

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 28th January 2010 at 11 am

AGENDA

- | | | | |
|---|--|----|--|
| 1 | Welcome and apologies
Apologies should be sent to Jackie Howell at
jackie.howell@bwhct.nhs.uk, tel 0121 627 2601 | | Enc |
| 2 | Questions from the public on matters relating to the agenda | | |
| 3 | Declarations of interest | | |
| 4 | Minutes of the meeting held on 17 th December 2009 | | 1

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| 5 | Matters arising from the minutes of the meeting held on 17 th December 2009 (where not covered by agenda items) | | |
| 6 | Trust Chair's report | HH | 2

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| 7 | Report of the proceedings of the Board in private session | HH | Oral |
| 8 | Report by the Chief Executive | SP | 3

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PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE

9	Red Risk Register and Assurance Framework	SIP	4		J:\BOARD OF DIRECTORS\2010\A-
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10	Amber Risk Register	SIP	5		J:\BOARD OF DIRECTORS\2010\A-
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11	Patient Experience reporting	JO	6		J:\BOARD OF DIRECTORS\2010\A-
ASSURANCE					
12	Cancer targets update	JO	7		J:\BOARD OF DIRECTORS\2010\A-
ORGANISATIONAL PERFORMANCE					
13	Integrated Performance Report, November 2009	JO NS JaB	8		J:\BOARD OF DIRECTORS\2010\A-
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14	Integrated Performance Report, December 2009	JO NS JaB	9		J:\BOARD OF DIRECTORS\2010\A-
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15 Patient Safety Report

PT

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16 Monitor submission, Q3 2009-2010

SIP

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MEMBERS' COUNCIL MATTERS

17 Update from the Chairman of Council

HH

Oral

CLASS 'A' POLICIES FOR APPROVAL

18 Use of the Auditors for non-audit services

JaB

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Dates of next meetings

Thursday 25th February 2010
Thursday 25th March 2010
Thursday 29th April 2010 (Medical School)

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 17th December 2009**

PRESENT:	Helen Hemberg	In the Chair
	Ian Booth	Non-Executive Director
	Jason Burn	Interim Finance Director
	David Draycott	Non-Executive Director
	Nigel Gardner	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

IN ATTENDANCE: Steve Parsons Head of Corporate Affairs

ACTION

FTP/1209/1 WELCOME AND APOLOGIES

FTP/1209/1.1 The Chairman recorded the Board's congratulations to Mr Burn on his appointment as the substantive Director of Finance.

FTP/1209/1.2 There were no apologies for absence.

**FTP/1209/2 QUESTIONS FROM THE PUBLIC ON MATTERS
RELATING TO THE AGENDA**

FTP/1209/2.1 There were no questions from members of the public on the business of the meeting.

FTP/1209/3 DECLARATIONS OF INTEREST

FTP/1209/3.1 No interests were declared in any item on the agenda for the meeting.

**FTP/1209/4 MINUTES OF MEETING HELD ON 27th NOVEMBER
2009**

FTP/1209/4.1 The minutes of the meeting held on 27th November 2009 were approved with the following amendments:

ENCLOSURE 1

- FTP/1109/8.3, last bullet “principal” should read “principle”
- FTP/1109/8.5, 6th line, “principals” should read “principles”
- FTP/1109/13.3, last bullet, should read “Mr Rison noted that he had discussed various issues arising from the report with Mr Burn prior to the meeting.”

FTP/1209/5

MATTERS ARISING FROM THE MINUTES OF THE MEETING HELD ON 27th NOVEMBER 2009

AMMALIFE

FTP/1209/5.1

A question was raised as to how the discussion between the Board and a representative from AMMALIFE should be conducted, and it was agreed that this should be separate from formal Board proceedings. The Chairman undertook to contact the relevant parties, including Dr Buchan.

HH

FTP/1209/6

TRUST CHAIR’S REPORT

FTP/1209/6.1

The Chairman referred to Enclosure 2, and noted the following points:

- The thanks of the Board to Christine Peverelli for the organisation of a successful Volunteer’s Lunch earlier in the week
- The meetings held with other Chairs, which had been well-received and could form the basis for ongoing future discussions

FTP/1209/7

MEETING OF THE BOARD IN PRIVATE SESSION

FTP/1209/7.1

The Chairman reported that the following items had been considered in private session:

- Reports from various Board Committees
- An update on progress towards the NHSLA assessment on CNST and Maternity Standards
- A review of the Trust’s strategy for estate, and related projects
- A paper on how to meet the challenges of the future
- The Monitor response to the Q2 submission, which would be circulated to Governors

FTP/1209/8

REPORT BY THE CHIEF EXECUTIVE

FTP/1209/8.1

Mr Peak presented Enclosure 4, and drew attention to the following points:

Dr Foster data

ENCLOSURE 1

- FTP/1209/8.2 It was noted that the information issued by Dr Foster was different to that provided by CQC; the base database (HES data) was the same, but the processing highlighted different areas. There had been a significant level of disquiet about the process, including some Trusts contemplating legal action. Although this Trust was not in the league tables, the published information on the website about the Trust appeared to be inaccurate and would be addressed with Dr Foster if required. **SP**
- FTP/1209/8.3 Val Davidson
The Board recorded its congratulations to Val Davidson on her recent leadership award from the Chief Scientific Officer.
- FTP/1209/8.4 Performance
The Chief Executive noted the following high-level performance data, and that the November reports would be presented in full at the January 2010 meeting:
- The Trust reported a £710k cumulative surplus, which was above plan
 - The forecast for the year end was £900k, with a range between £750k and £1.2 million
 - The current view was that that RRE would be 4, although that was subject to confirmation
 - There were continuing concerns regarding the performance of the Clinical Support Directorate, which were the subject of continuing management focus **Execs**
 - The Performance Group meeting had indicated that the Trust was on target for CIP targets in the year
 - The majority of Foundation Trusts were experiencing a tightening of the position
 - The spend on the Neo-Natal Unit new build in the year would be between £4 million and £5 million, dependent on the timing of invoices **JaB**
- FTP/1209/8.5 The Chief Executive's report was **NOTED** with thanks.
- PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE**
- FTP/1209/9** **Red Risk Register and Assurance Framework**
- FTP/1209/9.1 The Head of Corporate Affairs presented Enclosure 4, and the following points were noted:
- ORAG had discussed the Red Risks within its area; the Clinical Governance Committee had held an in-

ENCLOSURE 1

- depth review of risks within the Gynaecology area
 - Mr Draycott commented that arrangements were being made for him to access the database remotely to randomly review the risk entries **C Roper**
 - A review of equipment for ultrasound scanning had led to the entry of a new risk; this area had been addressed by the Management Board at its meeting the previous day, and a capital spend in the current year had been identified as necessary. In discussion, the Board was advised that this was not an area that had been overlooked, but its priority rating in comparison to other areas had meant it had not been included in the programmed replacements. **JaB**
 - The Clinical Governance Committee had requested that risks were broken down into smaller parts, which could then be graded individually; this was being addressed but would take time and resource to implement **C Roper**
- FTP/1209/9.2 A question was raised about the Trust's preparedness for pandemic influenza, and it was reported that about 20% of the priority 1 staff had taken up the option of vaccination; however, it was a voluntary programme and this level of take-up reflected the Trust's historic performance on seasonal flu. The Board discussed this issue, and some Directors suggested that this performance was disappointing. It was noted that further efforts would be undertaken to obtain take-up in clinical areas. **NS/ JO**

FTP/1209/9.3 The Board **noted** the Red Risk Report

ASSURANCE

FTP/1209/11 **Cancer- National Target pathway update**

- FTP/1209/11.1 Jane Owen presented Enclosure 5, and the following points were noted;
- Meeting the targets remained challenging; there had been good months in October and November, but December looked less good
 - More detailed reporting of areas of difficulty, respecting the privacy of patients, would be brought to the Board to give greater context **JO**
 - Delays had been identified in the IMR pathway; the Trust had now terminated the SLA arrangements with the Royal Orthopaedic and put alternative arrangements in place
 - A new Specialist Nurse was now in post to lead training sessions; they would also develop new ideas, based on their experience of tracking patients
 - The Trust was tracking about 80 patients at any given time, which could vary up to about 100; many

ENCLOSURE 1

of these would eventually be determined not to be on the cancer pathway after investigation

- The actions that had been put into place were designed to prevent unnecessary delays; however, the small number of patients made it difficult to confidently state that the targets could be achieved
- The pathway had not yet eliminated all non-medical delays; this was a focus of the work both in the Trust and with the Trusts that partnered us for the pathway

JO/ PT

FTP/1209/11.2 The Board **noted** the update on cancer target achievement.

ORGANISATIONAL PERFORMANCE

FTP/1209/12 **West Midlands Public Health Observatory- 6-monthly update**

FTP/1209/12.1 The Board noted Enclosure 6, and the following observations were made:

- A Director commented that this area may be considered for cuts by the SHA given the current funding climate; it was confirmed that a contract existed between the Secretary of State (via the SHA) and the Trust to regulate the work of the PHO and also the effects of a withdrawal from this area by the SHA
- A Director commented on the section on the PHO's contribution to the Trust, and questioned whether more could be achieved. The Chief Executive commented that he had recently discussed this with Dr Kemm and there was a willingness to contribute to the Trust's work through the provision of analyst resource and using their surplus to earn additional income. It was confirmed that the PHO had asked for Trust input into their future planning, which was being considered
- It was reported that the Observatory was actively seeking to maximise its opportunities, but was also delivering well on its core business. It was also noted that the PHO was replicated in each SHA area, but concerns about their future were noted.

FTP/1209/12.2

The Board:

- **Noted** the update report
- **Requested** that the next report should include details on progress to working together, and also an overview of the PHO's financial position

SP

MEMBERS' COUNCIL MATTERS

FTP/1209/13 **Report of the Members' Council Chair**

ENCLOSURE 1

FTP/1209/13.1 The Trust Chairman reported that Council had met on Monday 14th December, and the following were the main points:

- Council had considered the performance report for Q1, as part of a new approach to performance reporting based on extract information from the 'dashboard' considered by the Board
- Governors had engaged in a workshop session, designed to enable more engagement and involvement in the work of Council by all Governors. Directors commented that they considered that this had been a successful experiment
- The Council had considered and commented on proposed Constitutional amendments, which would be coming forward to the Board in January 2010.

CLASS 'A' POLICIES FOR APPROVAL

FTP/1209/14 Cash Management Policy

FTP/1209/14.1 Mr Burn presented Enclosure 7 and a comment was made that the usual indemnity clause was missing; clarification would be sought as to whether it should be added.

SIP

FTP/1209/14.2 Subject to that point, and with leave to add the standard indemnity clause if appropriate, the Board **approved** the Cash Management Policy.

Dates of next meetings

Thursday 28th January 2010

Thursday 25th February 2010

Thursday 25th March 2010

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

Birmingham Women's

NHS Foundation Trust

**Board of Directors, 28th January 2010
Report of the Chairman to the Public Session**

NHS Constitution consultation

Two new legal rights for patients have been proposed for addition into the Constitution. These are

- Treatment within a maximum of 18 weeks from a GP referral and to be seen by a cancer specialist within 2 weeks from a GP referral, or where this is not possible, for the NHS to take reasonable steps to offer a range of alternative providers; and
- NHS health checks for those aged 40 to 74 to assess their risk of heart disease, stroke, diabetes and kidney disease.

A national consultation has been launched and the Trust is taking an active part in this. Our responses will be delivered within the timeframe of February 4th.

Changes to Board timings

As from next month's Board meetings, we plan to change the timing of the Public Board meeting so that it starts at 9am in the morning. This is to make it easier for members of the public to attend. The private Board meetings will then follow this meeting. The schedule of dates already issued for this year remains unchanged.

Burdett Trust

As reported last month, we welcome Vijaya Nath to this month's meeting, as part of the development programme being undertaken by Jane Owen, our Director of Nursing and Midwifery. We look forward to the results of Vijaya's observations and deliberations.

Activities

- Meetings with Elisabeth Buggins, SHA, and Jerry Blackett of Birmingham Chamber of Commerce.
- Visits from the Chair and Chief Executive of the Birmingham Children's' hospital, and Mark Simmonds MP, Shadow Health Minister.
- Board to Board session with the Birmingham Children's team.
- Attended Monitor's introductory session for new Chairs and Chief Executives.
- Presentations by short listed firms for new external auditors.

HH January 2010

Birmingham Women's



NHS Foundation Trust

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

CONTEXT AND BACKGROUND FOR REPORT

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

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The paper updates the Board on :

- Health Innovation Education Clusters (HIECs)
- Early Adopter – Lorenzo
- New Neonatal Unit Scheme update
- Electronic Staff Record (ESR) Data
- Lean Methodologies Update

RECOMMENDATIONS

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

1. Health Innovation Education Clusters (HIECs)

I am pleased to report that, following a presentation to the Department of Health (DH), the bid to establish a HIEC has been successful. All three bids from the West Midlands SHA area were successful out of a total of 17 nationally with 3 bids being rejected.

Guidance on implementation is expected in due course. I would like to take this opportunity to say thank you to the bidding team for their hard work in securing DH support.

2. Early Adopter – Lorenzo IT Project

To report that very good progress is being made towards the implementation date of the 10th May 2010 for the new Lorenzo patient administration system. The Board will be aware that Birmingham Women's NHSFT is one of five early adopter sites nationally and will be the third organisation to go live.

The Project Team have begun initial testing of the latest software with training for around 500 users set to start in March. Communications will be stepped up over the coming month to raise awareness of the extent of the change. The implementation will pave the way for further IT developments such as electronic clinical documentation, care pathways and the electronic test request and results module by the end of 2010.

3. New Neonatal Unit Scheme Update

I am pleased to report that the development of the new scheme is continuing within budget and on target for its expected completion date of July 2010.

The original scheme excluded provision for upgrading or refurbishing the link corridor which both connects the Delivery Suite to the new unit as well as the main hospital thoroughfare to the new unit and Norton Court.

With the new building progressing it has become increasingly apparent that this corridor is in poor structural and presentational shape, suffering from very limited climate control. It will be used to transfer new borns by cot from Delivery Suite to the Neonatal Unit. The sudden drop in temperature experienced on entrance to the corridor presents a minor clinical risk to babies. The corridor will also be used as the main thoroughfare for mothers, relatives and staff to get into the new unit. Finally, it is also used by staff to get to and from Norton Court as well as by Medical Physics to transport their equipment. From both an operational and aesthetic perspective, with the support of senior clinical staff, the Executive team are recommending varying the scheme to include a refurbishment and upgrade of the corridor.

The Trust has had a quote from IHP and Vinci for amending the scheme to incorporate a complete upgrade and refurbishment of the corridor. The cost comes in at £108,629.72 excluding VAT.

The Trust has sufficient funds to pay for this amendment to the scheme. However, there may be additional funding released which could benefit this. To date no use has been made of the £444,044 contingency fund allocation included within the overall scheme element. If no calls are made on this contingency fund the Trust will *share* a proportional return on the fund with the construction and design partners. This could be used to offset the additional cost of the corridor upgrade. However, with another 6 months left to scheme completion there can be no guarantee that the contingency will not be used.

The Board of Directors is recommended to **SUPPORT** the proposed variation to the original scheme.

4. Electronic Staff Record (ESR) Data

The Trust has received confirmation that the accuracy of its employee data held on ESR is officially the best in the country. This positive result reflects the sustained efforts made by Richard Shaw, Workforce Information Officer within the Human Resources team. Accurate ESR data is important for a variety of reasons. It is critical for correct pay and pensions as well as for delivering statutory compliance with the Data Protection Act.

5. Lean Methodologies Update

Following the agreement reached at the December Board to proceed with a phased roll out of lean methodologies, Neil Savage and I will meet with NHS Elect on the 22nd January to plan the training and support for the lean projects identified shortly through the annual planning cycle.

The Management Board received an encouraging update from Linda Bentley in early January on the progress with the NHS Improvements lean pilot within Histopathology. A similarly encouraging update on the Productive Ward Project was provided to the Management Board in December by Noureen Wasique.



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

CONTEXT AND BACKGROUND FOR REPORT

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

The attached paper extract is valid on the date of production, 11th January 2010. As the risk register is a live document, further work will have been undertaken between this date and the date of the Board meeting.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

Changes to the red risk register since the last report

Two new risks have been added to the red risk section of the register, numbers 111 and 112. Both of these relate to risks of not meeting the national targets for cancer waiting times.

Review and assurance

At its meeting on 10th January, ORAG reviewed the red risk register entries that related to corporate risks. This included in-depth review of the two new risks recorded in this category, numbers 111 and 112, relating to cancer waiting times.

At its meeting on 8th January, the Clinical Governance Committee held an in-depth review of the red risks related to the Neo-Natal Directorate. This concluded that further actions were needed to provide assurance, and this work is in hand.

RECOMMENDATIONS

ENCLOSURE 4

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

CURRENT RED RISKS

ID	Title	Opened	Review date	Risk Type	Risk Subtype	Adequacy of controls	Manager
3	Norton Court	14/10/08	31/03/10	Corporate	Complex		Neil Savage
106	Financial Trust income 10/11	27/10/09	25/01/10	Corporate	Financial		Damon Harris
100	CCL Maternity Information System	07/08/09	31/12/09	Clinical	Compliance		Tracey Johnston
98	Risk to Trust services from Pandemic Flu	03/07/06	31/01/10	Corporate	Organisational		Steve Peak
112	Compliance with Cancer Waiting standards for treatment at Cancer Centre	05/01/10	16/02/10	Corporate	Compliance		Delreita Bernard
111	Compliance with Cancer Waiting standards	05/01/10	16/02/10	Corporate	Compliance		Delreita Bernard
6	Delivery of the laboratory Down's Screening Service	13/12/07	02/02/10	Corporate	Complex		Helen Samson
8	Neonatal Unit capacity	01/03/05	29/01/10	Clinical	Clinical		Michele Emery
9	Lack of midwifery staff	12/10/06	31/03/10	Clinical	Clinical		Jenny Henry
10	Delivery of category 1 caesarean section within 30 minutes	28/08/07	31/03/10	Clinical	Complex		Becky Williams
102	Insufficient Radiologist cover for neonatal directorate	29/09/09	29/01/10	Clinical	Clinical		Imogen Morgan
109	Radiology - Ultrasound Machines	17/11/09	31/03/10	Clinical	Clinical		Samantha Mattis

12th January 2010



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

CONTEXT AND BACKGROUND FOR REPORT

The Board has requested that it is advised quarterly of the risks that are currently entered on the Risk Register with Amber status. The previous report was in October 2009.

Amber risks are reviewed in detail as part of the risk management work of the Clinical Governance Committee and the Organisational Risk and Governance Committee. All risks are subject to regular review by the relevant manager, as identified on the register.

The paper copy of the register extract attached to this report is valid as at the date of production, 12th January 2010. The register is a live system and subject to constant updating, therefore the paper extract may be out of date.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

There are currently 23 amber risks on the register. As part of the preparation of this paper, those risks where the review date has been passed have been drawn to the attention of the relevant manager for action.

2 of the risks are current at Uncertain Assurance (Red), and one at Limited Assurance (Amber). All others are green-rated.

Amber risks are subject to review by both ORAG and the Clinical Governance Committee, as part of their work reviewing the risk register more generally. ORAG is instituting a process of ensuring that amber risks are reviewed in a systematic way over a period of meetings; the Clinical Governance Committee reviews risks on a directorate by directorate basis and includes amber and red risks in these reviews.

RECOMMENDATIONS

ENCLOSURE 5

The Board is invited to note the current contents of the Amber Risk Register.

CURRENT AMBER RISKS

ID	Title	Opened	Review date	Risk Type	Risk Subtype	Adequacy of controls	Manager
4	Trust not being able to function as a Perinatal Centre	01/07/05	03/01/11	Clinical	Clinical		Michele Emery
16	Failure or delay in achieving annual savings requirements	01/03/07	30/06/09	Corporate	Financial		Jason Burn
18	PAS critical failure or major system outage	01/03/07	31/03/10	Corporate	Complex		Jason Burn
21	Reconfiguration and redevelopment of Sandwell & West Birmingham	14/10/08	29/01/10	Clinical	Financial		Becky williams
23	Higher than planned activity in NNU	14/10/08	31/01/10	Clinical	Financial		Imogen Morgan
31	Staff not attending mandatory training	07/06/05	31/03/10	Corporate	Complex		Neil Savage
33	Ad hoc changes in expenditure	01/03/07	30/06/09	Corporate	Financial		Jason Burn
37	Healthcare associated infections from outside areas	01/09/08	29/03/10	Clinical	Clinical		Michele Emery
38	Risk of sick newborn babiesacquiring infection	01/09/08	30/01/10	Clinical	Clinical		Michele Emery
39	Demand Management from PCTs	10/11/08	31/03/10	Corporate	Financial		Jason Burn
40	Patient Choice effects on referral flows	12/11/08	31/03/10	Corporate	Financial		Jason Burn
41	Part of Neonatal facility funded by charitable appeal	14/10/08	31/12/10	Corporate	Financial		Nick Reading
42	Sustainability of community clinics - Gynae	12/11/08	31/03/10	Clinical	Financial		Delreita Bernard
43	Work funded via block contracts	12/11/08	26/02/10	Corporate	Financial		Jason Burn
44	Information Security	12/11/08	31/03/10	Corporate	Complex		Jason Burn

54	DATIX and risk management records	02/03/09	30/11/09	Corporate	Complex		Peter Thompson
57	Reputation effect of high profile infections.	01/01/04	29/03/10	Corporate	Infection Control		Jane Owen
59	Group Strep A infections	02/03/08	31/03/10	Clinical	Infection Control		Jane Owen
81	Hand hygiene compliance	01/04/05	14/01/10	Clinical	Infection Control		Jane Owen
84	Inadequate sign off mentors for student midwives.	13/03/09	31/03/10	Clinical	Compliance		Jenny Henry
87	Failure to achieve NHSLA standards	13/03/09	30/06/09	Clinical	Complex		Peter Thompson
91	Clinical Genetics Patient Records	21/04/09	30/04/10	Clinical	Clinical		Angela Daly
113	Single handed manager of Somerset database	05/01/10	16/02/10	Corporate	Compliance		Delreita Bernard

12th January 2010

Birmingham Women's



NHS Foundation Trust

SUBJECT :	PATIENT EXPERIENCE - HOW TO CAPTURE AND UTILISE FEEDBACK
REPORT BY :	Jane Owen
AUTHOR :	Jane Owen

CONTEXT AND BACKGROUND FOR REPORT

This report provides information on the current status of patient experience feedback and how it is managed.

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

- Patient feedback provides a rich source of information on the quality of services we provide.
- The trust currently collects a great deal of data but does not have an identified resource to analyse the data to provide useful information.
- There is a regulatory requirement to collect real time patient feedback
- Three key areas are recurrent themes in patient feedback. We should concentrate on these in the first instance.

RECOMMENDATIONS

To debate and agree the recommendations in the report

PATIENT EXPERIENCE - HOW TO CAPTURE
AND UTILISE FEEDBACK

1. Purpose and Background

This report provides information on the current status of patient experience feedback and how it is managed. It also makes some recommendations for improvement to ensure timely feedback can be utilised to improve the quality of services provided.

The importance of patient experience and feedback has been recognised in the NHS for some time. Traditionally the two main sources of patient experience feedback used in the NHS have been through complaints and the National Patient Survey programme. Complaints are a rich source of feedback and recent reforms to the complaints procedure challenge Trusts to implement changes as a result of complaints and to learn from the feedback. The National Patient Survey uses standardised questionnaires and is an opportunity for the Trust to be benchmarked against other providers. Real time feedback is a more recent initiative and there is evidence to suggest that meaningful feedback should be collected within two weeks of treatment given to a patient. The time delays following the inpatient survey and the publication of results do not allow the Trust to be responsive in a timely manner.

Patient feedback is often collected in an ad-hoc way which is no longer satisfactory. It is now necessary to amend our approach not only to meet the needs of women using the service, but also to comply with CQC registration and is one of the vital signs in the Operating Framework.

It is clear that more can be done to continuously improve services and to make them more responsive to patients and service users.

2. Current Trust Systems to Collect Patient Feedback

At present patient feedback is collected in a variety of ways, some as part of a national initiative and some as local initiatives. The whole could be seen as a “scatter gun approach”. The current systems for obtaining feedback could lead to patients being over burdened with numerous requests for feedback on similar items. The following are just some of the methods used.

National Inpatient Survey
Patient real time feedback utilising Doctor Foster trackers
Bedside television surveys
Variety of ad-hoc surveys run by various internal departments
Survey of all women delivered in the last 12 months run by the Maternity Services Liaison Committee
Neonatal Unit parent feedback questionnaire
Genetics regular patient satisfaction surveys and feedback on leaflets
Visits by members of staff in the health shop to community settings
PALS, Complaints and the newly introduced Compliments, Suggestions and

Complaints Leaflet

Through patient groups such as MSLC, Delivery Suite Forum, Continence Group and the Women's Hospital Council which feeds into the Patient Experience sub group of the Members Council

We need to participate in national surveys as well as carry out real time surveys and implement timely actions to address any areas of weakness. National surveys can be useful for highlighting poor performance against our peer groups. The maternity survey in 2008 gave 5 areas where BWNFT performed poorly. As a result of this, hand held devices were used to drill down and ask specific questions relating to these 5 areas so that the maternity directorate could monitor improvement. This is a useful method that should be extended to other areas of the trust for example gynaecology outpatients.

Experience over the last twelve months has shown a lack of commitment and a low priority rating from clinical staff to obtaining user views. There has been very poor utilisation of both the hand held devices and the bedside televisions. It has become clear that there needs to be strong leadership and an organisational culture of wishing to obtain patient feedback and acting on the results. Line Managers within the clinical areas should have clear objectives relating to patient experience with accountability and reporting structures to the professional heads within the Directorates. Organisational behaviour/culture change is vital if we are to be successful in collecting feedback. It should fit in with the trust's quality improvement strategy and link to the organisational development strategy.

3. The Way Forward

The information collected over the last two years has clearly identified areas of patient concern which should be explored further. Regular items of feedback relate to cleanliness of bathrooms and toilets, communication and general customer care. As a starting point, all patient areas should be surveyed using a standard set of questions. It will then be possible to have baseline information on which to build. For example, gynaecology patients may have a different experience of customer care on one ward than the other.

Patient feedback needs to be recognised as a high priority across the trust. There needs to be focussed attention on implementing feedback systems and ensuring regular and sufficient feedback to be meaningful. It is recommended that this is managed as a project in the first instance, with the appointment of a project manager for one year, after which time the processes should be embedded within the directorates. The cost of this would be approximately £30,000

There needs to be investment in both collecting and analysing data to ensure feedback is used to bring about improvement. The Trust is in a fortunate position to now have the support of volunteers who have improved the uptake of the bedside television surveys and in completing the questionnaires on the patient trackers. This support needs to be extended to ensure that surveys are carried out every two weeks in the clinical areas to ensure a significant proportion of service users are surveyed.

The trust should aim to benefit patients' by making a small difference to a large number of patients rather than a large difference to a few.

4. **Recommendations**

The Board of Directors is asked to debate and agree the following recommendations for collecting and utilising patient feedback:-

1. To agree the 3 main areas of focus for patient feedback - January Board of Directors
2. Appoint a project Manager to manage patient feedback as a formal project. The project manager reporting to the Nurse Director who will be the Board level leader having oversight of the whole programme. The project leader would be appointed on a twelve month fixed term contract from April 2010,
3. The project manager to review current data collection methods and ensure that the devices chosen represent value for money and are appropriate for use.
4. Review of administrative support to analyse the data. This is vital to ensure the data is analysed into useful information which can then be used to implement changes and improvements.
5. At the same time, a programme of organisational development should be implemented to address customer care training and cultural issues. The listening into action programme could help facilitate this.
6. Consider how governors can feed into the process of patient feedback, once the systems are established—January 2011.

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

CONTEXT AND BACKGROUND FOR REPORT

This report highlights updates in December 2009 from the Gynae Directorate action plan.

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

- Escalation plan to identify named individual for contact when delays – **some progress but not complete.**
- Cancer waiting time plan circulated to all stakeholders.
- Clinical champions to be identified for each pathway – **not complete.**
- Identify named person to be responsible for tertiary referral system – **carried forward to January 2010.**

RECOMMENDATIONS:

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

GYNAECOLOGY ONCOLOGY
Achieving and Sustaining Cancer Waiting Time Targets
ACTION PLAN 2009-10

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

Objective	Action Required	Person Responsible	Action By	Progress
Operational Effectiveness Develop the Operational Policy for Cancer Services so as to Clearly identify responsibilities for cancer tracking team.	Policy to include: <ul style="list-style-type: none"> ▪ Identification of tailored reports to meet organisational needs ▪ Performance management arrangements across the Trust ▪ Integration of cancer team into operational management on a daily basis ▪ Escalation Policy with clearly defined roles and responsibilities for individuals including tertiary referrals ▪ Management of Tertiary referrals Cancer waiting times management eg DNAS, unfit for treatment, refuse diagnostics and including management of 2ww referrals	Gynaecology Oncology Unit Lead	Mar 2010	
	Formulate escalation Policy identifying named individuals to be contacted when patient delays occur on clinical pathway which Oncology Administration Department are unable to resolve.	Gynaecology Oncology Unit Lead / Gynaecology General Manager	Dec 2009	Gynae Oncology Locality (GOL) meeting held 10.12.09. Action plan discussed. Agreed operational mtg tba within next 2 weeks. Will need to liaise with Unit lead who will be on leave subsequently, may need to roll forward to January.

	Sustaining Cancer Waiting Times Plan to be circulated to all stakeholders.	Gynaecology General Manager	Dec 2009	Plan shared with Board, GOL 10.12.09. PCT 17.12.09. To be shared with MDT 11.01.10 on return of Unit Lead.
	Plan to be endorsed by Trust Board		Nov 2009	completed
Effective Pathway Design - Effective pathways deliver quality and timely care to patients throughout their cancer journey. Effective pathway development, implementation and evaluation across organisational boundaries will support the delivery of sustainable Cancer Waiting Times	Identify Clinical Champions for each pathway.	Gynaecology General Manager	Dec 2009	Work with pathways ongoing
	Audit patients against clinical pathway	Oncology Data Manager Service Improvement facilitator	Ongoing	Work with PMB commenced.
	Share audit results with clinical teams	Oncology Data Manager Service Improvement facilitator	Ongoing	
	Review and redesign clinical pathways (including tertiary referrals) in conjunction with Clinical Champions and MDT. Pathways will be timed and designed to ensure treatment is well within the 62 day target. Pathway redesign will be prioritised addressing most problematic areas first.	Gynaecology Oncology Unit Lead	Mar 2010	Update from GOL 10.12.09 - Work ongoing with Service Improvement Facilitator (SIF), regards to information pathways. Clinicians need to be identified, to be contacted in next phase, Jan 2010.
	Capacity Issues - As part of pathway redesign, capacity issues to be identified and resolved with relevant diagnostic teams to ensure sufficient diagnostic and treatment slots are available to treat patients coming through the 2 week wait route.	Gynaecology General Manager		Outsourcing scans to Alliance Medical wef 09.12.09 in order to increase capacity and reduce waits.
	Review referral system and information and communication strategy with tertiary centres to support referrals	Oncology Data Manager	Jan 2010	Work ongoing with SIF

	Identify named person to be accountable for tertiary referral system in Trust	Gynaecology General Manager	Dec 2009	To be discussed with Unit Lead Jan 2010.
	Document and share pathways with stakeholders	Gynaecology General Manager	Apr 2010	
	Test redesigned pathways against national best practice	Oncology Data Manager	Mar 2010	
	Audit redesigned pathways quarterly	Oncology Data Manager	Ongoing	
Robust Data Information and Administrative Systems - Information systems must be complete and robust to guarantee delivery of the standard for all patients. Effective navigation of patients will only be possible if data is complete and the information tells you where patients are in the pathway.	Develop clear protocols to support data capture with clarity about which individuals own and revise it.	Oncology Data Manager	Feb 2010	
	National reporting requirements including Weekly PTL and End of Month Report <ul style="list-style-type: none"> ▪ Traffic Light Report ▪ Tertiary Referral Report ▪ Target Date Report ▪ Performance Reports ▪ Highlight Report ▪ Suspended patient report ▪ Breach Report ▪ 31 day Report 	Oncology Data Manager	Jan 2010	Meet weekly with General Mgr and/or Unit Lead to review PTL and performance report. Tertiary referral report to be forwarded to Genral Mgr and Unit Lead monthly wef from Dec 09.
	<ul style="list-style-type: none"> ▪ Review use of Somerset database and Business continuity plan ▪ Scope benefits and feasibility of using MDT functionality on Somerset creating an electronic patient record which can be accessed by all clinicians. 	Oncology Data Manager	Mar 2010	

<p>Prospective Patient Management and Navigation - Prospective management of patients allows you to know where patients are in the system, navigate patients through the pathway ensuring they are in the right place at the right time receiving the right care whilst enhancing the flow in the patient's journey between departments within and across organisations.</p>	<p>Develop a cancer team to navigate patients through the diagnostic and treatment pathways:-</p> <ul style="list-style-type: none"> ▪ Develop a job description to incorporate tracking, patient navigation. ▪ Review skill mix and identify whole time equivalents required to undertake all duties ▪ Ensure the Trust has the resilience within the oncology administrative Department to support effective delivery of service. ▪ Present results to Trust Board with recommendation to implement new structure. ▪ Recruit to post subject to approval 	<p>Oncology Data Manager</p>	<p>Jan 2010</p>	<p>JD drafted and submitted for matching 10.12.09. Job Matched, VAF submitted Jan 2010.</p> <p>Patient Tracker Post submitted in the Directorate Business Plan 2010/11.</p> <p>Succession planning – MDT co-ordinator retiring Feb 2010. VAF submitted Dec 2009.</p>
	<p>To underpin the navigational role and clearly identify responsibility and accountability, incorporate into Operational Policy the following:-</p> <ul style="list-style-type: none"> ▪ Tracking role ▪ MDT coordination ▪ Clinical data capture ▪ How to "track a patient" through the clinical pathways - escalation policy ▪ Local and National guidance on patient management i.e.suspensions, DNAs, when to remove a patient from the database, breaches 	<p>Gynaecology Oncology Unit Lead</p>	<p>Mar 2010</p>	
	<p>Review access policy for patients referred on the 2ww. Monitor adherence to policy.</p>	<p>Oncology Data Manager</p>	<p>Jan 2010</p>	<p>Mtg being arranged with Patient Access Manager.</p>

	<p>Put in place systems and processes to ensure that the trust switches from reactive to proactive management of patients. This will encompass the role clarity needed for MDT coordinators and more active management of patients on the PTL.</p>	<p>Development of PTL reporting to assist tracking. Improved monitoring of PTL Managerially</p>	<p>Jan 2010</p>	<p>Weekly operational report identifying patients attending Colposcopy appointments to facilitate tracking.</p> <p>New tracking system implemented in Colposcopy Nov 2009, feedback positive to date.</p> <p>Proposal to pilot similar system in hysteroscopy.</p> <p>Pilot use of comments field in Lorenzo for inputting of target dates, which gets printed on the clinic lists, identifying patients on 62 day pathway.</p>
	<p>It is recommended that the Directorate closely monitor notice periods for clinical annual leave and that leave is managed in such a way that it does not impact on patient treatment in line with the annual leave policy.</p>	<p>Review policy to ensure 6 week notice is enforced and that appropriate "cover" is agreed.</p>	<p>Ongoing</p>	<p>Plans in place to cover Christmas Annual Leave, additional clinics and contingency theatre lists have been arranged throughout this period.</p>
	<p>CNS Capacity</p>	<p>Exploring options to appoint and additional gynae CNS to see follow up patients, releasing consultant time to see more potential cancer patients</p>	<p>Mar 2010</p>	

Birmingham Women's

NHS Foundation Trust



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

CONTEXT AND BACKGROUND FOR REPORT

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

Owing to the timing of the December 2009 meeting, the dashboards for November and December 2009 are presented to this meeting.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

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

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

RECOMMENDATIONS

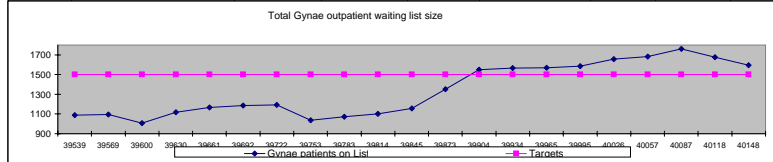
The Board are asked to consider the performance information and to be assured that this has been managed appropriately by the Executive Management Team.

2) Key Performance Indicators - Nov 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	433	Adverse Change	Performance	433	
	Total Gynae outpatient waiting list size		>1500	1500	1678	Favourable change	Performance	1678	
	Total Genetics waiting list size		>1400	1400	1106	Favourable change	Performance	1106	
	Referral Rates - Gynae	1586	<1507 and >1665	1586	1504	Favourable change	Performance	1726	
	Referral Rates - Maternity	1894	<1799 and >1989	1894	1920	Favourable change	Performance	1880	
	Referral Rates - Genetics	691	<588 and >650	619	635	Favourable change	Performance	708	
Productivity & Efficiency	Maternity LOS postnatal	1.93		1.93	2.04	No change	Performance	2.01	
	Gynae Length of Stay (exc daycases and emergencies)	3.1		2.90	1.70	Favourable change	Performance	2.05	
	Daycase rate 1 - as % of all elective admissions	50%		>50%	53%	Adverse Change	Performance	57%	
	Gynaecology Daycase Over Stay Rate	13.86%	>10%	5%	3.53%	Adverse Change	Performance	4%	
	Gynae Pre operative Avg LOS	0.15		0	0.07	Adverse Change	Performance	0.07	
	Elective Admitted patients surgery within 2 days - no of breaches	0	>0	0	1	Adverse Change	Performance	10	
	Theatre utilisation	80%	<75	80%			Performance		
	Gynae New to FU ratio	1.40		<1.50	1.58	Adverse Change	Performance	1.47	
	Non Obstetric diagnostic scans >= 6 weeks	0	>0	0	0	No change	Performance	0.00	
	Occupancy Rate - Neonatal ITU	80%	<76%	80%	78%	Adverse Change	Performance		
Clinical Quality (Monthly)	Written Complaints	<9	>10	9	11	Favourable change	Clinical Governance		
	Responded to within agreed timescale	95%	95%	95%	80%	Favourable change	Patient Experience		
	PALS	20 cases	>25 cases	20 cases	21	Favourable change	Quarterly report to CGC		
	Compliments				3	Favourable change	Patient Experience		
	Experience of Patients-top 20% of in patient survey			To be in the top 20%					
	Annual Neonatal deaths(BWH born)-benchmark=level 3 units/per 1000	3 per 1000	>	3 per 1000	6.4	Favourable change			
	Annual Neonatal Deaths (outborn transfers to NNU)				15.0				
	Annual Stillbirths per 1000 live births	5.4	>7		6.49	Favourable change		6.5	
	Annual Stillbirth rate excluding <500gm/congenital abnorm.								
	Annual Corrected Stillbirth rate per 1000 live births-IUTs	3.9	>4	<4					
	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%			Infection control		
	MRSA Total admission tests			100%			Infection control		
	Essence of Care Indicators				Neonates	Maternity	Gynae	Clinical Support	Genetics
	1 Communication		not achieved	In Progress	Ongoing	Reaudited Sept		audited	
	2 Continence		not achieved	Not relevant	Not audited	Reaudited Sept		Not relevant	
	3 Hygiene		not achieved	In Progress	Not audited	Reaudited Sept		Not relevant	
	4 Nutrition		not achieved	In Progress	Not audited	Reaudited Sept		Not relevant	
	5 Pressure Ulcers		not achieved	Not relevant	Not audited	Reaudited Sept	Not relevant	Not relevant	
6 Privacy & Dignity		not achieved	In Progress	Ongoing	Reaudited Sept	Not relevant	audited		
7 Record Keeping		not achieved	In Progress	Ongoing	Reaudited Sept		audited		
8 Safety		not achieved	In Progress	Audited	Reaudited Sept		Not audited - assessed individually		
9 Self Care		not achieved	Not relevant	Not audited	Reaudited Sept		Not relevant		
10 Promoting Health		not achieved	In Progress	Not audited	Reaudited Sept	Not relevant	audited		
11 Care Environment		not achieved	In Progress	Ongoing	Reaudited Sept		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				Clinical governance		
	PEAT Annual Inspection Results			maintain excellent		Due Feb 2010			
COQUINS	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	£397K	£710k	Adverse Change	Finance	£875K	
	Year to date I&E normalised	plan or >	off plan	£(146)k	£(222)k	Adverse Change	Finance	N/A	
	In month run rate	plan or >	off plan	£50k	£3k	Adverse Change	Finance	N/A	
	In month run rate normalised	plan or >	off plan	£(9)k	£(41)k	Adverse Change	Finance	N/A	
	Year to date Ebitda	plan or >	off plan	£3,295k	£3,731k	Adverse Change	Finance	£5,471K	
	Year to date Ebitda margin	plan or >	off plan	5.8%	6.7%	No Change	Finance	6.4%	
	Year to date CIP performance	plan or >	off plan	£1,811k	£1,835k	Adverse Change	Finance	£2,613K	
	CIP recurrent/non-recurrent delivery	plan or >	off plan	70/30	50/50	Favourable Change	Finance	51/49	
Workforce	Contracted WTE	1322	>1388	<1322	1406.06	Adverse Change	Head Count:1618		
	Agency/Bank spend as a % of directorate payroll	2.85	>2.85%	<2.85%	4.19%	Adverse Change			
	Sickness Absence Rate %	4%	>4%	<4%	4.99%	Positive Change	2,454.68 Days Lost		
	Staff Turnover Rate %	14%	>14.10%	<14.10%	11.18%	Positive Change	Leavers:10		
	Employee Investigations	4weeks	>4 weeks	<4 weeks	7	Adverse Change	3 over 4 weeks		
	KSF - Staff groups with Job Outlines %	85%	<85%	>85%	69.27%	Adverse Change	1046/1510		
	KSF - Staff who have received PDR %	50%	<50%	>50%	45.61%	Positive Change	628/1377		
	Pay as a % of Trust Income	58.69%	>58.69%	<58.69%	63.45%	Adverse Change			
	Staff Grievances	tbc	2	1	0	No Change			
	Harassment and Bullying	tbc	2	1	1	No Change			
NHS Staff Satisfaction	70%	>65%	<70%	70%	No Change	2008 Survey			
CQC Targets	Cancer 2 week wait	No lapses	Outside Tolerance	93%	91.9%	Adverse Change	Performance	95.2	
	Cancer 1 month diagnosis to treatment	No lapses	Outside Tolerance	96%	100.0%	No change	Performance	96.9	
	Cancer 1 month subsequent treatment standard	No lapses	Outside Tolerance	94%	100.0%	New	Performance	100	
	Cancer 2 month GP urgent referral to treatment	No lapses	Outside Tolerance	85%	33.3%	Adverse Change	Performance	74.4	
	Cancer 2 month Cervical Screening Report Received to treatment	No lapses	Outside Tolerance	90%	100.0%	No change	Performance	93.3	
	Cancer 2 month from upgrade to treatment	No lapses	Outside Tolerance	To be Determined	100.0%	No change	Performance	88	
	Cancelled Operations on day of surgery	1	>1	<1	1	Adverse Change	Performance	10	
	Cancelled Operations not admitted within 28 days	No lapses	Breach	No lapses	No lapses	No change	Performance	No lapses	
	Inpatients waiting >26 weeks	0>standard	Breach	No lapses	No lapses	No change	Performance	No lapses	
	Outpatients waiting >13 weeks	0>standard	Breach	No lapses	No lapses	No change	Performance	100 Breaches	
	Admitted patients seen within 18 weeks			>90% by Dec 08	93.6%	Adverse Change	Performance		
	Non-admitted patients seen within 18 weeks			>95% by Dec 08	96.5%	Adverse Change	Performance		
	Data quality on ethnic group	100%	<95%	100%	94.0%	Adverse Change	Performance	95.0%	
Engagement in clinical audits	implemented	Breach	Implemented			Clinical Governance			
Maternity HES data quality indicator		>15%	<15%	9.9%	Adverse Change		8.5%		
Vital Signs	BreastFeeding Initiated	67%	>60%	67%	60.00%	Adverse change	Performance		
	Smoking during pregnancy	11%	13%	11%	12%	positive change	Performance		
	% of Women seen by 12 weeks	80%	<78%	80%	96%	positive change	Performance		
	Referral to stop smoking service: % referral to stop smoking service			To be Determined			Commissioning Report		
Commissioner Set	% time slots available for 'Choose and Book'	100%	<95%	100%			Commissioning Report		
	Percentage of SUS data altered in period	5%	>10%	5%	0%	Favourable change	Commissioning Report		
	Information Governance Toolkit Level 2 minimum attainment		<100%	100%	97%	No change	Commissioning Report		
Foundation Status	Number of Members	5000 by end of year	Negative	Net 50				5000	

Market Trend Awareness Strategy

Indicator	Target	Trend/actual	Commentary	Action	Completion date	Lead	Risk	Impact
Total Gynae outpatient waiting list size	1500	1594						



Indicator	Target	Trend/actual	Commentary	Action	Completion date	Lead	Risk	Impact
Maternity LOS postnatal	1.93	2.04						

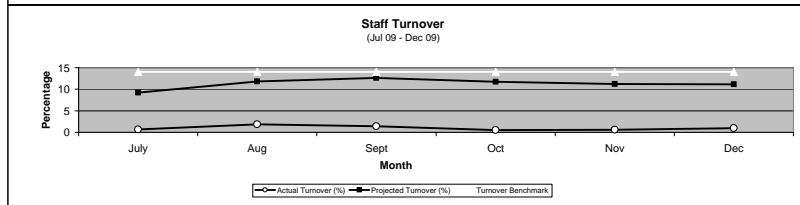
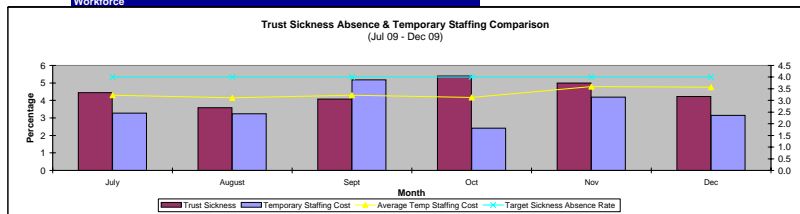
Productivity & Efficiency

Clinical Quality

Core Standards

Finance

Workforce



QOC Targets

Vital Signs

Commissioner Set

Birmingham Women's NHS Foundation Trust

Finance Report for the Period
April 2009 to December 2009

Summary Financial Position

Key Points

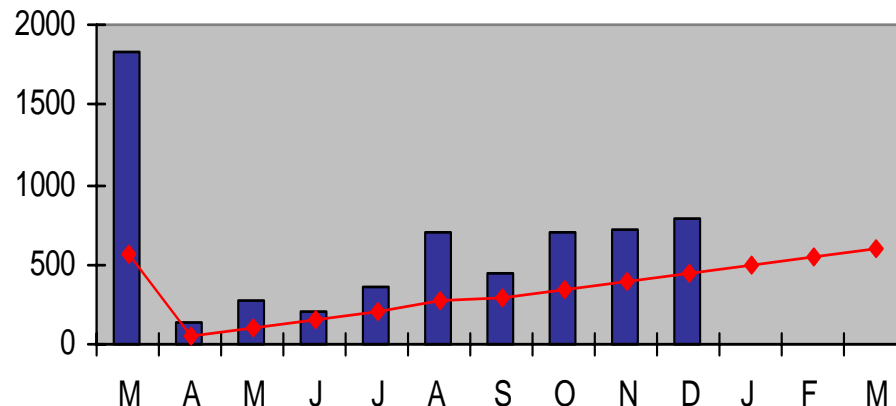
- This is the finance report to the end of December 2009, Month 9. The results show a net surplus of £793k, which is £347k above plan and converts to a Monitor risk rating of 4.

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

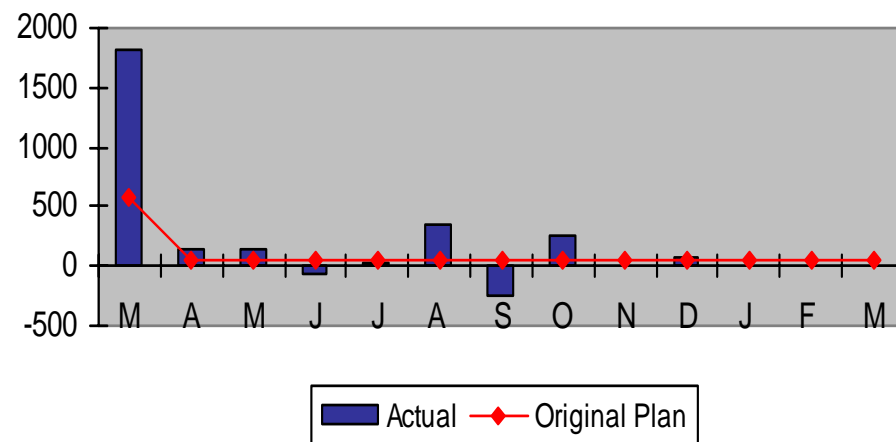
- The summary £347k variance comprises the following:-
 - A favourable £28k income variance;
 - A favourable £427k expenditure variance;
 - An above plan EBITDA position totalling 6.6%
 - A favourable £151k variance for depreciation;
 - An adverse variance of £259k for interest receivable.
- The in-month position was a net surplus of £83k, further details of which are included within the income and spending trends sections of this report.
- The planned end of year position is a surplus of £0.6m. The current forecast based on the overall position stands at £1.1m.

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

Cumulative plan, results & forecast



Month by month plan, results & forecast



Actual Original Plan

Income

Key Points

- The income attributable to the end of month 9 is £63.3m, which is £28k ahead of target. This favourable variance reflects additional income received from the Specialist Commissioners and from non-contracted activity. Income in ACU continues to be behind plan with the year end forecast adjusted to reflect this. R&D income also shows a significant adverse variance but this is offset by favourable expenditure variances.

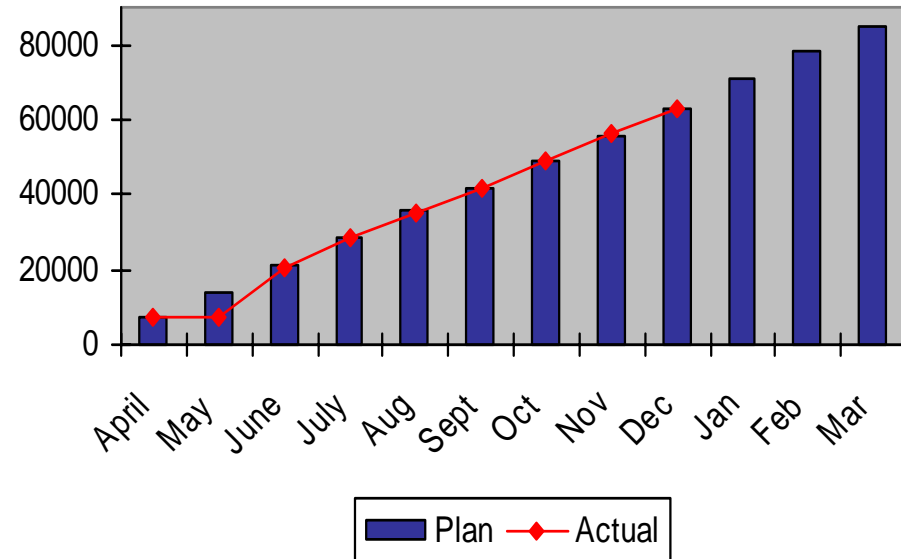
Healthcare Income

- At Month 9 this is £241k above target, included within which is an assessment of cumulative contract over-performance, equating to £175k, and the additional funding received from the Specialised Commissioners.
- Private patient income is behind plan at Month 9 and is forecast to under-achieve at year end. The current forecast income (£750k) would equate to 1.1% in terms of the private patient cap, which is well within the Trust's maximum level of 2.2%.

Performance with Commissioners

- An assessment of cumulative over-performance has been made for Month 9, which equates to £175k 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 £332k for elective and non-elective and a further £41k under-performance on other Gynaecology contract lines.
- Maternity – favourable variance of £346k for non-elective and outpatients which is lower than in previous months.
- Neonatology – favourable variance of £314k predominantly with specialist commissioners outside the region.
- Clinical Genetics – referrals are currently ahead of target; and Laboratory Genetics – number of tests currently ahead of target.

Spending Trends within Directorates

Key Points

- The table opposite shows the combined positions of pay, non-pay and directorate income variances. Healthcare income is not shown here but is included in the service line reports.
- The table has been expanded to show the hosted organisations (National Genetics Education Centre, Cancer Intelligence Unit and Public Health Observatory) and R&D separately. R&D especially has large counteracting variances across pay, non-pay and income so the intent is to provide greater clarity in the expanded table.
- At Month 9 there is a favourable variance of £207k across all the directorates. This represents a small increase from last month with Clinical Support's continuing deterioration being offset by gains in Genetics, Maternity and Gynaecology.
- Clinical Support's end of year forecast has been revised given the deterioration and now stands at a deficit of £672k. The Directorate continue to be tasked with reviewing their expenditure position and year end forecast in detail to address the situation and clearly this will be a priority for the newly appointed Associate Director when they join the Trust in February.
- Genetics also continue to investigate their expenditure position, analysing trends in non-pay consumables expenditure linked to income generation. Directorate income has improved substantially this month following an exercise to bring outstanding invoicing up to date.
- 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 the efficiency programme.

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

Directorate Pay and non-pay variances from budget

Year to date £ 000s	Month 09				Month 08			
	Pay	Non-Pay	Dir'ate Income	Total	Pay	Non-Pay	Dir'ate Income	Total
Maternity	213	-19	33	227	188	-20	23	191
Gynaecology	383	-73	-85	225	353	-95	-69	189
Genetics	-237	-270	418	-89	-209	-264	265	-208
Neonatal	-74	11	22	-41	-42	9	11	-22
Clinical Support	-263	-213	-95	-571	-179	-215	-72	-466
Facilities	-31	59	37	65	-3	75	34	106
R&D	225	280	-500	5	207	241	-444	4
Corporate Services	312	-9	83	386	302	-6	95	391
Hosted Organisations	0	0	0	0	0	0	0	0
	528	-234	-87	207	617	-275	-157	185

Directorate Pay and non-pay variances from budget

Year to date £ 000s	Month 07				Forecast EOY			
	Pay	Non-Pay	Dir'ate Income	Total	Pay	Non-Pay	Dir'ate Income	Total
Maternity	144	-11	17	150	196	5	60	261
Gynaecology	366	-36	-56	274	509	-155	-136	218
Genetics	-125	-255	223	-157	-103	-339	416	-26
Neonatal	-30	12	9	-9	-151	11	31	-109
Clinical Support	-112	-152	-124	-388	-360	-298	-14	-672
Facilities	-16	50	14	48	-48	134	57	143
R&D	191	206	-393	4	263	186	-442	7
Corporate Services	280	-43	114	351	312	-84	55	283
Hosted Organisations	-40	-1	17	-24	0	0	0	0
	658	-230	-179	249	618	-540	27	105

Cost and Efficiency Improvements

Update on performance

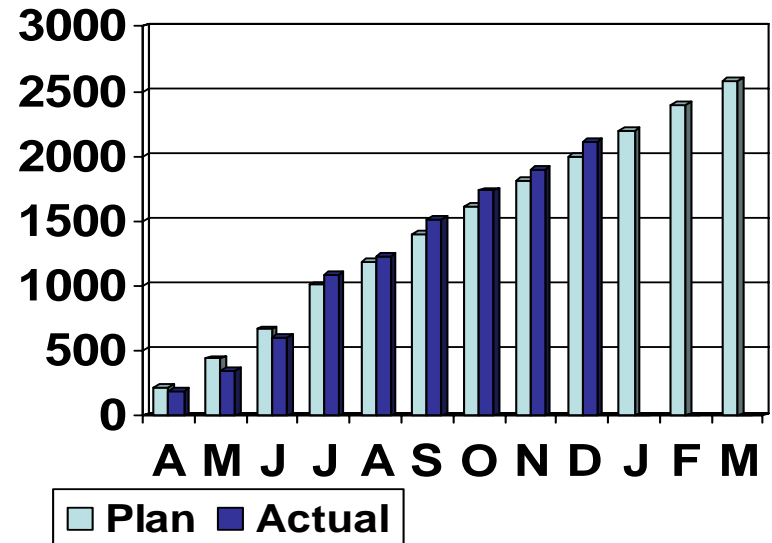
Overall Summary

- As at the end of December 2009 savings of £2,112k have been identified as saved, against a target of £2,008k. 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 October. The traffic light results are (split by the 2.6m plan) :-
 - Red £38K
 - Amber £469K
 - Green £2,077K
 - Total £2,584K
- This proportion of schemes rated as green, amber and red remains very similar when compared to month 8. Work will continue on identifying alternative schemes to replace any red schemes and amber schemes will be monitored closely to ensure that any barriers to delivery are understood.
- The recurrent/non recurrent split is planned to be 70/30%, which is consistent with the approach adopted in previous years. The assessment of this as at month 9 is showing a split of 51/49%, which will continue to be reviewed and challenged on a monthly basis to ensure that overly cautious approaches have not been adopted when declaring whether a scheme is recurrent or not.

Savings delivery - cumulative

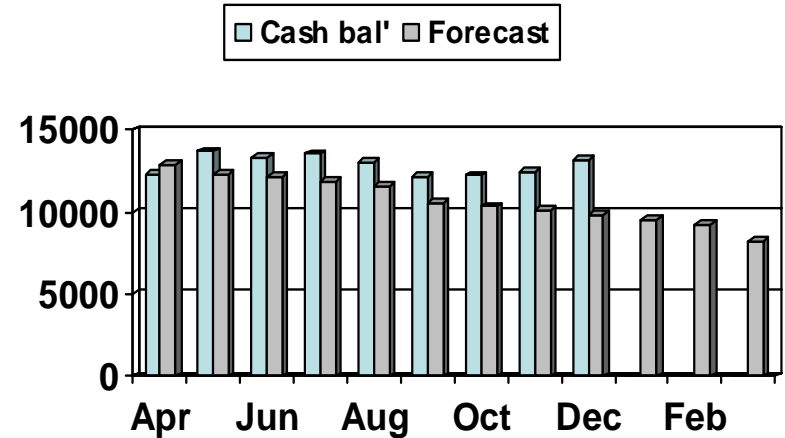


NB savings include additional income with respect to the some directorates

Cash Flow 1

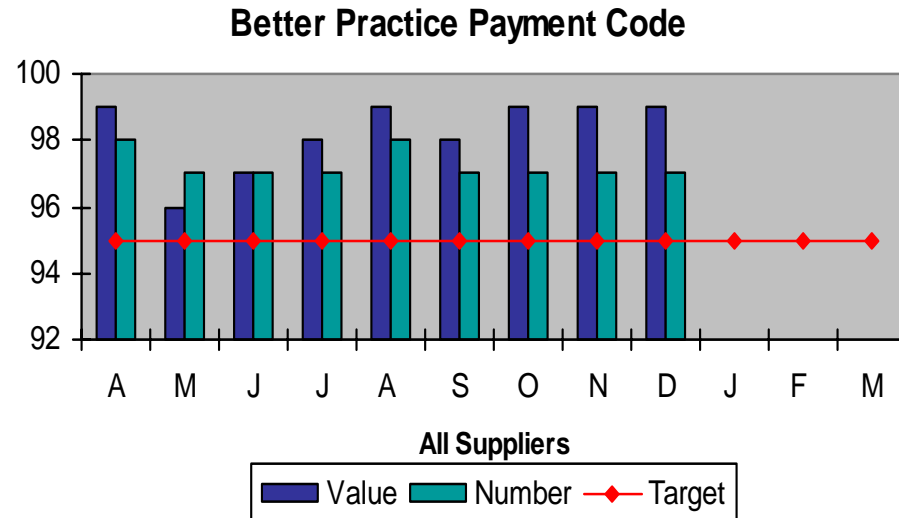
Cash Balances

- The cash position remains strong with a balance at the end of December totalling £13.1m. Deferred income and accruals are recorded as £5.9m.
- The reserve account held with our commercial bank was converted to a Special Interest Bearing Account (SIBA) with effect from the 4th September. This account now pays an interest rate of base + 0.20% (currently 0.70%) and currently holds just over £4.5m. A further £3m has now returned from a 3 month deposit with Lloyds TSB and will be transferred into the SIBA until reinvested.



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

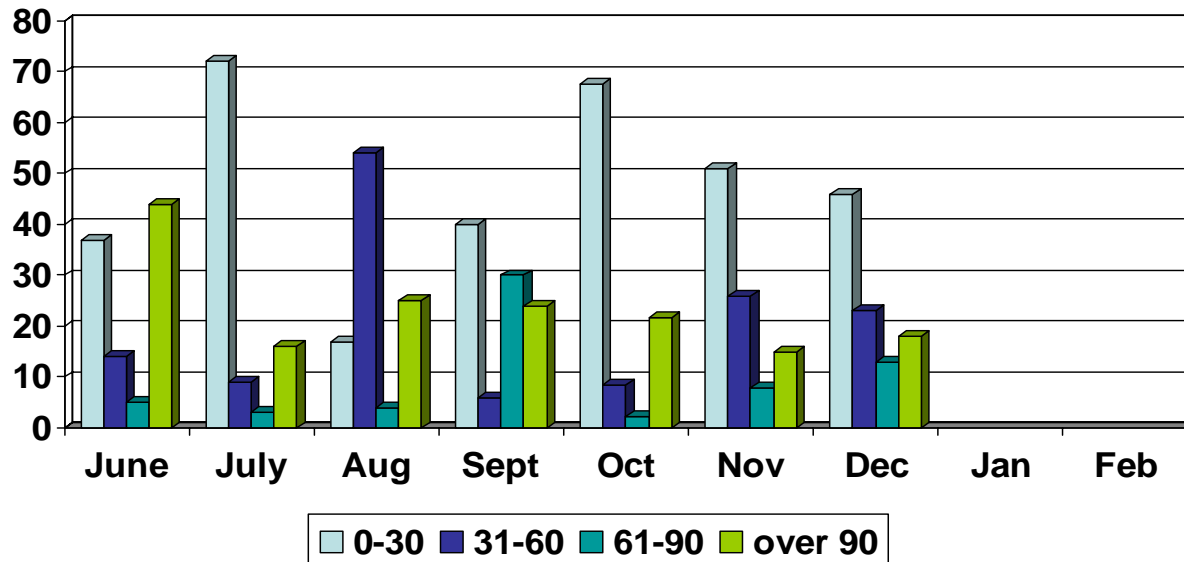
- The Better Practice Payment Code (formerly PSPP) targets NHS organisation to pay 95% of all supplier invoices within a period of not more than 30 days. Within this, the payment for local trade suppliers has been adjusted to payment within 10 days; this is in line with the Prime Minister's request to all public bodies.
- The cumulative performance for Month 9 by number is 97% and by value is 99%.



Cash Flow 2

Debtors (amounts owing to the Trust)

- Total Debtors valued £3.8m at the end of December, which represents a £0.5m increase compared to the end of November. Of the £3.8m, £2.3m relates to trade debtors and £1.5m to accrued income.
- In terms of aged debt information, the total value of debts over 90 days is just over £400K.
- 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.

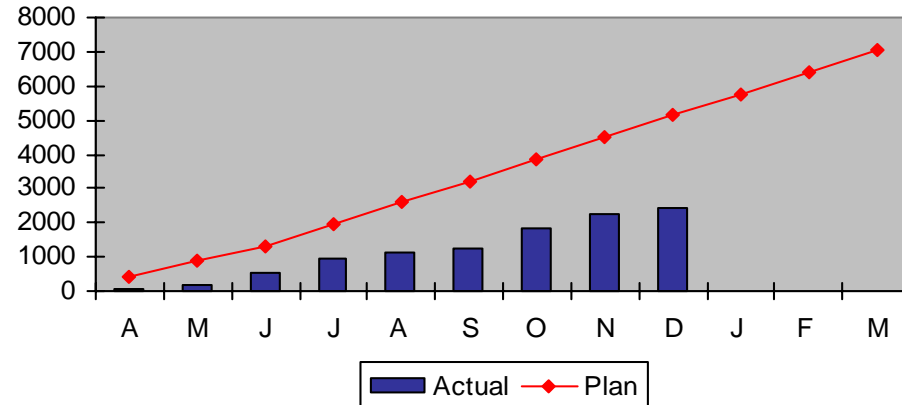


Cash Flow 3 – Capital Spending

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 9 position shows expenditure of £2.4m against all schemes. The current forecast is for the original programme to be fully utilised by year-end with a further scheme considered in addition, being:
 - £116k Neonatal Surgical cot – as previously advised

Monthly build up of the programme



2009/10 Capital Plan

Capex program

	Plan	Actual
PACS	0	(24)
Neonatal Unit Upgrade / Decant	4,944	600
Genetics White Paper	0	26
CHP Installation	0	8
Replacement PCs	150	144
Capital Equipment Replacement	780	1,020
Backlog Maintenance	929	590
Norton Court Roof	150	0
Other	91	81
TOTAL CAPITAL PROGRAMME	7,044	2,446

Up & Down-side Risks

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

Conclusions and Recommendations

CONCLUSIONS

1. The Trust is reporting a £793k surplus to the end of December, Month 9, which equates to a Monitor risk rating of 4.
2. Within the overall position and as explained previously, there is a small positive income variance in addition to the positive expenditure variance. This position will continue to be monitored and reviewed as we progress through the final quarter of the financial year.
3. As highlighted last year tight control of expenditure was and still is required throughout 2009/10, particularly in relation to non pay where this is not linked to increased activity.
4. Whilst being offset by other areas the Clinical Support position continues to deteriorate and will be a priority for the newly appointed Associate Director to address when they join the Trust in February, together with increased monitoring by the Executive Team
5. The full year forecast is currently a £1,134k surplus, with a surplus range for the year between £0.8m and £1.2m.

RECOMMENDATIONS

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

BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE
REPORTING PERIOD : - December 09 (Period 9)

Form F1	This Month			Year To Date			Full Year Forecast		
	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's
<u>Income (+)</u>									
Healthcare Income	5,610	5,448	(162)	50,380	50,622	241	67,362	67,648	286
Private Patient Income	103	47	(56)	835	537	(298)	1,144	750	(394)
Other Income	1,552	1,703	151	12,019	12,104	84	16,346	16,546	200
Total Income	7,265	7,198	(67)	63,234	63,262	28	84,852	84,945	92
<u>Operating Costs (-)</u>									
Pay Costs	(4,879)	(4,835)	44	(42,213)	(41,553)	661	(56,910)	(55,809)	1,101
Non Pay Costs	(1,975)	(1,933)	41	(17,314)	(17,548)	(234)	(22,999)	(23,491)	(492)
Total Operating Costs	(6,853)	(6,768)	85	(59,527)	(59,100)	427	(79,909)	(79,300)	609
EBITDA	412	430	18	3,707	4,162	455	4,943	5,644	702
EBITDA % Margin	5.7%	6.0%	0.3%	5.9%	6.6%	0.7%	5.8%	6.6%	0.8%
Depreciation (-)	(281)	(247)	34	(2,527)	(2,376)	151	(3,370)	(3,214)	156
Interest (+/-)	33	13	(19)	294	35	(259)	392	75	(317)
Surplus / Deficit before dividend	164	197	33	1,474	1,820	347	1,965	2,504	540
Dividend (-)	(114)	(114)	0	(1,027)	(1,027)	0	(1,370)	(1,370)	0
Surplus / (Deficit) cfd	50	83	33	446	793	347	595	1,134	540

Birmingham Women's

NHS Foundation Trust



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

CONTEXT AND BACKGROUND FOR REPORT

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

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

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

Corrected Neonatal mortality and Stillbirth rates are now expressed both as a rolling 1 year rate and graphically with statistical process charts.

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

RECOMMENDATIONS

To discuss and note the findings of the report

Weekly Safety indicators published 15th January 2010

Please find this weeks patient safety indicator results. Well done to all concerned for collecting the data and for the absence of events

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

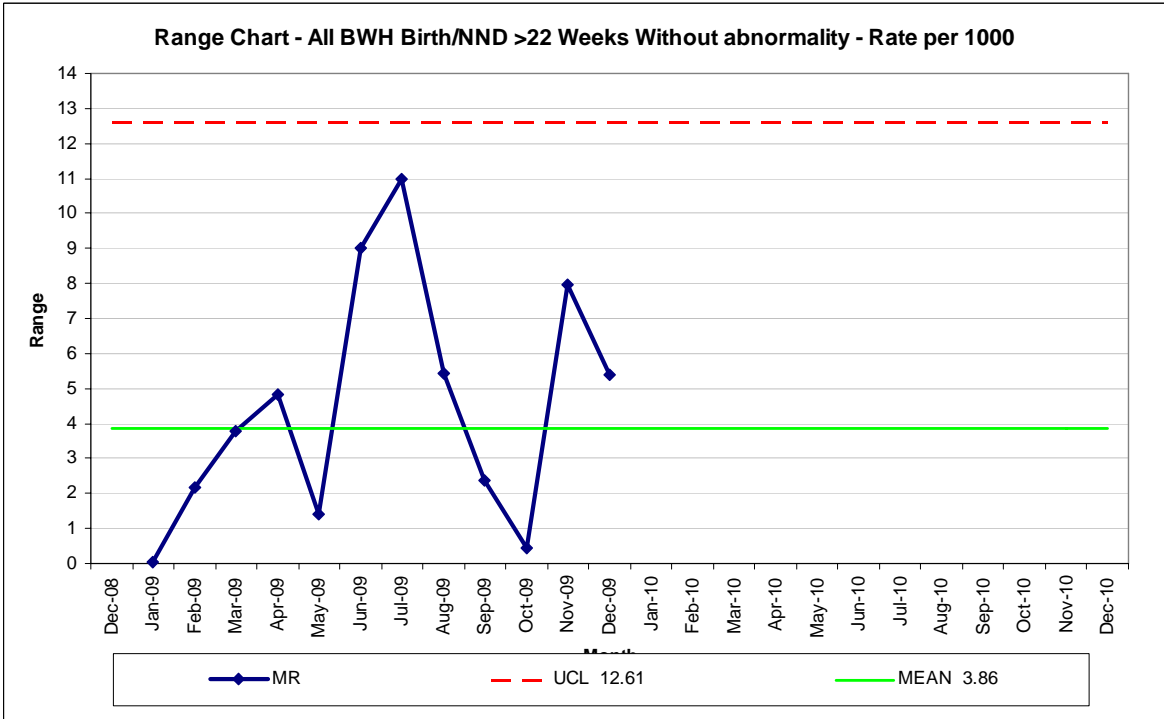
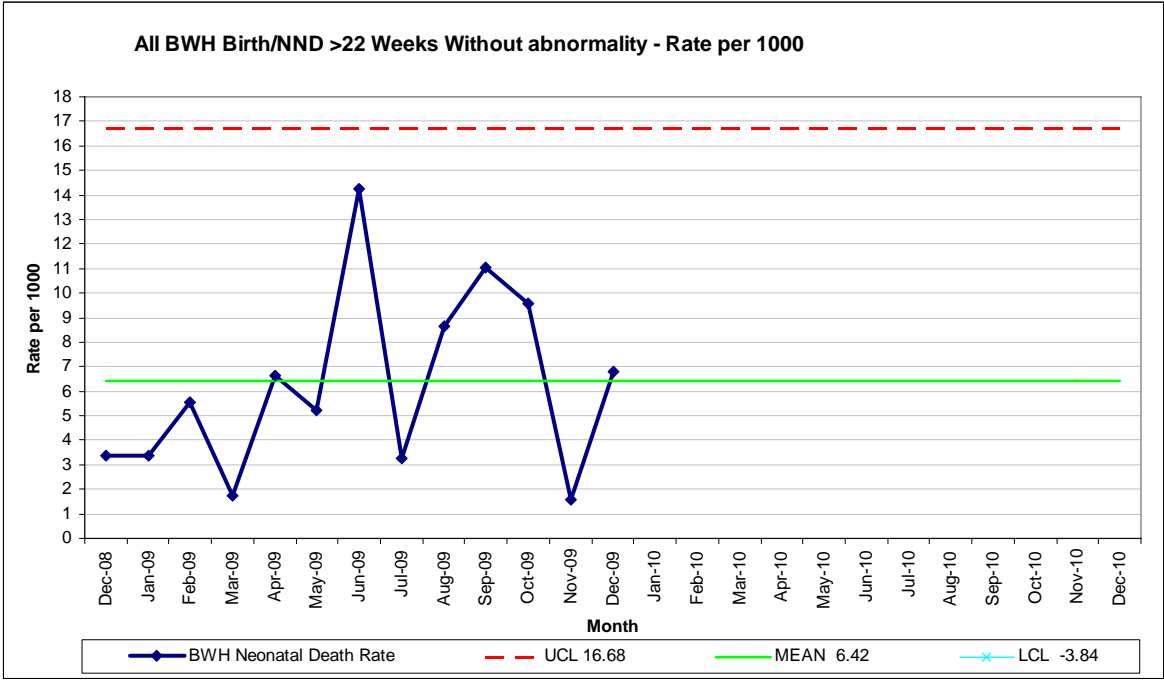
*These indicators include the time since mandatory reporting of these infections was introduced

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

Mortality Rates

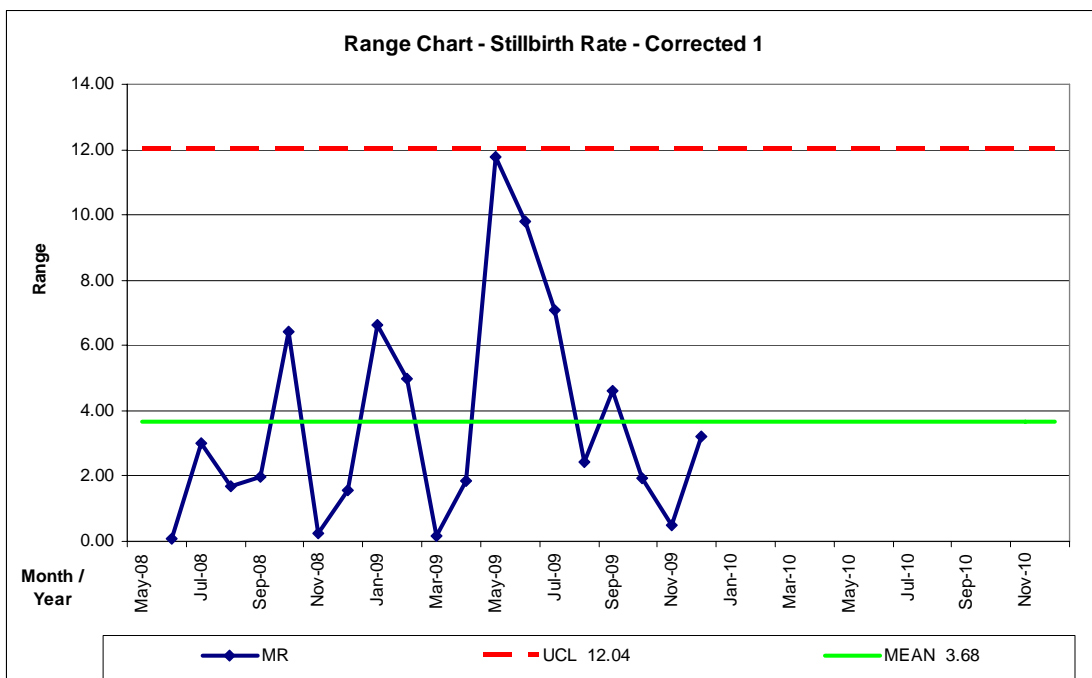
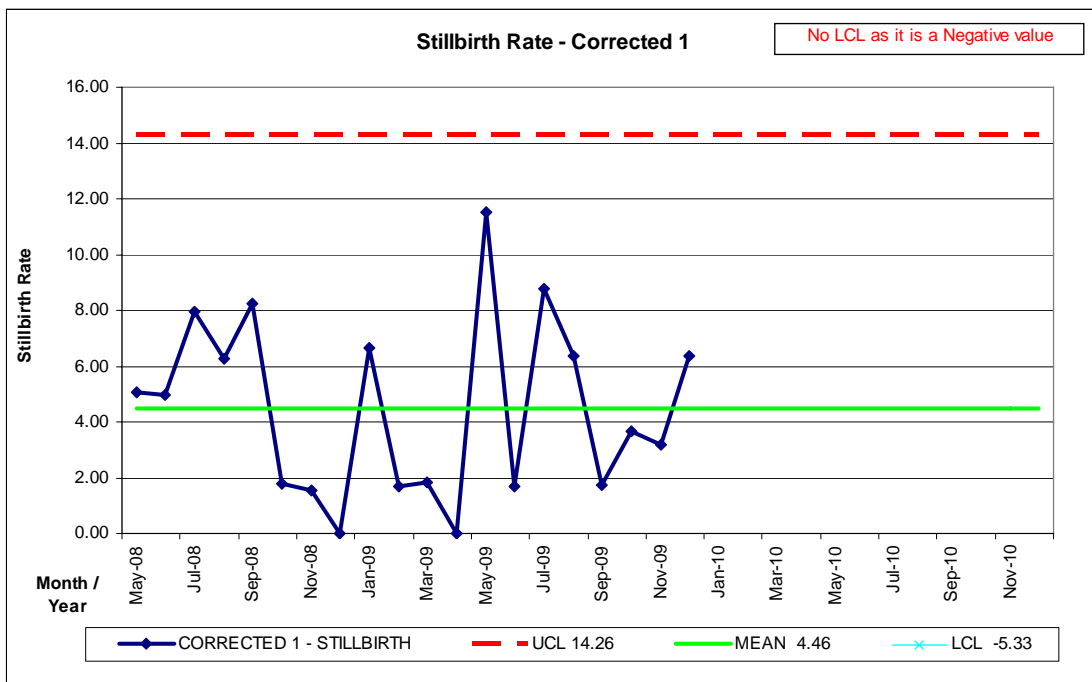
Corrected Neonatal Mortality Rates

Rolling annual rate corrected for lethal congenital abnormalities, delivery <22 weeks gestation and birth weight <500g is 5.9/1000.

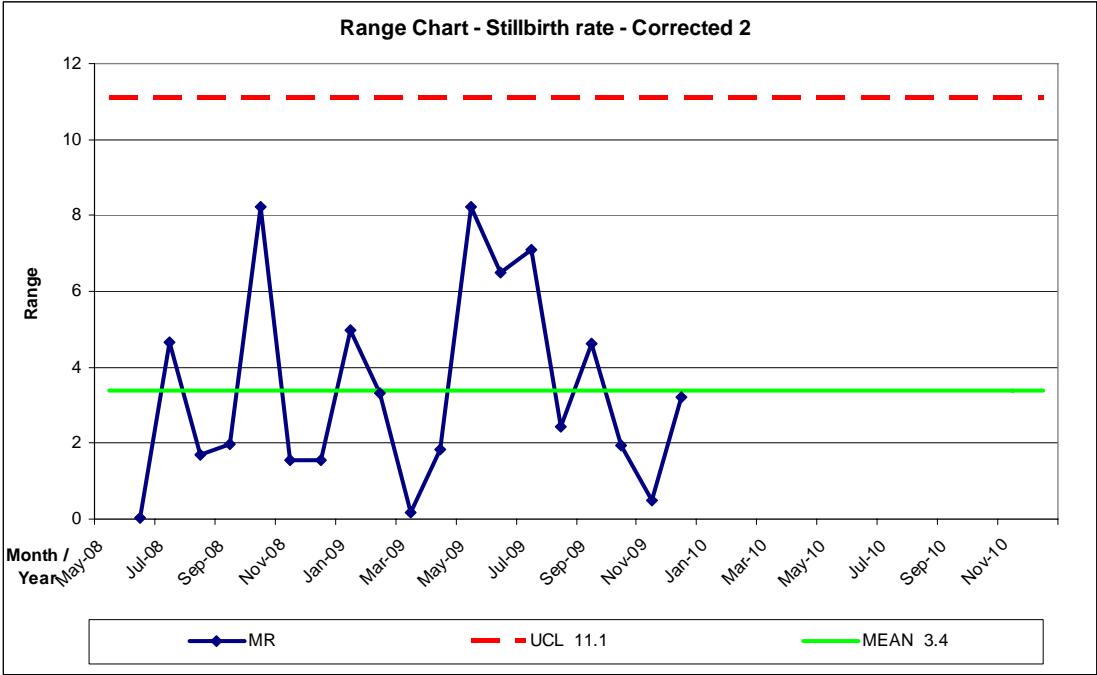
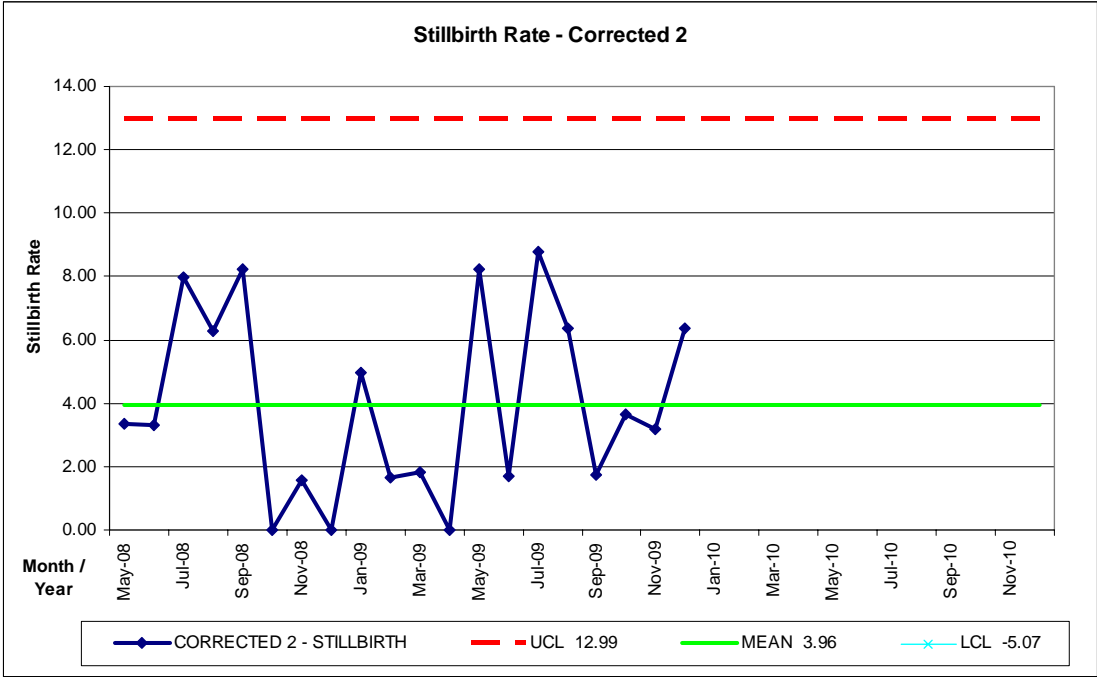


Corrected Stillbirth Rates

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



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



Serious Untoward Incidents (SUI)

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

Directorate	Number of SUI s this month
Clinical support	0
Genetics	0
Gynaecology	0
Maternity	0
Neonatology	1

Executive Walkabouts

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

- Neonatal unit
- Radiology
- Catering
- Gynaecology outpatients
- Wards 3 and 4 (Postnatal floor)
- Delivery suite
- Birth centre
- Finance
- Informatics
- Clinical Genetics

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

PJ Thompson
Medical Director

SUBJECT :	Monitor submission, Q3 2009-2010
REPORT BY :	Steve Parsons, Head of Corporate Affairs
AUTHOR :	Steve Parsons, Head of Corporate Affairs Jane Owen, Director of Nursing, Midwifery & Operations

CONTEXT AND BACKGROUND FOR REPORT

Under the provisions of the *Compliance Framework*, the Trust is required to report to Monitor quarterly on its performance. This report is to include a declaration approved by the Trust Board in respect to the Trust's performance against the targets set out in the *Compliance Framework* (including national Department of Health targets), financial performance details, any exception reporting items, and an update on Board and Members' Council changes.

From this year, Monitor requires the Board declaration to include an assessment of the governance rating for the Trust (Green, Amber or Red). This is calculated based on the weightings indicated in the *Compliance Framework*, Appendix B.

Copies of the proposed submissions are attached to this report.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

For Quarter 3 of 2009-2010, the Board is invited to declare:

- Green for Governance Risk
- Declaration 1 (compliance) in respect of compliance with the targets set out in the *Compliance Framework*

The Trust's performance in respect of the cancer targets in Quarter 3 (October, November and December 2009) was as follows:

	Target	Performance
Referral to date first seen (14-day)	93%	95%
Referral to treatment (62-day)	85%	89%
Cervical screening (62-day)	90%	100%
Upgrade to 62-day standard	NOT SET	N/A
Diagnosis to Treatment (31-day)	96%	100%

ENCLOSURE 11

Subsequent Treatment (31-day)	94%	100%
<p>The other targets that apply to this report, as set out in the <i>Compliance Framework</i>, continue to be met for the quarter. Accordingly, it is possible to recommend to the Board that it declares full compliance and self-assesses for Governance as 'Green'.</p> <p>The documents also confirm the election of Michaela Revel-Maton and Fiona Anderson as Governors, and the appointment of Jason Burn as Director of Finance.</p>		

RECOMMENDATIONS

The Board is invited to:

- a. **Approve** making Declaration 1 as attached to this report, including the plan to move to compliance;
- b. **Authorise** the Chairman to sign the Declaration on behalf of the Board;
- c. **Approve** the financial statement, exception report and other items report for submission to Monitor.

«Organisation_Name»
In Year Governance Declaration
Quarter three 2009/10 (1 October – 30 December 2009)

NHS foundation trusts must confirm compliance with the Authorisation in relation to all targets and national core standards listed on page 41 of the *Compliance Framework* issued by Monitor in March 2009. No supporting detail is required unless compliance cannot be confirmed.

Please state the Board's declaration of its Governance Risk Rating in the box below:

Risk Rating: (select as appropriate from the pull down list) **Green**

Please sign one of the two declarations below. If you sign declaration 2, provide supporting detail in the format set out below.

Declaration 1

The Board confirms that all targets and national core standards have been met over the period (after the application of thresholds) and that sufficient plans are in place to ensure that all known targets and national core standards that will come into force will also be met.

Signed << [Click here to Paste Signature](#) >> on behalf of the Board of Directors

Acting in capacity as: [Click here to enter text.](#)

Declaration 2

For one or more targets the Board cannot make Declaration 1 and has provided relevant details on the following page(s)

The Board confirms that all other targets and national core standards have been met over the period (after the application of thresholds) and that sufficient plans are in place to ensure that all known targets and national core standards that will come into force will also be met.

Signed << [Click here to Paste Signature](#) >> on behalf of the Board of Directors

Acting in capacity as: [Click here to enter text.](#)

Note: Monitor will accept either an electronic signature or a hand written signature on this declaration.

«Organisation_Name»
In Year Governance Declaration
Quarter three 2009/10 (1 October – 30 December 2009)

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1.
For *each*, please provide the information requested in the format set out below:

Target or Standard

Click here to enter text.

Name the healthcare target or national core standard involved

The Issue

Click here to enter text.

This should include (1) a description of the issue that has arisen, identifying the area(s) of the Authorisation to which it applies, (2) an assessment of the consequences of the issue including the magnitude (e.g. performance levels achieved or estimated) and (3) the timeframe in which it will come into effect or if it has already done so, when it occurred.

Proposed Actions

Click here to enter text.

This should include (1) a summary of the proposed actions that will be put in place to address the issue, (2) the process that will be applied in reviewing the effectiveness of these actions as appropriate to the circumstances of the issue, and (3) a work plan that details the timelines of these actions.

Next Steps

Click here to enter text.

This should include (1) a list of third parties the NHS foundation trust has and intends to notify of the issue and (2) a proposal of the support required from Monitor (if any).

Repeat this format on additional pages as required for each target.

Add Page

APPENDIX 4

**QUARTERLY REPORT TO MONITOR:
OTHER ITEMS REQUIRING REPORTING**

Changes in membership of Board of Directors

At a meeting of the Non-Executive Directors and the Chief Executive held on 3rd December 2009, Mr Jason Burn was appointed as the substantive Director of Finance.

At its meeting in December 2009, the Members' Council agreed to start the process for the appointment of a further Non-Executive Director consequent on the elevation of Helen Hemberg to the Trust Chair, including the agreement of the required Appointments Committee and the specific skills sought in the post. The process for appointment is continuing, and current planning is for a recommendation to be laid for the consideration of Council in early March 2010.

Changes in Members' Council

The following changes in the membership of the Members' Council have taken place during the period under review:

- As advised in the previous return, Jamileh Mourtada resigned as a Governor owing to ill-health
- In an election for one Governor in the Midwifery staff constituency, Michaela Revel-Maton was elected unopposed
- In an election for one Governor for the Public West Midlands constituency, 2 candidates were nominated. After a ballot of the members in that constituency, Fiona Anderson was elected, with Revathi Timms forming a reserve list for the seat. Turnout in this election was 6.6%.
- In an election for three Governors for the Heart of Birmingham and North & East Birmingham area of the Public Constituency, no nominations were received. The Trust is now reviewing its options with regard to these seats, including reviewing whether an alternative arrangement of constituencies would be more beneficial.



Policy for the use of auditors for non-audit work

Policy category and number:	Class A- number 7604
Version:	0.2
Name of approving committee:	Board of Directors
Ratified by:	Board of Directors
Date ratified:	[Add text here]
Date issued:	[Add text here]
Review date:	[Add text here]
Name of Lead Officer	Director of Finance
Name of originator/author:	Jason Burn
Job title of author:	Director of Finance
Target audience:	External Auditors, Audit Committee

Version Control Sheet

Version	Date	Author	Status	Description of Amendment
0.1	15.1.2010	Steve Parsons	Initial Draft	
0.2	21.1.2010	Steve Parsons	Amendments as requested by Audit Comm	Deletion quotation marks in Section 4 (Indemnity)

DRAFT

Content Page

Version Control Sheet 2

- 1. Introduction..... 4
- 2. Objectives..... 4
- 3. Policy Scope..... 4
- 4. Indemnity Statement 4
- 5. Document Definitions 4
- 6. Duties and Responsibilities 5
- 7. Procedures 5
- 8. Review, Monitoring, and Revision Arrangements 7

Appendix A Template Plan for Dissemination of Procedural Documents..... 8

Appendix B – Equality Impact Assessment Tool..... 10

Appendix C- Policy Checklist 12

DRAFT

1. Introduction

The Trust recognises the importance of the independence of the external Auditors in undertaking their statutory role (See National Health Service Act 2006) and in maintaining the confidence of Members' Council and the Board in their independence. Equally, the Trust recognises that in certain circumstances the most economic, efficient and effective method of procuring some services is via the firm that undertakes the Trust's external audit, subject to the over-riding need to protect audit independence.

2. Objectives

The objective of this policy is to protect the independence of the external audit process, by defining those areas where use of the auditor for other services is prohibited; those areas where use of the auditor for non-audit services may be acceptable, and the procedures to be followed; and the reporting mechanisms in respect of any decision to utilise the services of the auditor for non-audit services.

3. Policy Scope

This policy applies to all occasions where consideration is given to the provision by the external auditor of non-audit services.

4. Indemnity Statement

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

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

5. Document Definitions

"Audit Committee" means the Committee established under Section 21 of the Trust's Authorisation.

"Auditor" means the auditor appointed by Members' Council under Section 36.2 of the Trust Constitution.

Policy Title: Use of the Auditor for Non-Audit Work

Policy Number:

Version: 0.1

Date: 15th January, 2010

Birmingham Women's NHS Foundation Trust

6. Duties and Responsibilities

The Auditor has the responsibility for ensuring that they undertake a statutory audit in accordance with law, and within relevant ethical standards. They are responsible for advising the Audit Committee when any situation may threaten their independence as auditors.

The Audit Committee is responsible for addressing and determining requests for use of the auditor for non-audit work, in accordance with this policy.

The project lead is responsible for considering whether an application should be made to the Audit Committee for the use of the auditors for non-audit work, and for the provision of full information to the Committee in accordance with this policy.

7. Procedures

7.1 Threats to independence

7.1.1 The Institute of Chartered Accountants in England and Wales have identified threats to the independence of the external audit process as:

- **Self-interest**, where an interest in the outcome of the work or the depth of relationship with the Trust may conflict with the Auditors' duty to be objective;
- **Self-audit**, where the auditors review work by their colleagues and may feel constrained in identifying risks and shortcomings
- **Advocacy**, which may properly occur to a limited extent in engagement but threatens independence if the auditor advocates an extreme position in an adversarial matter
- **Familiarity or trust**, where the level of constructive criticism is reduced from the auditor as a result of assumed knowledge and/ or ongoing long-term relationships with Trust personnel.

7.1.2 It is the policy of the Trust to minimise, within reason and having regard to the economic, efficient and effective use of public funds, the threats to the independence of the external audit process.

7.2 Statutory audit work and related tasks

7.2.1 This type of work focuses around the tasks required to fulfil the auditor's duties under the National Health Service Act 2006, the relevant guidance from Monitor (See *The Audit Code for NHS Foundation Trusts*, which is guidance issued by Monitor under paragraph 24(5) of Schedule 7 to the National Health Service Act 2006.) and professional ethical guidance issued by relevant auditing bodies. It may also encompass certain regulatory functions undertaken at the request of a statutory regulator (Monitor, the Care Quality Commission or other relevant regulator).

7.2.2 Statutory audit work will usually be planned, discussed and approved by the Audit Committee in advance of its being undertaken. It is expected, in the usual course of events, to fall outside the scope of this policy.

7.2.3 For related work that exceeds an anticipated value of £5,000, the specific approval of the Audit Committee should be obtained before the work is undertaken. This has regard to the possible effect of non-audit fees on the overall relationship between the Trust and the auditor, and possible threats to audit independence arising from these.

7.3. Non-audit work which may be undertaken with Audit Committee approval

7.3.1 In respect of certain projects, it may be considered that the auditors are best placed to undertake certain work despite their position as auditors. The main circumstances where this may occur are:

7.3.1.1 Where the particular knowledge of the Trust's operations make the auditors particularly suitable to undertake a task (taxation advice, due diligence, accounting advice)

7.3.1.2 Where the auditors have particular experience or market leadership which is not easily available from other sources

7.3.2 In all such cases the following steps must be undertaken:

7.3.2.1 The project lead must confirm the scope of the work and a quote from the auditors in respect of the work proposed to be undertaken.

7.3.2.2 The project lead should obtain confirmation from the auditors that no unacceptable risks to audit independence have been identified if the auditors undertake the work proposed

7.3.2.3 The project lead should prepare a paper for Audit Committee that sets out the specific reason(s) why it is advantageous to use the auditors for the work; what steps are proposed to be undertaken to protect audit independence; and what other options had been considered prior to seeking the use of the auditor for non-audit services.

7.3.2.4 Appropriate consideration must be given to the requirements of public procurement, and also to the requirements of the Trust's Standing Orders related to procurement. (See Board Standing Order 9 (Tendering and Contract Procedure))

7.3.2.5 The Audit Committee must consider and approve the use of the auditor **prior** to any work being undertaken or legal agreement being signed.

7.2.3.6 The default position is that permission to utilise the auditor will be declined; it is for the project lead to make a compelling case as to why the circumstances mean that the auditor should, exceptionally, be used to provide non-audit services.

7.3.2.7 The Audit Committee shall report each application under this section to the following meeting of the Board of Directors.

7.3.2.8 The Audit Committee, via the Board of Directors, shall report each approval granted under this section to the Members' Council, having regard to the Council's statutory responsibility for the appointment and removal of the auditor.

7.4 Other non-audit services prohibited

Save as provided above, no non-audit services shall be provided to the Trust by the auditor.

8. Review, Monitoring, and Revision Arrangements

The Board of Directors will receive a report from the Audit Committee on each occasion application is made to the Committee for authorisation under this policy.

The Members' Council will receive a report from the Audit Committee, via the Board of Directors, on each occasion that an application for authorisation under this policy is approved.

The auditor shall include within their ISO360 (Management Letter) for each year of audit, an appendix which summarises any additional work undertaken for the Trust.

This policy shall be subject to formal review and re-enactment three years after approval.

The Audit Committee shall annually review the effectiveness of this policy, in liaison with the auditor.

Appendix A Template Plan for Dissemination of Procedural Documents

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

Title of document:	Policy for the use of Auditors for non-audit work		
Date finalised:		Dissemination lead:	Jason Burn
Previous document already being used?	Yes / No (Please delete as appropriate)	Print name and contact details	
If yes, in what format and where?	N/A		
Proposed action to retrieve out-of-date copies of the document:	N/A- new policy		
To be disseminated to:	How will it be disseminated, who will do it and when?	Paper or Electronic	Comments
Directors	Circulation with Feb Board papers Steve Parsons	E	
Auditors	Circulation Steve Parsons	E	
Internal Auditors	Circulation Steve Parsons	E	
Finance Dept	Management brief Jane Davidson	E	
Governors	Entry into Govs library Jenna McGlinchey	P	

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

Policy Title: Use of the Auditor for Non-Audit Work
 Policy Number:
 Version: 0.1
 Date: 15th January, 2010
 Birmingham Women's NHS Foundation Trust

Dissemination Record to be used once document is approved.

DRAFT

Appendix B – Equality Impact Assessment Tool

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

Policy/Function Details	
Name of Policy/Function ¹ , Service, Plan, SLA, Function, Contract or Framework:	Use of Auditors for Non-Audit Work
Is this a new policy or function?	New <input checked="" type="checkbox"/> Existing <input type="checkbox"/> Updated <input type="checkbox"/>
Responsible Manager	Director of Finance
Date Assessment Completed:	
Sources of Data	

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

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

Policy Title: Use of the Auditor for Non-Audit Work

Policy Number:

Version: 0.1

Date: 15th January, 2010

Birmingham Women's NHS Foundation Trust

Assessment Narrative	
Are there any alternative service/policy provisions that may reduce or eradicate any negative impacts?	
How have you consulted with stakeholders and equalities groups likely to be affected by the policy?	
What are your conclusions about the likely impact for minority equality groups of the introduction of this policy/service?	
How will the policy/service details (including this Equality Impact Assessment) be published and publicised?	
How will the impact of the policy/service be monitored and reviewed?	
Assessor Name:	
Assessor Job Title:	
Date Completed:	

Appendix C- Policy Checklist

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	Title		
	Is the title clear and unambiguous?	Y	
	Has all the information on the front page been completed?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	Rationale		
	Are reasons for development of the document stated?	Y	
3.	Development Process		
	Is the method described in brief?	Y	
	Is the responsible policy leads name and title clearly printed?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	Outline discussed with Audit Committee Nov 09 Guidance from Auditors sought
4.	Content		
	Is the objective of the document clear?	Y	
	Are the intended outcomes described?	Y	
	Is the language used in the document clear, jargon free and spelt correctly?	Y	
5.	Format		
	Does the policy conform to the prescribed policy format?	Y	
6.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited using Harvard referencing?	N/A	

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

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