalities of maintaining prompt information flows amongst the stakeholders.

In practice this is an opportunity for the key stakeholders to revisit the detail in the architecture of the regulatory system so as to make sure that there is:

- Sound mutual understanding of the respective roles and responsibilities;
- Clarity of purpose and terminology amongst stakeholders; and
- Mutual agreement on detailed roles, activity and information flows.

### **Management action**

We are aware that Monitor has already identified and addressed some of the matters referred to in this report. The Corporate Plan 2009-2012 also includes activities related to our recommendations. Therefore, we have sought to position matters raised and the related recommendations in that context.

We are also aware that certain of our recommendations are of necessity subject to agreement with other stakeholders or are subject to Monitor's need to analyse the feasibility and cost/benefit.

### **Acknowledgement**

We would like to thank the many members of Monitor's management and staff for their assistance during this review.

### **Recommendations**

The main recommendations that we make in the body of this report are:

Area	Recommendations
<b>Assessment</b>	<ol style="list-style-type: none"><li>1. Obtain stronger assurances at Assessment on the state of quality</li><li>2. Stronger focus required on quality and clinical governance</li></ol>
<b>Compliance</b>	<ol style="list-style-type: none"><li>3. Redefine the quality and clinical governance thresholds in Compliance</li><li>4. Enhance stakeholder information flows to help assess compliance against revised thresholds</li><li>5. Include an evaluation of the impact FT plans have on clinical risk</li><li>6. Provide access to clinical management skills</li><li>7. Increase the nature and level of assurance obtained on clinical data and clinical governance</li></ol>
<b>Intervention</b>	<ol style="list-style-type: none"><li>8. Consolidate intervention system documentation</li><li>9. Document decisions not to intervene</li><li>10. Enhance central documentation of events at Issue Trusts</li><li>11. Increase the level of engagement with Governors</li></ol>
<b>Structural matters</b>	<ol style="list-style-type: none"><li>12. Continue to strengthen the senior management structure and skills including clinical management skills</li><li>13. Establish an interim recruitment process</li><li>14. Make use of stakeholder dialogue to continue developing information flows and working practices</li></ol>




# 3. Key findings and recommendations

In this section we set out our findings and recommendations. This section starts with a narrative that explains the findings established by the audit. It is followed by summarised findings and recommendations structured as:

		<b>Pages</b>
<b>3.1</b>	Assessment	9 to 10
<b>3.2</b>	Compliance	11
<b>3.3</b>	Intervention	12
<b>3.4</b>	Structural matters	13
<b>3.5</b>	Detailed Findings and Recommendations	14 to 18

In the detailed findings and recommendations we have differentiated between those where Monitor is in a position to implement the recommendation itself from those that are dependent on further discussion, development and agreement with stakeholders, for example, the CQC, the DH, SHAs and PCTs.

## Key

-  Findings
-  Recommendations primarily within Monitor's control
-  Recommendations primarily dependent on further third party dialogue

## 3.1 Key findings – Assessment

### Background

The Assessment process at Monitor is designed to establish whether or not a Trust is ready for Foundation status. Prior to receiving an application at Monitor other stages of approval will have already been reached. These are:

- The SHA-led Trust Development Phase: the SHA works with the Trust to prepare it for FT applicant status. The SHA is required to support the Trust in its application to the Secretary of State for referral to Monitor; and
- Secretary of State-led Support Phase: prior to referring the Trust to Monitor, the DH undertakes its own review of the potential FT applicant and refers that Trust to Monitor for Assessment and subsequent authorisation, should it be satisfied the Trust is ready for Foundation status. This referral provides Monitor a level of assurance from the DH that it considers the applicant Trust to be of a sufficient standard to become an FT.

Monitor undertakes a high level review of referrals from the Secretary of State through its batching process and at times has delayed FT applicants if there are high level outstanding issues.

Once in the Assessment process, prior to the authorisation of Mid Staffs, Monitor's work in Assessment to review quality and clinical governance included:

- A detailed review of board processes to identify and manage clinical risks including interviews with board members and clinical governance sub committees, interviews at directorate level and a review of action plans;
- Evidence of compliance with the NHS Litigation Authority's risk management standard of level 1 and above;
- A review of external information from other regulators e.g. external reviews by the HCC, including the Annual Health Check;
- Interviews with external parties, specifically the PCT and SHA;
- A review of performance data including target performance and standardised mortality; and
- A review of data from surveys and other benchmarking data, staff/bed ratios, day case rates, average length of stay and bed occupancy.

Assessment teams also were beginning to seek views from the HCC's local representative, although this was not a formalised and consistently applied component of Monitor's Assessment process.

Through these consultations and the analysis performed by the Assessment team, Monitor seeks to establish whether there are any negative indicators of quality or clinical governance effectiveness.

In the autumn of 2007 and up to March 2008 the primary basis of the evaluation of quality performance was on the DH Targets and National Core Standards as well as Monitor's own assessment of the effectiveness of broader governance processes at the FT applicant as described above.

The purpose of Monitor's process has not been to re-evaluate the quality performance data provided by the SHA, PCTs and HCC (now the CQC). It has been to understand what that information indicates and whether there are any indications of management strength or weakness in the context of clinical governance processes i.e. the effectiveness of oversight of quality performance within the Trust.

Monitor defers decisions on FT applicants pending receipt of independent reviews on topics of concern related to clinical governance or where broader governance concerns exist. Decisions are also deferred if an FT applicant is subject to an independent clinical inquiry.

Finally, there is no clear definition of what constitutes good / best practice in clinical governance that has been agreed by the current key stakeholders, including the CQC and PCTs. Accordingly there is no agreement amongst stakeholders of the key indicators of potential weaknesses in quality performance and clinical governance.

### Findings

The evaluation of quality and clinical governance relies heavily upon information from other stakeholders as well as self certifications from and dialogue with the FT applicant. The focus of the activity at SHAs, PCTs and the HCC is on historical quality performance. Other than the SHA-led Trust development phase prior to referral to the DH, and Mid Staff's own preparatory work to prepare for FT status, no specific pieces of work were undertaken by stakeholders outside of their normal cycle of activity to provide further assurance to Monitor of the status of quality and clinical governance at Mid Staffs prior to authorisation.

## 3.1 Key findings – Assessment (continued)

### Findings (continued)

The historical financial information provided by FT applicants is audited by their external auditors. In addition, a firm of independent accountants is commissioned to conduct a historical due diligence review and provide an independent opinion on the two year working capital forecasts and on the financial reporting procedures. This is not the case on quality performance measures. There is no standard evaluation during Assessment of the potential quality implications of cost improvement plans (CIPs).

The quality indicators used by Monitor, at the time Mid Staffs was approved, were primarily the DH Targets and National Core Standards. However, the Assessment team did also review risk information and quality performance data provided by Mid Staffs. This included standardised mortality (SMR) data and a supporting CHKS report in 2007 commissioned by Mid Staffs to review clinical coding, as the Trust primarily attributed the high SMR to data concerns around coding. Mid Staffs had action plans in place to address the coding issues identified in the CHKS report.

Monitor consulted with stakeholders (SHA, PCT) during the Assessment process for Mid Staffs with the exception of the HCC. Neither the PCT nor the SHA expressed concerns about quality performance or A&E during these meetings with Monitor. However, at that time, Monitor did not, as a discipline, require written confirmation from all stakeholders that there were no outstanding concerns, contra indicators or other matters that Monitor needed to know at the point of authorising a Trust for Foundation status. The actual level of formal assurance provided from each stakeholder had not been specifically defined at that time.

The Board to Board (B2B) meeting did include, as a matter of course, challenge on quality performance. However, this was not necessarily as structured as the challenge of financial performance and did not consider in any depth the risks of reducing quality of service that might be associated with delivering a cost improvement programme (CIP) at the Trust.

The Assessment team at Monitor has developed a significant depth of experience since its inception. However, the Assessment team at Monitor does not include any long-standing experience of clinical management and clinical governance in

health delivery. Monitor does have two non executives with clinical managerial experience (mental health and acute) and one of these attends an FT applicant's Board to Board meeting to provide more in depth challenge on clinical matters.

At the time of the Mid Staffs' Assessment, Monitor did not include as a part of its Assessment process a formal independent review of clinical governance at FT applicants prior to authorisation.

### Changes made since March 2008

Following the authorisation of Mid Staffs, Monitor gained formal agreement from the HCC that they would confirm in writing for each FT applicant if any concerns existed or that no outstanding concerns existed, i.e. provision of negative assurance. Since July 2008, this has included a number of emails from the HCC to Monitor providing details of any outstanding concerns it was aware of at the FT applicant. From January 2009 the HCC (now CQC) provides Monitor with Organisational Risk Profile (ORP) reports summarising all outstanding concerns of which it is aware, including details of planned or ongoing investigations.

These FT applicant ORP Reports are updated before the B2B and prior to authorisation by Monitor to highlight any current outstanding concerns from the CQC. The Assessment Director at Monitor is working with the CQC to further evolve these reports.

Since the authorisation of Mid Staffs, Monitor has continued to evolve its Assessment processes. In particular, processes have been extended to cover a more systematic review of performance data including:

- Board reporting and analysis of standardised mortality rates;
- More detailed analysis of results from patient and staff surveys; and
- A review of themes arising from complaints and Serious Untoward Incidents (SUIs).

Monitor is also in dialogue with the NPSA to understand the level of additional information they can provide on each applicant FT over and above published data.

Meetings are now held with the DH Infection Control team to gain intelligence on applicant FTs' performance on HCAI (including review of action plans) and also with the DH Intensive Support team to obtain intelligence on 18 weeks performance.

## 3.2 Key findings – Compliance

### Background

Monitor's Compliance system relies on the evaluation of quarterly and annual performance information and comparisons against budgets and targets provided directly by FTs, together with other third party information and intelligence, to identify matters of concern.

Mid Staffs had not been authorised long enough for the relevant issues cited by the HCC to be identified as a part of the Compliance system at Monitor. Therefore, there are no direct findings arising from Mid Staffs that impact specifically on Compliance. However, there are matters that we believe should be reconsidered by Monitor based on the findings within Assessment. These relate mainly to the lack of clarity regarding the threshold for quality and clinical governance being applied on Assessment as the basis for authorisation.

The matters that read across to Compliance are, broadly:

- **Threshold:** the quality standard being applied by Compliance to quality and clinical governance;
- **Stakeholder information:** What information is or ought to be used during Compliance to inform Monitor in discharging its responsibilities;
- **Forward look at Quality:** Whether and how the quality impact of business plans and CIPs should be considered as a part of the Compliance regime;
- **Clinical management expertise:** Whether access to additional expertise in clinical management within the Compliance team would provide Monitor with additional value in evaluating and monitoring FTs' performance; and
- **Assurances:** What assurances might be required from the stakeholders including the FT itself on a continuing basis regarding the effectiveness of clinical governance and quality of underlying data.

### Changes made since March 2008

Since March 2008 a range of further information has been used by Compliance to evaluate the state of FTs. This now includes:

- More formal reviews of SUIs, complaints and surveys (staff and patients);
- The capture of relevant information in Monitor's holistic risk indicator one page report showing a heatmap of potential governance and clinical issues in the context of authorisation;
- More formal and greater interaction with PCTs and SHAs. For example, Monitor's Compliance teams more often combine their annual visits to the FT with SHA and PCT visits;
- Compliance managers leading on specific topics regularly liaise with a wider range of specialists at the DH for a number of the higher risk DH targets and standards contained within Monitor's Compliance Framework; and
- Since autumn 2008, Monitor's relationship managers in its Compliance team have attended the annual risk summits hosted by the HCC (now the CQC) to share knowledge with other regulators and stakeholders on issues identified at FTs.

## 3.3 Key findings – Intervention

### Background

Any FT rated Amber within Monitor's Compliance Framework is regarded as an Issue Trust which places it within Monitor's escalation and intervention processes. Quality and clinical governance issues are reflected in Monitor's Governance Risk Rating within the Compliance Framework. For Amber rated Issue Trusts, Monitor requests additional information on the causes of the risk and the actions proposed and confirms its expectations and timeframe for action. Monitor may hold a formal regulatory meeting subject to the Trust meeting defined escalation criteria.

FTs are rated Red for their Governance Risk Rating when their service performance score (based on the DH Targets and National Core Standards) exceeds 3.0 and / or one or more aspects of governance gives rise to a concern that the FT could be in significant breach of its terms of authorisation. Additionally, FTs achieve a Red Risk Rating for Governance if they are Amber for 3 consecutive quarters for failing to achieve the same national requirement. For Red rated FTs, Monitor further increases the intensity of its monitoring activity. This includes a formal assessment as to whether an FT may be in significant breach of its authorisation.

A decision by Monitor to use its powers to intervene may result in changes to the Board or require an action plan, potentially with the use of external support and review. Monitor has to date formally intervened 7 times (in a total of 3 FTs) since its inception; twice for financial issues and five times for more general governance issues, of which two occasions were at Mid Staffs.

### Findings

There are a number of documents within Monitor that refer to Interventions and their basis. However, there is no single document or manual that describes all aspects of regulatory escalation including the internal and external communications.

While records of events are maintained within Compliance on the Portfolio Update System, the system does not currently capture all meetings held by senior management. Therefore, the record lacks certain key information, events, external communications and decisions.

A series of decisions was made in relation to Mid Staffs between March 2008 and April 2009. While the final decision to intervene was clearly recorded, we were unable to find a clear record of support for earlier decisions such as the decision not to intervene during this period. Accordingly, it has not always been possible to check how decisions were made and their basis.

In 2009 after the publication of the Mid Staffs HCC report, Monitor met all the Governors of Mid Staffs. We understand that the Governors at that time were not clear as to Monitor's role and their powers and accountabilities. To date, there has been no training provided for Governors by Monitor or a predefined structure for such meetings, or mechanism for ongoing dialogue.

### Changes made since March 2008

Since March 2008 a range of further measures has been introduced to the Intervention process to improve the information available to Monitor on the state of FTs' action and to provide a further stimulus to ensure timely and effective action. The measures adopted by Monitor now include:

- Increased use of third parties to undertake specialist reviews to determine whether there are deeper or specific governance concerns;
- Asking for evidence of changes made to address concerns over the previous 12 months as well as forward looking actions where Monitor is not convinced on the quality of clinical governance but all DH standards are being met;
- Engaging with Governors at Issue Trusts, when appropriate, to explain the seriousness of the breach and to provide a reminder of their accountabilities and responsibilities in driving mitigating action locally; and
- Clarification and publication of accelerated escalation processes for C.Difficile, MRSA, 18 weeks and Accident and Emergency waiting times; to reflect ongoing or potentially significant issues at a number of FTs, unrelated to Mid Staffs.

## 3.4 Key findings – Structural matters

### Management Capacity

Since its creation in 2004 Monitor has operated with an annual budget of under £18M supporting a staff that has only recently grown to around 100 and a small senior management team. At 1 August 2009, Monitor has now authorised 122 FTs and as such is continuing to review resources required to respond to the increasing needs.

The most time consuming matters for the senior management after Authorisation, following a formal handover from Assessment to Compliance teams, arise from Issue Trusts and on Intervention. While Monitor has only formally intervened on seven occasions using its legal powers, over the years there has been a larger number of Issue Trusts close to Intervention when extensive senior management time and attention has been required.

### Findings

At the time of publication of the Mid Staffs report and intervention in early March 2008, Monitor had another intervention in process.

Monitor's top management structure comprises a small number of individuals with limited capacity to manage multiple concurrent interventions. While there was sufficient management capacity, the volume of work limited Monitor's ability to address other matters in its Corporate Plan.

The Executive Chairman was heavily involved in discussions regarding Mid Staffs from March 2008 through to intervention. Due to this executive role, it was not easy for him to stand back to take a broader view of the needs of the stakeholders and any associated communications during this period.

While the senior management team has been drawn from a range of professional disciplines this does not include practical experience of clinical management.

The Executive Chairman has an extensive network of contacts across the NHS and throughout its stakeholder network. This is less well developed amongst other members of the senior management team.

### Stakeholder relationships

Monitor has continuously evolved its processes since its inception in 2004 and has many established stakeholder relationships which are used to develop the effective flow of information in support of improved regulation.

We have observed the following changes in stakeholder relationship management, communication and interaction, since March 2008:

- Relationships with the newly formed CQC are under development at the time of drafting. The senior management teams of both organisations are now meeting on a monthly basis to agree a high level Memorandum of Understanding (MoU), with a view to determining detailed practical arrangements for ongoing liaison; and
- From 1 April 2009 PCTs have been charged with responsibility for holding FTs to account for quality performance where it is agreed within their contract. It is not yet clear what impact this will have on the level or quality of information on quality and clinical governance available to Monitor on Assessment and subsequently.

In order to address certain of the recommendations we believe that Monitor will inevitably need to enter into a more extensive dialogue with the key stakeholders in order to exchange information and ideas on topics such as defining:

- Clinical governance;
- What constitutes the minimum requirements at Assessment for clinical governance;
- What constitutes appropriate proxy indicators for clinical governance within the Compliance regime; and
- What might comprise a formal review of clinical governance.

## 3.5 Detailed findings and recommendations – Assessment

Findings	Recommendations
<p>Monitor could improve its ability to manage the risks associated with authorisation by ensuring the completeness of assurances received from stakeholders.</p>	<p><b>1. Obtain stronger assurances at Assessment on the state of quality:</b> Monitor should continue with its revised practice of ensuring that formal communication takes place with key stakeholders during the Assessment process and that written confirmation of any issues or concerns is obtained (where agreed) from each stakeholder at the point of authorisation to ensure clearance. Stakeholders Monitor should seek written assurance from include: the CQC, DH (and PCTs, SHAs where not covered by the DH process). Additionally, Monitor may wish to continue to consult with: the Parliamentary and Health Service Ombudsman, the Health Overview and Scrutiny Committee, NPSA, NHSLA, and Internal and External auditors of the Trust.</p>
<p>For Mid Staffs, some concerns were identified through the Assessment process regarding the impact of planned CIPs. At that time Monitor did not have a mechanism in place to evaluate the service quality impact of CIPs on Trusts, i.e. there was no forward looking analysis of the potential clinical impacts.</p> <p>Monitor's Assessment procedures at the time did not include a formal evaluation by an independent third party of clinical governance of FT applicants. Therefore, clinical governance was not supported by an independent opinion or as in depth analysis as received for financial governance.</p>	<p><b>2. Stronger focus required on quality and clinical governance:</b> Monitor should continue to undertake its own analysis of quality performance and clinical governance but seek to rely on the information and assurances provided by its stakeholders on quality and clinical governance as much as possible. In order to reduce the level of risk Monitor will need to:</p> <ul style="list-style-type: none"> <li><b>a) Redefine quality performance:</b> Where gaps are identified in quality performance, these should be explored as part of Monitor's review with the FT applicant and actions should be agreed to mitigate issues to an acceptable level. If Monitor's concerns on quality matters are not cleared, it should consider engaging an independent qualified third party to undertake a review of the relevant topic prior to authorisation. This might be a specific area such as MRSA performance.</li> <li><b>b) Define clinical governance:</b> Monitor should develop a definition of clinical governance that addresses its Assessment (and Compliance) needs and validate this with its stakeholders to ensure consistency of understanding.</li> <li><b>c) Identify any gaps in information available to evaluate clinical governance and address them:</b> Evaluate the information already received and its quality and work with the key stakeholders to identify and address gaps in information and evidence.</li> <li><b>d) Clinical governance reviews:</b> Monitor should include in its Assessment programme a formal evaluation of clinical governance at FT applicants based on the framework defined and making use of the information available from its key stakeholders. While such review can be performed by Monitor's Assessment staff we believe that greater insights will be gained by using staff with extensive clinical management experience and / or requesting an independent third party to provide an opinion.</li> <li><b>e) Forward looking assessment of clinical risks:</b> Monitor should define a formal scope of work to evaluate the forward looking impacts of the business plan on clinical quality in more depth. This should include a focus on the quality impact of CIPs. Formalised activities to enhance existing Assessment processes could include: requiring FT applicants to set quality objectives and measures on application; seeking comment in applications regarding the quality impact of business plans and considering using third parties to undertake focused exercise.</li> <li><b>f) Focused in-depth challenge on quality and clinical governance at the B2B:</b> Monitor should use the information gained from the above work to develop a specific agenda for each B2B to provide a focused in-depth challenge on quality and clinical governance based on the findings from Assessment work performed. Consideration should be given to using clinical management specialists to enable more experienced challenge.</li> <li><b>g) CQC Transition period:</b> It is not yet clear to what extent the work of the HCC and the resulting information flows, such as the ORP Reports, will be incorporated into an overall conclusion or rating of the quality performance of a Trust as part of its registration. Accordingly Monitor needs to establish a contingency plan that will address any shortfall in information during this transition period. This may include developing its own tests for quality and clinical governance effectiveness.</li> </ul>

## 3.5 Detailed findings and recommendations – Compliance

Monitor should apply the learning gained from Assessment to ensure that the principles flow through into Compliance to maintain that same standard of performance.

Findings	Recommendations
<p>The Compliance Framework makes use of the DH Targets and National Core Standards to underpin the service performance element in the Governance Risk Rating. Other information used includes SUIs, local press and patient and staff surveys, in line with Assessment practices.</p>	<p><b>3. Redefine the quality and clinical governance thresholds in Compliance:</b> Monitor should re-evaluate the thresholds implicit in the Compliance Framework in the light of any changes being made to the Assessment process. In doing this Monitor will need to be clear as to the rationale for and basis of any differences between the two. As a part of this re-evaluation, Monitor should also consider whether it wishes to place more focus on quality and clinical governance matters by including a specific clinical governance element in the Compliance Framework, and the specific indicators it would use to measure compliance.</p>
<p>The range of quality indicators used in Compliance is not the same as that used during Assessment. This reflects the differences between the underlying bases used by Monitor for Assessment and Compliance. One document not used in Compliance is the CQC's ORPs. Other differences include less face to face time and greater reliance in Compliance on self certification by Trusts.</p>	<p><b>4. Enhance stakeholder information flows to help assess compliance against revised thresholds:</b> Depending upon the decision regarding the threshold to be applied, Monitor may need to increase or change the quality and quantity of data and information it receives from stakeholders on quality and clinical governance in order to meet its objectives. For example, Monitor may consider whether its Compliance teams liaise with the CQC to receive the CQC's Trust specific ORP Reports outlining outstanding concern levels as they are updated. Any changes will need to be negotiated with the relevant stakeholders.</p>
<p>Forward looking clinical quality risks are not explicitly analysed in depth during the Annual Risk Assessment (ARA) process.</p> <p>From our review of a sample of Issue Trusts, it was not clear whether the current Compliance regime includes indicators to demonstrate how Trusts drive innovation and continuous improvement in the quality agenda.</p>	<p><b>5. Include an evaluation of the impact FT plans have on clinical risk:</b> Monitor should consider how best to challenge an FT's forward evaluation of clinical risks.</p> <p><b>a) Evaluate the impact of the business plan on clinical governance:</b> Monitor could research how to apply the forward looking process used at Assessment as part of the challenge of the quality impact of the business plans during the ARA process. This could include a review of the principal clinical risks and uncertainties and associated mitigation and a specific focus on evaluating the impact of CIPs on quality, where CIPs are of a material value.</p> <p><b>b) Continuous improvement in quality:</b> Monitor could adapt the ARA process to request explicit inclusion of the clinical risks in the business plan as a trigger to help its challenge of an FT's focus on innovation and continuous improvement in their quality agenda.</p>
<p>Within the Compliance team, there is no practical experience of clinical risk management. The team have developed knowledge of clinical risks through their work since 2004.</p>	<p><b>6. Provide access to clinical management skills:</b> As a part of its re-evaluation of the Compliance Framework, Monitor should consider the benefit to be derived from greater access to clinical management skills. We believe that this might enable a more effective challenge to quality and clinical governance matters.</p>

## 3.5 Detailed findings and recommendations – Compliance (continued)

Findings	Recommendations
<p>The Chief Accounting Officer is the Chief Executive at the FT and Monitor's Senior Relationship Managers liaise primarily with them, although practice varies across Compliance teams and often includes a wider set of individuals.</p> <p>Monitor relies primarily on Board self certification on matters such as quality standards and performance, but underpins this with other published information, soft intelligence and the analysis of the DH Intensive Support Teams. Where Monitor has concerns as to the basis of self-certification made by FTs, it has required independent reviews in the past.</p> <p>The level of assurance over clinical governance through the Compliance process is less rigorous than that required over financial governance. There are currently no formal requirements placed on Trust Boards or external auditors to positively validate quality data; although it is expected that Trust Boards will want and need to validate data in support of their own objectives.</p> <p>The Audit Commission's recent 2009 publication 'Taking it on Trust', highlighted concerns as to the level of reliance that should be placed on self certification processes and the strength of assurance provided.</p>	<p><b>7. Increase the nature and level of assurance obtained on clinical data and clinical governance:</b> In order to reduce the risk of failing to identify emerging issues at FTs, Monitor should consider ways of strengthening the level of assurance it obtains over the actual performance level in FTs. There is a range of ways in which this might be achieved and we have provided examples below for Monitor's consideration, depending on the Compliance philosophy adopted in point 3 above:</p> <ul style="list-style-type: none"><li><b>a) Broaden interaction with individuals at the FT:</b> Monitor could broaden its Senior Relationship Manager interactions to include representatives from the FTs involved in clinical governance. Monitor could define minimum interaction, for example, formal discussion with FTs by the relationship team as part of the periodic or annual assessment of risk. Other key individuals might include the Medical Director, Chair of the Clinical Governance Committee (or equivalent), Head of Governance and Head of Risk Management. Monitor could include them in their face to face visits to the FTs in addition to the Chief Executive.</li><li><b>b) Self certification processes:</b> Monitor could investigate the feasibility and cost benefit associated with requiring FTs to establish assurance processes or a more formal challenge to their assessment of the quality of clinical data as an additional mechanism to support the Statement of Internal Control (SIC) in an FT's annual report and accounts.</li><li><b>c) Strengthen Internal Audit assurance:</b> Monitor could investigate the feasibility and cost benefit of requiring an FT's Internal Auditors to undertake an annual or periodic review of clinical governance and data quality as part of their Internal Audit plan to support the SIC. This might be a review focused on a particular topic or issue.</li><li><b>d) Periodic assurance on clinical governance and data quality:</b> Monitor could consider using an appropriately qualified third party to undertake periodic clinical governance effectiveness and data quality assurance reviews at FTs. This might be required at all FTs on a rolling basis.</li><li><b>e) Independent assurance provided by the FT's External Auditors:</b> Monitor could investigate the feasibility and cost benefit of changing the FT Audit Code to require FTs' External Auditors to provide more formal assurance regarding the effectiveness of clinical governance structures, activities, processes and underlying data quality.</li><li><b>f) Re-assess FTs periodically:</b> Depending on their risk appetite, Monitor could consider undertaking a more in depth review of FTs. This would involve a similar challenge process as on authorisation but could not impact authorisation itself. Such a review could be either following the ARA process if indicators of unacceptable residual risk are identified or on a rolling basis, for example every 3 to 5 years, to provide in-depth challenge to FTs' business plans, quality accounts and governance structures.</li></ul>

## 3.5 Detailed findings and recommendations – Intervention

Findings	Recommendations
<p>There are a number of documents that describe the various elements of the Compliance and Intervention processes. These do not include a description of the role expected of Communications.</p>	<p><b>8. Consolidate the intervention system documentation:</b> Monitor should consolidate the escalation and intervention processes and system in an Intervention Manual. This should include not only external actions with Issue Trusts but also internal roles and actions for each part of Monitor and cross working processes between senior management, Compliance, Communications, Legal and other teams.</p>
<p>For Mid Staffs, a number of internal meetings were held at which the potential need to intervene was discussed. There is no evidence to support the decisions not to intervene.</p>	<p><b>9. Document decisions not to intervene:</b> When decisions are made not to intervene, Monitor should find a way to capture the basis of the decision in order to build up a case history of judgements for later reference and aid corporate knowledge and learning.</p>
<p>Since the inception of the Portfolio Update System in 2008, key events have been logged for each FT in the portfolio by the Compliance team. However, the entries for Mid Staffs over the period under review do not reflect all the meetings undertaken by senior management. External communications with Parliament, the public and broader stakeholders are not recorded in the system.</p>	<p><b>10. Enhance central documentation of events at Issue Trusts:</b> Monitor should establish a mechanism to ensure that it can record in the Portfolio Update System all key events and communication associated with an Issue Trust. This revised process should include not just direct communications but also those with stakeholders. We are aware of the Information Project that is currently underway and it may make sense to include this recommendation in the scope.</p>
<p>At the time of authorisation the Governors have only just been elected.</p> <p>Monitor does not have the statutory remit to evaluate the adequacy of Governors' skills, competencies and performance.</p> <p>Some of the Governors at Mid Staffs were not aware of Monitor's role and the powers of the Governors and their accountability to Monitor during the period under review.</p>	<p><b>11. Increase the level of engagement with Governors:</b> Monitor should engage with Governors as part of their stakeholder relationship management to maintain awareness of its role and Governors' accountabilities to Monitor. New draft advice for Governors has already been issued during 2009 for consultation.</p> <p><b>a) Training for Governors:</b> Monitor should continue to encourage the development and provision of training for Governors as cited in the Monitor Corporate Plan for 2009-12.</p> <p><b>b) Include Governors in the dialogue at Issue Trusts:</b> Should an FT become an Issue Trust at risk of Intervention, Monitor should consider formally briefing Governors, or their representative, to refresh their understanding of their role in challenging the Board's plans and to ensure they are aware of the level of concern at Monitor and the nature and seriousness of the breach. This may require Monitor and the Governors establishing a primary point of contact within the Governor group for each FT.</p>

## 3.5 Detailed findings and recommendations – Structural Matters

Findings	Recommendations
<p>At the time of publication of the Mid Staffs report and Intervention in early March 2008, Monitor had another Intervention running.</p> <p>Monitor's top management structure comprises a small number of individuals – with limited capacity to manage multiple concurrent interventions. While there was sufficient management capacity, the volume of work limited Monitor's ability to address other matters in its Corporate Plan.</p> <p>The Executive Chairman was heavily involved in discussions regarding Mid Staffs from March 2008 through to Intervention. It was not possible for him to stand back to take a broader view of the needs of the stakeholders and any associated communications as well as taking an active part in the operational aspects.</p> <p>Monitor's NHS clinical managerial experience and expertise is limited to two Non Executive Directors.</p> <p>The Assessment and Compliance teams do not include individuals with skills in clinical management.</p>	<p><b>12. Continue to strengthen the senior management structure and skills including clinical management skills:</b> Monitor is in the process of recruiting a new Compliance Director (splitting the role of the Regulatory Operations Director) and a further Portfolio Operations Director and should continue to enhance its top level management structure in order to:</p> <ul style="list-style-type: none"> <li>– Enable focus on operational matters, while ensuring that the regulatory strategy continues to develop;</li> <li>– Provide more contingency and back-up cover;</li> <li>– Enhance flexibility when dealing with multiple interventions and assist with greater delegation;</li> <li>– Enable greater delegation;</li> <li>– Provide more capacity for change.</li> </ul> <p><b>a) Access to senior clinical management skills:</b> We believe that Monitor should access skills in clinical management to support its actions in responding to the recommendations in this report. This would not require a permanent position, but would help Monitor to ensure that any developments made best use of knowledge on clinical management and clinical governance. Once the ongoing requirements are clear a decision could be made regarding the need to recruit and the appropriate skills.</p> <p><b>b) Independent challenge role on Interventions:</b> As a part of the structure for Issue Trusts with a Red Risk Rating for Governance, Monitor should consider assigning an individual from the senior management team to take on an independent challenge role. The Executive Chairman could fulfil this role while the other officers address the operational aspects of the Intervention.</p>
<p>The Executive Chairman was able to identify interim managers for Mid Staffs using his personal contacts and networks. There is no formal process in place within Monitor to identify interim managers.</p>	<p><b>13. Establish an interim recruitment process:</b> In order to be sustainable for the future, Monitor should plan how to identify interims in the event of future Intervention. We believe that this is likely to involve the increased use of personal networks amongst the senior management team.</p>
<p>The CQC and PCTs are still clarifying their roles and developing action plans for addressing their responsibilities. Given the extent of the CQC and PCTs' roles, the working relationships Monitor has with them will be fundamental in enabling it to discharge its duties to best effect in the future.</p>	<p><b>14. Make use of the stakeholder dialogue to continue developing information flows and working practices:</b> Monitor already has an extensive dialogue with the various stakeholders and should continue to strengthen and formalise these relationships. This should include developing working protocols and encourage continuous improvement in:</p> <ul style="list-style-type: none"> <li>– Information flows;</li> <li>– Understanding leading practice approaches to clinical governance;</li> <li>– Strength of assurance provided;</li> <li>– Sharing and resolution of mutual concerns at Issue Trusts and problems using scenarios and stress testing;</li> <li>– Identifying and agreeing the most appropriate responses to emerging issues.</li> </ul>

# Appendix A. Glossary of terms

Acronym	Definition
<b>B2B</b>	Board to Board: Monitor's Board challenge the FT applicant Board's strategy and any risks and concerns identified prior to authorisation
<b>CHI</b>	Commission for Health Improvement (Healthcare Commission's predecessor)
<b>CIP</b>	Cost Improvement programme / plan
<b>CQC</b>	Care Quality Commission: primarily accountable for the inspection of healthcare bodies for clinical quality performance from 1 April 2009
<b>DH</b>	Department of Health
<b>FT / FT applicant</b>	Foundation Trust / Trust applying for Foundation Trust status
<b>HCAI</b>	Health care acquired infections e.g. MRSA
<b>HCC</b>	Healthcare Commission (Care Quality Commission's predecessor)
<b>MoU</b>	Memorandum of Understanding or principles of working between two organisations
<b>ORP</b>	Organisational Risk Profile report produced by the CQC on each FT or FT applicant summarising concerns
<b>PCT</b>	Primary Care Trust
<b>SfBH</b>	Standards for Better Health
<b>SHA</b>	Strategic Health Authority
<b>SIC</b>	Statement of Internal Control
<b>SMR / HSMR</b>	Standardised Mortality Rate / Hospital Standardised Mortality Rate
<b>SUI</b>	Serious Untoward Incident

Definition
<p align="center"><b>Clinical Quality or Quality</b></p> <p>Lord Darzi in 'High Quality Care for All' defined quality in the NHS as safe and effective care of which the patient's whole experience is positive. The components of clinical quality include patient safety, patient experience and clinical effectiveness, with performance measured by clinical indicators.</p> <p><b>Definition:</b></p> <p>We use quality or clinical quality in this report to refer to the components referred to above.</p>
<p align="center"><b>Clinical Governance</b></p> <p>From 1999, Trust Boards assumed a legal responsibility for quality of care that is equal in measure to their other statutory duties (proper financial management of the organisation and an acceptable level of patient safety). Clinical governance is the mechanism by which that responsibility is discharged.</p> <p>Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.</p> <p>Clinical governance will be delivered via the Quality Framework, as described by Lord Darzi in 'High Quality Care for All'. There are seven steps in the Quality Framework: quality standards; measure quality; publish quality performance; recognise and reward quality; clinical leadership; safeguard quality; stay ahead.</p> <p>Components to consider within the quality framework include risk management, clinical audit, research and development, patient involvement, information management, staff involvement, education / training and development.</p> <p><b>Definition:</b></p> <p>Within this report we use the term Clinical Governance to mean the combination of the structures and arrangements in place at, and immediately below, the Board level to manage and monitor clinical performance, plan and manage continuous improvement, identify performance that may be below standard or out of line, investigate it and take management action.</p>

# Appendix B. Staff interviewed and documents examined

## Staff Interviewed

Name	Title
Bill Moyes	Chairman and Chief Executive
Adrian Masters	Director of Strategy
Stephen Hay	Chief Operating Officer
Kate Moore	Director of Legal Services
Rebecca Gray	Director of Public Affairs and Communications
Edward Lavelle	Regulatory Operations Director
Miranda Carter	Assessment Director
Yvonne Mowlds	Portfolio Operations Director
Patrick Fraher	Portfolio Operations Director
Stephanie Coffey	Senior Relationship Manager / Senior Compliance Manager
Paul Streat	Senior Relationship Manager / Senior Compliance Manager
Katie Cox	Compliance Manager
Carla Wilson	Senior Legal Advisor
David Hill	Senior Assessment Manager
Craig Watson	Assessment Manager
Claire Lucas	Assessment Manager
Anna Jefferson	Communications Manager
Jonathon Marron	Policy Director
Sonia Brown	Chief Economist
William Bessell	Q&T Compliance Manager

## Documents Examined

Mid Staffs FT application documentation including the integrated business plan, historical due diligence, self certification, governance structures, risk management and performance data
Mid Staffs Board to Board papers and minutes
Mid Staffs Compliance Files from 1 February 2008 to date
Monitor Compliance Committee agendas, papers and minutes over the period under review
Monitor Board papers and minutes over the period under review related to Mid Staffs
Monitor communications sent and received regarding Mid Staffs over the period under review with a variety of stakeholders
Holistic risk indicators for a sample of Issue Trusts and supporting Compliance Committee papers
Example Organisational Risk Profile from the CQC
Example FT applicant Monitor Board Decision pack from 2009
Compliance Framework over the period and Monitor Compliance Escalation Procedures for Issue Trusts
HCC Investigation into Mid Staffs final report and drafts
Monitor's Guide for FT Applicants
Monitor Compliance Team and Assessment Team job descriptions

# Appendix C. Summary chronology

Date	Event and High level Summary
Pre 1 October 2007	Mid Staffs Performance: 2006/7 HCC ratings = Fair (Quality), Good (Resources), 2005/6 HCC ratings = Fair (Quality), Fair (Resources), 2004/5 HCC star rating = 1*
1 October 2007 – 8 October 2007	Mid Staffs Assessment process begins following Secretary of State referral in June 2007.
8 October 2007 – 14 November 2007	Monitor holds meetings with Mid Staffs' Board, management and staff.
15 October 2007	Monitor meets Mid Staffs' SHA.
14 November 2007	Monitor meets Mid Staffs' PCT.
5 December 2007	Mid Staffs' Board to Board.
6 December 2007 – 25 January 2008	Communication between Mid Staffs and Monitor to clarify outstanding issues.
7 January 2008	Mid Staffs submits self certification.
30 January 2008	Monitor Board Decision on Mid Staffs.
1 February 2008	Mid Staffs is authorised by Monitor.
13 March 2008	HCC notifies Monitor of the investigation at Staffordshire Ambulance Service NHS Trust and the impact on Mid Staffs.
16 March 2008	HCC announces investigation at Mid Staffs.
March 2008	The Mid Staffs' Board decides to fund the shortfall in nurses.
March 2008	The Monitor Compliance team contacts the HCC's Investigations team and agrees ways of working and dialogue during the Mid Staffs' investigation.

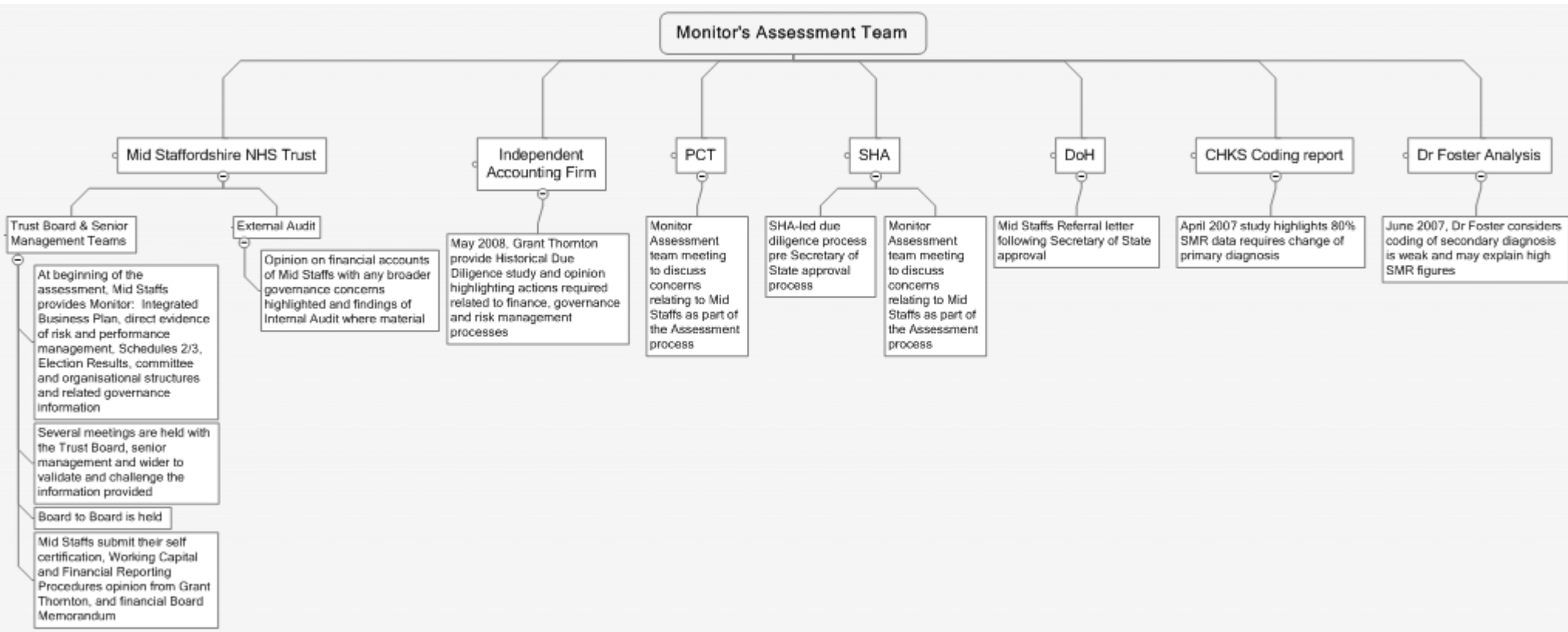
Date	Event and High level Summary
March 2008	Monitor reviews the Mid Staffs' Assessment pack.
March to August 2008	Monitor maintains dialogue with HCC and Mid Staffs' Board.
26 March 2008	HCC meets Mid Staffs' Chair, CEO and Executive Team regarding the investigation.
8 May 2008	Monitor holds an early meeting with Mid Staffs' Board.
20-22 May 2008	The HCC Investigation team visit Mid Staffs' A&E ward.
23 May 2008	HCC letter to Mid Staffs summarising a formal notification of concerns and their provisional findings from the A&E visit.
May 2008	Discussion amongst the Monitor Executive Team regarding the potential need to intervene at Mid Staffs.
29 May 2008	Monitor holds a call with Mid Staffs' CEO to encourage early corrective action in response to feedback from the HCC.
May 2008	Mid Staffs engages PWC to provide support.
3 June 2008	Mid Staffs writes to the HCC summarising the actions being taken to address the concerns raised by the HCC's first letter.
6 June 2008	Monitor's Executive management meet to discuss whether to intervene at Mid Staffs.
June 2008	Mid Staffs starts its Emergency Care action plan in response to issues identified in the first HCC letter.
7 July 2008	Second HCC letter to Mid Staffs highlighting the themes of concerns raised by patients and relatives.
24 July 2008	Mid Staffs responds to the HCC second letter summarising their Confidence in Caring action plan.

## Appendix C. Summary chronology (continued)

Date	Event and High level Summary
August 2008	Chairman of Mid Staffs' is re-elected by the Governors.
September 2008	PWC presents its initial report to Mid Staffs'.
October 2008	South Staffs PCT issues a Performance Notice on A&E.
October 2008	HCC Annual Health Check is published, showing Mid Staffs rated as: Good for quality and Good for resources.
October 2008	Mid Staffs is declared compliant with the Hygiene Code following an inspection by the HCC.
7-9 October 2008	HCC visits Mid Staffs focusing on governance.
15 October 2008	Third HCC letter to Mid Staffs summarising key areas for action arising from the investigation.
29 October 2008	PWC reports the findings of their governance review.
Late October 2008	HCC issues the first draft of its report to Mid Staffs and Monitor for comment.
November 2008	South Staffs PCT issues second Performance Notice on A&E.
27 November 2008	Monitor writes to Mid Staffs requiring Mid Staffs to redress and sustain performance in A&E by the end of 2008.
November 2008	Mid Staffs meet the A&E target throughout November
December 2008 and January 2009	Mid Staffs receives 3 further mortality alerts from Dr Foster and the HCC re December 2008 and January 2009.
22 December 2008	HCC issues the second draft of its report to Mid Staffs and Monitor for comment.
30 January 2009	HCC issues the third draft of its report to Mid Staffs and Monitor for comment.
20 February 2009	Monitor's Executive Chairman emails the Chairman of Mid Staffs summarising the areas that will be taken into account in determining whether an Intervention would be needed and what the likely course of action could be.

Date	Event and High level Summary
23 February 2009	Monitor Compliance team meets with Head of the HCC Investigations to discuss whether special measures may need to be applied.
3 March 2009 8.45am	Special Monitor Board meeting is held to discuss Mid Staffs, approve an Intervention and propose as an interim Chairman, and an interim Chief Executive.
3 March 2009 am	Monitor sends a letter by email to the Council of Governors at Mid Staffs explaining why Intervention was necessary.
3 March 2009 pm	Chairman of Mid Staffs resigns at the Governors' meeting.
3 March 2009 pm	The Monitor Executive Chairman formally requests David Stone to step in as interim Chairman at Mid Staffs.
3 March 2009 pm	Monitor issues a press release announcing the appointment of interim chair and the Mid Staffs Intervention Monitor issues Section 52 notices to the Trust.
5 March 2009	Monitor issues a press release announcing the appointment of an interim Chief Executive at Mid Staffs.
16 March 2009	Secretary of State for Health holds a meeting with Monitor, the HCC and advisors to discuss the HCC report.
By 17 March 2009	David Stone and Eric Morton were appointed as interim Chairman and Chief Executive respectively at Mid Staffs.
17 March 2009	HCC sends a letter to the Minister for Health highlighting that during the HCC's unannounced visit to the Mid Staffs A&E ward at the end of February 2009, significant improvement had been made when compared to the May 2008 visit.
18 March 2009	The HCC report on Mid Staffs is published. Covering letter to Monitor advises that no 'special measures' were required.
2 April 2009	Monitor visit Mid Staffs to gain an update. The Monitor team also meets the Governors of Mid Staffs.

# Appendix D. Mid Staffs stakeholder information flows at Assessment



# Management response to the Internal Audit Report on lessons learnt from Mid Staffordshire NHS Foundation Trust

3 September 2009



# Management response to the Internal Audit Report on lessons learnt from Mid Staffordshire NHS Foundation Trust

## Introduction and purpose of response

1. As the Independent Regulator of NHS Foundation Trusts our two core statutory roles are to:
  - Assess and authorise applicants for foundation trust status; and
  - Regulate foundation trusts to ensure they remain compliant with the terms of their authorisation.
2. Our approach, and the principle behind the foundation trust policy, is that the boards of foundation trusts have primary responsibility for the performance of their trust. Therefore, the focus of our assessment process is on the capability of the board to operate an autonomous organisation capable of providing the best possible care for its patients and service users and value for money to the taxpayer. The focus of our compliance activity is on ensuring that the board continues to manage the trust effectively. This includes the identification and management of financial risk and clinical risk (and indeed any other major risk to the foundation trust's performance and organisational health). Where boards fail to meet their obligations we consider intervening using the substantial powers granted to us in statute.
3. Following the significant failings in the quality of care at Mid Staffordshire NHS Foundation Trust (Mid Staffs) identified by the Healthcare Commission investigation (which started in March 2008 and completed in March 2009), Monitor used its powers to intervene appointing interim replacements for the Chair and Chief Executive. We again used our formal powers in July 2009 to appoint a full time chief executive for a period of two years starting in August 2009. We are now working with the trust, the Care Quality Commission (CQC) and other partners to ensure that the trust is progressing with its plans to return the hospital to a position where it is fully compliant with its authorisation and can provide a consistently good quality of care to its patients.
4. A number of reviews have been carried out concerning the events and current state of care at Mid Staffs, which have reported over the last few months. First, the Healthcare Commission's own report was published in March 2009. Subsequently reports by Professor Sir George Alberti on progress in A&E and related wards, and by David Colin-Thomé on the commissioners' role, have also been published.
5. Monitor's Board judged it would be helpful to consider how Monitor's own methods and processes could be improved to help reduce the risk of such failings in the quality of care in future. The Board therefore commissioned KPMG, who are Monitor's Internal Auditors, to conduct a review of lessons learned from the events at Mid Staffs between October 2007 (the start of the assessment process) and April 2009. The scope of the

review was focused on the areas of governance and clinical quality, where the Healthcare Commission report identified major issues at the trust.

6. Internal Audit reported to the Monitor Board in July 2009, making recommendations for improvements in Assessment, Compliance, Intervention and Structural Matters. The Board accepted all the recommendations.
7. Senior management prepared this response setting out actions to be taken to put these recommendations into effect. This document was also approved by the Board at the July 2009 Board meeting.

## Overview of response

8. Monitor, as the Independent Regulator of Foundation Trusts, contributes to a system of quality regulation and improvement in the health sector. Efforts to develop and improve this quality system continue each year. Recent enhancements include the introduction of registration by the CQC (in full for healthcare providers from April 2010) and the work programme arising from the Darzi Report in 2008 covering areas such as Quality Accounts. The failings identified at Mid Staffs by the Healthcare Commission, and in subsequent reviews by David Colin-Thomé and Professor Sir George Alberti, have demonstrated the need to make the system of quality regulation more effective. The KPMG Internal Audit report describes the gaps in the overall system and identifies specific improvements to make Monitor's regulatory systems more effective. Addressing the recommendations of the report requires Monitor to consider how we can improve our own procedures - as we have done in this review - but also suggests we encourage our partners to consider changes in their own processes to improve the system as a whole. The key players in the system of quality regulation of providers are the Department of Health, strategic health authorities, CQC and Monitor. We will need to work closely together to ensure our various contributions are properly coordinated. The National Quality Board (NQB) provides an appropriate forum for this coordination.
9. Monitor's senior management team believes the various reviews over the last six months into the events at Mid Staffs point to the following main conclusions on our contribution to the system of quality regulation:
  - The essential need for risk-based regulation of hospitals has been reinforced, supported by **a development programme which helps foundation trust boards** in carrying out their role as the 'first line of regulation';
  - Given Monitor's statutory composition and framework, it cannot lawfully delegate any of its functions. However, in our consideration of the risks of failure **in matters of quality performance and safety, Monitor will seek to place significant weight on the advice and judgements of the Care Quality Commission** in order to avoid duplicating regulatory roles, expertise, and the monitoring systems and processes that they are best able to develop and operate. Consequently, improvements to the systems of assurance on quality will need to be agreed, developed and operated through close working with our partners in CQC and the Department of Health. In

particular, the authorisation threshold for foundation trusts with regard to quality performance will need to be periodically revised and restated as registration and periodic review is introduced, and as the wider approach to quality in the NHS evolves following the Darzi Report; and

- Monitor will need to continue to **enhance its approach to assurance on whether a foundation trust's board is adequately carrying out its role in ensuring good clinical governance** in the trust. By clinical governance we mean the combination of structures and arrangements in place at, and immediately below, the board level to manage and monitor clinical performance, plan and manage continuous improvement in patient care, identify performance that may be below standard or out of line, investigate it and take management action.

10. Monitor continually seeks to improve its processes. Many of the areas addressed in the KPMG Internal Audit recommendations are already scheduled for review in 2009-10 as part of our 2009-12 Corporate Plan. For example, changes have been planned to the Compliance Framework for 2010-11, to the Annual Risk Assessment round, and to our approach towards knowledge capture and management. There have already been significant enhancements to the Assessment process following the start of the Healthcare Commission investigation on Mid Staffs in early 2008 which the KPMG Internal Audit review supports. However, the KPMG Internal Audit has identified a number of areas where we judge that significant additions to our work programme are necessary. In particular a series of actions intended to strengthen our approach to gaining appropriate assurance that the trust board is ensuring good clinical governance.
11. As is the case with all regulators, Monitor has finite funding which it needs to allocate on the basis that best mitigates risk in the system. Many of our responses to the Internal Audit report will be subject to considerations of proportionality, consultation with the sector and, where appropriate, negotiation with our partners in managing the system, before the best detailed approach can be agreed on. However, we can set out proposals we intend to develop and test with our partners over the next few months.
12. The 14 main recommendations made by Internal Audit in their report are shown in the table below.

Area	Recommendations
<b>Assessment</b>	<ol style="list-style-type: none"> <li>1. Obtain stronger assurances at Assessment on the state of quality</li> <li>2. Stronger focus required on quality and clinical governance</li> </ol>
<b>Compliance</b>	<ol style="list-style-type: none"> <li>3. Redefine the quality and clinical governance thresholds in Compliance</li> <li>4. Enhance stakeholder information flows to help assess compliance against revised thresholds</li> <li>5. Include an evaluation of the impact foundation trust plans have on clinical risks</li> <li>6. Provide access to clinical management skills</li> <li>7. Increase the nature and level of assurance obtained on clinical data and clinical governance</li> </ol>
<b>Intervention</b>	<ol style="list-style-type: none"> <li>8. Consolidate intervention system documentation</li> <li>9. Document decisions not to intervene</li> <li>10. Enhance central documentation of events at Issue Trusts</li> <li>11. Increase the level of engagement with governors</li> </ol>
<b>Structural matters</b>	<ol style="list-style-type: none"> <li>12. Continue to strengthen the capacity of the senior management structure and skills including clinical management skills</li> <li>13. Establish an interim recruitment process</li> <li>14. Make use of stakeholder dialogue to continue developing information flows and working practices</li> </ol>

# Responses to recommendations

## Assessment

We agree with all recommendations in this section. While we have made significant improvements in the level of information and assurance gathered as part of our assessment process since March 2008 and focus increasingly on matters of clinical governance, we recognise the need to enhance our approach, in particular to clinical governance, and the need to work closely with partners to gain assurance around the quality of care provided by applicant trusts.

### 1. Obtain stronger assurances at Assessment on the state of quality

1. We will seek written assurances from the CQC and the Department of Health that they have no significant clinical quality concerns with the applicant before we take our authorisation decision:
  - We currently ask for confirmation of any quality concerns from the CQC at two points in our assessment process to ensure we have an up to date view from the CQC before we take our authorisation decision. This confirmation includes details of any planned or ongoing investigations. As registration is fully introduced we will seek to change the basis of this written assurance to confirmation that CQC is content that the applicant is compliant with registration standards at authorisation, and that there are no planned or ongoing investigations. As the CQC develops its approach to Quality Risk Profiles we will also discuss with them whether the assessment summarised in those documents could provide us with an additional, useful source of assurance.
  - We will write to the Department of Health before we take our authorisation decision to request written confirmation that they are not aware of any significant concerns which have arisen since the Secretary of State referral which should be considered as part of the assessment process. Where appropriate we would notify CQC of any such concerns.
  - We will also continue to engage with other relevant stakeholders as part of our due diligence process on each application to understand any concerns they may have. This will include SHA, PCTs, the NPSA and the Parliamentary and Health Service Ombudsman.

## 2. Stronger focus required on quality and clinical governance

- a. Identify any gaps in information available to evaluate clinical governance and address them;
  - b. Redefine quality performance;
  - c. Define clinical governance;
  - d. Conduct clinical governance reviews;
  - e. Conduct a forward-looking assessment of clinical risks;
  - f. Conduct a focused in depth challenge on clinical governance at the Board to Board; and
  - g. Conduct additional tests on quality during the CQC transition period.
1. We will determine whether or not there should be an additional quality 'bar' for foundation trusts, above the registration standard, to replace the current requirement in the Compliance Framework to comply with targets and national core standards. We will write to the Secretary of State to establish the Department of Health's view on this issue.
  2. Subject to agreement with CQC, Monitor will place significant weight on CQC assurance that essential standards of quality performance are being met by the applicant and that services are safe. This will avoid Monitor duplicating the role of our partners in the system. We will also refer any serious concerns or risks on performance against essential standards which we identify during assessment to CQC for consideration.  
We will continue to conduct reviews during assessment of historic performance in specified areas related to our Compliance Framework:
    - on any national targets included in the Compliance Framework; and
    - on any key clinical metrics included in the Compliance Framework.
- As now, where necessary, we will consult and engage qualified third parties to support these reviews, for example the Healthcare Acquired Infections team at the Department of Health.
3. We will initiate a study to build on our existing work with applicants to develop an improved approach to evaluating during assessment the board's role in assuring clinical governance in the trust. This is likely to include:
    - research on good practice in clinical governance;
    - identifying existing sources of assurance on clinical governance;
    - working with our partners to determine how the level of assurance can be improved; and
    - considering how the judgement of the assessment team on clinical governance might best be supplemented through access to specialist advice and/or independent opinions.

Once developed, we would introduce this new approach on assuring clinical governance into the assessment process for future applicants.

4. We have started to develop our approach to assessing the clinical risks associated with cost improvement plans; for example, we now request evidence on how the board has assessed clinical risks of cost improvement plans (CIPs) and undertake benchmarking analysis on future staffing ratios. But we recognise that our approach needs further development.

We will conduct a review on how we could more effectively require applicants to consider the quality impact of their forward plans. For example, we could expect boards to set out:

- quality improvement objectives and programme as part of the five year plan;
- key performance indicators the board will use to identify if clinical quality is at risk, for example staffing ratios;
- principal clinical risks to the five year plan; and
- how they have assessed the clinical quality risks of CIPs.

Once an improved approach to integrated business planning has been developed, we will enhance our approach to assessment, using third party expertise as necessary. A possible review of CIPs might include analysis and challenge during assessment of:

- Evidence of the board setting the strategic direction for the CIPs;
- Evidence of engagement with clinicians in the CIP programme and their sign off and ongoing involvement in its implementation;
- Evidence of risk assessment of the CIPs and thorough evaluation of the clinical risks that could impact the organisation as a result of the CIP;
- Evidence of how these are going to be managed and monitored during implementation of the CIP, i.e. clinicians have set clinical quality indicators they will monitor to ensure no adverse impacts on the business as usual activities as a result of the CIP; and
- Evidence of how the board plans to keep appraised on the CIPs performance/progress against implementation and what oversight and performance monitoring (financial and clinical) is planned, i.e. oversight/governance of the CIP.

5. We will further develop Board-to-Board packs and meetings to encourage greater focus and challenge on clinical governance and on clinical risks to the business plan. Recent Board-to-Board agendas have already begun to develop in this direction resulting in some recent decisions to defer applications based on issues of clinical governance.
6. We agree we will need access to additional clinical governance skills. Once our approach to assurance on clinical governance is clearer we will determine the best balance for accessing those skills between in-house options (such as additions to the management team) and external expertise.
7. Significant developments to the system of quality regulation are planned over the next 18 months. In particular, CQC will introduce the full system of registration for

hospitals from April 2010. It will also develop both periodic reviews and the system of ongoing quality data monitoring, and we understand that the NHS Medical Director is planning to introduce additional quality tests for foundation trust applicants. In the transition period, before registration by CQC and these other enhancements have been completed, we will continue to place material weight on the CQC Organisational Risk Profiles and to conduct additional tests ourselves to conclude on the clinical quality performance of an applicant. We will require applicants to demonstrate that:

- they continue to meet the quality bar set by the Department of Health at the time of Secretary of State referral;
- They have a minimum governance rating on service performance as set out in the Compliance Framework of at least amber; and

We will also review the Organisational Risk Profiles from the CQC to ensure that:

- the risk rating attributed to overall level of concern is no worse than *minor concerns*;
- the risk rating attributed to the confidence of the trust's ability to meet regulatory requirements is at least *confident*; and
- the trust is not under investigation, no investigations are planned and there are no preliminary inquiries into mortality outlier data.

We will continue to:

- work with the CQC to develop further the assurance we can obtain from the Organisational Risk Profiles that we currently receive, in advance of the full introduction of the Quality Risk Profiles that the CQC will develop to inform the registration requirements;
- share quality concerns identified in the assessment process with the CQC and will request them to consider the impact of these concerns on their overall view of clinical quality of the organisation before concluding on the authorisation decision;
- require confirmation of any quality concerns from the CQC at two points in our assessment process to ensure we have an up to date view from the CQC before we take our authorisation decision;
- write to the Department of Health before we take our authorisation decision to request written confirmation that they are not aware of any clinical concerns which have arisen since the Secretary of State referral which should be considered by Monitor as part of the assessment process; and
- engage with other relevant stakeholders as part of our due diligence process on each application to understand any clinical concerns they may have. This will include SHAs, PCTs, NPSA and the Parliamentary and Health Service Ombudsman.

We will also continue to carry out our current work programme on clinical governance during the transition period.

## **Compliance**

We agree with all recommendations in this section. Our compliance regime has been developed to ensure that we are able to identify current and emerging risks and ensure that they are dealt with effectively by the boards of foundation trusts. This system has worked well. We have increasingly worked with partner organisations to help us identify and then successfully address problems. The proposed actions below will help us to continue to evolve this approach, including refinement of indicators reflecting quality of governance.

### **3. Redefine the quality and clinical governance thresholds in Compliance**

1. We will continue to develop how the introduction of registration standards should be reflected in the Compliance Framework.
2. We will evaluate quality metrics emerging from work led by the Department of Health and CQC's periodic review methodology to determine whether a selection of these could supplement, and possibly over time replace, the national targets currently used as indicators in the governance rating.
3. We will conduct a study to determine whether regular targeted evaluation of clinical governance, reflecting key elements of the framework developed for assessment, could be integrated into the compliance monitoring regime at an acceptable cost/benefit.

### **4. Enhance stakeholder information flows to help assess compliance against revised thresholds**

1. CQC will be our primary source of information on clinical quality. We will hold monthly meetings with them to discuss:
  - emerging clinical quality concerns with specific foundation trusts (which will be informed by the CQC Quality Risk Profiles, as these develop);
  - handling of issue foundation trusts, where there are clinical quality concerns; and
  - potential interventions related to clinical quality issues.
2. We will continue to contribute to risk summits organised by CQC on clinical quality issues for foundation trusts.
3. We undertook a review in 2008, the "Information Project", to understand how Monitor could better capture, analyse and share relevant information on clinical quality and clinical governance and other information across Assessment and Compliance. We will continue to progress the work programme arising from that study, including recruitment of a Director of Knowledge Management in 2009 to lead future work on the design and implementation of our strategy on information management.

## **5. Include an evaluation of the impact foundation trust plans have on clinical risks**

- a. Evaluate the impact of the business plan on clinical governance
  - b. Include clinical risks in the business plan to promote continuous improvement
1. We will review and as appropriate revise the guidance to foundation trusts on consideration of clinical quality risks during the annual planning round. For example, requiring evaluation by the foundation trusts of the clinical risk implications of major CIPs.
  2. We will conduct a study to determine the feasibility and cost/benefit implications of:
    - rating the clinical quality and clinical governance risk of future plans of all foundation trusts as part of the annual planning round; and
    - requiring more detailed risk assessment and mitigation exercises to be carried out for higher risk forward plans.

## **6. Provide access to clinical management skills**

1. Monitor will continue to access and use qualified third parties to conduct targeted studies on particular clinical risk areas, for example A&E and MRSA. We will look to establish and develop relationships with additional sources of clinical expertise for such studies, helping to minimise duplication of such capabilities in the system e.g. CQC experts, National Clinical Directors, SHA Medical Directors and SHA Directors of Nursing.
2. As part of the recruitment and development of the senior team within Compliance, we will look to target and attract personnel with relevant hospital operational experience.
3. Once our approach to assurance on clinical governance is clearer we will continue to review the need to secure additional access to expertise in clinical governance.

## **7. Increase the nature and level of assurance obtained on clinical data and clinical governance**

- a. Broaden interaction with individuals at the foundation trust  
  
Investigate feasibility of:
  - b. Additional self certification processes (to support the Statement of Internal Control)
  - c. Strengthen Internal Audit assurance
  - d. Conduct periodic assurance on clinical governance and data quality
  - e. Require independent assurance from foundation trust's external auditors
  - f. Reassess foundation trusts periodically.
1. Relationship Managers already have contact with a range of staff at foundation trusts, however greater consistency in our approach and interaction is possible. We will draw up a list of key officials at foundation trusts that Relationship Managers are expected to interact with each year, for example during the annual planning round or in-year relationship visits, or when specific clinical quality issues arise. This will ensure these foundation trust executives have regular access to Monitor to raise

quality concerns directly with us. These officials will include:

- a Medical Director;
- a Director of Nursing;
- a Chair of the Clinical Governance Committee or equivalent; and
- a Head of Risk Management or equivalent.

2. We will conduct a study to determine the feasibility and cost/benefit implications of requiring foundation trust boards to obtain greater assurance on clinical governance (including clinical data) through:
  - reporting in the Statement of Internal Control;
  - additional use of Internal Audit; and
  - additional assurance work by External Audit.
3. We will continue to develop with third party advisors a clinical governance review as an option for use with foundation trusts whose clinical quality performance or future plans indicate increased risk in this area.
4. We will conduct a study to determine the feasibility and cost/benefit implications of conducting in depth reviews of foundation trusts similar to an assessment. This could be either on a periodic basis or as part of the annual plan process with all foundation trusts being seen every few years, but trusts with greater risks seen more frequently. Alternatively this could be considered as an escalation option where the ongoing risk rating process suggested major problems.

## **Intervention**

We agree with all recommendations in this section. We have used our formal intervention powers seven times but have in general been able to deal with emerging problems effectively working with trust boards without recourse to our statutory powers. The proposed actions below will help to formalise all elements of the process of intervention ensuring that we can be as consistent as possible in our approach and ensure knowledge is captured in the most appropriate way. These commitments also reflect the importance of governors in the accountability and good governance of NHS foundation trusts and enhance our direct relationship with boards of governors.

### **8. Consolidate intervention system documentation**

1. We will develop and publish an escalation and Intervention Manual for use by all Monitor staff. This will consolidate the existing guidance and include further guidance to the extent gaps currently exist.

### **9. Document decisions not to intervene**

1. Monitor already fully documents all decisions to use our statutory intervention powers. We will in addition minute meetings and other discussions at key decision points where, for instance, decisions are made **not** to intervene.

### **10. Enhance central documentation of events at Issue Trusts**

1. We will establish, as part of the Information Project, mechanisms to ensure all significant communications relating to Issue Trusts are captured in a single central system, building on our Portfolio Update System, including:
  - senior management meetings and conversations with key Department of Health, SHA and CQC officials;
  - press releases and public statements; and
  - communications with Parliament, including written submissions and transcripts of oral evidence.

### **11. Increase the level of engagement with governors**

- a. Encourage training for governors
  - b. Include governors in the dialogue at Issue Trusts
1. Monitor will encourage the development of appropriate training for governors by third parties (such as the Appointments Commission) and by foundation trusts themselves. We have recently consulted on a guide for governors.
  2. We will ask each board of governors to nominate a governor (other than the Chair) as our contact point for correspondence to be shared with the trust's governors.
  3. We will, where appropriate, write to the board of governors of foundation trusts at risk of significant breach of their terms of authorisation:

- setting out the nature of the risk of breach, and possible consequences; and
- reminding governors of their role and of Monitor's role.

4. We will ensure that governors are notified of our actions where we have formally intervened.

## **Structural matters**

We agree with all recommendations in this section. Monitor has intentionally remained a small organisation committed to employing high calibre staff and delivering maximum impact with the resources available to us. The findings in this section and our responses reflect the need for Monitor to develop both its internal resources and external sources of relevant information and support in order to effectively identify risks and manage the increasingly complex issues within the foundation trust sector.

### **12. Continue to strengthen the capacity of the senior management structure and skills including clinical management skills**

- a. Strengthen access to senior clinical management skills
  - b. Assign an independent challenge role on interventions
1. We agree we will need access to additional clinical governance skills. Once our approach to assurance on clinical governance is clearer, we will determine the best balance for accessing those skills between in-house options (such as additions to the management team) and external expertise.
  2. As part of the recruitment and development of the senior team within Compliance, we will also look to target and attract personnel with relevant hospital operational experience. Though such experience is not identical to clinical governance experience, we believe there will be some gain in terms of better understanding of the operational processes and systems of hospital reporting on which clinical governance relies.
  3. We have strengthened the senior levels of the Assessment team by appointing a second Assessment Director.
  4. Monitor will continue to strengthen and formalise our relationships with external advisors who currently provide Monitor with advice on specific clinical issues. This includes the HCAI, A&E and 18 weeks teams at the Department of Health, senior clinicians and nurses and the CQC.
  5. A senior individual within Monitor, who is not directly involved with the specific case, will be assigned to an independent challenge style role on trusts where we are proposing to intervene formally using our statutory powers. The scope of the challenge role will be set out in the Intervention Manual.
  6. In addition, reflecting the growth in the number of NHS foundation trusts, and the number of potential issues in the future, we have already initiated actions to build further capacity within the senior part of our Compliance team:
    - the current role of the Regulatory Operations Director will be split into two roles – Director of Regulation and Compliance Director. This will provide additional senior resource to oversee the operation of compliance activities, whilst continuing to develop our regulatory approach; and

- we plan to increase the number of Portfolio Operations Directors from two to four by the end of 2009, which will allow us to also introduce increased experience in the operation of hospitals.

### **13. Establish an Interim recruitment process**

1. We will extend our contact at a senior level with chairs and chief executives through a more systematic programme to ensure we establish and maintain a broader network of personal contacts when the need for the appointment by Monitor of interim chairs and chief executives and other senior executives arises.

### **14. Make use of stakeholder dialogue to continue developing information flows and working practices**

We will continue to develop our working relationships with our partners, by:

1. Agreeing memorandums of understanding with both CQC and the Department of Health.
2. Developing working practices with CQC to support ongoing:
  - policy development;
  - authorisation;
  - monitoring, e.g. using risk profiles to identify issue foundation trusts
  - handling issue foundation trusts; and
  - formal intervention (both on registration standards and on breaches of the terms of authorisation).
3. Working as a member of the National Quality Board (NQB) to set out the design of the quality improvement system for providers including foundation trusts. In particular, we are currently working on a Mid Staffs sub-group to consider lessons learned for the system as a whole on how significant quality issues can best be identified and addressed in future. We will share the KPMG Internal Audit report and this management response with the NQB sub-group to assist their review.
4. Understanding how commissioners will track provider performance on clinical quality against contracts and how this can best be integrated with quality regulation. We will consider how best to develop this understanding – whether working through the NQB, or by working with a lead SHA.
5. Continuing to encourage PCTs to raise clinical quality concerns directly with Monitor at assessment or as part of the compliance process by building on the existing information we provide for PCTs and close working with the PCT Network.
6. Considering how best to ensure that Local Involvement Networks are aware of our role.



# Monitor

Independent Regulator  
of NHS Foundation Trusts

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# Birmingham Women's

## NHS Foundation Trust

### Report on Healthcare Commission Inpatient Survey 2008 – Gynaecology Directorate

#### Introduction

The Care Quality Commission has undertaken surveys of inpatients throughout Acute and Specialist Trusts in 2002 then annually from 2004 onwards. The survey is undertaken at this Trust by Picker Institute Europe and the results are then fed to the Care Quality Commission who produce a benchmark report which compares the performance of all Trusts involved in the survey. Individual Trust responses are scored on a scale of 0 to 100 which represents the best possible response. Trust scores then identify them as being in the best performing 20% of Trusts, intermediate 60% of Trust or worst performing 20% of Trusts.

The Care Quality Commission provided the Trust with a summary report on its scores in the survey, so the trust can benchmark its performance against other trusts and identify any areas for improvement. To ensure fairer comparisons across the results from all trusts, survey data are standardised by age, gender and admission method (emergency or elective) as the views of a respondent can reflect not only their experience of NHS services, but can also relate to certain demographic characteristics, such as their age and sex.

#### Sample

A total of 421 inpatients completed the survey, a response rate of 50%, the same as in 2007. The national response rate was 54%. 100% of the respondents were identified as female. Patients who had used any services other than gynaecology were excluded.

Scores were awarded for 60 questions included in the benchmark report. For this survey, a trust score for questions relating to mixed sex accommodation were not included.

#### Summary of Survey Results

The trust performed well in comparison to other trusts across England with the majority of responses in the best performing 20% of trusts. Although the total in this category had decreased slightly, there was a marked increase in the number of responses from intermediate 60% of Trusts to the threshold score between intermediate 60% and best 20% performing Trusts.

In 2007 there were no scores within the worst 20% performing trusts or on the threshold between intermediate 60% and worst 20% performing Trusts. In 2008 there were 2 areas that scored within the worst 20% performing trusts and one that was on the threshold between intermediate 60% and worst 20% performing Trusts.

These are summarised in table below.

<b>Benchmark</b>	<b>No of questions scoring in that category</b>	<b>%age BWH 2008</b>	<b>%age BWH 2007</b>	<b>%age BWH 2006</b>	<b>%age BWH 2005</b>
Best performing 20% of Trusts	43/60	71.7%	78.7%	36%	66%
Threshold between Best Performing 20% of Trusts & Intermediate 60% of Trust	6/60	10%	1.6%	9.1%	7.5%

ENCLOSURE 6

Intermediate 60% of Trust	8/60	13.3%	19.7%	40%	21%
Threshold between Intermediate 60% & Worst Performing 20% of Trusts	1/60	1.7%	0	-	-
Worst Performing 20% of Trusts	2/60	3.3%	0	9.1%	2%

**Areas In Best Performing 20% of Trusts**

1/43 achieved the highest score for all Trusts. This related to patients feeling involved in decisions about their discharge.

7/43 areas scores were only 1 from highest scores for all Trusts. These included:

Area	Trust Score	Highest Trust Score
Not bothered by noise at night from other patients	83	84
Not bothered by noise at night from staff	89	90
Not feeling threatened by other patients or visitors	99	100
Doctors not talking in front of patients as if they weren't there	93	94
Prompt response to call button	75	76
Seeing posters etc about how to complain	64	65
Not wanting to complain about their care	97	98

**Areas on Threshold between Best Performing 20% of Trusts & Intermediate 60% of Trust**

6/60 areas were in this category

Area	Trust Score
Admission date changed by Trust	94
Confidence and trust in doctors treating them	91
Different members of staff giving different information	82
Family / close friends had opportunity to talk to a doctor	67
Staff answered questions about operation/procedure	88
Cleanliness of toilets and bathrooms	84

**Areas in Intermediate 60% of Trust**

8/60 areas were in this category compared with 12/61 in 2007 and several of these were very close to the threshold with the best 20% performing trusts. These are listed in the table below.

Area	Trust Score	Threshold Score with top 20%
Given enough privacy when being examined/treated in Emergency Department	88	90
Time waiting to be admitted to a bed on a ward	62	67
Being offered a choice of hospital for 1 <sup>st</sup> appointment	39	41
Offered choice of hospital food	88	90
Given enough privacy when being discussing your condition or treatment	80	83
Told how to expect to feel after operation or procedure	72	74
Family given enough information by hospital staff prior to discharge	59	60
Hospital staff did everything to help control pain	84	85

**Areas on Threshold between Worst Performing 20% of Trusts & Intermediate 60% of Trust**

Area	Trust Score
Staff explained what would be done during operation/procedure	83

**Areas In Worst Performing 20% of Trusts**

Area	Trust Score	Threshold Score with Intermediate 60%
Staff explained risks & benefits of operation/procedure	85	87
Given clear written instructions about medicines on discharge	69	71

**Comparison with 2007 Results**

There were 6 areas highlighted in 2007 survey for priority work to improve. All of these were in the 60% Intermediate Trusts.

Two of these six areas showed significant improvement:

- Given written information about what to do after leaving hospital - ↑ in top 20% best trusts
- Staff answered questions about operation/procedure - ↑ on threshold of top 20% best trusts

Three areas remain in the intermediate 60% of Trusts but two have shown improvement in scores. These are:

- Were you offered a choice of food?
- Were you offered a choice of hospital for your first appointment?

The difference between the score for the third area and the threshold for best 20% has increased indicating a reduction in performance. This related to:

- Length of time waited for admission

Performance for the remaining area worsened considerably and scored in worst 20% of Trusts:

- Were you given clear written information about your medicines?

**Actions Required**

Actions required for further improvement have been identified in Appendix 1 Action Plan.

The Gynaecology Directorate will prioritise the areas that scored within the worst 20% performing trusts or on the threshold between intermediate 60% and worst 20% performing Trusts and also the area that reduced in performance from 2007 action plan. Two of these four areas, reducing waiting times and written information about medication have also been identified by SBPCT as areas for improvement.

**Conclusions**

The Trust has performed extremely well in the latest survey of what our patient think of the services we provide for them. All staff involved with providing Gynaecology Services particularly medical and nursing staff should be recommended on the standard of care they have provided, at a time when additional workload was required to meet 18 week targets. However there are two areas of concern. It is disappointing that written information about medication on discharge remains a consistent problem. The second area of concern relates to explanation of risks and benefits and what would happen during operation/procedure when related questions about answering questions about operation/procedure scored so well. Currently patients are given this information verbally on three occasions; time decision made to treat, preoperative assessment

## ENCLOSURE 6

and on morning of surgery b during preop ward round by surgeon as well as written information. This will require further discussion with clinical staff to identify way forward.

Jacky Cotton  
Head of Nursing – Gynaecology  
26<sup>th</sup> June 2009

## ENCLOSURE 6

## INPATIENT SURVEY 2008 - ACTION PLAN

produced June 2009

Question	Score for BWH	Threshold for best 20% of Trusts	Threshold for worst 20% of Trusts	Action	Expected Outcome	Lead Person	Date for Completion	Completed
<b>Admission to hospital</b>								
Length of time waited for admission (On 2007 action plan)	56	65	55	Continue to work to achieve 11 week maximum wait for admission.	↓ waiting time for admission & ↑ satisfaction	Delreita Bernard	Dec 09	
<b>Operations and Procedures</b>								
Staff explained risks & benefits operation/procedure	85	91	87	For further discussion with Medical staff and pre op nursing staff.  Staff to check understanding at end of explanation	Patients understand risks & benefits of procedure fully.	Mr Afnan/ Jacky Cotton	August 09	
Staff explained what would be done during operation/procedure	83	87	83	For further discussion with Medical staff and pre op nursing staff.  Staff to check understanding at end of explanation	Patients understand procedure fully.	Mr Afnan/ Jacky Cotton	August 09	
<b>Leaving hospital</b>								
Were you given clear written information about your medicines? (2006 & 2007as well)	69	79	71	All TTOs are dispensed in their original packaging with patient information leaflets (PIL) inside. As reported in 2006 & 07 action plan, awaiting appointment of lead pharmacist through SLA with UHB.  Develop labels to put on boxes directing patients to PIL.  To be discussed at Ward Meetings.	Improved pharmacy input to ward areas.  Patient aware of PIL in box of medication.	Jacky Cotton + Ward Managers  Jacky Cotton / Emily Hartwell	August 2009  Sept 09	

# Birmingham Women's

## NHS Foundation Trust



<b>SUBJECT :</b>	Winter and Flu Resilience Plans
<b>REPORT BY :</b>	Jane Owen, Director of Nursing Neil Savage, Director of Workforce & Organisational Development
<b>AUTHOR :</b>	Jane Owen, Neil Savage, Jacky Cotton

### CONTEXT AND BACKGROUND FOR REPORT

All trusts are required to assess their resilience plans and share the results with the SHA by the end of September 2009. Subsequently, each SHA Board is required to publish a 'statement of readiness' against key elements of the national Demand and Capacity Guidance, HR Guidance and Critical Care Checklist, covering the whole SHA health economy.

In order to promote consistency of reporting and presentation of information that will go into the public domain, the attached template of headings and discussion areas has been developed to support SHA Flu Lead Directors and Directors of Communications in formulating their statement for presentation to their September SHA Board meeting. It also gives the Board of Directors a visual assessment of BWNFT state of readiness and clarifies areas for further planning.

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

The attached template report presents the current status of preparedness. Additional on-going planning and procedural work is being undertaken to ensure maximum resilience by the end of October.

### RECOMMENDATIONS

The Board of Directors is asked to DISCUSS and NOTE the attached Winter and Flu Resilience Plan report and the actions taken to date.

## Winter and Flu Resilience plans checklist

Organisation name: **BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST**

Board meeting date: 24.09.09

Q	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria GREEN - assured and ready now AMBER - in progress complete by end Sept RED - in progress complete after end Sept	If RAG status is red predicted completion date	Page / para ref in Flu and Winter resilience plans
	<b>Health economy wide issues</b>					
1	<b>Leadership</b> - organisations in the Health Economy demonstrate joined up multi-agency approach to planning. Flu Resilience plans for each organisation in the Health Economy have been shared and agreed. Agreements in place on any local cross borough border issues to ensure patient care is seamless.	Y	Y			pg 19
2	<b>Local leaders</b> - every organisation has senior leadership arrangements in place to manage Flu and Winter resilience which is clearly documented. There is a reliable system in place for keeping the CEO, Board and Flu Lead Director apprised of progress, receiving exception reports and for escalating their involvement as required.	Y	Y			pg 6 sect 5
3	<b>SITREP reporting</b> - every organisation has in place robust procedures to comply with all SITREP reporting processes.	Y	Y			pg 11
4	<b>Resilience plans tested</b> - assurance that both Winter and Flu resilience plans have been tested or exercised particularly known stress points in the plan.	Y	Y			pg 14
5	<b>Infection control</b> - plans take into account both Swine Flu and also major increase in activity in 'surge' conditions.	Y	Y			pg 34
6	<b>Escalation processes</b> – there is a clear well communicated multi-agency plan for health economy response to 'surge' demand that is owned and shared with all key health and social care partners in the health economy. The trigger levels to move to each escalation level are well defined and understood by all agencies.	Y	Y			pg 19
	<b>Patients</b>					
7	<b>Antiviral Collection Points</b> - facilities in place so that anyone with suspected swine flu gets issued with antivirals within 48 hours including those patients without a GP and vulnerable groups - include PCTs full roll out plan of ACPs.	N	N/A			N/A
8	<b>Vaccination programme</b> for each PCT's patients is in place and is flexible enough to respond to vaccine supply issues and priority group issues.	N	N/A			N/A
	<b>Winter resilience plans</b>					
9	<b>Discharge processes</b> – multi-agency co-ordination to minimise the number of delayed transfers of care.	N	N/A	N/A	N/A	N/A
10	<b>A&amp;E performance</b> - specific plans to cope with 2 known dips in A&E performance early December and early January.	N	N/A	N/A	N/A	N/A
11	<b>Business continuity</b> - evidence that organisation has a robust plan to respond to issues such as bad weather (snow).	Y	N			
	<b>Flu Pandemic second wave resilience</b>					
R	<b>Enhanced capacity in 'surge' demand</b> - details of capacity that can be made available in each organisation for each key service including staffing and equipment resources. Details of the trigger levels to release this capacity into the organisation.	Y	Y			Appendix 1
13	<b>Capacity modelling</b> - each health economy has taken account of worst case scenario set out by DH in July 2009 and has plans in place to respond to the peak weeks of the pandemic.	Y	Y			Appendix 1
14	<b>Essential services</b> - plan identifies clinical and non-clinical essential services that must continue to be provided or that can be scaled back in a pandemic, as well as identifying critical and non-critical functions	Y	Y			Appendix 1
15	<b>Logistics</b> - plans identify and regularly review key vital supplies, without which the trust could not function, and include local plans as to how these supplies can be maintained (e.g. utilities, food, linen, medical supplies).	Y	Y			pg 11
16	<b>Communication</b> - plan for effective communication to staff, patients and the wider community before, during and after the pandemic.	Y	Y			pg 7
17	<b>Recovery from pandemic</b> -plan includes detail on recovery from a pandemic.	Y	Y			pg 18

**Winter and Flu Resilience plans checklist**

Organisation name: **BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST**

Board meeting date: 24.09.09

Q	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria GREEN - assured and ready now AMBER - in progress complete by end Sept RED - in progress complete after end Sept	If RAG status is red predicted completion date	Page / para ref in Flu and Winter resilience plans
	<b>Specific organisational capacity issues</b>					
18	<b>Acute hospital capacity</b> – senior clinical decision making for initial assessment of emergency admissions / inpatient capacity / A&E - UCC interface / Maternity Services Capacity – clear policies exist which prioritise women who need hospital care and limit unnecessary admission.	Y	Y			appendix 1 / pg16
19	<b>Critical care capacity</b> – organisation has been through critical care checklist provided by DH (available early August) and have specific plans to increase capacity by 100% to respond to Flu and clear and agreed prioritisation plans.	N/A	N/A	N/A	N/A	N/A
20	<b>Primary care capacity</b> - including normal GP capacity and out of hours services. Plans in place to ensure that those most likely to access healthcare services have care plans to reduce the likelihood that they will be admitted.	N/A	N/A	N/A	N/A	N/A
21	<b>Intermediate care capacity</b> – implementing simplified access criteria, enhancing admission avoidance and palliative care services.	N/A	N/A	N/A	N/A	N/A
22	<b>Social care capacity</b> – streamlining placement process, understanding total potential nursing and residential home capacity in each Borough with ability to utilise capacity. Plans in place to ensure social care workforce resilience	N/A	N/A	N/A	N/A	N/A
23	<b>Mental Health capacity</b> - robust acute psychiatric liaison services to minimise A&E breaches and timely assessment of inpatients.	N/A	N/A	N/A	N/A	N/A
24	<b>Ambulance capacity</b> - plans from each hospital to deliver the required 'hand over' waiting time targets.	N/A	N/A	N/A	N/A	N/A
25	<b>Diagnostic and therapy capacity</b> – enhanced levels of services working 7 days per week in both primary and secondary care.	N/A	N/A	N/A	N/A	N/A
	<b>Staffing</b>					
26	<b>Seasonal and Swine Flu vaccination plans</b> for organisation's staff, that prioritises staff to be vaccinated according to service needs.	Y	Y			pg 13
27	<b>Medical staff plans</b> - demonstrate that have recruited sufficient staff to cover EWTD rotas in all critical services and that number of medical staff available take account of the busiest times of day. If the decision is taken nationally for a temporary derogation of WTD compliance to be instated, the terms and conditions of job offers to all medical staff are amended to reflect this.	Y	Y			
28	<b>Maximise available staffing levels</b> in all roles during an influenza pandemic, including arrangements for temporary postponement of all training, appropriate re-deployment of staff, re-employment of newly retired staff or staff who have left recently, flexible working arrangements (part-time to full-time, working at home, etc) and refresher course for staff who have a clinical background, but who no longer practice.	Y	Y			pg 11
29	<b>Response to likely absence levels</b> due to sickness, carer responsibilities and the impact of the anticipated closure of schools, that are not reliant on temporary staffing solutions. Cover arrangements are in place for all key members of staff who may be taken ill, such as CEO, the Board, senior clinicians, and Flu Resilience team. Review of all policies that may affect staff attendance to ensure that they clarify how staff should report sickness during the pandemic.	Y	Y			pg 6
30	<b>Engagement with the Trade Unions</b> to ensure their contribution and support for staff arrangements over the period of the pandemic	Y	Y			

Note:  
PCTs may wish to complete separate checklist for Commissioning and Provider functions

Additional Trust Commentary
Meeting on 16.9.09 at HEFT to discuss plans with other Acute Trusts and agree planning assumptions / mutual organisational assistance
1st wave swine flu has partially tested existing plans. Plans amended in response during use.
Escalation process identified in Major Incident Plan. Agreement needed across Local Health Economy about assumptions of other Trusts on Specialist Trust status
Relates to ACPs set up by PCT in Primary Care. Arrangements are in place if inpatients / women presenting at Triage on Delivery Suite to have Relenza dispensed if thought to be appropriate PCT responsibility
Some policies and individual plans still require further updating. A programme is in place to finish this by end of October. HR policy for pandemic flu staffing being developed with Staff Side.
Capacity relates mainly to staffing & this is included in the plan identifying critical core business and what can be delivered depending on staffing levels. HR policy for pandemic flu staffing being developed with Staff Side.
Work in progress by departments



# Birmingham Women's

## NHS Foundation Trust



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

### CONTEXT AND BACKGROUND FOR REPORT

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

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

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

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

### RECOMMENDATIONS


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

# 1) Performance Dashboard Template Aug 2009

Market trend Awareness



Productivity & Efficiency



Clinical Quality



**Key:**

No Alerts




Alert on 1 indicator



Alerts on more than 1 indicator




Core Standards




Finance


Workforce




CQC Targets



Vital Signs



Commissioner Set



2) Key Performance Indicators - Template August 2009

Dataset	Indicator	Bench mark	Trigger	Target	Monthly Actual	Position against target( colour), Trend from previous month 'text'	Detailed report	Forecast Year End Position	
		National Benchmark							
Market Trend Awareness/ Strategy	Total inpatient and daycase waiting list size		>500	500	470	Adverse Change	Performance		
	Total Gynae outpatient waiting list size		>1500	1500	1658	Adverse Change	Performance		
	Total Genetics waiting list size		>1400	1400	1142	Favourable change	Performance		
	Referral Rates - Gynae	1586	<1507 and >1665	1586	1471	Favourable change	Performance		
	Referral Rates - Maternity	1894	<1799 and >1989	1894	1690	Favourable change	Performance		
Referral Rates - Genetics	691	<588 and >650	619	592	Favourable change	Performance			
Productivity & Efficiency	Maternity LOS postnatal	1.93		1.93	1.87	Favourable change	Performance		
	Gynae Length of Stay (exc daycases and emergencies)	3.1		2.90	2.32	Adverse Change	Performance		
	Daycase rate 1 - as % of all elective admissions	50%		>50%	57%	Favourable change	Performance		
	Gynaecology Daycase Over Stay Rate	13.86%		>10%	5%	0.82%	Favourable change	Performance	
	Gynae Pre operative Avg Los	0.15			0.08	Adverse Change	Performance		
	Elective Admitted patients surgery within 2 days - no of breaches	0		>0	0	1	Adverse Change	Performance	
	Theatre utilisation	80%		<75	80%	86.0%	Favourable change	Performance	
	Gynae New to FU ratio	1.40		<1.50	1.41	Favourable change	Performance		
	Non Obstetric diagnostic scans >= 6 weeks	0		>0	0	0	Favourable change	Performance	
	Occupancy Rate - Neonatal ITU	80%		<76%	80%	111%	Favourable change	Performance	
	Clinical Quality (Monthly)	Written Complaints	<9	<10	9	4	Favourable Change	Clinical Governance	
Responded to within agreed timescale		95%	95%	95%	80%	Favourable Change	Patient Experience		
PALS		20 cases	>25 cases	20 cases	10.0	Favourable Change	Quarterly report to CGC		
Compliments					3.0	No Change	Patient Experience		
Experience of Patients				To be determined					
Neonatal deaths						new report			
Annual Stillbirth rate per 1000 live births uncorrected		5.4	>7.4	>7.4	6.8	new report	May 08-09		
Annual Stillbirth rate per 1000 live births corrected					4.1	New report	May 08-09		
MRSA Bacteremia		<6 cases	>0	0	0.0	No Change	Infection control		
Cdiff		0	>0	0	0.0	No Change	Infection control		
MRSA Elective Tests				100%	100				
MRSA Total admission tests			100%						
<b>Essence of Care Indicators</b>				<b>Neonates</b>	<b>Maternity</b>	<b>Gynae</b>	<b>Clinical Support</b>	<b>Genetics</b>	
1 Communication		not achieved	In progress	Ongoing	Audited	on going	audited		
2 Continence		not achieved	Not relevant	In progress	Audited	on going	not relevant		
3 Hygiene		not achieved	In progress	Not audited	Audited	on going	not relevant		
4 Nutrition		not achieved	In progress	Not audited	Audited	not relevant	not relevant		
5 Pressure Ulcers		not achieved	Not relevant	Not audited	Audited	not relevant	not relevant		
6 Privacy & Dignity		not achieved	In progress	Ongoing	Audited	on going	audited		
7 Record Keeping		not achieved	In progress	Ongoing	Audited	on going	audited		
8 Safety		not achieved	In progress	In progress	Audited	on going	not audited		
9 Self Care		not achieved	Not relevant	Not audited	Audited	not relevant	not relevant		
10 Promoting Health		not achieved	In progress	Not audited	Audited	on going	audited		
11 Care Environment		not achieved	In progress	Ongoing	Audited	on going	audited		
Core Standards	Safety	compliance	breach	No lapses	No lapses	no change	Clinical Governance		
	Clinical & cost effectiveness	compliance	breach	No lapses	No lapses	no change	Clinical Governance		
	Governance	compliance	breach	No lapses	No lapses	no change	Clinical Governance		
	Patient Focus	compliance	breach	No lapses	No lapses	no change	Clinical Governance		
	Accessible and responsive care	compliance	breach	No lapses	No lapses	no change	Clinical Governance		
	Care environment and amenities	compliance	breach	No lapses	No lapses	no change	Clinical Governance		
	Public Health	compliance	breach	No lapses	No lapses	no change	Clinical Governance		
Clinical Quality (Quarterly)	Serious Untoward Incidents		>6						
	PEAT Annual Inspection Results			maintain excellent					
	<b>CQUINS</b>								
	User Experience in Maternity Clinics		Not meeting milestone	Achieving	Achieving	No Change	Commissioning Report		
	Maternity Early Booking		Not meeting milestone	Achieving	Achieving	No Change	Commissioning Report		
	Outpatient Hysteroscopy Pathway		Not meeting milestone	Achieving	Achieving	No Change	Commissioning Report		
Gynaecology Urgent Clinics		Not meeting milestone	Achieving	Achieving	No Change	Commissioning Report			
Finance	Year to date I&E position	plan or >	off plan	£273K	£698K	Favourable Change	Finance	£874K	
	Year to date I&E normalised	plan or >	off plan	£(84)K	£(139)K	Favourable Change	Finance	N/A	
	In month run rate	plan or >	off plan	£50K	£341K	Favourable Change	Finance	N/A	
	In month run rate normalised	plan or >	off plan	£(4)K	£244K	Favourable Change	Finance	N/A	
	Year to date Ebitda	plan or >	off plan	£2,085K	£2,589K	Favourable Change	Finance	£5,473K	
	Year to date Ebitda margin	plan or >	off plan	5.9%	7.3%	Favourable Change	Finance	6.3%	
	Year to date CIP performance	plan or >	off plan	£1,189K	£1,231K	Adverse Change	Finance	£2,613K	
	CIP recurrent/non-recurrent delivery	plan or >	off plan	70/30	32/68	No Change	Finance		
Trust	Contracted WTE	1322	1388	<1322	1350.23	Adverse Change	Head Count:1556		
	Agency/Bank spend as a % of directorate paybill	2.85	>2.85%	<2.85%	3.24%	Positive Change			
	Sickness Absence Rate %	4%	>4%	<4%	3.59%	Positive Change	1,695.76 Days Lost		
	Staff Turnover Rate %	14%	>14.10%	<14.10%	11.83%	Adverse Change	Leavers:29 (M&D Rotation)		
	Employee Investigations	4weeks	>4 weeks	<4 weeks	2	Positive Change	1 over 4 weeks		
	KSF - Staff groups with Job Outlines %	85%	<85%	>85%	72.19%	Adverse Change	1046/1449		
	KSF - Staff who have received PDR %	50%	<50%	>50%	32.37%	Adverse Change	469/1449 (From ESR)		
	Pay as a % of Trust Income	64.90%	64.90%	64.90%	63.90%	Positive Change			
	Staff Grievances	tbc	2	1	0	No change			
	Harassment and Bullying	tbc	2	1	1	No change			
	NHS Staff Survey: Extent to which Trust values my Work	70%	65%	70%	70%	No Change	2008 Survey		
CQC Targets	Cancer 2 week wait	No lapses	Outside Tolerance	93%	94%	Adverse Change	Performance		
	Cancer 1 month diagnosis to treatment	No lapses	Outside Tolerance	96%	100%	No change	Performance		
	Cancer 2 month GP urgent referral to treatment	No lapses	Outside Tolerance	85%	75%	Favourable Change	Performance		
	Cancer 2 month Cervical Screening Report Received to treatment	No lapses	Outside Tolerance	90%	0%	New	Performance		
	Cancer 2 month from upgrade to treatment	No lapses	Outside Tolerance	To be Determined	50%	New	Performance		
	Cancelled Operations on day of surgery	1	>1	<1	0	Favourable Change	Performance		
	Cancelled Operations not admitted within 28 days	No lapses	Breach	No lapses	No lapses	No Change	Performance		
	Inpatients waiting >26 weeks	0>standard	Breach	No lapses	No lapses	No Change	Performance		
	Outpatients waiting >13 weeks	0>standard	Breach	No lapses	0	Favourable Change	Performance		
	Admitted patients seen within 18 weeks			>90% by Dec 08	92.9%	Favourable Change	Performance		
	Non-admitted patients seen within 18 weeks			>95% by Dec 08	96.6%	Favourable Change	Performance		
	Data quality on ethnic group	100%	<95%	100%	95.0%	Favourable Change	Performance		
	Engagement in clinical audits	implemented	Breach	Implemented			Clinical Governance		
Maternity HES data quality indicator			To be Determined						
Vital Signs	BreastFeeding initiated	67%	>60%	67%	62.00%	Adverse Change	Performance		
	Smoking during pregnancy	11%	13%	11%	15%	Adverse Change	Performance		
	% of Women seen by 12 weeks	80%	<78%	80%	92%	No change	Performance		
	Referral to stop smoking service: % referral to stop smoking service			To be Determined	31%	new report	Commissioning Report		
Commissioner Set	% time slots available for 'Choose and Book'	100%	<95%	100%	99%	No change	Commissioning Report		
	Percentage of SUS data altered in period	5%	>10%	5%	0%	No change	Commissioning Report		
	Information Governance Toolkit Level 2 minimum attainment		<100%	100%	93%	No change	Commissioning Report		
Foundation Status	Number of Members	5000 by end of year	Negative	Net 50	15	First report	Total: 4208	5000	



Market Trend Awareness Strategy

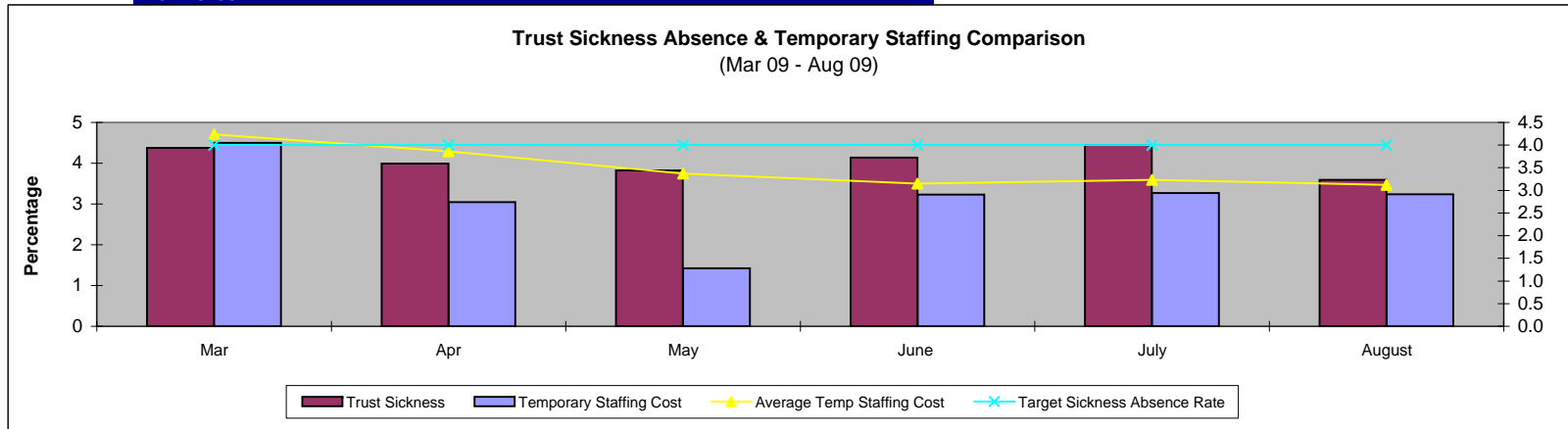
Productivity & Efficiency

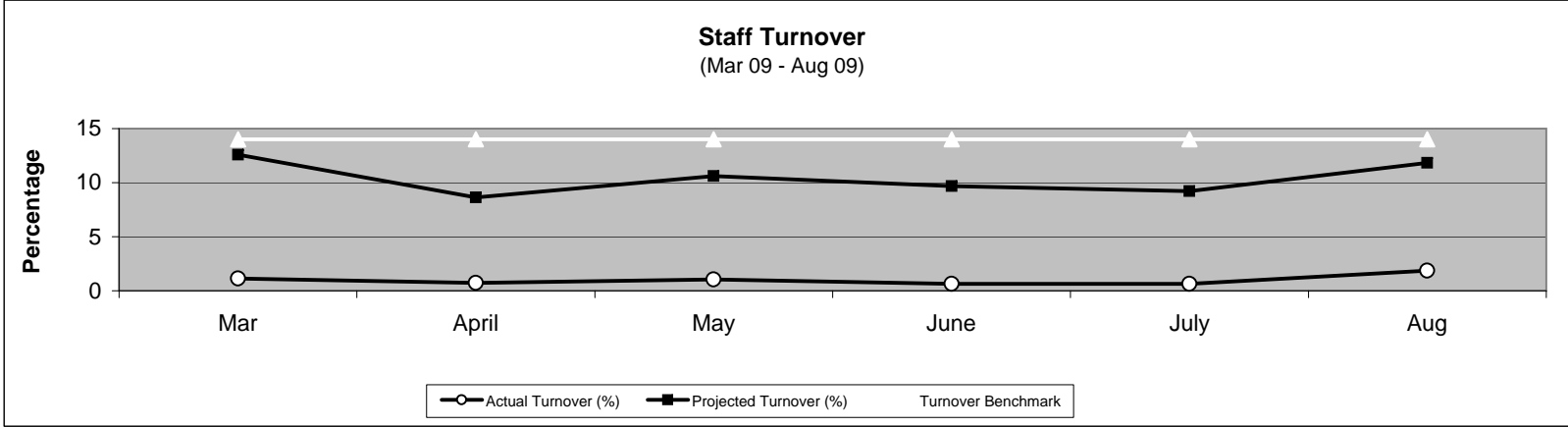
Clinical Quality

Core Standards

Finance

Workforce





**CQC Targets**

**Vital Signs**

**Commissioner Set**

# Birmingham Women's NHS Foundation Trust

Finance Report for the Period  
April 2009 to August 2009

# Summary Financial Position

## Key Points

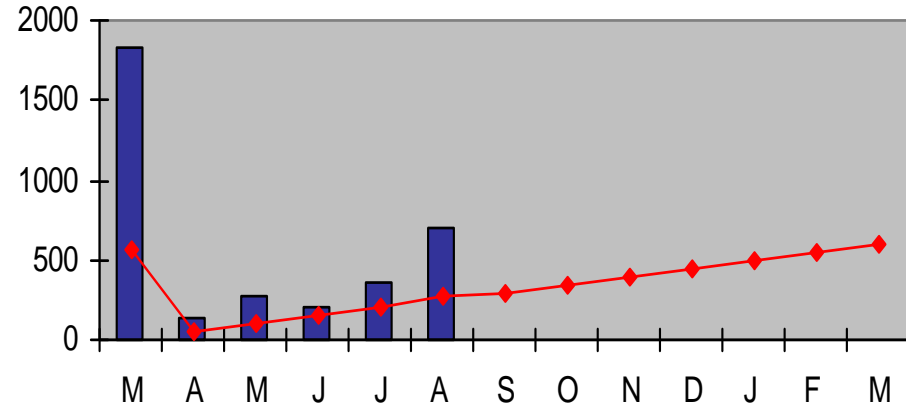
- This is the finance report to the end of August 2009, Month 5. The results show a net surplus of £698k, which is £425k above plan and converts to a Monitor risk rating of 4.

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

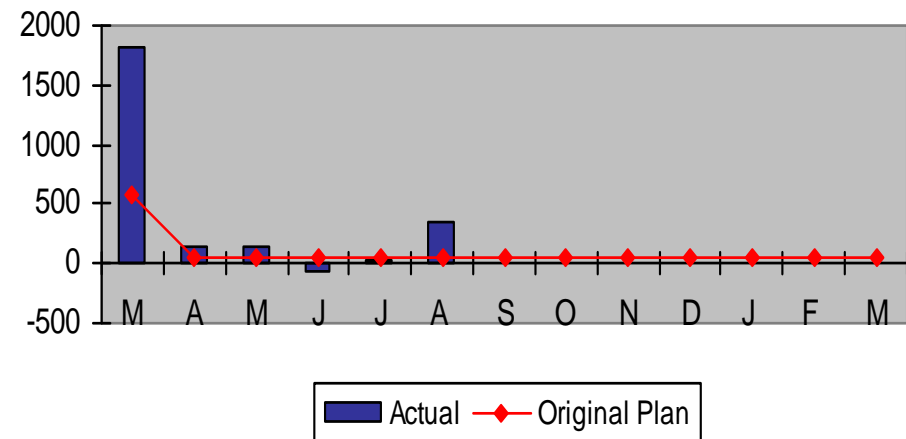
- The summary £425k variance comprises the following:-
  - An adverse £40k income variance;
  - A favourable £544k expenditure variance;
  - An above plan EBITDA position totalling 7.3%
  - A favourable £71k variance for depreciation;
  - An adverse variance of £151k for interest receivable.
- The in-month position was a net surplus of £341k, further details of which are included within the income and spending trends sections of this report.
- The planned end of year position is a surplus of £0.6m. The current forecast based on the overall position stands at £0.9m.

The forecast range for the year, when considering potential up and down-side risks, is a surplus between £0.5m and £1.2m.

## Cumulative plan, results & forecast



## Month by month plan, results & forecast



# Income

## Key Points

- The income attributable to the end of month 5 is £35.5m, which is £40k behind target. This small adverse variance relates primarily to income in ACU and R&D being behind plan, although this is offset by under spends within expenditure.

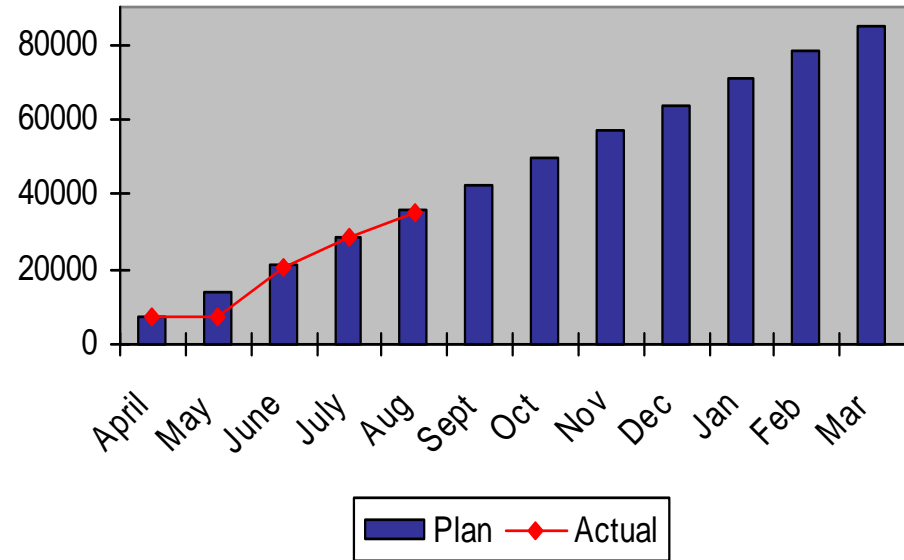
## Healthcare Income

- This is now £286k above target, an improvement of £93k on Month 4. The improvement includes an increase of £50k in the assessment of cumulative contract over-performance, which for Month 5 totals £200k.
- Private patient income is behind plan at Month 5. However, the forecast is to achieve the full-year target by year end. Achievement would equate to 1.7% in terms of the private patient cap, which is within the Trust's maximum level of 2.2%.

## Performance with Commissioners

- An assessment of cumulative over-performance has been made for Month 5, which equates to £200k and is included within the financial position.

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



## Performance by Specialty

- Gynaecology – adverse variance of £266k for elective and non-elective (underperformed by total of 133 spells). Offset by £42k over-performance on other Gynaecology contract lines.
- Maternity – favourable variance of £361k for non-elective and outpatients.
- Neonatology – significant improvement in performance driven by out of area activity. Data is being checked and validated to ensure income is retrieved.
- Clinical Genetics – referrals are currently ahead of target; and Laboratory Genetics – number of tests currently below target.

# Spending Trends within Directorates

## Key Points

- The table opposite shows the combined positions of pay, non-pay and directorate income variances. Healthcare income is not shown here but is included in the service line reports.
- At month 5 there is a favourable variance of £338k across all the directorates, an improvement across all areas with the exception of Clinical Support which has deteriorated slightly.
- Clinical Support continue to look in detail at their expenditure position and year end forecast with respect to cost pressures not identified as part of budget setting with a view to managing these internally.
- Genetics also continue to investigate their expenditure position including ongoing work to analyse and understand the trends in non pay expenditure linked to income generation. The improvement this month is in their ring fenced areas and relates to a “catch up” of income for trainees, which has been validated.
- The favourable variance in Gynaecology has increased by a similar amount to previous months as certain posts remain vacant. Recruitment is planned to take place in the coming months and this has been factored into the year end forecast.
- The improvement in the Facilities position relates predominantly to the revision of accrual assumptions on transport and energy expenditure. Further information was acquired since the Month 4 position was reported with the year to date and year-end forecast adjusted accordingly.
- Whilst underspends in pay offset the deficit on non pay and directorate income, tight control of expenditure needs to be maintained along with ensuring the delivery of efficiency programmes.

## Directorate Pay and non-pay variances from budget

Year to date £ 000s	Month 05				Month 04			
	Pay	Non-Pay	Dir'ate Income	Total	Pay	Non-Pay	Dir'ate Income	Total
Obstetric and Fetal	76	20	-6	90	62	20	-10	72
Gynaecology	269	-8	-33	228	227	-28	-21	178
Genetics	-113	-172	168	-117	222	-251	-154	-183
Neonatal	8	17	-7	18	3	9	-9	3
Clinical Support	-36	-18	-52	-106	-19	-46	-32	-97
Facilities	10	72	5	87	3	25	-15	13
Corporate Services	388	30	-281	137	325	-16	-210	99
	<b>602</b>	<b>-59</b>	<b>-206</b>	<b>337</b>	<b>823</b>	<b>-287</b>	<b>-451</b>	<b>85</b>

## Directorate Pay and non-pay variances from budget

Year to date £ 000s	Month 03				Forecast EOY			
	Pay	Non-Pay	Dir'ate Income	Total	Pay	Non-Pay	Dir'ate Income	Total
Obstetric and Fetal	40	29	-6	63	54	7	-22	39
Gynaecology	182	-18	-19	145	315	109	-44	380
Genetics	150	-110	-170	-130	-85	-370	391	-64
Neonatal	12	9	-9	12	18	19	-18	19
Clinical Support	15	39	-39	15	-292	-137	-11	-440
Facilities	-6	17	7	17	-79	202	23	146
Corporate Services	269	57	-170	156	505	-141	-219	145
	<b>662</b>	<b>22</b>	<b>-407</b>	<b>278</b>	<b>436</b>	<b>-311</b>	<b>100</b>	<b>225</b>

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

# Cost and Efficiency Improvements

## Update on performance

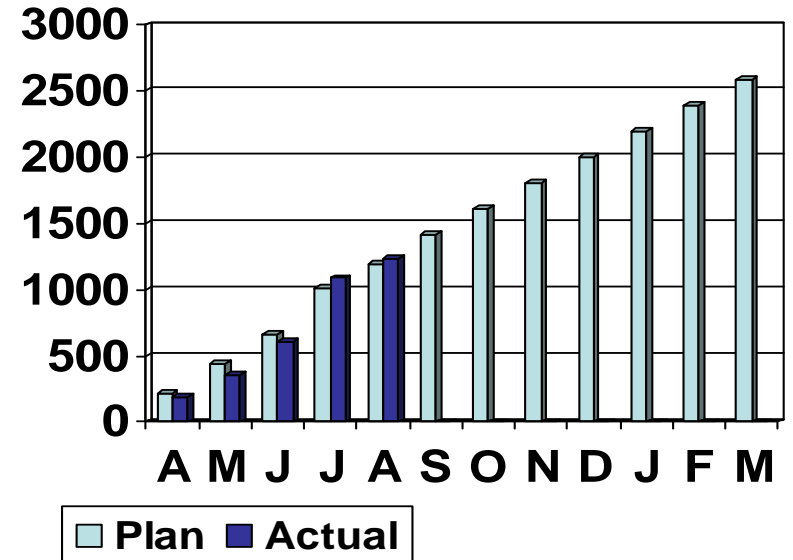
### Overall Summary

- As at the end of August 2009 savings of £1,231k have been identified as saved, against a target of £1,189k. The forecast for year-end is to achieve the full target of £2.6m, identified at the start of the year.

### Traffic light summary

- The CIP annual targets have been updated from the meeting held in August. The traffic light results are (split by the 2.6m plan) :-
  - Red £14K
  - Amber £316K
  - Green £2,254K
  - Total £2,584K
- This proportion of schemes rated as green, amber and red remains very similar when compared to month 4. Work will continue on identifying alternative schemes to replace any red schemes and amber schemes will be monitored closely to ensure that any barriers to delivery are understood.
- The assessment of the recurrent/non recurrent split as at Month 5 remains 32/68%, which is behind the planned level of 70/30%. This will continue to be reviewed and challenged on a monthly basis to ensure that overly cautious approaches have not been adopted when declaring whether a scheme is recurrent or not.

## Savings delivery - cumulative



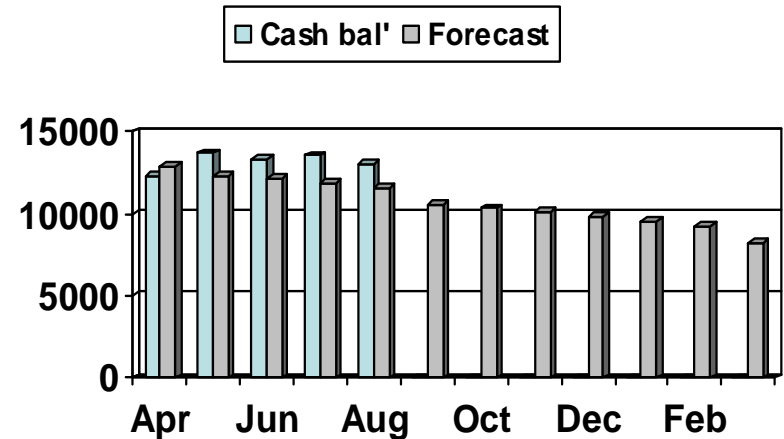
NB savings include additional income with respect to the some directorates



# Cash Flow 1

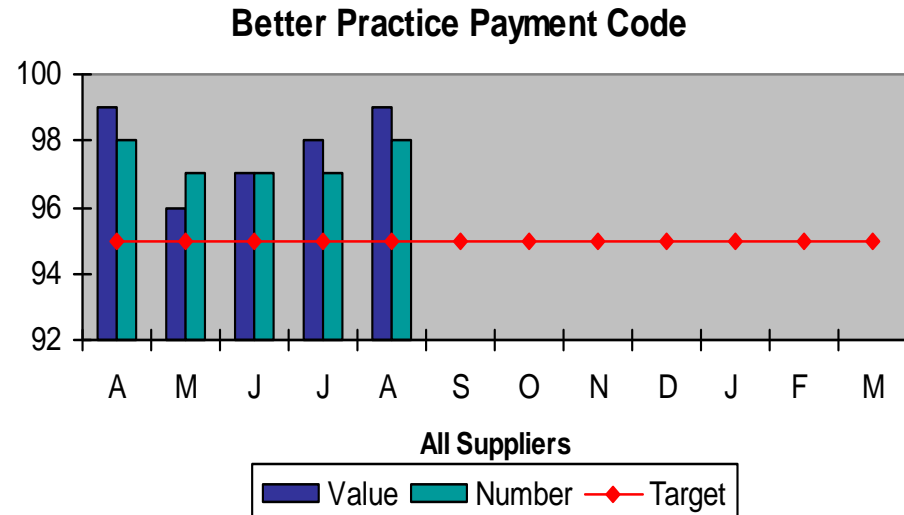
## Cash Balances

- The cash position remains strong with a balance at the end of August totalling £13.0m. Deferred income and accruals are recorded as £5.1m.
- As at 31<sup>st</sup> August all non-operational cash remained in the Paymaster General's Office account (PGO). However, the reserve account held with our commercial bank was converted to a Special Interest Bearing Account (SIBA) with effect from the 4<sup>th</sup> September. This account now pays an interest rate of base + 0.20% (currently 0.70%) and currently holds just over £3m. A further £3m has been placed on cash deposit for 3 months at 0.80% with Lloyds TSB. The Trust's working capital facility is also with this institution.



## Creditors (money owed by the Trust)

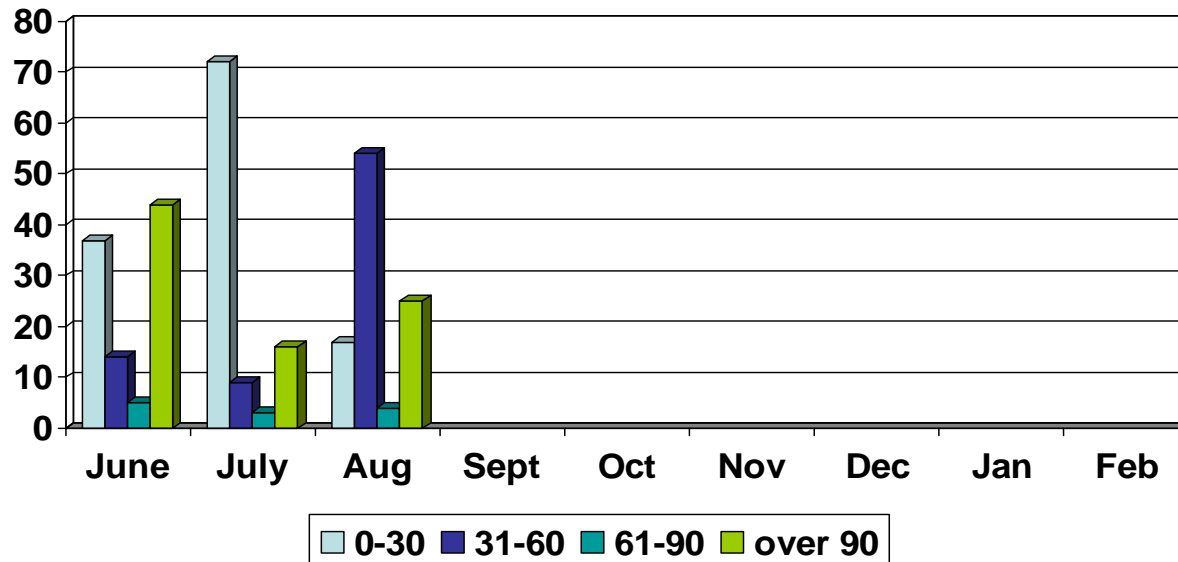
- The Better Practice Payment Code (formerly PSPP) targets NHS organisation to pay 95% of all supplier invoices within a period of not more than 30 days. Within this, the payment for local trade suppliers has been adjusted to payment within 10 days; this is in line with the Prime Minister's request to all public bodies.
- The cumulative performance for Month 5 by number is 98% and by value is 99%.



# Cash Flow 2

## Debtors (amounts owing to the Trust)

- Total Debtors valued £3.2m at the end of August, which represents a £0.3m decrease compared to the end of July. Of the £3.2m, £2.2m relates to trade debtors and £1.0m to accrued income.
- In terms of aged debt information, the total value of debts over 60 days remains at just under £400K, the same level as last month.
- The importance of monitoring and acting upon aged debt continues to be expressed to finance managers and the credit control section, and will be actively managed on a monthly basis, particularly in relation to those currently over 90 days.



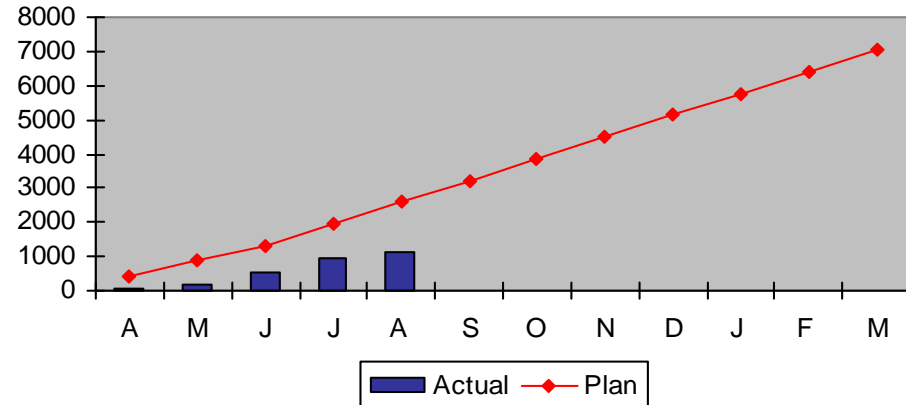
# Cash Flow 3 – Capital Spending

## Key Points

- The total planned spend for the year is £7.0m as recommended within the 2009/10 annual plan. The planned programme is shown opposite and the delivery of this is being managed through the Capital Development Group.
- The Group has allocated funding to the highest priorities for those schemes over and above the Neonatal Unit. It will focus on continued performance management of all the agreed schemes to ensure they are progressed throughout the year.
- The Month 5 position shows expenditure of £1.1m against all schemes. The current forecast is for the original programme to be fully utilised by year-end with two further schemes considered in addition, being:
  - £116k Neonatal Surgical cot – as previously advised
  - £290k Mortuary refurbishment – this addition to the original figure reflects a further review of the necessary works required to retain the Trust's HTA licence

With respect to the latter a review of the overall programme will be undertaken to assess whether there is scope to offset the increased costs.

## Monthly build up of the programme



## 2009/10 Capital Plan

### Capex program

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

### Plan Actual

0 (24)  
 4,944 269  
 0 3  
 0 8  
 150 64  
 780 325  
 929 357  
 150 0  
 91 124

### TOTAL CAPITAL PROGRAMME

7,044 1,127

# Up & Down-side Risks

<u>Risk</u>	<u>Maximum</u>	<u>Likelihood</u>	<u>Included in forecast</u>
Challenge to income by PCTs	Circa 1% £0.7m	Low	Yes
Failure to deliver 18 weeks	Maximum 5% penalty - £458k	Low but needs to be kept under review	No (is included in forecast range)
Elective Activity underperformance	Maximum £500k	Likely	Will be incorporated into the overall forecast for healthcare income
Failure to deliver CIP plans fully	Red schemes & 50% amber not delivered	Low – green schemes currently account for 88% of the total programme	Yes
Expenditure creep Unplanned & unavoidable non-pay expenses	TBC	High	£311k covered by pay position
CQUIN Payment (upside)	£308k	Likely	Currently held in reserves (is included in forecast range)

# Conclusions and Recommendations

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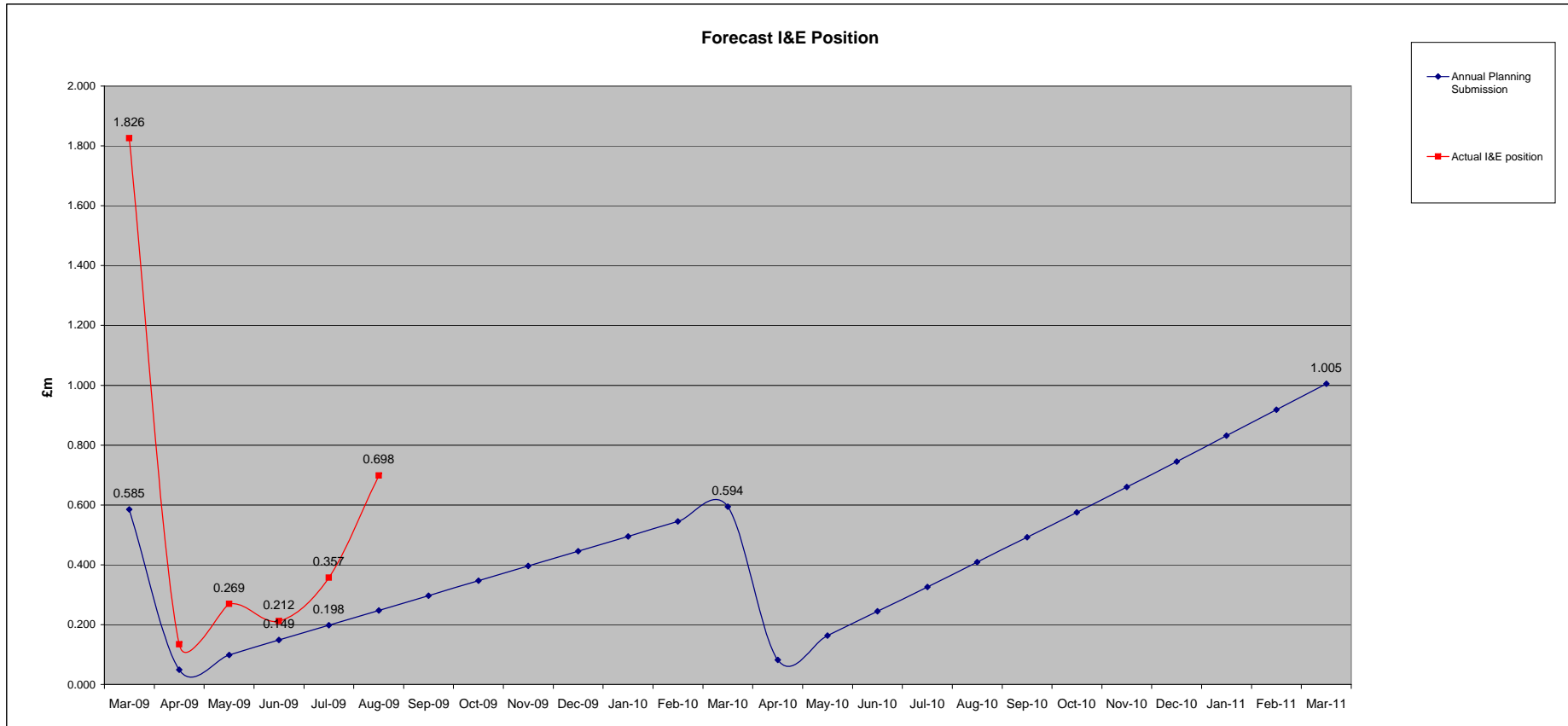
## CONCLUSIONS

1. The Trust is reporting a £698k surplus to the end of August, Month 5, which equates to a Monitor risk rating of 4.
2. Within the overall position and as explained previously, there is a negative income variance but a positive one with respect to expenditure. This position will continue to be monitored and reviewed as we progress through the year.
3. As highlighted last year tight control of expenditure will need to be maintained throughout 2009/10, particularly in relation to non pay, where this is not linked to increased activity.
4. The full year forecast is currently a £874k surplus, with a surplus range for the year between £0.5m and £1.2m. This will continue to be developed and assessed through the year.

## RECOMMENDATIONS

- The Board is asked to:
  - Consider the financial position of the Trust at the end of August 2009.
  - Note the current forecast is that the Trust will meet and potentially exceed its planned financial surplus as submitted to Monitor.

	Mar - 09	Apr - 09	May - 09	Jun - 09	Jul - 09	Aug - 09	Sep - 09	Oct - 09	Nov - 09	Dec - 09	Jan - 10	Feb - 10	Mar - 10	Apr - 10	May - 10	Jun - 10	Jul - 10	Aug - 10	Sep - 10	Oct - 10	Nov - 10	Dec - 10	Jan - 11	Feb - 11	Mar - 11
Annual Planning Submission	0.585	0.050	0.099	0.149	0.198	0.248	0.297	0.347	0.396	0.446	0.495	0.545	0.594	0.082	0.163	0.244	0.326	0.409	0.492	0.575	0.660	0.745	0.832	0.919	1.005
Actual I&E position	1.826	0.135	0.269	0.212	0.357	0.698																			



# Birmingham Women's

NHS Foundation Trust

<b>SUBJECT:</b>	Register of Sealing of Trust Documents
<b>REPORT BY:</b>	Steve Parsons, Head of Corporate Affairs
<b>AUTHOR:</b>	Steve Parsons, Head of Corporate Affairs

## KEY ISSUES FOR TRUST BOARD CONSIDERATION AND DECISION:

In line with the Standing Orders and Standing Financial Instructions for the Trust this report details the sealing of the most recent document as recorded in the Register of Sealing.

Seal No.	Date	Description of Document Sealed	Value	Signed By	Attested By
38	28.8.09	NNU Project- Appointment of Integrated Health Project as principal supply chain partner	£334,288	Steve Peak	Jason Burn

## RECOMMENDATION:

The Board is invited to **NOTE** the application of the Trust seal to the above agreements.