MEETING OF THE FOUNDATION BOARD OF DIRECTORS
HELD IN PUBLIC
In the 5th Floor Gynaecology Seminar Room,
Birmingham Women's Hospital
On Thursday 25th September 2008

PRESENT : **Judith Mackay, Chair**
Ian Booth
Julie Burgess
Jason Burn
Estelle Carmichael
David Draycott
Nigel Gardner
Helen Hemberg
Jane Owen
Robin Rison
Peter Thompson
Tim Woods

APOLOGIES : None

IN ATTENDANCE : Neil Savage — Designate Director of Workforce & Organisational Development
Diana Wyllie — Minute taking

FTP09/08/1 **WELCOME AND APOLOGIES**

The Chairman welcomed those present to the meeting, including Neil Savage, the designate Director of Workforce and Organisational Development who would be commencing in post in mid October. There were no apologies for absence.

QUESTIONS FROM THE PUBLIC ON MATTERS RELATING TO THE AGENDA

There were no questions from the public on matters relating to the agenda.

DECLARATIONS OF INTEREST

There were no declarations of interest.

MINUTES OF MEETING HELD ON 28TH AUGUST 2008

The minutes of the meeting held on 28th August 2008 were **APPROVED** and signed as a correct record.

MATTERS ARISING FROM THE MINUTES OF THE MEETING HELD ON 28TH AUGUST 2008

There were no matters arising.

TRUST CHAIR'S REPORT

Annual General Meeting
The Chair reported that the Trust's AGM held on Monday 15th September 2008 had been well supported by governors, members and staff. As usual the Staff Recognition Awards had been a successful part of the event.

MEETING OF BOARD IN PRIVATE SESSION

The Chair reported that the Board had met in private session earlier that day and had discussed :-

- Strategies from Maternity, Genetics and Gynaecology
- Minutes from Board sub committees, including Management Board.

The business of the private session had not been concluded prior to the commencement of the public session and the following items would be discussed after close of business of the public session :

- 2 root cause analyses
- recommendation from Audit Committee on the appointment of the Internal Auditor
- Board agenda planner

ORAL REPORT BY CHIEF EXECUTIVE

The Chief Executive drew attention to the following items :

Healthcare Commission Inspection

Official notification had been received that the Trust would be subject to a spot inspection anytime between 1st October and 31st December 2008. Inspectors would arrive without notice and could access any part of the organisation. During their visit they would wish to meet with :-

- Director of Nursing,/DIPC Jane Owen
- Consultant Microbiologist, Jim Gray
- Other members of the infection control team
- Chief Executive (nominated deputies, in order, were Peter Thompson, Tim Woods)
- Chair (nominated deputies in order were Ian Booth and Robin Rison).
- Heads of Nursing/Maternity who undertook the matron's roles.

The Board were assured that the Trust had prepared well for the visit over the preceding year, but it was essential to always remain proactive on control of infection issues.

The Board noted that the Trust was continuing to monitor implementation the Uniform and workwear Policy and particular focus was on staff not leaving the hospital in uniform.

In preparation for the inspection the Trust had already provided electronic evidence of policies/procedures etc to the Healthcare Commission.

Publication of Annual Health Check Scores

Noted that publication of these results would be publicised on 16th October, although the Trust would be notified of its own result on 14th October (embargoed until 16th October). The Chief Executive would notify the outcome of the scores to the organisation on 16th October.

Julie Burgess

Electrical Services

The Board was notified that due to the failure of an old electric switch box, power to parts of the Trust had been interrupted. The Board were assured that emergency arrangements were quickly put in place. The Management Board have requested an urgent review of the electric system to assess whether there are any other areas of concern and

Estelle Carmichael

further funds would be made available to address any further problems. This work has already commenced.

Peter Thompson emphasised that all the clinical and the facilities teams had worked well, including the external contractor and staff from the UHB Trust, to build up a plan quickly. Estelle Carmichael endorsed the good teamwork.

Clinical Academic in Reproductive Medicine

The Board were reminded that it had been a two year process to replace the post vacated by Professor Martin Whittle upon his retirement. However, interviews had now taken place resulting in the appointment of Mr Arri Coomarasamy who would take up post in mid November 2008. It was noted that Mr Coomarasamy had previously been a trainee at the Trust and would bring with him an existing reputation as a researcher and some research grants.

Clinical Visits

This month the Chief Executive had shadowed

- Mr K Chan, Consultant Gynaecology Oncologist
- Portering Department

And once again these visits had provided useful insights into the exceptional work of the individual consultant and the important work of the portering department.

Sweep of Board Minutes

A sweep of Board minutes over the last year had been undertaken as part of a good housekeeping measure to ensure that the there were no matters that required the Board's attention. A report would be presented to the next meeting.

Julie Burgess October 08 Agenda

The Chief Executive's report was **NOTED** with thanks.

PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE

Red Risk Register and Assurance Framework

Presenting the paper 08/08/public/A9/V1, Jane Owen stated that all updates had been printed in red.

Jane Owen drew attention to the following specific risks :

- TRUS 0148 (replacement of delivery suite windows) - Work was ongoing with the replacement window programme with new UPVC windows being fitted a room at a time in order that only one delivery room was out of action at any one time.

The following issues were raised in discussion :

- Responding to a question from Ian Booth, Jane Owen explained that once the new datix system was operational, and for incidents this would be 30th September 2008, then trends could be mapped. Currently the Maternity Directorate recorded incidents in a different way to the Clinical Governance Department and this had lead to inconsistencies in the figures, and as she had stated the previous month, there would be little value in producing incorrect trend data.
- Datix would be implemented initially for incidents, followed then by risk register, complaints and litigation.
- Peter Thompson explained that he would be expecting the number of recorded incidents to drop when datix was initially introduced and then when staff became more familiar with the system recorded incidents would rise until a steady state was reached, at which point trend mapping could be undertaken.

The Board of Directors **NOTED** the reported updates to the Red Risk Register.

AMBER RISK REGISTER

Presenting paper 08/09/public/A10/V1, Jane Owen explained that all updates had been printed in red.

The following points were raised in discussion :

- Jane Owen advised that the assurance framework would be scored in the same way as incidents were scored in the future.
- Jane Owen **tabled** a document entitled "Assurance Framework for Infection Control". She reported that all Directorates had reviewed the control of infection incidents locally and where necessary these would be included on the appropriate risk register.
- Jane Owen reported that on the Trust's U drive documents associated with the Health Act were able to accessed by staff and had hyperlinks where necessary.
- Julie Burgess reminded the Board that work was currently being undertaken by NHS Elect on a corporate risk gap analysis and an update would be presented to the October Board.

October 08 BoD Agenda Jane Owen

The Board **NOTED** the updates to the Amber Risk Register.

ORGANISATION PERFORMANCE

<u>Integrated Performance Report (including Finance Report)</u>

Paper 08/09/public/A12/V1.

Activity

Presenting the activity related content of the Integrated Performance Report, Jane Owen drew attention to the following main points :

- *Elective Admitted Patients Surgery within 2 days – number of breaches* : Jane Owen explained that the report indicated that 3 patients had breached this standard. However, the case notes for each of these patients had been reviewed and it was confirmed that each patient had been admitted within 2 days. The figure in the chart should therefore read "*monthly actual 0"* and the chart should be green.
- *Stillbirth Rate per 1000 live births* : Jane Owen reported that this was the second month where there had been an increase in stillbirths and an alert report had been included in the report.
- *HCC Access Targets – application of waiting time targets to Clinical Genetics* : Julie Burgess

reported that she had met with Nick Chapman, the National 18 Week Lead. She explained that the Trust would meet the Genetic 18 week target by the end of December 2008, but not the 13 week wait. The Department of Health and GENCAG had now recognised that there were inconsistencies in the way in which data was recorded within the Department of Health and therefore differences in how Trusts applied data to the targets leading to discrepancies between Trusts. The Chief Executive had received verbal assurances that if the Trust met the 18 week target, then any breaches to the 13 week target resulting from the long term lack of clarity from the Department of health would be mitigated. Confirmation of this in writing was still awaited by the Chief Executive. This situation would again be reported in the Trust's next quarterly report to Monitor.I It was noted that Monitor had also attempted to seek clarity in this area and likewise were unable to gain clarity. If the Trust did not receive mitigation for the 13 week target then the Healthcheck score for the following year would be adversely affected as the Trust would have breached this standard. The Board appreciated that there must be equity across all Genetic Units and welcomed the Chief Executive's personal efforts to resolve the discrepancies at a national level. The Chair concluded, therefore, that it was essential that the Trust received this letter of clarity from the Department of Health in order that the Trust was then mitigated for the 13 week target and an urgent meeting with the Specialist Commissioners would then be held in order ensure that sufficient funding was available to meet the newly clarified genetics targets. **Jane Owen**

- *Essence of Care* – The Directorates were continuing to make excellent progress in this area which was key to improving the patient experience at the Trust.

Workforce

Presenting the workforce related content of the Integrated Performance Report, Estelle Carmichael drew attention to the following main issues :

- *Contracted WTE* – the benchmark figure

had now been amended to reflect the financially established WTE for the Directorates in accordance with Directorate budgets. Whilst this still showed as an adverse change in red Estelle Carmichael indicated that this was not significantly above the benchmark and, therefore, should not cause concern for the Board.

- *Sickness Absence* – this had dropped from 5.22% to 3.85% for this reporting period.
- *Staff Turnover Rate* – the projected turnover rate for the year was 15.02% which equated to 48 leavers. However, she explained that by taking out the 20 junior medical staff who were on rotational contracts by the nature of their training, the turnover figure decreased to 10.46% and was within the benchmark.
- *KSF (staff who have received a PDR %)* – Estelle Carmichael explained that the department had slightly changed the way in which this figure was recorded and had therefore made it more robust which accounted for the slight drop in the figure. However, she assured the Board that the Trust was on target to achieve 50% having received a PDR by the end of December 2008.

The following discussions were noted :

- Ian Booth raised his continuing concern with regard to the blip in sickness absence during July/August and believed this was an ongoing trend for the summer period. Estelle Carmichael explained that there had been a peak in activity during the summer and as such sickness levels increased during such times, she also explained that staff had greater childcare issues during the summer, but it was difficult to implement flexible working for short periods. She confirmed to Robin Rison that return to work interviews were actively undertaken within the Directorates.

Finance

Presenting the finance related content of the Integrated Performance Report, Tim Woods drew attention to the following main issues :

- *Summary financial position* – the Trust had recorded a small surplus of £538,000 for the period up to the end of August.
- *Income* - there had been a slight decrease in private patient income for the period, but Tim Woods assured the Board that this was now expected to pick up and would be managed in line with our Private Patient Cap.
- *Gynaecology Theatres* – in order to undertake maintenance on the theatres, one theatre was closed down for a period during August and this had impacted upon the elective work. The Board noted that although it was planned to close a theatre in October for maintenance work this had been brought forward to August and had not been calculated into the activity plans for August. In future a planned closure would take place in August as this would assist with staffing over the summer period. Peter Thompson also advised that this was an ideal time for a planned theatre closure allowing consultant staff to be available to assist with the new intake of junior medical staff.

The following points were then noted during discussions :

- In response to a question from Robin Rison, Tim Woods stated that although the Trust was reporting a surplus over the last two to three months he did not believe that Monitor would be unduly concerned as this was not a major swing either way from the Trust's financial plan. He confirmed that this would not impact upon the Trust's financial rating. Although he appreciated that major financial swings, particularly adversely, would cause Monitor concern.
- A detailed summary outlining the CIP position would be provided at the October meeting.

Tim Woods
October BoD Agenda

- As part of the annual planning exercise Tim Woods would be reviewing investments for the future year. It was noted that this financial year had been the "bulge" year for CIPs. Tim Woods suggested that the credit crunch would ultimately hit the NHS via a smaller uplift in tariffs.

- Estelle Carmichael and Tim Woods would be looking at the new IFRS ruling with regard to undertaken annual leave and the implications for the accounts year end. **Estelle Carmichael/ Tim Woods**

The Chair reminded the Board that it must be mindful of improving services to the patient and inventive of increasing investments to services. **Agreed** that the financial report would in future include a paragraph on savings against investments in order to demonstrate quality of care in relation to finance. **Tim Woods Ongoing in financial report**

The Board of Directors :

- **NOTED** the Integrated Performance Report
- And were **ASSURED** that performance was being appropriately managed by the Executive Management Team.
- **AGREED** that the financial report would in future include a paragraph on quality of care. **Tim Woods**

NHS Constitution – Update

Estelle Carmichael explained that in order for the Trust to submit a full response the following actions were being taken :

- An email had been circulated to all staff asking for comments on the NHS Constitution by 26th September
- A discussion had taken place at the Members' Council meeting to gain their views on 15th September
- JNC would be discussing the matter at their meeting the following week
- A working party was being established to review all the responses. The group would have representatives from across the organisation including Governors. Estelle Carmichael also invited a Non-Executive Director to be part of the group. **Chair**
- The outcome of the Trust's response would be communicated via Core Brief and a final response submitted by the deadline of 17th October 2008. **Estelle Carmichael**

The following issues were raised in discussion :

- Estelle Carmichael acknowledged that to

date she had not had a huge response from staff.

- Both Ian Booth and Peter Thompson commented that the NHS Constitution appeared to take a "soft" approach to the responsibility of the patient towards NHS staff, whereas the employee's responsibility to the patient was made very clear. The Chair stated that this point had been made at the Members' Council meeting and asked that Estelle Carmichael reviewed the draft minutes of this meeting. **Estelle Carmichael**

CHAIR'S REPORT on Members' Council Matters

The Chair reported on the following items :

- The Members' Council had considered a report on membership at its meeting on 15th September. A copy of these minutes would be **appended to the Board minutes**.
- The Chair explained that the Trust had an enthusiastic group of Governors and consideration needed to be given to the timing of meetings to ensure maximum attendance and involvement. **Chair**
- The importance of Executive Directors and Non-Executive Directors attending Members' Council meetings as observers. The Board also supported the suggestion of ensuring a programme to ensure joint working between the Board and the Governors. The Chair was currently considering how best to take this forward. **Chair**
- The AGM had taken place on 15th September and she congratulated the Chairs of the Members' Council sub committees for their presentations at the meeting. The format of the AGM had been very successful and well attended and she suggested that the same format was followed for next year. The Board was **supportive** of this. **Head of Corporate Affairs**

NOTED the verbal update from the Chair and **AGREED** that the Chair should arrange a joint working session between the Board and the Governors in the near future. **Chair**

POLICY

Pest Control Policy

Jane Owen introduced the policy (paper 08/09/public/A15/V1) explaining that it was a new policy and had been approved by the Infection Control Committee and Management Board.

Ian Booth identified that on the last page of the policy the list of common pests should read "List of Common Pests (not **exclusive**) and not inclusive as stated in the policy.

APPROVED the policy with the minor amendment detailed above for dissemination within the Trust. **Jane Owen ASAP**

ANY OTHER BUSINESS

Neonatal Decant

Estelle Carmichael reported that the tender for the Neonatal Modular decant had been won by E. Manton Ltd, and work would shortly commence on site.

Date of Next meetings
Thursday 30th October 2008
Thursday 27th November 2008
Thursday 18th December 2008

SUBJECT :	Appointment of Board Directors to Board and Members' Council Committees
REPORT BY :	Judith Mackay, Chairman
AUTHOR :	Steve Parsons

CONTEXT AND BACKGROUND FOR REPORT

The Board is responsible for the appointment of Directors to the various Committees of the Board, within the agreed Terms of Reference.

The Non Executive Directors have reviewed the appointment Non-Executive Directors, and the Executive Directors have reviewed the appointment of Executive Directors to the various Committees. These recommendations are contained in the Appendix 1.

The proposed appointments for the Women's Charities Committee are included for information only, as those appointments are the responsibility of the Trustee.

The Non Executive Directors have reviewed the advisory NED appointments for Committees of the Members' Council, and the Executive Directors have reviewed the relevant staff appointments to support those Committees. The suggested appointments are also in the Appendix 2 .

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Audit Committee is required to have at least one member with recent and relevant financial experience. Robin Rison has been identified as fulfilling this requirement.

The Trust Chairman will be an ex-officio member of the committees, unless otherwise noted.

RECOMMENDATIONS

The Board is invited to:

a. Approve the appointments to Committees set out in Appendix 1; and
b. Agree the suggested designations to support Council Committees as set out in Appendix 2.

Appendix 1- Appointments to Board Committees

Senior Independent Director- David Draycott

Audit Committee

Robin Rison (Chair)
Helen Hemburg
Prof. Ian Booth
Nigel Gardner

Business Investment and Opportunities Committee

Non-Executive	Executive
Helen Hemburg (Chair)	Chief Executive
David Draycott	Director of Finance & Information
Robin Rison	Commercial Director
Judith Mackay (*ex-officio*)	Director of Nursing & Midwifery

Women's Charities Committee

Non-Executive	Executive
Nigel Gardner (Chair)	Chief Executive
Helen Hemburg	Director of Finance & Information
Judith Mackay (*ex-officio*)	

Clinical Governance Committee

Non-Executive	Executive
Prof. Ian Booth	Director of Nursing & Midwifery
Nigel Gardner	Medical Director
Judith Mackay (*ex officio*)	

Equality and Diversity Committee

Non-Executive	Executive
Judith Mackay (Chair)	Director of Workforce & Organisational Development
David Draycott	

Nomination and Remuneration Committee

All Non-Executive Directors; Chaired by Judith Mackay

Organisational Risk and Governance Committee

Non-Executive	Executive
David Draycott	Director of Workforce & Organisational Development
Judith Mackay (*ex-officio*)	Commercial Director

Appendix 2- Supporting appointments for Member's Council Committees

Patient Experience Committee

Non-Executive	Executive
Helen Hemburg	Director of Nursing & Midwifery
Judith Mackay (*ex-officio*)	

Estates and Environment Committee

Non-Executive	Executive
Robin Rison	Director of Workforce & Organisational Development
Judith Mackay (*ex-officio*)	

Membership Committee

Non-Executive	Executive
David Draycott	Head of Corporate Affairs
Nigel Gardner	
Judith Mackay (*ex-officio*)	

Nomination and Remuneration Committee

Executive – Director of Workforce and Organisational Development

Judith Mackay to attend by arrangement.

SUBJECT :	Corporate Red Risk Register and Assurance Framework
REPORT BY :	Jane Owen – Director of Nursing & Midwifery
AUTHOR :	Catherine Roper Risk Manager

CONTEXT AND BACKGROUND FOR REPORT

Red Risks are reported to the Board of Directors on a monthly basis in order to provide assurance to the Board that risk is being managed effectively within the Trust.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board are asked to consider the revised Red Risk Register and Assurance Framework.

The Board's attention is drawn to updates in the report highlighted in red.

RECOMMENDATIONS

ENCLOSURE 3

Combined Corporate Red Risk Register and Assurance Framework

15/10/08

Incident Month September

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Description and definitions:

The Purpose of NHS Assurance Frameworks

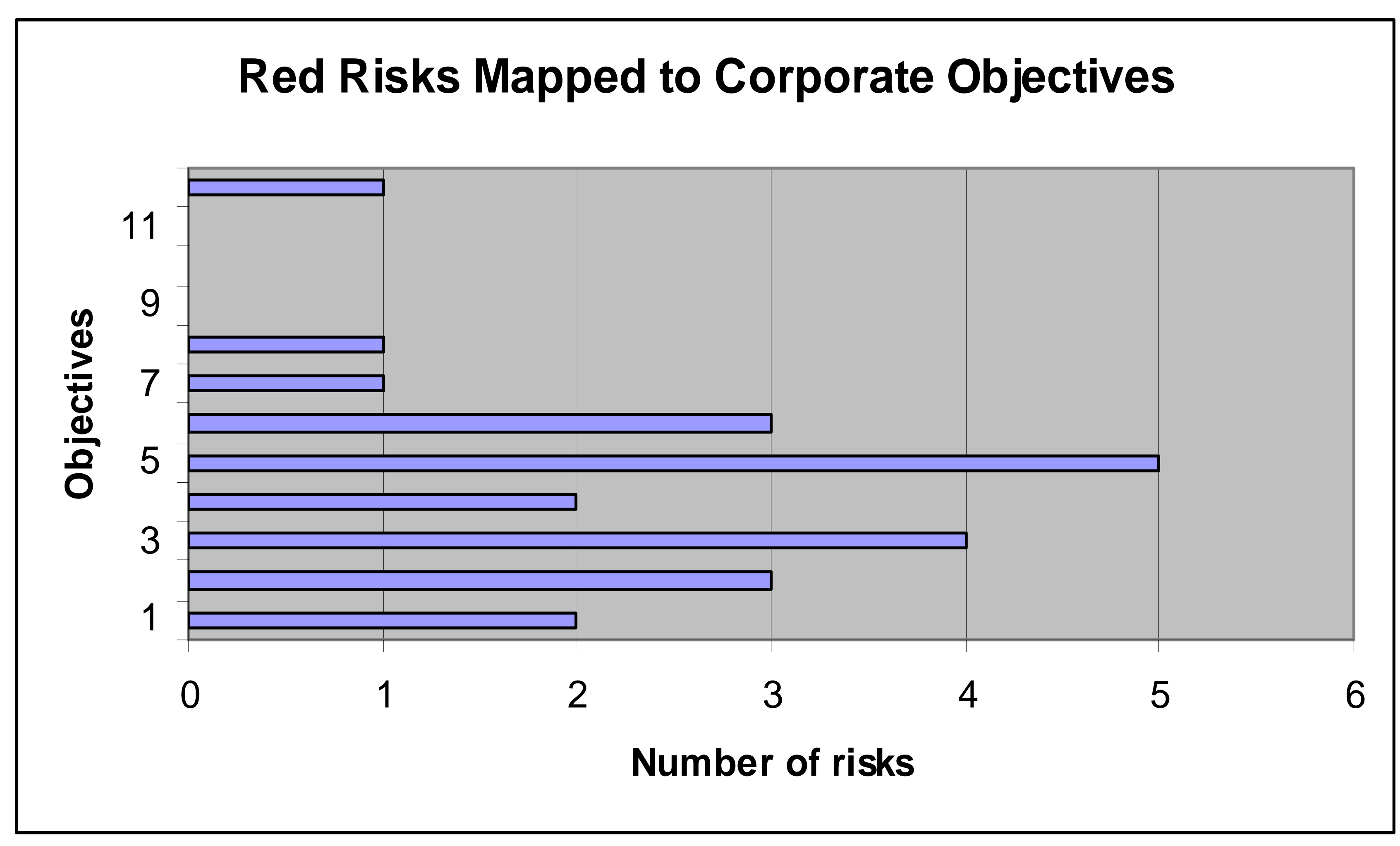
The purpose of a NHS Assurance Framework should be to provide Boards with a single, focused, ***iterative*** process that generates a unified evidence base showing progress towards achieving its organisational aim (i.e. a Patient Led NHS).
It incorporates the following elements:

- What the organisation aims to deliver **(corporate objectives)**
- The factors which could prevent these objectives being achieved **(principal risks)**
- The significance of the principal risks **(impact)**
- The processes in place to manage those principal risks **(controls)**
- The extent to which the controls will reduce the likelihood of a risk occurring **(likelihood)**
- The evidence that appropriate controls are in place and operating effectively **(assurance)**
- The gaps in control and assurance **(action)**
- The level of challenge from Board members to satisfy themselves that risks are being reasonably managed to meet objectives **(challenge and disclosure)**

'The Standards for Better Health: Improving Board Assurance'. Healthcare Standards Unit, April 2006

Distribution of Corporate Risks.

Almost Certain 5		3	5		
Likely 4				3	
Possible 3			7	7	1
Unlikely 2					
Rare 1					
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5



Red Risks Mapped to Corporate Objectives
Objectives
11
9
7
5
3
1
0
1
2
3
4
5
6
Number of risks

Corporate Objectives 2008/09

1. We will ensure that patients and visitors are served professionally with good hotel services and facilities, excellent customer care and a welcoming environment

2. We will deliver the core performance targets and achieve an excellent rating for quality of services

3. We will deliver faster, shorter pathways and one stop care to deliver the 18 week referral to treatment target and to streamline care pathways for all our patients.

4. We will ensure that excellent standards of Infection Control and a clean environment are maintained.

5. We will ensure that the Trust continues to provide and further develop high quality, safe, clinically excellent services

6. We will continue to develop effective partnerships with all stakeholders, including our Members' Council

7. We will further develop models of care and care pathways across organisational boundaries to ensure a seamless service to patients as close to home as possible

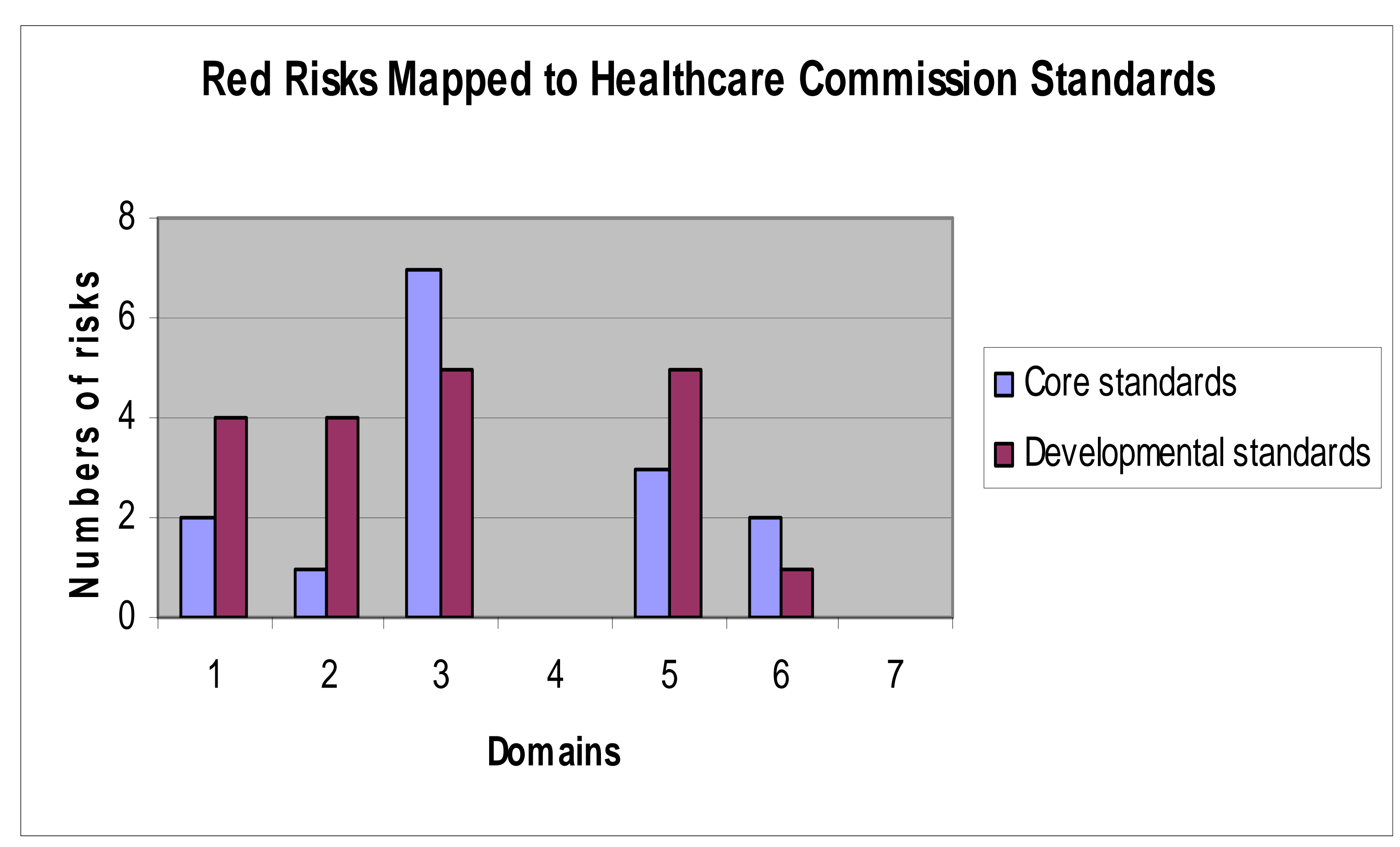
8. To promote and expand the local and specialist services we provide to the people of the West Midlands and beyond

9. We will be an Employer of Choice recruiting and retaining and developing the best staff

10. We will make best use of our resources and achieve our financial plan

11. To further enhance our reputation for excellence in research, education and training

12. We will invest in our estate and IT infrastructure to ensure clinical care is supported and enabled by effective support services.


Red Risks Mapped to Healthcare Commission Standards
Numbers of risks
8
6
4
2
0
1
2
3
4
5
6
7
Domains
Core standards
Developmental standards

Healthcare Commission Standards (Standards for Better Health)

- **First Domain - Safety**
  Patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.
- **Second Domain – Clinical and Cost Effectiveness**
  Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes
- **Third Domain – Governance**
  Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.
- **Fourth Domain - Patient Focus**
  Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.
- **Fifth Domain - Accessible and Responsive Care**
  Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.
- **Sixth Domain - Care Environment and Amenities**
  Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.
- **Seventh Domain - Public Health**
  Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Timeline for variation in Corporate Red Risk scores
In the last 12 month period (September 2007 – October 2008)

Risk Ref/ Date 1st appeared on red register	Target Reduction Date	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08
TRUS 0281 (Jan-05)	July 2010												
TRUS 0298 (Jun-05)	01/02/09												
TRUS 0304 (Dec-05)	30/11/08		15										
TRUS 0373 (Jul 07)	30/09/08												
TRUS 0374 (Sep 07)	31/11/08												
TRUS 0375 (Sep 07)	31/03/08												
TRUS 0377 (Dec 07)	31/10/08		16										
TRUS 0148 (Sept 08)	01/01/09											15	
TRUS 0380 (Sept 08)	31/3/09											16	

1 - 3	Low risk	4 - 8	Moderate Risk	9 - 14	Significant Risk	15 - 25	High Risk

Corporate Red Risk Profile

Risks Added September

Risk Reference No.	Description	Assessment Date	Next Review date	Owner	Target Reduction Date
TRUS 0380	**Risk of failure of the electrical supplies and resulting effects to the infrastructure across the Birmingham Women's Hospital, including fire**	09/09/08	Monthly	Director of Workforce and Organisational development	**March 09**

Mapped to Corporate Objectives (*list numbers as per 2008/9 corporate objectives*)	Mapped to Health Care Commission Standards (*link to core and developmental standards*)
1, 12	C20a, C21, D1, D12.

Table 2 Controls, Assurance and Further Action Required

What controls have been put in place to mitigate this risk				What actions are required to make this control adequate?		
Description of control	**Start Date & End Date**	**Assurance (Evidence of Controls working)**	**Assurance - is the control Adequate Insufficient Uncertain ?**	**Further actions required to improve control**	**Start Date**	**End Date**
1. Refurbishment programme to minimise the risk to the electrical supplies and infrastructure across the Trust site.	**Sept 08**	New equipment installed to meet current electrical safety and HTM standards. Uninterrupted power supply.	A	1. Secure funding. 2. All L.V (Low voltage) busbar risers and distribution panels to be inspected cleaned and serviced.	Sept 08 Oct08	Oct 08 March 09

What controls have been put in place to mitigate this risk				What actions are required to make this control adequate?		
Description of control	**Start Date & End Date**	**Assurance (Evidence of Controls working)**	**Assurance - is the control** **A**dequate **I**nsufficient **U**ncertain ?	**Further actions required to improve control**	**Start Date**	**End Date**
			A	3. All fused switch units to be replaced with modern MCCB.	Oct 08	March 09
				4. Replace the Ellison distribution panel located within the estates department.	Oct 08	March 09
				5. All electrical distribution switchgear to be labelled in accordance with the current HTM.	Oct 08	March 09
				6. Plan a detailed series of shutdowns to facilitate the above works.	Oct 08	Nov 08
				7. Prepare a specification for the work.		
				8.Tender the scheme to obtain the best costing for the work.	Sept 08	Oct 08

What controls have been put in place to mitigate this risk				What actions are required to make this control adequate?		
Description of control	Start Date & End Date	Assurance (Evidence of Controls working)	Assurance - is the control **A**dequate **I**nsufficient **U**ncertain ?	Further actions required to improve control	Start Date	End Date
					Oct 08	Nov 08
2. Maintain a supply of emergency electrical equipment in the event of a further failure, including a spare molded circuit breaker, extension leads torches, portable generator.	Sept 08	All necessary stocks readily available if needed.	A	Communicate to relevant on call estates personnel.	Sept 08	March 09
3. Contingency plans prepared to be actioned in the event of such power failure.	Sept 08		A	Communicate plans to all operational and on call managers.	**Sept 08**	March 09

Risk Reference No.	Description	Assessment Date	Next Review date	Owner	Target Reduction Date
TRUS 0148	**Windows in poor repair in delivery suite**	01/07/08	Monthly	Head of Midwifery	**01/01/09**

Mapped to Corporate Objectives (*list numbers as per 2008/9 corporate objectives*)	**Mapped to Health Care Commission Standards** (*link to core and developmental standards)*
1, 12	C20, C21, D12

What controls have been put in place to mitigate this risk				**What actions are required to make this control adequate?**		
Description of control	**Start Date & End Date**	**Assurance (Evidence of Controls working)**	**Assurance - is the control** **A**dequate **I**nsufficient **U**ncertain ?	**Further actions required to improve control**	**Start Date**	**End Date**
1. Planned programme for estates to replace windows		Ongoing replacement in progress	A	Monitoring of programme to prevent timescales slipping		01/01/09

Updates Since September Report

ID	Risk Description and update	No. of related incidents in September	Risk Owner
TRUS 0281	Insufficient capacity in Neonatal Unit to meet service needs		Directorate Management Board
TRUS 0298	The potential risk of the Trust not being able to function as a Perinatal Centre due to the: Inadequate inappropriate building and working environment Lack of facilities to increase cot capacity Specialist nurses roles not adequately being developed and the national shortage of trained Neonatal Nurses. • **Refurbishment plans for Neonatal Unit –Building work commenced 6.10.08**	**1**	Directorate Management Board
TRUS 0304	Care could be compromised due to the lack of midwifery staff • **22 Band 5 Midwives appointed (10 from PCT for Community)** • **Vodaphone to carry out speed tests, delayed rollout to December 08** • **Team Managers now have laptops.**	**46**	Head of Midwifery
TRUS 0373	Hospital security risk due to ageing of systems. Components: 1. Potential Failure of baby tagging system • **Delays caused due to supply of components from Israel, all enabling works complete but cannot activate without awaited parts , estimated delivery end October 08 with installation complete by end November 08** 2. Potential Failure of CCTV system 3. Potential Failure of Identity Card system	0	Director of Workforce and Organisational Development

TRUS 0374	Clinical Genetics Familial Cancer referrals: Risk of breaching 13 week Waiting List Targets(please note that these are Clinical Genetics Advisory Group targets not national targets) • **Additional outreach clinic venue availability to be identified but difficult as local Trusts increase capacity to comply with 18 wks** • **Completion of Access Policy for Clinical Genetics following discussion with all stakeholders. Cascading to all staff to ensure compliance with agreed policy completed September 08**	0	Clinical Director of Genetics
TRUS 0375	Risk of not achieving delivery of category 1 caesarean section within 30 minutes as per NICE guidance when a second theatre is required.	0	Associate Director for Clinical Support
TRUS 0377	Delivery of Trust Down's Screening Service could be severely compromised due to lack of appropriately qualified senior staff at Clinical Scientist level and above. This could have a detrimental effect on accreditation of laboratory and consequently clinical service as service could be stopped immediately; loss of business and external income and damage to trust image.	0	Associate Director of Clinical Support
TRUS 0148	Windows in poor repair in delivery suite:- Ongoing replacement of windows by Estates Department.	0	J Henry
TRUS 0380	Risk of failure of the electrical supplies and resulting effects to the infrastructure across the Birmingham Women's Hospital, including fire.	**1**	Director of Workforce and Organisational Development

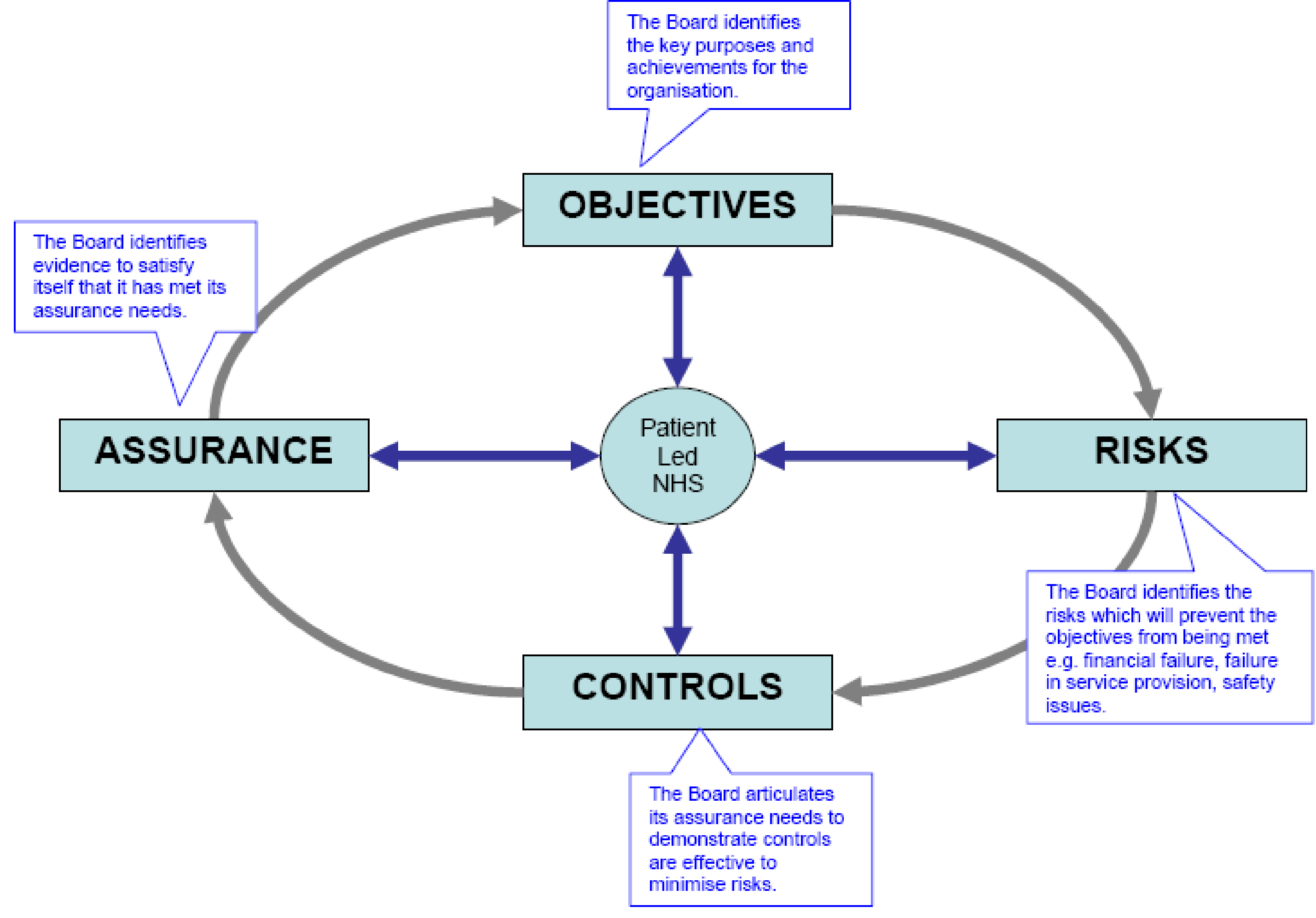
- **Assurance Levels**

The assurance levels of controls in all Red Risks have been reviewed by the Risk Owners since the September report. All current actions provide adequate levels of assurance that the risks are controlled with the exception of :-

TRUS 0304 Care could be compromised due to the lack of midwifery staff.
The assurance with regard to implementation of the community IT programme remains uncertain.

TRUS 0298 The potential risk of the Trust not being able to function as a Perinatal Centre due to the:
Inadequate inappropriate building and working environment
Lack of facilities to increase cot capacity
Specialist nurses roles not adequately being developed and the national shortage of trained Neonatal Nurses.
The assurance with regard to the nursing establishment remains inadequate.

Model for Structured Assurance



from *'The Standards for Better Health: Improving Board Assurance'. Healthcare Standards Unit, April 2006*

Birmingham Women's NHS Foundation Trust

MATRON'S REPORT TO INFECTION CONTROL COMMITTEE

Quarterly period	July-Sept 2008
Directorate	Clinical Support Services
Matron	Gael Peters

1. Hand hygiene audit

Ward/Dept		% Score	Nurse /Midwives	Medics	AHP's	Others
Theatre	**Q2**	**80%**	**91%**	**50%**	**N/A**	**100%**
& Recovery	Q1	100%	100%	100%	100%	N/A

The score for theatre staff is encouraging, however the medical staff score has dropped considerably. This shortfall has been identified within the gynaecology recovery area when medical staff have failed to roll up sleeves when hand washing. Therefore all staff members have been reminded of the policy and a re-audit will take place in both gynaecology and obstetric theatres by the end of October.

2. Cleaning & the environment

All departments in the directorate have been visited this quarter to monitor the standards of cleanliness. Simple housekeeping measures have been introduced to maintain the standards within the directorate. Cleaning schedules have been reviewed and it is apparent that more cleaning time is required in all areas of the directorate to meet and maintain the standards of cleanliness we expect. Notice boards have been revamped, removing old and out of date information and orders placed for Apron/glove dispensers. We have also introduced Alcohol gel at the point of use in patient areas.

3. Decontamination

The directorate is leading the transfer of decontamination services from our current supplier to BBraun and we are currently in our notice period with Synergy Healthcare. The migration date has been confirmed as 17th November and the National Decontamination Team is visiting the Trust on 16th/17th October to complete a "readiness check" thereby ensuring that both parties are ready for the migration process. This contract covers decontamination services for the whole of the Trust and all clinical areas are actively involved in this project. A Trust project group is implementing the project plan to ensure that all aspects of the project are ready for a safe transfer to the new service provider.

4. Untoward incidents

There were no untoward incidents to report for this period.

SUBJECT :	Matron's Report for the Gynaecology Directorate –Infection Control Q2
REPORT BY :	Jacky Cotton Head of Nursing - Gynaecology
AUTHOR :	Jacky Cotton

CONTEXT AND BACKGROUND FOR REPORT

This report provides information to the Infection Control Committee and the Trust Board of Directors concerning issues affecting the prevention and control of infection within the Gynaecology Directorate

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board is asked to consider the enclosed report. Key issues include:
There were no cases of MRSA bacteraemia.
Introduction of screening of elective patients for MRSA
Improvements in compliance of hand hygiene audit by medical staff
Improvements in environment of clinical areas

RECOMMENDATIONS

The Board are asked to consider the enclosed information and to be assured that this is being managed to improve performance.

Birmingham Women's NHS Foundation Trust
MATRON'S REPORT TO INFECTION CONTROL COMMITTEE

Quarterly period	July-Sept 2008
Directorate	Gynaecology
Matron	Jacky Cotton

1. **Infection surveillance**

1.1 Newly detected cases of colonisation or infection with MRSA
- Two cases (detected at pre-op screening and deemed to have been acquired elsewhere).

1.2 Mandatory MRSA & VRE bacteraemia surveillance
- No cases.

1.3 Mandatory Clostridium difficile surveillance since 1 April 2007
- No cases.

2. **Hand hygiene audit**

Ward/Dept		**% Score**	**Nurse /Midwives**	**Medics**	**AHP's**	**Others**
Ward 7	**Q2**	**88%**	**86%**	**100%**	**N/A**	**100%**
	Q1	85%	100%	40%	N/A	100%
Ward 8	**Q2**	**82%**	**100%**	**80%**	**0%**	**60%**
	Q1	88%	89%	75%	100%	100%

No significant change in compliance rates compared with the previous quarter. However, compliance by medical staff has improved.
The reduction in compliance by nursing staff on Ward 7 is disappointing and the Ward Manager will be raising this issue with all staff.

The actual numbers of AHP and other staff delivering direct patient care on the ward is low so any non-compliance will results in ability to achieve high percentage. Ward managers will be working closely with these staff when on their wards to improve compliance scores to required 95% by end of December 2008.

3. **Cleaning & the environment**

Cleaning schedules displayed in public areas. Review of these has identified additional hours required for housekeepers in Assisted Conception Unit. Environmental inspections have been undertaken and all areas have liaised closely with Estates Department. Backlog maintenance has been addressed and storage facilities have been improved on Ward 8. Further reviews are being undertaken by Ward/Departmental managers to ensure all environmental works identified have either been rectified or are planned to be undertaken in the near future.

Disposable curtains were already in use on Ward 7, EPAU & Gynae Outpatients but have now been installed in all clinical areas throughout the Directorate

4. Progress against key objectives in the Annual Programme

Routine MRSA screening of all elective Gynaecology patients commenced w/c 15.09.08. To date one MRSA-colonised patient has been detected who would not have been screened under the previous risk-based screening programme.

5. Response to recent national guidance

NPSA Safety Alert: Clean Hands Save Lives, 2 September 2008
Alcohol gel now provided at the point of care in Wards 7 & 8.
An audit of hand hygiene provision in Gynaecology out-patients will be completed by December 08.

6. Antibiotic use

A system of identifying patients whose length of stay is 6 days or longer to Microbiology has been introduced, to allow review of their antibiotic therapy.

7. Untoward incidents

None

An action plan has been produced in response to the Wound Site Specific Surveillance Study undertaken earlier in the year. If a patient is readmitted with a wound infection, staff will complete an Incident Report. They will also inform the Infection Control Team who will then undertake an in-depth investigation into their care to identify any avoidable factors linked to their infection.

SUBJECT :	Matron's Report for the Maternity Services Directorate –Infection Control Q2
REPORT BY :	Jenny Henry, Head of Midwifery
AUTHOR :	Jenny Henry

CONTEXT AND BACKGROUND FOR REPORT

This report provides information to the Infection Control Committee and the Trust Board of Directors concerning issues affecting the prevention and control of infection within the Maternity Services Directorate

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board is asked to consider the enclosed report. Key issues include:
There were no cases of MRSA bacteraemia.
Introduction of screening of elective patients for MRSA
Improvements in compliance of hand hygiene audit by medical staff
Improvements in environment of clinical areas

RECOMMENDATIONS

The Board are asked to consider the enclosed information and to be assured that this is being managed to improve performance.

Birmingham Women's NHS Foundation Trust
MATRON'S REPORT TO INFECTION CONTROL COMMITTEE

Quarterly period	July-Sept 2008
Directorate	Maternity Services
Matron	

1. **Infection surveillance**

1.1 Newly detected cases of colonisation or infection with MRSA
- No cases

1.2 Mandatory MRSA & VRE bacteraemia surveillance
- No cases.

1.3 Mandatory Clostridium difficile surveillance since 1 April 2007
- No cases.

2. **Hand hygiene audit**

Ward/Dept		**% Score**	**Nurse /Midwives**	**Medics**	**AHP's**	**Others**
Ward 1	**Q2**	**85%**	**100%**	**33%**	**N/A**	**67%**
	Q1	67%	75%	40%	N/A	100%
Wards	**Q2**	**87%**	**95%**	**33%**	**100%**	**60%**
3&4	Q1	94%	92%	100%	N/A	100%

This audit did not include the department area's e.g. antenatal clinic, delivery suite, birth centre and day assessment area. A person has been identified for delivery suite and is currently undertaking a hand hygiene audit.
The areas for concern remain the medical staff however we are unable to identify the specific group as both obstetricians and paediatricians will have been included in this group. There has been a significant improvement with the staff on Ward 1 and a continued improvement with the staff on ward 3 and 4.

Action Plan

1. Continue to raise the profile of hand hygiene in all areas.
2. Clinical Directors to be informed of the outcome
3. Continue to challenge the medical staff when observed not adhering to the hand washing guidance. To report persistent non adherence of medical staff to the Clinical Director.

3. Cleaning & the environment

All area's in maternity have received and inspection. All staff have been reminded of their roles and responsibilities regarding the clean schedule. There is a visible improvement in the ward and department areas

Lists of outstanding work have been forwarded to the Estates Department and is continuing.

The annual mattress audit for all clinical areas has been undertaken. The results are currently being collated and a programme for any mattresses and covers which require replacement will be reported to the Directorate Team.

Earlier this year a bed audit was undertaken and identified that the majority of beds in maternity would require replacing as the hydraulic system of many of the beds were faulty. Monies have been identified for a bed replacement programme and the Directorate is currently working with the manual handling team to identify suitable replacements.

4. Progress against key objectives in the Annual Programme

New operational guidance on MRSA screening from the DH (31 July 2008) indicated for the first time a requirement to screen certain 'elective' and 'high risk' Maternity cases.

The Directorate met with the PCT to discuss the new recommendations. The trust has recommended that universal screening would be the optimum choice. While the PCT agree with our proposal in principle they would like to undertake a costing exercise as they believe that some of the costs will be in PBR.

5. Response to recent national guidance

NPSA Safety Alert: Clean Hands Save Lives, 2 September 2008

Alcohol hand gel will be introduced at the patient bedside in Wards 1, 3 & 4 once brackets are received from the supplier. Audit of hand hygiene facilities in Maternity Outpatient services will be undertaken by December 2008.

6. Antibiotic use

Antibiotic use in maternity services in considered to be low-risk in relation to the agents used, duration of therapy and the possibility of adverse effects (promotion of resistance; *C. difficile*). No new initiatives to monitor or control use are planned this year.

7. Untoward incidents

None

SUBJECT :	Matron's Report for the Neonatal Directorate –Infection Control Q2
REPORT BY :	Michèle Emery, Head of Nursing/Matron (Neonatal)
AUTHOR :	Michèle Emery, Charlotte King (Matron)

CONTEXT AND BACKGROUND FOR REPORT

This report provides information to the Infection Control Committee and the Trust Board of Directors concerning issues affecting the prevention and control of infection within the Neonatal Directorate

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board is asked to consider the enclosed report. Key issues include:
There were no cases of MRSA bacteraemia.
The results of the hand hygiene audit on the Neonatal Unit are cause for concern.
The results of the hand hygiene audit on ward 2 are improved and now meet the target.
There remain concerns about the environment of the Neonatal Unit.

RECOMMENDATIONS

The Board are asked to consider the enclosed information and to be assured that this is being managed to improve performance.

Birmingham Women's NHS Foundation Trust

MATRON'S REPORT TO INFECTION CONTROL COMMITTEE

Quarterly period	July-Sept 2008
Directorate	Neonatal
Matron	Michèle Emery

1. Infection surveillance

1.1 Newly detected cases of colonisation or infection with MRSA

- 3 cases in patients (all asymptomatic colonisation); 1 colonised staff member. 2 of the patients' cases, and the staff member case, relate to a possible untoward incident described later.
- The other case (also asymptomatic colonisation) was detected on an admission screen using the new laboratory screening method.

1.2 Mandatory MRSA & VRE bacteraemia surveillance

- No cases.

1.3 Mandatory Clostridium difficile surveillance since 1 April 2007

- No cases.

2. Hand hygiene audit

Ward/Dept		**% Score**	**Nurse /Midwives**	**Medics**	**AHP's**	**Others**
NNU	**Q2**	**75%**	**67%**	**88%**	**N/A**	**N/A**
	Q1	80%	76%	100%	N/A	N/A
Ward 2	**Q2**	**95%**	**100%**	**90%**	**100%**	**N/A**
	Q1	75%	100%	50%	N/A	100%

This table shows excellent and improved results from ward 2 with nurses/midwives achieving 100% compliance in this audit. By comparison the results from the neonatal unit are disappointing showing a worsening on the previous quarter's performance. In order to improve compliance the following actions have been taken:

- Audits have been examined to identify specific areas of non compliance such as following removal of gloves or after completion of a procedure. These areas have been highlighted to staff.
- Emails have been sent to ward 2 nurse/midwives commending them on their performance and encouraging them to maintain this.
- Emails have been sent to neonatal unit staff showing the results and reminding them of the correct procedure and encouraging them to improve compliance.
- The World Health Organisation 5 moments for hand hygiene document has been circulated to all staff and posters displayed on the NNU

- Individuals have been targeted.
- Hand hygiene audits will be carried out on a biweekly basis to monitor performance.

3. Cleaning & the environment

Cleaning schedules are visible and labelled in all areas of the Direcotrate. Daily 'walk abouts' are carried out by the shift leader on NNU to inspect the environment and a record is kept of findings and actions taken. Weekly environmental audits have commenced on ward 2.
Environmental maintenance is reported to Estates as required.
An assessment has been made of the NNU flooring by an external contractor. This is cause for concern as areas of the floor require complete removal of the flooring with repair to the underlying structure. This would be very disruptive and require the closure of rooms so that it may be undertaken. As the unit will be moving in 4 months time this seems an unnecessary risk to capacity. In the mean time cracks in the flooring are being repaired with tape. This has been raised as a red risk on the register and controls and assurances are in place to mitigate the risk.
Areas of formica work surfaces require repair, this issue is being addressed by the Estates Department.
An audit has been completed on the Neonatal Unit and Transitional Care ward of all mattresses. Actions have been taken as appropriate.

4. Progress against key objectives in the Annual Programme

All admissions to the NNU are routinely screened to determine their general bacterial flora. The laboratory has added an additional culture plate to its standard operating procedure for processing these samples to improve both the speed and sensitivity of MRSA detection.

5. Response to recent national guidance

NPSA Safety Alert: Clean Hands Save Lives, 2 September 2008
This has been emailed to all staff to read.
Posters from the alert concerning the five moments of hand hygiene are displayed on the Neonatal Unit and Ward 2.

6. Antibiotic use

An antibiotic audit is currently being devised to be performed in November 2008.

7. Untoward incidents

MRSA was detected in a routine OPS from a 34-day old baby on 21 July 2008. The only possible risk factor for MRSA was that the grandmother (who regularly visited) was a healthcare worker.

Testing of same-room contacts of the index case identified one further colonized baby, although the antibiotic sensitivities of this strain were different to those of the index strain.

Staff screening was undertaken in response to possible nosocomial acquisition of MRSA. The only colonized staff member identified was a Pharmacist who had no direct patient contact.

It is not clear that any of the three cases were linked.

ENCLOSURE 4

SUBJECT :	Matrons’ reports
REPORT BY :	Jane Owen DIPC
AUTHOR :	Michelle Emery, Gael Peters, Jacky Cotton, Jenny Henry, Justine Jeffrey Charlotte King

CONTEXT AND BACKGROUND FOR REPORT

The Board is committed to the prevention and control of healthcare-associated infections (HCAIs) in the Trust. Effective prevention and control of HCAIs has to be embedded into everyday practice and applied consistently by everyone. The Board has an important role in ensuring that appropriate and adequately resourced arrangements for infection prevention and control are in place, and in monitoring standards through an assurance framework and knowledge of the annual infection control programme.

As part of the regular reporting and assurance to the board the Director of Infection Prevention and Control (DIPC) presents an annual report and programme of work as well as quarterly directorate reports from the matrons.

These reports provide information and assurance on issues affecting infection prevention and control, across the directorates and demonstrate that infection control is an integral part of the directorate’s activities.

They have been presented and discussed in full at the October Infection Control Committee.

KEY ISSUES FOR THE BOARD OF DIRECTORS’ CONSIDERATION AND DECISION

- The introduction of routine screening for MRSA within gynaecology.
- Improvements in the environment of clinical areas (excluding NNU)
- The continuing concern with the neonatal unit environment.
- The results of hand hygiene audits and the Matron’s actions to address shortfalls

RECOMMENDATIONS

To receive and note the quarterly reports and to be assured that actions are in place to address any areas of concern.

ENCLOSURE 5

SUBJECT :	Quarterly Infection Control report
REPORT BY :	Jane Owen-Director of Infection Prevention and Control (DIPC)
AUTHOR :	Jim Gray

CONTEXT AND BACKGROUND FOR REPORT

This report provides assurance relating to infection control surveillance and activities in quarter 2 . The report has been presented and discussed at the October meeting of the clinical governance committee. It should be taken with

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

- No reported cases under mandatory surveillance.
- Hand hygiene audit results
- MRSA routine screening
- HCC visit/ inspection

RECOMMENDATIONS

To note the content of the report and the actions highlighted in the matrons reports to address hand hygiene audit results

Birmingham Women's NHS Foundation Trust
INFECTION CONTROL REPORT TO THE CLINICAL GOVERNANCE GROUP
2008/09 Quarter 2

Infection Control Committee
Date of meeting since last report: 17 July 2008
Date of next meeting: 16 October 2008

Infection surveillance & audit

Quarter 1
Figures given in the Quarter 1 report (prepared 25 June 2008) confirmed as correct for the quarter.

Quarter 2 (prepared 21 June 2008)

Newly detected cases of colonisation or infection with MRSA Apr – Jun 2008
- Gynaecology: 1 (detected at pre-op screening and deemed to have been acquired elsewhere).
- Obstetrics: 0
- Neonates (NICU): 2 (source uncertain: see Untoward Incidents section)

Mandatory MRSA & VRE bacteraemia surveillance since 1 April 2007
- No cases.

Mandatory Clostridium difficile surveillance since 1 April 2007
- No cases.

Report on Infection Control Audits undertaken

Hand hygiene audits

In line with the annual infection prevention and control programme directorates are required to undertake a minimum of one observational hand hygiene audit each quarter, in each of their in-patient ward areas. Audits were completed in June and September. Results are fed back to the infection control directorate leads for further dissemination and action. The target is for each area to achieve scores of at least 95% by the end of this financial year. Results are summarized in Table 1.

Overall Results
- Quarters 1 and 2 were similar with overall compliance scores of 86% and 85% respectively.
- Nurses and Midwives scores increased from 88% to 92% in Quarter 2.

- Medical staff scores remained the same at 73%, although individual ward scores were much lower in the Obstetric wards.
- Scores for AHP's and others (mainly domestics and porters) where both lower in Quarter 2.

To improve accessibility to hand decontamination products, alcohol hand gel is currently being introduced at the point of care in all in-patient ward areas. The impact of this will be monitored during hand hygiene audits in Quarter 3. Updated hand hygiene posters have also been distributed to all clinical areas.

Table 1.

Ward/Dept		% Score	Nurse /Midwives	Medics	AHP's	Others
NNU	**Q2**	**75%**	**67%**	**88%**	**N/A**	**N/A**
	Q1	80%	76%	100%	N/A	N/A
Ward 2	**Q2**	**95%**	**100%**	**90%**	**100%**	**N/A**
	Q1	75%	100%	50%	N/A	100%
Ward 1	**Q2**	**85%**	**100%**	**33%**	**N/A**	**67%**
	Q1	67%	75%	40%	N/A	100%
Ward	**Q2**	**87%**	**95%**	**33%**	**100%**	**60%**
3&4	Q1	94%	92%	100%	N/A	100%
Ward 7	**Q2**	**88%**	**86%**	**100%**	**N/A**	**100%**
	Q1	85%	100%	40%	N/A	100%
Ward 8	**Q2**	**82%**	**100%**	**80%**	**0%**	**60%**
	Q1	88%	89%	75%	100%	100%
Theatre	**Q2**	**80%**	**91%**	**50%**	**N/A**	**100%**
& Recovery	Q1	100%	100%	100%	100%	N/A
Overall	**Q2**	**85%**	**92%**	**73%**	**75%**	**71%**
Scores	Q1	86%	88%	73%	100%	100%

Untoward incident: Two babies on NNU with MRSA, 21-25 July 2008

MRSA was detected in a routine OPS from a 34-day old baby on 21 July 2008. The only possible risk factor for MRSA was that the grandmother (who regularly visited) was a healthcare worker.

Testing of same-room contacts of the index case identified one further colonized baby, although the antibiotic sensitivities of this strain were different to those of the index strain.

Staff screening was undertaken in response to possible nosocomial acquisition of MRSA. The only colonized staff member identified was a Pharmacist who had no direct patient contact.

Unannounced Healthcare Commission visit

The Trust has received notice that it will be visited between October and December 2008.

MRSA screening

Screening of all elective Gynaecology admissions commenced on 15 September 2008

The laboratory methodology for infection screening of admissions to the NNU has been modified to include an indicator medium specific for MRSA.

New operational guidance was issued on 31 July 2008, which for the first time indicated that screening of 'high risk' Maternity cases is required. Maternity Services and Infection Control met on 18 September 2008 to discuss, following which Commissioners have been approached to determine if any additional funding may be available.

Hand hygiene

NPSA Patient Safety Alert 2nd edition 2 September 2008 requires that by 31 March 2009 all Trusts will undertake an audit focusing on provision of hand hygiene facilities at the point of care, and develop and implement an action plan to address issues identified in the audit.

The availability and accessibility of alcohol hand gel has been reviewed in the in-patient ward areas. Alcohol hand gel was not readily available at the point of care in 4 or 6 bedded patient rooms. This is currently being addressed by the introduction of bedside alcohol gel dispensers. They are now in place in the Gynaecology wards and will be introduced into the Obstetric wards over the next 2 weeks when further brackets are received from the supplier. An audit focusing on hand hygiene facilities in the Outpatient areas will also be undertaken.

Antibiotic prescribing

The risks associated with inappropriate antibiotic prescribing are described on the Risk Register. One recently introduced additional control is that Gynaecology patients whose actual or predicted length of stay exceeds 6 days are reported to Microbiology each Monday, so that an assessment of the appropriateness of any antibiotic therapy can be made.

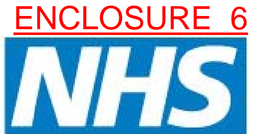
2) Key Performance Indicators - September 2008

ENCL 6 Integrated Performance Report - Dashboard.xls

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	377	Favourable change		377
	Total Gynae outpatient waiting list size		>1500	1500	1186	Adverse change	Performance	1186
	Referral Rates - Gynae	1440	<1368 and >1512	1461	1576	Adverse change	Performance	1440
	Referral Rates - Maternity	1883	<1789 and >1977	1519	1946	Adverse change	Performance	1884
	Referral Rates - Genetics	587	<558 and >616	577	691	Adverse change	Performance	587
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 & responsive care	compliance	Breach	No lapses	no lapses	No change	Clinical Governance	
	Care environment & amenities	compliance	Breach	No lapses	no lapses	No change	Clinical Governance	
	Public health	compliance	Breach	No lapses	no lapses	No change	Clinical Governance	
Productivity & Efficiency	Maternity LOS postnatal	1.93		1.93	2.05	Adverse change	Performance	2.08
	Gynae Length of Stay (exc daycases and emergencies)	3.1		2.90	2.25	Favourable change	Performance	2.26
	Daycase rate 1 - as % of all elective admissions	50%		>50%	54%	Adverse change	Performance	51%
	Gynaecology Daycase Over Stay Rate	13.86%	>10%	5%	8.47%	Adverse change	Performance	8.00%
	Gynae Pre operative Avg Los	0.15			0.07	Favourable change	Performance	0.14
	Elective Admitted patients surgery within 2 days - no of breaches	0	>0	0	0	no change	Performance	
	Theatre utilisation	80%	<75	80%	84.0%	Adverse change	Performance	
	Gynae New to FU ratio	1.40		<1.50	1.45	Adverse change	Performance	1.50
	Occupancy Rate - Neonatal ITU	80%	<76%	80%	101%	Favourable change	Performance	88%
	Genetics DNA Rate	11.00%	>11%	<11%	11.00%			
	Stillbirth rate per 1000 live births	5.4	>7.4	<7.4	9.1	Favourable change		7.2
Clinical Quality (Quarterly)	Serious Untoward incidents		>2	<2	£1		RCA	
	Litigation - New	2	>5		3	Adverse		
	Litigation - Ongoing 06/07	77			63	Adverse		
Finance	Year to date I&E position	plan or >	off plan	£260k	£597k	Favourable change	Finance	£1,713k
	Year to date I&E normalised	plan or >	off plan	£(336)k	£23k	Adverse change	Finance	
	In month run rate	plan or >	off plan	£43k	£59k	Adverse change	Finance	N/A
	In month run rate normalised	plan or >	off plan	£(56)k	£(36)k	Favourable change	Finance	
	Year to date Ebitda	plan or >	off plan	£2,771k	£2,781k	No Change	Finance	£6,081k
	Year to date Ebitda margin	plan or >	off plan	7.3%	7.3%	No Change	Finance	7.9%
	Year to date CIP performance	plan or >	off plan	£1,259k	£1,265	No Change	Finance	£2,500k
	CIP recurrent/non-recurrent delivery	plan or >	off plan	70/30	55,45	Favourable change	Finance	60,40
	Contracted WTE	1283.07	>1285	<1277	1299.99	Adverse change	Head Count:1497	
	Agency/Bank spend as a % of directorate paybill	2.85	>2.85%	<2.85%	3.62%	Adverse change		3.00%
	Sickness Absence Rate %	4%	>4%	<4%	4.24%	Adverse change		4.20%
	Staff Turnover Rate %	14%	>14.10%	<14.10%	13.86%	Positive change	Leavers:10	14.10%
Workforce	Employee Investigations	4weeks	>4 weeks	<4 weeks	2	Positive change		0
	KSF - Staff groups with Job Outlines %	85%	<85%	>85%	73.36%	Positive change	989/1348	85%
	KSF - Staff who have received PDR %	50%	<50%	>50%	21.29%	Positive change	287/1348	80%
	Pay as a % of Trust Income	66.80%	>66.80%	<66.80%	63.96%	Adverse change		
	Consultant appraisal undertaken in previous 12 months %	100%	<100%	100%	100%	No Change		100%
	Consultants with revised job plan	80%	<80%	>80%	85%	No Change		100%
HCC Access Targets	Cancer 2 week wait	No lapses	Breach	No lapses	No lapses	No Change	Performance	
	Cancer 1 month diagnosis to treatment	No lapses	Breach	No lapses	No lapses	No Change	Performance	
	Cancer 2 month GP urgent referral to treatment	No lapses	Breach	No lapses	No lapses	No Change	Performance	
	Cancelled Operations on day of surgery	1	2	1	5	Adverse change	Performance	26
	Cancelled Operations not admitted within 28 days	No lapses	Breach	No lapses	0	No Change	Performance	
	Choice information in place	implemented	Lapse	Implemented	Implemented	No Change	Performance	
	Inpatient & outpatient booking	100%	Breach	100%	100%	No Change	Performance	
	Inpatients waiting >26 weeks	0>standard	Breach	No lapses	No lapses	No Change	Performance	
	Outpatients waiting >13 weeks (inc Genetics)	0>standard	Breach	No lapses	76	Not previously reported	Performance	
	Admittied patients seen within 18 weeks			>90% by Dec 08	97.0%	Favourable change	Performance	
	Non-admittied patients seen within 18 weeks			>95% by Dec 08	87.0%	Adverse change	Performance	
	Data quality on ethnic group	100%	<95%	100%	94.0%	Adverse change	Performance	95.0%
Vital Signs	Smoke free NHS	Implemented	Lapse	Implemented	implemented		Performance	
	PALS cases	20 cases	>25 cases	20cases	12cases	Favourable change	Quarterly Report to CGC	
	MRSA Bacteraemia	<6 cases	>0	0	0	no change	DIPC	
	CDIFF	0	>0	0	0	no change	DIPC	
	Waiting times for MRI & CT	0>	Breach	No lapses	no lapses	no change	Performance	
	BreastFeeding initiated	67%	>60%	67%	62.00%	Adverse change		
	Smoking during pregnancy	11%	13%	11%	18%	Adverse change		
	% of Women seen by 12 weeks	80%	<78%	80%	88%	No Change		
Patient Experience	Patient Written Complaints	<5	6	<5	6	No change	Patient Experience	
	Complaint Written Response within 25 day deadline	95%	95%	95%	44%	Adverse Change	Patient Experience	
	Compliment of service letters received By CEO				2		Patient Experience	
	PEAT annual inspection results			maintain excellent				
	Essence Of Care Indicators	Review standards annually	not achieved	Audit standards			Quarterly Quality Indicator Report	
				Neonates	Maternity	Gynae	Clincial Support	Genetics
	1 communication		not achieved	Audited	Audited	Audited	Audited	Audited
	2 continence		not achieved	Not relevant	Audited	Audited	Audited	Not relevant
	3 hygiene		not achieved	In progress	Audited	Audited	not audited	Not relevant
	4 nutrition		not achieved	In progress	Not Audited	Audited	not relevant	Not relevant
	5 pressure ulcers		not achieved	In progress	Not Audited	Audited	ongoing	Not relevant
	6 privacy and dignity		not achieved	In progress	Audited	Audited	ongoing	Audited
	7 recordkeeping		not achieved	Audited	Ongoing	Audited	Audited	Audited
	8 safety		not achieved	In progress	Audited	Audited	ongoing	Not audited
	9 self care		not achieved	Not relevant	Audited	Audited	not relevant	Not relevant
	10 promoting health		not achieved	In progress	Not Audited	Audited	Not audited	Audited
	11 care environment		not achieved	Audited	Ongoing	Audited	Ongoing	Audited
Foundation Status	Number of Members	5000 by end of year	<120	150 increase per month				5000

assessed on an individual basis

ENCLOSURE 6

Birmingham Women's 

NHS Foundation Trust

SUBJECT :	Integrated Performance Report
REPORT BY :	Jane Owen/Tim Woods/Estelle Carmichael
AUTHOR :	Jane Owen

CONTEXT AND BACKGROUND FOR REPORT

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

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board are asked to consider the enclosed Dashboard Report that highlights detailed activity 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 2009.

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.

SUBJECT :	Healthcare Commission Annual Health Check scores
REPORT BY :	Julie Burgess
AUTHOR :	Steve Parsons

CONTEXT AND BACKGROUND FOR REPORT

This report advises the Board of the outcome of the 'Annual Health Check 2007-2008' for the Trust.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board is asked to consider the enclosed Healthcare Commission report. The 'top-line' scores for the Trust are:

- Quality of Services- Good (2006-2007 – Excellent)
- Use of Resources- Excellent (2006-2007- Fair)

In Quality of Services, the Trust moved from 'Fully Met' to 'Almost Met' on the Existing National Targets category.

Areas that were highlighted were:

- Core Standard C01a (Incidents- Reporting and Learning) was Not Met (2006/2007- Not Met)
- Information in place to support choice was Failed (2006/2007- Achieved)
- Compliance with guidelines concerning obesity was Under Achieved (no comparator available for 2006/2007)

A copy of the full report by the Healthcare Commission for this Trust is attached to this paper.

The Board is invited to note that the Trust has identified a technical issue in the analysis of the Quality of Service grade, which is considered sufficient to support an appeal to raise the Quality of Service score. This appeal is being submitted to the Commission, and the Board will be advised of progress at future meetings.

RECOMMENDATIONS

The Board is asked to:

a. Consider the Trust's performance in the 2007-2008 Annual Health Check, and
b Note that the Trust has submitted an appeal to increase the score for Quality of Services.

Birmingham Women's NHS FT summary tables for Quarter ended 30 Sep 2008

Financial performance £m

	Current Quarter			YTD			FY
£m	**Actual**	**Plan**	**Variance**	**Actual**	**Plan**	**Variance**	**Plan**
Income							
NHS Clinical income	15.0	14.9	0.1	30.3	29.8	0.5	59.6
PBR (Clawback)/Relief	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private patient income	0.2	0.3	(0.1)	0.5	0.5	(0.0)	1.0
Other income	3.9	3.4	0.6	7.6	6.7	0.9	13.4
Total income	**19.1**	**18.5**	**0.6**	**38.4**	**37.0**	**1.4**	**74.0**
Expenses							
Pay Costs	(12.6)	(12.5)	(0.0)	(25.3)	(25.1)	(0.3)	(50.1)
Drug costs	(0.4)	(0.3)	(0.1)	(0.8)	(0.6)	(0.1)	(1.3)
Other Costs	(5.0)	(4.3)	(0.7)	(9.5)	(8.5)	(1.0)	(17.0)
Total costs	**(17.9)**	**(17.1)**	**(0.8)**	**(35.6)**	**(34.2)**	**(1.3)**	**(68.4)**
EBITDA	**1.2**	**1.4**	**(0.2)**	**2.8**	**2.8**	**0.0**	**5.6**
Depreciation	(0.8)	(0.9)	0.1	(1.6)	(1.8)	0.2	(3.6)
Net Interest	0.2	0.1	0.1	0.3	0.2	0.1	0.4
Profit/(Loss) on asset disposal	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Taxation	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC dividend	(0.4)	(0.4)	0.0	(0.9)	(0.9)	(0.0)	(1.8)
	0.1	**0.1**	**(0.0)**	**0.6**	**0.3**	**0.3**	**0.6**
Exceptional items	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net surplus / (deficit)	**0.1**	**0.1**	**(0.0)**	**0.6**	**0.3**	**0.3**	**0.6**
EBITDA % income	6%	8%	(0.0)	7%	7%	(0.0)	8%

	Current Quarter			YTD			FY
	Act	**Plan**	**Var**	**Act**	**Plan**	**Var**	**Plan**
Income	19.1	18.5	0.6	38.4	37.0	1.4	74.0
Pay Costs	(12.6)	(12.5)	(0.0)	(25.3)	(25.1)	(0.3)	(50.1)
Drug costs	(0.4)	(0.3)	(0.1)	(0.8)	(0.6)	(0.1)	(1.3)
Other Costs	(5.0)	(4.3)	(0.7)	(9.5)	(8.5)	(1.0)	(17.0)
EBITDA	**1.2**	**1.4**	**(0.2)**	**2.8**	**2.8**	**0.0**	**5.6**
Depreciation	(0.8)	(0.9)	0.1	(1.6)	(1.8)	0.2	(3.6)
Net interest	0.2	0.1	0.1	0.3	0.2	0.1	0.4
Other	(0.4)	(0.4)	0.0	(0.9)	(0.9)	(0.0)	(1.8)
	0.1	**0.1**	**(0.0)**	**0.6**	**0.3**	**0.3**	**0.6**
Exceptional items	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net surplus / (deficit)	**0.1**	**0.1**	**(0.0)**	**0.6**	**0.3**	**0.3**	**0.6**
EBITDA %	6%	8%	-1%	7%	7%	0%	8%
EBITDA	1.2	1.4	(0.2)	2.8	2.8	0.0	5.6
Change in WC	(0.6)	(0.3)	(0.2)	1.9	(0.6)	2.5	(1.3)
Other	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)
CF Operations	**0.6**	**1.0**	**(0.4)**	**4.7**	**2.1**	**2.6**	**4.3**
Capital expenditure	(0.9)	(0.1)	(0.8)	(1.5)	(1.9)	0.4	(4.4)
Financing and other	(0.7)	(0.8)	0.0	(0.6)	(0.7)	0.1	(1.4)
Net cash flow	**(1.0)**	**0.1**	**(1.2)**	**2.5**	**(0.5)**	**3.0**	**(1.5)**
Period end cash	10.6	7.6	3.0	10.6	7.6	3.0	6.6

	Actual	Plan	Variance	Actual	Plan	Variance	Plan
EBITDA	**1.2**	**1.4**	**(0.2)**	**2.8**	**2.8**	**0.0**	**5.6**
Debtors	(0.6)	0.0	(0.6)	(1.2)	(0.0)	(1.2)	(0.0)
Creditors	0.3	0.0	0.3	3.4	1.6	1.8	1.6
Other change in WC	(0.3)	(0.3)	(0.0)	(0.3)	(2.2)	1.9	(2.8)
Non cash I&E items	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)
CF from operations	**0.6**	**1.0**	**(0.4)**	**4.7**	**2.1**	**2.6**	**4.3**
Capital Expenditure	(0.9)	(0.1)	(0.8)	(1.5)	(1.9)	0.4	(4.4)
Asset sale Proceeds	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Interest	0.1	0.1	0.1	0.3	0.2	0.1	0.4
Dividends paid	(0.9)	(0.9)	(0.0)	(0.9)	(0.9)	(0.0)	(1.8)
Movement in loans	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC received / (repaid)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net cash inflow/outflow	**(1.0)**	**0.1**	**(1.2)**	**2.5**	**(0.5)**	**3.0**	**(1.5)**
Opening Cash balance	11.7	7.5	4.2	8.1	8.1	0.0	8.1
Closing Cash Balance	**10.6**	**7.6**	**3.0**	**10.6**	**7.6**	**3.0**	**6.6**

	Actual	Plan	Variance	Actual	Plan	Variance	Plan
I&E CIP	0.6	0.6	0.0	1.3	1.2	0.1	2.5

	YTD performance in:			
	Q1	**Q2**	**Q3**	**Q4**
Key Metrics				
EBITDA margin	8.3%	7.3%		
EBITDA, % achieved	115.4%	100.4%		
ROA %	7.8%	6.2%		
I&E surplus margin (excl exceptional income, costs & impairments)	2.6%	1.6%		
Liquid ratio (closing)	49.0	43.9		

APPENDIX 3

QUARTERLY REPORT TO MONITOR: EXCEPTION REPORTING

The Trust has no matters for exception reporting in relation to finance, governance or mandatory services. However, the Trust wishes to draw to Monitor's attention the impact of the application of national waiting time targets to its clinical genetics service.

Application of 18-week Referral to treatment target

In our report for Quarter 4 of 2007/08 (April 2008), we drew attention to the probable impact of the decision made by the Department of Health in April 2008 that referrals to the Clinical Genetics Service should be included within the 18-week Referral to Treatment target.

We explained that such referrals represent approximately one-third of all referrals to the Trust and that their inclusion in the 18-week target can therefore be expected to have an adverse short-term impact on reported performance, which will be apparent in the report to be submitted to Monitor on 31 October 2008 in respect of Q2 of 2008/09. The Trust has plans in place to address this situation, which will not jeopardise our ability to meet the December 2008 target.

The relevant Key Performance Indicator (Non-Admitted Patients seen within 18 weeks) was at 88.4% for the month of August, and 87.0% for September. If the effect of the Clinical Genetics Service is excluded, the equivalent figures would be between 96% and 97%. The performance figures have improved significantly during October, as has the completeness of the data set, and the current forecast for the month of October is for performance to be between 91% and 92%. This continues the Trust on the path towards compliance by December 2008.

Application of 13-week target

The Trust has held continuing discussions, through its Chief Executive, with representatives from the Department of Health to clarify the application of appropriate targets for the Clinical Genetics Service. There has been some indication from the Department that they consider that this service may fall within a 13-week target and the 18-week target.

At the date of this return, no definitive guidance has been received by the Trust from the Department of Health. The Trust understands that a number of other NHS providers would be affected by any guidance that was issued by the Department of Health, and that there may therefore be some delay before a definitive position is reached. The Trust is putting in place plans to address the situation if the Department provides guidance to ‘back-date’ a 13-week target to April 2008.

APPENDIX 4

QUARTERLY REPORT TO MONITOR: OTHER ITEMS REQUIRING REPORTING

Changes in membership of Board of Directors

The following changes in the membership of the Board of Directors have taken place during the period under review:

- Neil Savage took up his appointment as Director of Workforce & Organisational Development on 13 October 2008
- Jason Burn has been appointed as Acting Commercial Director with effect from 11 August 2008

Changes in Members' Council

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

- Jamileh Mourtada was elected as a Governor of the Trust, representing the Public (Birmingham South) constituency, on 8 August 2008
- however, no nominations were received for three further seats, with the result that there are unfilled vacancies for elected Governors for the Public (Heart of Birmingham/Birmingham E&N) constituency (2 seats) and the Staff (Clinical Support) constituency (one seat): fresh elections to fill these vacancies will be called in early 2009
- Birmingham South PCT has appointed John McIlveen as its Appointed Governor for Birmingham South PCT to replace Dee Narga

Birmingham Women's

NHS Foundation Trust

SUBJECT :	Report to Monitor for Quarter 2 of 2008/09
COORDINATED BY :	Steve Parsons, Head of Corporate Affairs
AUTHORS:	Tim Woods, Jane Owen, Jane Davidson

CONTEXT AND BACKGROUND FOR REPORT

The Trust is required to submit its report for the second quarter of the 2008/09 financial year to Monitor by 31 October 2008.

The required content of the report (which is to be submitted electronically via Monitor's MARS portal) is set out in Appendix D of the Monitor Compliance Framework and consists of:

1. Financial information for the three months from 1 July to 30 September 2008: income and expenditure, balance sheet and cash flow statement, in each case showing actuals against plan.

2. Service performance targets: self-certification that all applicable national targets have been met during the three months from 1 July to 30 September 2008 and that plans are in place to ensure that all known targets that come into force will be met. In the Trust's case, the applicable targets are:
    - Maximum waiting time of 31 days from diagnosis to treatment for all cancers
    - Maximum waiting time of 62 days from urgent referral to treatment for all cancers
    - Maximum waiting time of six months for inpatients
    - Maximum waiting time of 13 weeks for outpatients
    - MRSA year-on-year reduction
    - 18-week maximum wait
    - All patients with operations cancelled for non-clinical reasons to be offered another binding date within 28 days
    - Implementation of choice and booking - convenience and choice-elective (inpatient and daycase) and outpatient booking
    - Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals

    No supporting detail is required by Monitor unless the Trust is unable to confirm its compliance with any of the targets.

3. Exception reporting: any significant issues arising during the period, for example where these involve potential failure to comply with the Trust's Authorisation or Prudent Borrowing Limit or the FT Financial Reporting Manual

4. Other items requiring reporting: elections of governors, changes in the membership of the Board of Directors or the Members' Council etc

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KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The reporting requirements summarised above are addressed as follows:

1. Financial information

Appendix 1 sets out the required financial information for the three months from 1 July to 30 September 2008 in the format required by Monitor.

2. Service performance targets

Appendix 2 sets out the template provided by Monitor for the Board's self-certification in respect of the Trust's compliance with applicable targets. It will be noted that two options are available:

- Declaration 1 confirms that all targets have been met (after application of thresholds) over the period and that plans are in place to ensure that all known targets which will come into force will also be met
- Declaration 2 applies where a Trust cannot confirm full compliance and requires details of the actions being taken to address those targets which have not been met

It is proposed that the Chairman be authorised to sign Declaration 1 on behalf of the Board. Appendix 2 explains how the assurance required to verify the self-certification is already provided to the Board through the monthly Integrated Performance Report (which incorporates the 18-week RTT Target report).

3. Exception reporting

There are no issues for exception reporting in relation to finance, governance or mandatory services.

However, Directors will recall that in its report for Quarter 4 of 2007/08 submitted to Monitor at the end of April 2008, the Trust gave advance warning (which was well received by Monitor) of the probable impact of the decision made by the Department of Health in April 2008 that referrals to the Clinical Genetics Service should be included within the 18-week Referral to Treatment target. It explained that such referrals represent approximately one-third of all referrals to the Trust, with the result that their inclusion in the 18-week target was expected to have an adverse short-term impact on the Trust's reported performance which would be apparent in the report to be submitted to Monitor on 31 October 2008 in respect of Q2 of 2008/09. The report assured Monitor that Trust had plans in place to address this situation, which would not jeopardise its ability to meet the December 2008 target.

In its report for Quarter 1 of 2008/09, the Trust explained that conflicting messages were being received from the Department of Health about whether, in addition to the 18-week target, clinical genetics should also be required to comply with the Healthcare Commission 13-week target for outpatient appointments.

Julie Burgess has been in discussion with the Department of Health with regard to this situation. To date, no definitive answer has been received to the question of which target will be applicable, although we are aware that the Department is

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considering the various options with a view to issuing guidance. As a number of other centres will be affected by any decision, there may be some delay in obtaining clarity on this point.

Appendix 3 sets out the current situation as described above.

4. Other items requiring reporting

Appendix 4 reports:

- that Neil Savage took up his appointment as Director of Workforce & Organisational Development on 13 October 2008
- the appointment of Jason Burn as Acting Commercial Director with effect from 11 August 2008
- the election of Jamileh Mourtada as a Governor of the trust representing the Public (Birmingham South) constituency
- that three positions of elected governor are currently vacant, no nominations have been received, and that fresh elections to fill these vacancies will be called in early 2009
- the appointment of John McIlveen as the Appointed Governor for Birmingham South PCT to replace Dee Narga

Having received informal guidance from Monitor, it is proposed that we formally advise Monitor that the Trust is considering participation in a joint venture for equitable access. The aim in advising them is to provide them with the context for this possible joint venture, and provide assurance that the process is being undertaken in accordance with the guidelines given in their guideline, *Risk Evaluation for Investment Decisions*. As aspects of this information are commercial in confidence, the detailed submission is presented to the Board in the papers for the private session.

RECOMMENDATIONS

The Board is invited to:

- **APPROVE** the submission to Monitor of the financial information set out in Appendix 1, subject to clearance by the Chairman and the Chief Executive of any material changes;
- **AUTHORISE** the Chairman to sign on behalf of the Board Declaration 1 as set out in Appendix 2, thus confirming that the Trust has met all applicable targets and has plans in place to ensure that all known targets that will come into force will be met;
- **AGREE** that, subject to updating to reflect developments up to the date of submission, Appendix 3 should be submitted as an exception report in order to update Monitor on the ongoing difficulties being experienced in obtaining clear national guidance on the waiting time targets applicable to clinical genetics; and
- **APPROVE** the submission to Monitor of Appendix 4 which reports on recent changes in the membership of the Board of Directors and the Members' Council, and also provides information as to the proposed Joint Venture currently under consideration by the Trust.

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SUBJECT :	**Foundation Trust Governance:** Progress report on Non-executive Directors' Job Description, Objectives and Performance Appraisal
REPORT BY :	Neil Savage, Director of Workforce & Organisational Development
AUTHOR :	Neil Savage, Director of Workforce & Organisational Development

CONTEXT AND BACKGROUND FOR REPORT

The purpose of this report is threefold.

Firstly, it presents the Board with the revised job description for Non-executive Directors. This job description is the result of extensive consultation and is attached as Appendix 1. In order to provide some useful background to this, the job description is supported in Appendix 2 with a summary from the Monitor 'Code of Governance' outlining the requirements relating to balance and independence of the Board of Directors.

Secondly, it presents a brief update on plans to develop objectives for Non-executive Directors.

Finally, the report presents a brief update on plans to develop performance appraisal criteria for the Chairman and Non-executive Directors.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

This report updates the Board on:

1. the proposed revised Non-executive Directors job description
2. plans to develop Non-executive Director objectives
3. plans to develop performance appraisal criteria for the Chairman and Non-executive Directors

RECOMMENDATIONS

The Board is asked to:

a. Consider and agree the proposed Non-executive Job Description outlined in Appendix 1

b. Consider and note the subsequent report.

Foundation Trust Governance:
Progress report on Non-executive Directors' Job Description, Objectives and Performance Appraisal

1. Background

NHS Foundation Trust (FT) Boards of Directors differ from non-FT Boards. As self-standing and governing bodies, FT Boards combine responsibilities and liabilities similar to the private sector but with the inclusion of various public sector accountabilities.

Given these differences, the Trust is required to continually demonstrate to Monitor it is able to maintain good governance, with accompanying clarity of roles and responsibilities. In addition, the Trust is required to demonstrate that comprehensive policies and procedures remain in place to ensure the effective working of the Board.

The purpose of this report is to summarise progress and plans on three key developmental areas in order to ensure these requirements continue to be met.

2. Non-executive Director job description

The proposed revised job description for Non-executive Directors is attached as Appendix 1. This job description is the result of extensive consultation. To assist the Board in its consideration of this, a summary is attached as Appendix 2 from the Monitor 'Code of Governance' outlining the requirements relating to balance and independence of the Board of Directors.

In summary, the job description clarifies a number of important points, including:

- Job Purpose - all Non-executive Directors
- Job Purpose - all Directors
- Main Duties and Responsibilities within the role of Non-executive Director

Additionally, the job description includes addendums clarifying the following specific roles:

- The Deputy Chair
- Chair of Audit Committee
- Senior Independent Director

Finally, it highlights that, in addition to these core responsibilities, the roles of individuals will need to include additional specific tasks to reflect:

1. Individual's particular skills, knowledge and experience, and
2. Individual's participation in Board committees, task groups or individual business projects.

3. Plans to develop Non-executive Director objectives

Under the terms of section A.3 of the NHS Foundation Trust Code of Governance, it is the Chairman's role and responsibility to set and agree the objectives of the Non-executive Directors. In this role, the Chairman is ultimately accountable to the Member's Council. Assuming the proposed revised job description is agreed, a formal process will be then be agreed for the setting and reviewing of Non-executive Directors' objectives.

To this end, the Director of Workforce and Organisational Development is working closely with the Chairman to develop and propose a framework to enable strategic objectives to be set, agreed and monitored. The timescale for completion of this is January 2009.

4. Plans to develop and propose performance appraisal criteria for the Chairman and Non-executive Directors

Under the terms of the aforementioned Code, the Board of Directors is required to ensure that adequate systems and processes are in place to enable maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery.

There are adequate systems and processes currently in place to achieve this, but it has been considered an apt time after the achievement of FT status to review and make recommendations for a process for the performance appraisal of both the Chairman and the Non-executive Directors.

To this end, the Director of Workforce and Organisational Development is working closely with the Chairman to develop and propose a new framework for performance appraisal. As part of this exercise assistance will be sought from the FT Network and a review will be carried out of good practice from other well established FTs. The timescale for completion of this is January 2009.

Once completed, these proposals will be taken to the Members' Council for consideration and agreement.

Neil Savage
Director of Workforce and Organisational Development

October 2008

Appendix 1

ROLE OUTLINE

Post: Non-Executive Director

Reports to: The Chair of the Trust

Accountable to: The Members' Council

Job Purpose - all directors

As members of the unitary Board all directors, whether executive or non-executive, are jointly responsible for the exercise of the powers and the performance of the Trust and for:

- providing active leadership of the Trust within a framework of prudent and effective controls
- ensuring compliance by the Trust with its terms of authorisation, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations
- setting the Trust's strategic aims, taking into consideration the views of the Members' Council, and ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives
- reviewing management performance
- ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance
- ensuring that the Trust exercises its functions effectively, efficiently and economically
- setting the Trust's values and standards of conduct and ensuring that its obligations to its members, patients and other stakeholders are understood and met
- ensuring constructive challenge to the decisions of the Board and to contribute to develop proposals on strategy

Job Purpose - all Non-Executive Directors

As part of their role as members of a unitary Board, Non-Executive Directors have a particular duty to ensure constructive challenge is made. Non-Executive Directors should therefore:

- scrutinise the performance of the Trust's management in meeting agreed goals and objectives
- monitor the reporting of performance
- satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management are robust and defensible

- take responsibility for determining the period of office, remuneration, allowances, and the other terms and conditions of office of the Chief Executive and other Executive Directors
- take responsibility for appointing and removing the Chief Executive
- together with the Chief Executive, take responsibility for appointing and removing the other Executive Directors
- support, encourage and where appropriate 'mentor' senior executives

Each Non-Executive Director is expected to focus objectively on the strategic and corporate business of the Trust and to bring to the Board independence and impartiality, calling on his or her wider professional experience and specialist knowledge to provide robust and constructive challenge to inform the discussions and debates leading to Board decisions.

Main Duties and Responsibilities within the role of Non-Executive Director

1. Uphold, and actively promote within the Trust, the highest standards of probity, integrity and governance and contribute to ensuring that the Trust's internal governance arrangements conform with best practice and statutory requirements.

2. Provide independent judgement and advice on issues of strategy, vision, performance, resources and standards of conduct and constructively challenge, influence and help the Board develop proposals on such strategies calling on his or her wider professional experience and specialist knowledge

3. In accordance with agreed Board procedures, monitor the performance and conduct of management in meeting agreed goals and objectives and statutory responsibilities, including the preparation of annual reports and annual accounts and any other statutory duties.

4. Obtain assurance that financial information is accurate and that financial controls and risk management systems are robust and defensible.

5. Bring independent judgement as well as experience, based on commercial, financial, legal or governance expertise from outside the Trust, and apply this to the benefit of the Trust, its stakeholders and its wider community.

6. Engage positively and collaboratively in Board discussion of agenda items and act as an ambassador for the Trust in engagement with stakeholders including the local community, dealing with the media in accordance with relevant guidance established by the Trust.

7. Engage effectively with the Members' Council, taking into consideration its role under the Trust's Constitution and supporting any committee of the Members' Council to which a non-executive director may be assigned.

8. Ensure the Trust has appropriate monitoring and reporting mechanisms in place to locally manage the risks arising out of Healthcare Associated Infections.

9. Contribute to the agreed process for evaluating the Chairman's performance.

The Deputy Chair - specific requirements if appointed

The Deputy Chairman's primary responsibility is to act in the place of the Chairman, when the Chairman is unavailable (whether for reasons of absence, conflict of interest or other reason). The Deputy Chairman may also assist the Chairman in performing his role, particularly with regard to governance issues.

This may include:
1. Fulfilling chairman's responsibilities for organizing and leading Board meetings when the Chairman is not available;
2. Keeping in close contact with the Chairman on key issues;
3. Actively participating in Board committees, in order to be well informed and stay current with the views of committees and their members;
4. Providing input on the Board agendas to the Chairman;
6. Advising the Chairman as to the quality, quantity and timeliness of the flow of information to the Board
7. Act as Deputy Chair of the Members Council

Chair of Audit Committee - specific requirements

The Audit Committee plays a crucial role in the governance of the Trust. It oversees the internal control principles and internal audit. It also acts as the primary interface with the external auditors and liaises directly with the Members' Council on any relevant matter requiring action or improvement arising from audit reviews. At least one of the non-executive members of the Audit Committee must have recent and relevant financial experience.

It is the role of the Chair of the Audit Committee to ensure the committee effectively discharges its delegated responsibilities and therefore this role requires separate consideration and evaluation.

Senior Independent Director - specific requirements if appointed

One of the non-executive directors who is independent in accordance with Provision A.3.1 of the NHS Foundation Trust Code of Governance will be appointed as the Senior Independent Director and will be available to members and governors if they have concerns which contact through the normal channels of Trust Chair, Chief Executive or finance director has failed to resolve or for which such contact is inappropriate.

The Senior Independent Director will lead a meeting of the Non Executive Directors to determine their evaluation of the Chairman's performance as part of an annual process agreed between the Chairman and the Governors for appraising the Chair.

Conclusion

This Role Description highlights the main areas of responsibility for the role of non-executive director and is not exhaustive. There will be other responsibilities required that will be consistent with this role.

It is likely that, in addition to these core responsibilities, the roles of individual non-executive directors will include additional specific tasks to reflect the following:
3. Each individual's particular skills, knowledge and experience; and
4. Each individual's participation in Board committees, task groups or individual business projects.

Appendix 2

Non-Executive Director Independence

From Section A.3.1 of the Monitor 'Code of Governance':

"A.3 Balance and independence of the board of directors

Main principle

The board of directors should include a balance of executive and non-executive directors (and in particular independent non-executive directors) such that no individual or small group of individuals can dominate the board's decision taking.
All directors should be able to exercise one full vote, with the chairman having a second casting vote on those occasions where a decision is tied.

Supporting principles

■ The board of directors should not be so large as to be unwieldy. The board should be of sufficient size that the balance of skills and experience is appropriate for the requirements of the business and that changes to the board's composition can be managed without undue disruption.
■ To ensure that power and information are not concentrated in one or two individuals, there should be a strong presence on the board of both executive and non-executive directors.
■ The value of ensuring that committee membership is refreshed and that undue reliance is not placed on particular individuals should be taken into account in deciding chairmanship and membership of committees.
■ Only the committee chairman and relevant members are entitled to be present at a meeting of the nomination, audit or remuneration committees, but others may attend by invitation of the committee.

Code provisions

A.3.1 The board of directors should identify in the annual report each non-executive director it considers to be independent. The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board should state its reasons if it determines that a director is independent notwithstanding the existence of relationships or circumstances which may appear relevant to its determination, including if the director:
■ has been an employee of the NHS foundation trust within the last five years;
■ has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust;
■ has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme;
■ has close family ties with any of the NHS foundation trust's advisers, directors or senior employees;
■ holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;
■ has served on the board for more than nine years from the date of their first election;

■ is an appointed representative of the NHS foundation trust's university medical or dental school.

A.3.2 At least half the board, excluding the chairman, should comprise non-executive directors determined by the board to be independent.

A.3.3 The board of directors should appoint one of the independent non-executive directors to be the senior independent director, in consultation with the board of governors. The senior independent director should be available to members and governors if they have concerns which contact through the normal channels of chairman, chief executive or finance director has failed to resolve or for which such contact is inappropriate. The senior independent director could be the deputy chairman.

A.3.4 The board of directors should include in its annual report a description of each director's expertise and experience. Alongside this in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.

A.3.5 No individual should hold, at the same time, positions of director and governor of NHS foundation trusts."

SUBJECT : Violence and Aggression Policy

REPORT BY : Jane Owen

AUTHOR : Catherine Roper
Risk Manager

CONTEXT AND BACKGROUND FOR REPORT

The policy is required in order to set out the expectations of the Trust with regard to the behaviour of staff, patients and visitors to the Trust. It documents the actions and procedures that the Trust will follow if staff, patients or visitors present with abusive, aggressive or violent behaviour.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board are asked to consider and approve the policy.

RECOMMENDATIONS

Prevention and Management of Violence, Abuse and Harassment In the Workplace Policy & Procedures

Date of Policy: 2008 Author: Catherine Roper

Date For Review: September 2011

Type:	Prevention & Management of Violence, Abuse and Harassment In the Workplace Policy & Procedure	Version: Ref:	1	Directorate:	Corporate

Aim:	To provide staff with guidance in managing the risks associated with violence, abuse and harassment at work.
Scope (who it applies to) :	This policy applies to all employees irrespective of grade, level, location or staff group working in the Trust

Ratified by: Date:	Health & Safety Committee Management Board
Final Approval by: Date:	Trust Board
Approval Signatories	Chief Executive
Implementation Date:	

Review and consultation process (when review required & by whom):	August 2011	
Responsibility for Implementation:	Director of Workforce & Organisational development	
Revisions:		
Date:	Author:	Description of Revision (Action by whom):

HISTORY

Review date:		Effective from:	
Effective to:			
Action Required by Trust/Dept			
Distribution methods:	All staff via Global email, Global U Drive, Intranet Please note that the electronic version of this document on U Drive is the only version maintained. Any printed copies may not necessarily contain latest updates and should be compared to the version on the U Drive.		

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1. Policy Statement

Birmingham Women's NHS Foundation Trust is committed to ensuring that all staff employed by the organisation are able to undertake their roles without the risk or threat of verbal or physical violence or abuse.

2. Scope of the Policy

This document describes the procedures to enable staff to prevent and manage situations where they are faced with any violent or abusive behaviour. It applies to all staff directly employed by the Trust in all working locations.
It may be adopted by the Independent Contractors within the boundaries of Birmingham Women's NHS Foundation Trust.

3. Definitions
For the purpose of this document the following definitions apply. Examples are also included for guidance:-

- ***Violence:***

"any incident where staff are abused, threatened or assaulted in circumstances relating to their work; involving an explicit or implicit challenge to their safety, well being or health" (NHS zero tolerance zone campaign)

  - The application of force, severe threat or serious abuse, by members of the public towards people, arising out of the course of their work, whether or not they are on duty.
  - Severe verbal abuse or threat, where this is judged likely to turn into actual violence.
  - Serious or persistent harassment (including racial or sexual harassment.)
  - Threat with a weapon, major or minor injuries, or fatalities
    (Skelmersdale Report 1988)

- ***Harassment:***

"Any conduct, based on age, sex, sexual orientation, gender assignment, disability, HIV status, race, colour, language, religion, political, trade union or other opinion or belief, national or social origin, associated with a minority group, domestic circumstances, property, birth or other status, which is not reciprocated or wanted and which affects the dignity of all men and women at work." (GWC Equal Opportunities)

- ***Verbal abuse:***

This list of examples is not exhaustive:-

  - Offensive language or innuendo
  - Sexist, racist or patronising remarks.
  - Racist, sectarian or sexually suggestive jokes or derogatory remarks.
  - Inappropriate or intimate questioning; uninvited, unreciprocated, unwelcome behaviour of a sexual nature.
  - Propositions and offensive remarks.
  - Name calling, including personal comments about physical looks.
  - Spreading malicious rumours or hurtful gossip
  - Threats of physical assault to staff or their family

- ***Physical Abuse:***

This list of examples is not exhaustive:-

  - Unwanted physical contact
  - Explicit physical gestures or attacks
  - Suggestive gestures (such as mimicking the effects of a disability)
  - Unnecessary touching or assault
  - Stalking which occurs at work or outside work, but is related to work

- ***Written Abuse:*** e.g.
  - Letters, faxes, e-mails or texts(often anonymous)

- ***Intimidation:*** e.g.

- Slander.
- Conduct that belittles in some way such as shouting at.
- Intrusion by pestering, spying, following.
- Unnecessary closeness.
- Apportioning blame wrongly.

- ***Displays of offensive material***: e.g.
  - Flags and emblems
  - Badges
  - Graffiti
  - Unnecessary highlighting of material.

- ***Bullying:*** e.g.
  Persistent, offensive, abusive, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanction, which makes the recipient feel threatened, humiliated or vulnerable, which undermines their self-confidence, and which may cause them to suffer stress.

- ***Aggression***: (Collins English Dictionary)
  - An attack or harmful action.
  - An offensive activity.

- ***Assault***: (Collins English Dictionary)
  - A violent attack either physical OR verbal.

- ***Lawful Visitors***:
Those persons with expressed or implied authority to enter the premises. Implied authority will vary depending on the circumstances and whether the person will have a valid reason to be in a particular location.

IF IN DOUBT – REPORT IN ACCORDANCE WITH THE INCIDENT REPORTING PROCEDURE

4. Background

Various additional information already exists which supports the Trust position. This includes legislation, requirements of external regulatory bodies and other Trust Policies and Procedures as listed below.

4.1 Principle Legislation

- The Health & Safety at Work etc. Act 1974

The Health and Safety at Work Act 1974 requires employers to provide safe working practices, environments and equipment/substances to maintain the health, safety and welfare of its employees, as far as is reasonably practicable. This includes the management of work related violence, abuse and harassment.

- The Management of Health & Safety at Work Regulations 1999

The Management of Health and Safety Regulations place an obligation on employers to look for and then control risks before incidents occur. They require all employers and self

employed people to assess the risks to staff / patients and any others who may be affected by their work or business. This is a 'predict and prevent' strategy rather than a 'react and rectify' strategy, which would be implemented following an incident.

- Data Protection Act 1998
- Crime and Disorder Act 1988

4.2 External Regulating Agencies
- Health and Safety Executive
- National Patient Safety Agency
- NHS Counter Fraud and Security Management Service
- NHSLA Risk Management Standards for Acute Trusts

4.3 Links to other Trust Policies /Procedures
- Health and Safety Policy
- Risk Management Strategy
- Risk Assessment TSP
- Lone Workers Policy
- Incident /Near Miss Reporting and Management Procedure.
- Occupational Health Policy
- Bullying and Harassment Policy
- Learning and Development Policy
- Security Policy
- Disciplinary Policy

This list is not exhaustive and it may be necessary to refer to other policies for additional information.

5. Responsibilities and Accountabilities

Specific responsibilities in relation to this procedure are as follows:-

5.1 Risk Manager will:-
- ♦ Maintain the central register of all Corporate/ Directorate/Departmental risks and action plans.
- Provide a 6 monthly report of all incidents involving abusive or violent behaviour, including all actions taken as a result, for presentation to the Health and Safety Committee.
- ♦ Provide advice and support to the Directorate Managers and staff as required
- ♦ Inform the PCT Clinical Governance Lead of all violent and abusive incidents

5.2 Directorate Managers will:-
- ♦ Provide adequate resources to reduce or control the risk, including training opportunities as necessary
- ♦ Monitor action taken to eliminate, control and reduce risks in the area of responsibility.
- Update the Risk Register as appropriate
- Notify the HSE of all incidents reportable under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.)

5.3 Heads of Department will:-
- Identify and implement action(s) required to eliminate, reduce and control the risks of violence, abuse and harassment, in consultation with their employees.
- Ensure that records are kept of all risk assessments relevant to the area

- Identify the training needs of staff within their service/department, with respect to the prevention and management of violence and aggression, as part of the annual Personal Development Review.
- ♦ Devise and implement procedures in consultation with staff, for staff to follow in the use of panic alarms, where appropriate
- Carry out a drill of this procedure at least once annually with staff.
- Ensure that support and debriefing is ALWAYS provided for employees following violent incidents.
- ♦ Ensure that a post incident analysis is carried out for all incidents involving violence and aggression.
- ♦ Treat all incidents, where employees "feared for their own safety", as category red in line with the Incident Reporting Procedure

All managers have a direct accountability for the management of violence and aggression in their area/service and should consider the list of potential causative factors and preventative measures contained in Appendices 1 and 2.

5.4 Occupational Health Service Department will :

- Ensure relevant counselling is provided for staff, following referral from individuals or managers.

5.5 Employees will:

- Assist in the development of local procedures for the prevention and management of violence and aggression in their service/department.
- Follow any local procedures, implemented by their Service/Departmental Managers and Support Managers, to prevent violent and abusive incidents.
- Report any violent and abusive incidents and near misses in accordance with the Incident Reporting Procedure.
- Ensure their own behaviour does not increase the likelihood of a violent /aggressive incident occurring.
- Attend relevant training when identified through the risk assessment process.

6. Preventing Violence and Aggression

6.1 The Trust will provide appropriate signage throughout its premises informing the public of its expectations of their behaviour and the measures it may take to enforce this.

6.1 The Trust does not expect employees to put themselves at risk for the sake of their patients. The situations where Trust employees may be subjected to violence include:

- Providing care
- Giving or withholding a service
- Exercising authority
- Working with people who are emotionally or mentally unstable.
- Working with people who are under the influence of drugs or alcohol.
- Working with people under stress.
- Working alone
- Working outside normal hours, particularly at night.
- Handling valuables(including drugs)
- Travelling in the community.

7. Action to be taken if a violent incident occurs.

7.1 Employees have a duty not to put themselves or their colleagues at risk. Where necessary staff should refer to local support mechanisms which may include in-house security, alarms and the police where the situation requires.

7.2 No member of staff should tolerate any level of physical or non-physical abuse and in order to ensure immediate safety staff should leave situations where they may or are being assaulted, threatened or intimidated. This may include:

- discontinuing telephone calls
- terminating appointments with patients
- leaving visits to patients
- leaving the neighbourhood (in the case of community staff).

7.3 Physical intervention is NOT encouraged and should only be carried out by staff who have been trained in these techniques.

7.4 There may be occasions when employees are subjected to verbal abuse etc from other employees. This is NOT acceptable and staff should also report this using the Bullying and Harassment Policy, as well as documenting the occurrence in accordance with the Incident Reporting Procedure.

7.5 The Trust has to balance its ability to deliver effective care and treatment with the needs of the patients. There may be circumstances in which it would be reasonable to withhold treatment from violent and abusive patients. This will always be as a last resort to ensure the safety and security of employees.

8. Maintaining services to patients

8.1 If the perpetrator of a violent incident is a patient requiring further treatment or care from staff, arrangements must be made by the responsible manager to endeavour to provide this without any further risk to staff. This action will include:

- informing patients of the Trust's policy regarding violence and aggression to staff
- ensuring that all staff, including those working for the PCT, FHS providers and NHS Trusts, who may come into contact with the perpetrator of a violence incident are made aware of the possibility of further violence and of the steps being taken to prevent this
- making arrangements for home visits and clinic appointments so that staff are protected such as visits being made by staff working in pairs, clinic appointments at specific times of the day, clinic appointments in the presence of a security officer.

8.2 If the responsible Manager considers that safe arrangements cannot be made then they must notify the Director of Nursing and Midwifery/Medical Director.

8.3 The Director of Nursing and Midwifery/Medical Director will confirm the action to be taken.

9. The Legal Position

9.1 In determining what action can be taken against abusive members of the public or visitors, the first point to consider is who is allowed on the Trust's premises i.e. lawful visitors.

9.2 If an out–patient/day patient becomes threatening and violent towards staff then the most senior person may decide to ask them to leave Trust's premises. If they refuse to leave the Police must be contacted to assist.

9.3 If a patient/relative/visitor or carer becomes threatening and violent, towards staff, in the patients/clients own home, and then the employee should leave immediately.

9.4 The decision to either provide the treatment in other premises or to withdraw treatment must be made by the Directorate Manager in consultation with the Director of Nursing and Midwifery/Medical Director.

9.5 Withholding treatment will ***ONLY*** be appropriate where violent and abusive behaviour is likely to:

- Prejudice any benefit the patient might receive from the care or treatment.
- Prejudice the safety of those involved in giving the care or treatment.
- Lead the member of staff offering care to believe that he/she is no longer able to undertake their duties properly.
- Prejudice the safety of other patients present at the time.
- Results in damage to property inflicted by the patient or as a result of containing them.

9.6 It will be inappropriate to withhold treatment/care from the following:-

- Patients, who in the expert judgment of a relevant clinician are not competent to take responsibility for their action e.g. an aggressive individual, who becomes violent as a result of an illness or injury.
- Mentally ill patients who may be under the influence of drugs and/or alcohol.
- Patients who, in the expert judgement of a relevant clinician, requires urgent emergency treatment.
- Other than in exceptional circumstances, any patient under the age of 16.

9.7 The withholding of treatment is time limited for a period of no more than 12 months with review every 6 months. However, the sequence of warnings and repeated withholding of treatment will recommence following further violent and abusive incidents.

9.8 Incidents of aggression or abuse by a member of staff will be dealt with in accordance with Trust disciplinary procedures.

10. Support for Staff

10.1 The Trust acknowledges that there may be occasions when staff may be affected physically or emotionally following a violent incident. Managers need to be aware that individuals will need active support and possibly counselling, especially after the incident and on returning or resuming work. This is particularly important given the potential impact of stress on the employee's current or future health.

10.2 Professional counselling can be arranged through the Trust's Occupational Health Services, if required. The Trust also employs an independent counselling service which staff can access confidentially.

11. Monitoring

11.1 The Trust's Health and Safety Committee is responsible for monitoring and reviewing the implementation of this policy and for receiving reports from the Risk Manager regarding all violent or abusive incidents and the actions taken or planned as a result.

11.2 Key Performance Indicators for implementation of the policy are:-

- Evidence of staff attending relevant training, identified as part of the risk assessment process.
- Evidence that Service/Departmental risk assessments have considered workplace violence and aggression.
- Evidence of local procedures for the prevention and management of violent and aggressive incidents.

12. References

- The Health and Safety at Work etc Act 1974 (HSW Act)
- The Management of Health and Safety at Work Regulations 1999
- The Reporting of Injuries, Diseases and Dangerous Occurrences
- Regulations 1995 (RIDDOR)
- www.hse.gov.uk
- Safety Representatives and Safety Committees Regulations 1977 (a)
- The Health and Safety (Consultation with Employees) Regulations 1996 (b)

Managers Checklist **Appendix 1**

The following should be considered when identifying the risks of Violence, abuse and harassment to staff. This list is not exhaustive.

- Unpredictable and unremitting workloads which often lead to fatigue and a diminished ability, both to identify at an early stage and to subsequently cope with potentially violent situations.
- The need to provide cover for nights, weekends and changeover periods between shifts.
- Individuals must not be left isolated for long periods, nor should junior or inexperienced staff have to cope alone, especially in situations where there is a recognised potential for violence, or where patients (and/or friends and /or relatives) may take advantage. See also Lone Worker Policy.
- Where there is a well established risk, an agreed minimum number of appropriately qualified staff should be on duty at any one time. Where appropriate, nursing staff will be designated to a patient who requires “special” observation.
- Attention should be taken in relation to any reduction/cessation of anti-psychotic drugs or alcohol withdrawal and an appropriate psychiatric opinion sought.
- As part of the risk assessment process, identify the training needs of their staff, with regard to violence and aggression.
- Lone Working.

Preventative Measures **Appendix 2**

The following should be considered to keep the likelihood of violence and aggression as low as possible:

1. Keep patients and visitors informed particularly in situations of acute distress and/or long waiting periods.

2. Keep staff informed: Information about clients/patients who are being cared for within different services/departments must be communicated in both written and verbal form. Particularly when:
   - New members of staff are involved.
   - New patients are admitted.
   - Change in the patient's medical/physical state, medication, behaviour of moods.
   - Known violent patients/clients being transferred /referred. In these situations staff should check the transfer/referral letter and obtain additional information prior to working alone.
   - Where domiciliary visits are made to patients/clients with a known or suspected history of aggressive or violent behaviour. (See Lone Working TSP)

3. Environment:
   Individuals may be anxious or apprehensive about unfamiliar surroundings or procedures.
   It is important that the workplace environments and surroundings are subject to risk assessment. This is equally important in the domiciliary setting as well as in the clinic/health centre.
   - Employees should pay particular attention to layout of ALL rooms including those in domiciliary settings where they provide care/treatment. E.g. Employees are nearer the door than patients; removal of items which could be used as a weapon, if there is a known risk.
   - Panic alarms are easily accessible.
   - Procedures should be devised AND implemented for staff to follow in the event of the panic alarm being sounded and a drill conducted at least once annually.
   - Reception staff should never be left isolated.
   - Ideally clinic rooms cannot be accessed without passing by Reception.
   - As far as possible one person should not open or lock up premises alone in darkness.
   - When clinics are in use out of main office hours, staff should use clinic rooms in close proximity to each other.
   - Never enter a location if there is ANY doubt about personal safety. E.g. if the person answering the door gives cause for concern or the patient is not in.
   - Remain aware of the domiciliary environment. E.g. escape routes in case problems arise.
   - Follow occupants in when entering houses and other buildings.

4. Arrange for patients/clients to be seen at a clinic/health centre rather than at home, if at all possible.

5. Arrange for another member of staff or a reliable relative of the patient/client to be present during the visit. E.g. if a member of staff is vulnerable to sexual harassment while visiting a member of the opposite sex.

6. Providing a taxi, if appropriate in areas where cars may be vandalised, or staff have to go through unsafe areas to make visits.

7. Training
It is important that staff are equipped with the skills and techniques which will enable them to deal with potential or actual violent incidents confidently and competently. Training in the prevention and management of violence and aggression must be made available to ALL front line staff who come into contact with patients/clients and relatives and regularly updated.

Comment: We must be clear about how this is provided, what it should contain and who should received the training before the policy should be implemented.

Assessment may identify additional training needs in methods to diffuse aggression and methods of physical control.

Training should include:

- Interpersonal skills
- Prevention and continual assessment of risk
- Managing aggression and de-escalation techniques.
- Conflict resolution training as identified by Counter Fraud and Security Management Services.

Appendix 3

FLOWCHART of action to take following ALL violent or abusive incidents

INCIDENT

- Document the incident in accordance with the Incident Reporting Policy completing all relevant sections on the same day
- If the individual affected *" feared for their own safety"* contact the relevant Locality/Service/Departmental manager, operational manager or on-call manager immediately

SERVICE/DEPARTMENTAL MANAGER

- All incidents in which the individual affected *"Feared for their own safety"* will be classed as Major and therefore subject to a full Root Cause Analysis
- Enable affected individual to access counselling if required.
- Inform the relevant Directorate Manager or on call manager

DIRECTORATE MANAGER

- In cases where a member of staff is the perpetrator, instigate the disciplinary procedure
- In the case of a patient or member of the public being the aggressor, identify if a letter is required (Stage 1 or 2) WITHIN 2 WORKING DAYS

HAS THE AGGRESSOR BEEN INVOLVED IN A SIMILAR INCIDENT BEFORE? (if a patient or member of the public is the aggressor)

NO

- Implement Warning Stage 1 if appropriate (Appendix 4)

√ Letter 1 to go within 5 WORKING DAYS
√ Letter 2 to go within 5 WORKING DAYS

YES

- Implement Withdrawing Services Stage 2 if appropriate (Appendix 6)

√ Letter 3 to go within 5 WORKING DAYS
√ Letter 4 to go to GP within 5 WORKING DAYS

Appendix 4

WARNING STAGE 1

1. An incident form must be completed by each member of staff involved ensuring all relevant fields are completed in accordance with the Incident Reporting Policy.

2. The Directorate Manager will prepare letters 1 and 2 and obtain the signature of the Chief Executive prior to posting WITHIN 5 WORKING DAYS with a copy of the policy, pages 1-10, attached.

3. A copy of the letters should be sent to the PCT Clinical Governance Lead

4. Review the incident with area/service/departmental manager, the appropriate Directorate Manager, the Director of Nursing Services/Medical Director and the PCT Clinical Governance Lead.

5. The full process must be recorded in the patient's care documentation.

6. This procedure to be used for every occasion an incident has occurred.

7. Any patient behaving unlawfully will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will prosecute perpetrators of crime on or against Trust property, assets and staff.

Clinical Review Checklist **Appendix 5**

The Birmingham Women's NHS Foundation Trust has a duty to provide a safe and secure environment for patients, staff and visitors. Violent or abusive behaviour will not be tolerated, and decisive action will be taken to protect staff, patients and visitors.

Those patients who, in the expert judgement of the relevant clinician, are not competent to take responsibility for their actions, will not be subject to this procedure. In the event of inappropriate behaviour by a patient, and following careful review by the appropriate Directorate Manager, the Director of Nursing Services/Medical Director and the PCT Clinical Governance Lead, the Withdrawing Services Stage 2 can be instigated.

Review to include (please delete)

♦ Is the patient/relatives known to have a history of violence?
Yes/No

♦ Is the patient suffering from a medical condition to cause him/her to be violent?
Yes/No

♦ If yes, what? …………………

♦ Has the patient suffered from a previous head injury?
Yes/No. If Yes insert date injury occurred……….…..

♦ Is the patient suffering from mental illness?
Yes/No

♦ Does the patient have a history of alcohol abuse?
Yes/No

♦ Does the patient have a history of drug abuse?
Yes/No

♦ Agreement that the Alert Code is to be used
Yes/No

Comments / action:

WITNESSES FOR THE TRUST

(Initiator of Procedure)

NAME……………………………… NAME…………………………….…..

DESIGNATION …………………… DESIGNATION………………………

Signed …………………………….. Signed ………………………………..

Date ……………………………….. Date……………………………………

Appendix 6

WITHDRAWING SERVICES STAGE 2

1. The decision to withdraw treatment must be taken by the Director of Nursing and Midwifery Services/Medical Director and the relevant Directorate Manager. This does not preclude the relevant clinician discharging a patient who no longer requires care in the normal manner.

2. The Medical Director/Director of Nursing and Midwifery must inform the patient's GP of the exclusion and the reasons for it.

3. The patient must be informed that they may challenge an exclusion using the established complaints procedure.

4. The Chief Executive must be informed by the Executive Director involved in the decision and will dispatch written confirmation to the patient's home WITHIN 5 WORKING DAYS.

5. The Medical Director/Director of Nursing and Midwifery must also inform the PCT Clinical Governance Lead in accordance with the Incident Reporting Policy. A detailed record of the rationale for exclusion and of any alternative arrangements for care should be kept in the patient's health records.

6. It is essential that all premises where health care services are provided are informed of the exclusion and reminded of the actions to take if the individual enters the premises to access services and responsibility for this lies with the Clinical Governance Lead at the PCT.

7. If an excluded individual returns in any circumstances the police should be called immediately. The Trust will subsequently seek legal redress to prevent the individual from returning to Trust property.

8. Such exclusion will last for a maximum of one year, subject to alternative care arrangements being made. The provision of such arrangements will be pursued with vigour by the relevant Directorate Manager.

9. Any patient behaving unlawfully will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will prosecute perpetrators of crime on or against Trust property, assets and staff.

Letter 1

Letter to the Aggressor - Warning Stage 1
(This letter is for guidance. Additional information may be added BUT DO NOT omit.)
Date
Re: Relatives
Relatives: address
Relatives: date of birth
Relatives: hospital number
Dear

I write further to your unacceptable behaviour in xxxxx. (Insert Clinic / ward/ address of where violence took place) on (insert date) xxxxxxxxxxx and to confirm to you that the Trust will be applying its Prevention and Management of Violence, Abuse and Harassment Policy & Procedure. This is in respect of your actions on these premises on this date.

The staff in xxxxx(insert Clinic/.Ward/ address of where violence took place) felt extremely threatened by your behaviour, which put themselves [and other patients and visitors] at risk. Birmingham Women's NHS Foundation Trust strives to provide a high standard of care to all patients, and your behaviour will not be tolerated in any area of the Trust or against any of its staff.

The Trust has followed the conditions outlined in its Policy which addresses individuals who are violent and abusive. This means that:
• Incident forms have been completed by staff,
• A letter will be sent to your GP advising them of this incident
• A record of this incident will be placed on your/ your relative's* records.

Should you on any occasion in the future fail to comply with the expected standards of behaviour detailed in the accompanying leaflet the Trust will have no alternative but to * withdraw services and / or make a full report to the Police.

Your GP would also be advised in order that your/ your relative's treatment can be provided in a more appropriate setting.

If you have any queries, or require any further information please contact me.

Yours sincerely

J.Burgess
Chief Executive
Birmingham Women's NHS Foundation Trust.
Note: A COPY OF THE SAFETY PROCEDURE SHOULD BE ATTACHED.
* delete as appropriate.

Letter 2
(This letter is for guidance. Additional information may be added BUT DO NOT omit.)
Letter to GP – Warning Stage 1

GP's name and address
Date
Re: Patient's
Patient's address
Patient's date of birth
Patient's hospital number

Dear
The above individual is currently receiving treatment at xxxxx (insert Clinic/Ward/address of where violence took place)

In order to protect the *environment/ other patients/ members of staff*, it has been necessary to instigate the Warning Stage procedure for individuals who are violent and/or abusive.

This Warning Stage requires the Trust to:
- Complete the appropriate incident forms,
- Issue a written warning to the patient about their behaviour.
- Issue a letter to you their GP advising them of this incident.
- Place a record of the incident on their care records.

If the patient continues to behave in a violent and threatening manner the Trust will withdraw all services for a maximum of 12 months.

This will also involve their immediate exclusion from the Trust premises and /or a full report made to the Police.

If you have any queries, or require any further information please contact me.

Yours sincerely

J.Burgess

Chief Executive
Birmingham Women's NHS Foundation Trust.
Note: A COPY OF THE SAFETY PROCEDURE SHOULD BE ATTACHED
*delete as appropriate

Letter 3
Letter to the Aggressor - Withdrawing Services Stage 2

(This letter is for guidance. Additional information may be added BUT NOTHING omitted.)

Date
Re: Relatives
Relatives: address
Relatives: date of birth
Relatives: hospital number

Dear

I write further to your repeated unacceptable behaviour in xxxxx (insert Clinic/Ward/ address of where violence took place) on (insert date) xxxxxxxxxxx and to confirm to you that the Trust will be applying its Prevention and Management of Violence, Abuse and Harassment Policy. This is in respect of your actions on these premises.

The staff in xxxxx (insert Clinic/.Ward/address of where violence took place) felt extremely threatened by your behaviour, which put themselves [*and other patients and visitors] at risk.
(insert details of this behaviour)
Birmingham Women's NHS Foundation Trust strives to provide a high standard of care to all patients, and your behaviour will not be tolerated in any area of the Trust or against any of its staff.

The Trust has followed the conditions outlined in its Policy which addresses individuals who are violent and abusive. This means that: [add to this list as necessary]

- Incident forms have been completed by staff,
- You have already received a written warning about your behaviour
- A report has been made to the Police.
- A record of this incident will be placed on your/ your relative's records.

The decision has therefore been taken to withdraw all clinical services involved in your care for **a maximum of 12 months**. Your GP has also been advised in order that * your/your relatives care can be provided in a more appropriate setting.
You may challenge an exclusion using the established complaints procedure.

Yours sincerely

J.Burgess
Chief Executive
Birmingham Women's NHS Foundation Trust.
• delete as appropriate

Letter 4

Letter to GP - Withdrawing Services Stage 2

(This letter is for guidance. Additional information may be added BUT NOTHING omitted.)

Date
Re: Relatives
Relatives: address
Relatives: date of birth
Relatives: hospital number

Dear

The above individual is currently receiving treatment at xxxxxx(insert Clinic/Ward/address of where violence took place)

They have been involved in a subsequent violent and abusive incident for which the Trust has followed the conditions outlined in its Policy which addresses individuals who are violent and abusive. This means that:

- A written warning has been issued
- Incident forms have been completed by staff,
- You have been informed of previous incident(s)
- A report has been made to the Police.

As a result of their behaviour, the Trust has withdrawn all services for a maximum of 12 months.

If you have any queries, or require any further information please contact me.

Yours sincerely

J.Burgess
Chief Executive
Birmingham Women's NHS Foundation Trust.

Policy for the Emergency Protection of a Child Following Birth

Signed by:

…………………………… ………………………………………..

Jane Owen | **Peter Thompson**
Director of Nursing and Midwifery | **Medical Director**

…………………………….
Supervisor of Midwives

Date of Policy: October 2008
Date of next review: October 2011

Authors: Elaine Giles

Type:	Policy for the Emergency Protection of a Child Following Birth	Version: Ref:	1	Directorate:	

Aim:	To provide staff with guidance for managing situations whereby a child has to be protected from harm following birth.
Scope (who it applies to) :	This policy applies to all employees irrespective of grade, level, location or staff group.

Ratified by: Date:	
Final Approval by: Date:	
Approval Signatories	Director of Nursing/ Midwifery: Medical Director: Supervisor of Midwives
Implementation Date:	October 2008
Review and consultation process (when review required & by whom):	October 2011 Lead Nurse/ Midwife for Safeguarding Children Partner agencies
Responsibility for Implementation:	Director of Nursing/ Midwifery

Revisions:		
Date:	Author:	Description of Revision (Action by whom):

HISTORY

Review date:		Effective from:	
Effective to:			
Action Required by Trust/Dept			

Distribution methods:	Hard copies to all policy folders, Global email, Global U Drive, Intranet

1. Introduction:

There are circumstances where it is unsafe for a baby to be in the care of its mother following birth.

A Child Protection Plan, which requires clear decision making, planning and implementation, is the means by which the baby is kept safe. This Policy outlines the process by which a Child Protection Plan is carried out and the circumstances in which a baby may be removed from a mother's care.

The Local Authority takes the lead in Child Protection Planning but it shares the responsibility with the Agency Partners for ensuring all staff act within the law.

2. Removal of a baby from its mother:

A baby can only be separated from its mother in very limited circumstances. A baby should not be removed from its mother unless:

- The mother explicitly, and with full understanding, agrees to that separation and the child is accommodated under Section 20 of the Children Act 1989; or
- There is a Court Order authorising separation. This may be an Emergency Protection Order under section 44 of the Children Act 1989, or an Interim Care Order under section 38 of the Children Act 1989; or
- The baby is taken into Police Protection under section 46 of the Children Act 1989; or
- There is a real and immediate risk to the baby of significant harm by a parent or carer and removal is necessary to protect the safety of the baby. Where a child is removed in these circumstances, it should only be seen as an interim measure and the Police or the Local Authority will need to seek a Court Order as a matter of urgency if the child is to be kept from its mother.

A separation of mother and baby outside of the circumstances set out above is unlawful and could be in breach of Article 8 of the European Convention on Human Rights Act.

3. The Decision Making Process:

The factors determining the need to remove a baby at birth may be numerous and will often be based upon information available from many different agencies. Fortunately, this is not an action that occurs frequently as such interventions can interfere with the bonding process between mother and baby and reduces the benefits to a baby's health that breast feeding can provide (Masson et al, 2004).

In most situations, concerns regarding an unborn child will be shared at a pre-birth Child Protection Conference, which will produce a detailed Child Protection Plan to address the risk of significant harm when the child is born.

Children's Services holds lead responsibility for the decision whether to remove a child following birth. It will make this decision in consultation with other agencies, and this consultation should always include the Local Authority's legal department.

4. Responsibility of Health Professionals When Attending a Pre-Birth Child Protection Conference:

The health professional in attendance must obtain from the Conference a clear statement of whether there is a Child Protection Plan and, if so, what that plan is.

If the Child Protection Plan includes the removal of the child from the mother, it must also state clearly -

- Whether the local authority intends to seek a Emergency Protection Order (EPO) or Police Protection; and/or
- Whether the mother has signed a Section 20 agreement, agreeing for the child to be accommodated by the Local Authority.

Following the pre-birth Child Protection Conference the health professional will inform the Lead Nurse/Midwife for Safeguarding Children (LNMSC) of the outcome.

5. Action planning:

The Local Authority response is to develop an effective action plan. Following a pre-birth Child Protection Conference, if the child is subject to a Child Protection Plan, the core group must establish a clear process for sharing information and agree a plan of action for implementation of the Child Protection Conference Plan.

The Child Protection Conference should give careful consideration to the membership and frequency of the core group. The agencies involved in the planning process will normally be Health, Children's Services and the Police.

The LNMSC will ensure an up to date 'alert' is distributed, as appropriate, internally and/or to bordering, regional units and West Midlands Ambulance Service. Distribution of national alerts is the responsibility of the Local Authority.

The social work team manager, in consultation with the LNMSC, must convene a planning meeting at least 6 weeks before the estimated date of delivery (EDD). The purpose of this meeting is to agree a plan ("the Child Protection Birth Plan") which includes:

- Contact between the parents and the baby
- Breast feeding

- Risk management
- Specific agency responsibilities

The Child Protection Birth Plan must allow for the possibility of the baby being born outside normal office hours – e.g. evening, weekend, Bank Holiday - or being born at home, or at a neighbouring hospital. This must include effective communication with the Emergency Duty Team to ensure a robust out-of-hours response to secure the safety of the baby. This responsibility lies with the Local Authority.

The Child Protection Birth Plan must state clearly that removal of the child without the mother's consent may require a court order. If the mother has consented to the removal, the plan must state that she can withdraw this at any time, and a copy of the signed consent ("the section 20 agreement") must be attached to the plan.

Every effort will be made to engage the parents in the decision making process and planning for the child's protection, seeking their cooperation in the process.

6. Implementation:

When the woman presents in labour and her child is subject to a Child Protection Plan, midwifery staff will consult the Child Protection Plan and alert the relevant professionals immediately.

If the child protection plan requires that the baby will be separated from the mother immediately, the baby can be accommodated on another ward until transfer to the community, **provided the relevant authority from the Court or the parents has already been sought. No baby should be removed from their mother unless one of the criteria set out in Section 2 of this Policy can be met.**

In those cases where an Order has been granted by the Court, e.g. Emergency Protection Order, Interim Care Order, or the child is subject to Police Protection, the social worker will provide copies of such Orders which will be filed in the hospital records. Section 20 agreements signed by the parent/s should also be included in the records.

Ongoing contact between the parents and the child is the responsibility of the Local Authority. The hospital may be able to assist in short term supervision for no longer than 3 hours. This will require specific agreement.

The social worker holds responsibility, through the core group process, for the detailed arrangements and implementation of the Child Protection Plan.

7. Discharge from hospital:

At the time of transfer from hospital, if the baby is not to remain in the parents' care, a discharge plan must be agreed between the social worker who will be collecting the baby and hospital staff.

The Local Authority must provide a car seat to transport the baby safely.

The social worker must have on their person the appropriate form of identification. Midwifery staff will not allow the baby to leave the hospital with anyone who does not carry appropriate identification.

The social worker must provide the following information to the Hospital staff:

- Name and address of carer where the baby is to be discharged
- General Practioner's name, address and phone number
- Health Visitor (if known)

Hospital staff must inform the social worker of any health issues relating to the baby, including:

- Feeding requirements
- Health issues
- Birth marks/ blemishes identified prior to discharge
- Follow up appointments
- Community midwifery visiting

8. Actual or attempted removal of a baby from hospital, contrary to the child protection plan:

If there is any attempt by a parent to remove a child, contrary to the child protection plan and without the permission of the Local Authority, the health professional must contact the police by dialling 999 in order to minimise the risk of significant harm. The health professional must also contact:

- Hospital security
- Lead Nurse/ Midwife for Safeguarding Children
- Named social worker/ Emergency DutyTeam
- Maternity Directorate Manager / Head of Midwifery
- Out of hours contact hospital cover and the operational manager

In any other situation where there is no immediate child protection plan for the child, but there are concerns of significant harm, health staff must initiate child protection procedures.

References:

Birmingham Safeguarding Children Board Policies and Procedures 2006

Children Act 1989, sections 20, 38, 44, 46

Human Rights Act 1998, section 8.

Masson, J; Winn Oakley, M; Pick, K (2004). Emergency Protection Orders, School Of Law Warwick University.

Working Together to Safeguard Children 2006.

R (G) v Nottingham City Council, 2008

Associated policies:

Safeguarding Children, BWH, 2008

Birmingham Safeguarding Children Board Child Protection Procedures, June 2007.

SUBJECT : Violence and Aggression Policy

REPORT BY : Jane Owen

AUTHOR : Catherine Roper
Risk Manager

CONTEXT AND BACKGROUND FOR REPORT

The policy is required in order to set out the expectations of the Trust with regard to the behaviour of staff, patients and visitors to the Trust. It documents the actions and procedures that the Trust will follow if staff, patients or visitors present with abusive, aggressive or violent behaviour.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board are asked to consider and approve the policy.

RECOMMENDATIONS

Prevention and Management of Violence, Abuse and Harassment In the Workplace Policy & Procedures

Date of Policy: 2008 Author: Catherine Roper

Date For Review: September 2011

Type:	Prevention & Management of Violence, Abuse and Harassment In the Workplace Policy & Procedure	Version: Ref:	1	Directorate:	Corporate

Aim:	To provide staff with guidance in managing the risks associated with violence, abuse and harassment at work.
Scope (who it applies to) :	This policy applies to all employees irrespective of grade, level, location or staff group working in the Trust

Ratified by: Date:	Health & Safety Committee Management Board
Final Approval by: Date:	Trust Board
Approval Signatories	Chief Executive
Implementation Date:	

Review and consultation process (when review required & by whom):	August 2011	
Responsibility for Implementation:	Director of Workforce & Organisational development	
Revisions:		
Date:	Author:	Description of Revision (Action by whom):

HISTORY

Review date:		Effective from:	
Effective to:			
Action Required by Trust/Dept			
Distribution methods:	All staff via Global email, Global U Drive, Intranet Please note that the electronic version of this document on U Drive is the only version maintained. Any printed copies may not necessarily contain latest updates and should be compared to the version on the U Drive.		

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1. Policy Statement

Birmingham Women's NHS Foundation Trust is committed to ensuring that all staff employed by the organisation are able to undertake their roles without the risk or threat of verbal or physical violence or abuse.

2. Scope of the Policy

This document describes the procedures to enable staff to prevent and manage situations where they are faced with any violent or abusive behaviour. It applies to all staff directly employed by the Trust in all working locations.
It may be adopted by the Independent Contractors within the boundaries of Birmingham Women's NHS Foundation Trust.

3. Definitions
For the purpose of this document the following definitions apply. Examples are also included for guidance:-

- ***Violence:***

"any incident where staff are abused, threatened or assaulted in circumstances relating to their work; involving an explicit or implicit challenge to their safety, well being or health" (NHS zero tolerance zone campaign)

  - The application of force, severe threat or serious abuse, by members of the public towards people, arising out of the course of their work, whether or not they are on duty.
  - Severe verbal abuse or threat, where this is judged likely to turn into actual violence.
  - Serious or persistent harassment (including racial or sexual harassment.)
  - Threat with a weapon, major or minor injuries, or fatalities
  (Skelmersdale Report 1988)

- ***Harassment:***

"Any conduct, based on age, sex, sexual orientation, gender assignment, disability, HIV status, race, colour, language, religion, political, trade union or other opinion or belief, national or social origin, associated with a minority group, domestic circumstances, property, birth or other status, which is not reciprocated or wanted and which affects the dignity of all men and women at work." (GWC Equal Opportunities)

- ***Verbal abuse:***

This list of examples is not exhaustive:-

  - Offensive language or innuendo
  - Sexist, racist or patronising remarks.
  - Racist, sectarian or sexually suggestive jokes or derogatory remarks.
  - Inappropriate or intimate questioning; uninvited, unreciprocated, unwelcome behaviour of a sexual nature.
  - Propositions and offensive remarks.
  - Name calling, including personal comments about physical looks.
  - Spreading malicious rumours or hurtful gossip
  - Threats of physical assault to staff or their family

- ***Physical Abuse:***

This list of examples is not exhaustive:-

  - Unwanted physical contact
  - Explicit physical gestures or attacks
  - Suggestive gestures (such as mimicking the effects of a disability)
  - Unnecessary touching or assault
  - Stalking which occurs at work or outside work, but is related to work

- ***Written Abuse:*** e.g.
  - Letters, faxes, e-mails or texts(often anonymous)

- ***Intimidation:*** e.g.

- Slander.
- Conduct that belittles in some way such as shouting at.
- Intrusion by pestering, spying, following.
- Unnecessary closeness.
- Apportioning blame wrongly.

- ***Displays of offensive material***: e.g.
  - Flags and emblems
  - Badges
  - Graffiti
  - Unnecessary highlighting of material.

- ***Bullying:*** e.g.
  Persistent, offensive, abusive, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanction, which makes the recipient feel threatened, humiliated or vulnerable, which undermines their self-confidence, and which may cause them to suffer stress.

- ***Aggression***: (Collins English Dictionary)
  - An attack or harmful action.
  - An offensive activity.

- ***Assault***: (Collins English Dictionary)
  - A violent attack either physical OR verbal.

- ***Lawful Visitors***:

Those persons with expressed or implied authority to enter the premises. Implied authority will vary depending on the circumstances and whether the person will have a valid reason to be in a particular location.

IF IN DOUBT – REPORT IN ACCORDANCE WITH THE INCIDENT REPORTING PROCEDURE

4. Background

Various additional information already exists which supports the Trust position. This includes legislation, requirements of external regulatory bodies and other Trust Policies and Procedures as listed below.

4.1 Principle Legislation

- The Health & Safety at Work etc. Act 1974

The Health and Safety at Work Act 1974 requires employers to provide safe working practices, environments and equipment/substances to maintain the health, safety and welfare of its employees, as far as is reasonably practicable. This includes the management of work related violence, abuse and harassment.

- The Management of Health & Safety at Work Regulations 1999

The Management of Health and Safety Regulations place an obligation on employers to look for and then control risks before incidents occur. They require all employers and self

employed people to assess the risks to staff / patients and any others who may be affected by their work or business. This is a ‘predict and prevent’ strategy rather than a ‘react and rectify’ strategy, which would be implemented following an incident.

- Data Protection Act 1998
- Crime and Disorder Act 1988

4.2 External Regulating Agencies

- Health and Safety Executive
- National Patient Safety Agency
- NHS Counter Fraud and Security Management Service
- NHSLA Risk Management Standards for Acute Trusts

4.3 Links to other Trust Policies /Procedures

- Health and Safety Policy
- Risk Management Strategy
- Risk Assessment TSP
- Lone Workers Policy
- Incident /Near Miss Reporting and Management Procedure.
- Occupational Health Policy
- Bullying and Harassment Policy
- Learning and Development Policy
- Security Policy
- Disciplinary Policy

This list is not exhaustive and it may be necessary to refer to other policies for additional information.

5. Responsibilities and Accountabilities

Specific responsibilities in relation to this procedure are as follows:-

5.1 Risk Manager will:-

- ♦ Maintain the central register of all Corporate/ Directorate/Departmental risks and action plans.
- Provide a 6 monthly report of all incidents involving abusive or violent behaviour, including all actions taken as a result, for presentation to the Health and Safety Committee.
- ♦ Provide advice and support to the Directorate Managers and staff as required
- ♦ Inform the PCT Clinical Governance Lead of all violent and abusive incidents

5.2 Directorate Managers will:-

- ♦ Provide adequate resources to reduce or control the risk, including training opportunities as necessary
- ♦ Monitor action taken to eliminate, control and reduce risks in the area of responsibility.
- Update the Risk Register as appropriate
- Notify the HSE of all incidents reportable under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.)

5.3 Heads of Department will:-

- Identify and implement action(s) required to eliminate, reduce and control the risks of violence, abuse and harassment, in consultation with their employees.
- Ensure that records are kept of all risk assessments relevant to the area

- Identify the training needs of staff within their service/department, with respect to the prevention and management of violence and aggression, as part of the annual Personal Development Review.
- ♦ Devise and implement procedures in consultation with staff, for staff to follow in the use of panic alarms, where appropriate
- Carry out a drill of this procedure at least once annually with staff.
- Ensure that support and debriefing is ALWAYS provided for employees following violent incidents.
- ♦ Ensure that a post incident analysis is carried out for all incidents involving violence and aggression.
- ♦ Treat all incidents, where employees “feared for their own safety”, as category red in line with the Incident Reporting Procedure

All managers have a direct accountability for the management of violence and aggression in their area/service and should consider the list of potential causative factors and preventative measures contained in Appendices 1 and 2.

5.4 Occupational Health Service Department will :
- Ensure relevant counselling is provided for staff, following referral from individuals or managers.

5.5 Employees will:
- Assist in the development of local procedures for the prevention and management of violence and aggression in their service/department.
- Follow any local procedures, implemented by their Service/Departmental Managers and Support Managers, to prevent violent and abusive incidents.
- Report any violent and abusive incidents and near misses in accordance with the Incident Reporting Procedure.
- Ensure their own behaviour does not increase the likelihood of a violent /aggressive incident occurring.
- Attend relevant training when identified through the risk assessment process.

6. Preventing Violence and Aggression

6.1 The Trust will provide appropriate signage throughout its premises informing the public of its expectations of their behaviour and the measures it may take to enforce this.

6.1 The Trust does not expect employees to put themselves at risk for the sake of their patients. The situations where Trust employees may be subjected to violence include:

- Providing care
- Giving or withholding a service
- Exercising authority
- Working with people who are emotionally or mentally unstable.
- Working with people who are under the influence of drugs or alcohol.
- Working with people under stress.
- Working alone
- Working outside normal hours, particularly at night.
- Handling valuables(including drugs)
- Travelling in the community.

7. Action to be taken if a violent incident occurs.

7.1 Employees have a duty not to put themselves or their colleagues at risk. Where necessary staff should refer to local support mechanisms which may include in-house security, alarms and the police where the situation requires.

7.2 No member of staff should tolerate any level of physical or non-physical abuse and in order to ensure immediate safety staff should leave situations where they may or are being assaulted, threatened or intimidated. This may include:

- discontinuing telephone calls
- terminating appointments with patients
- leaving visits to patients
- leaving the neighbourhood (in the case of community staff).

7.3 Physical intervention is NOT encouraged and should only be carried out by staff who have been trained in these techniques.

7.4 There may be occasions when employees are subjected to verbal abuse etc from other employees. This is NOT acceptable and staff should also report this using the Bullying and Harassment Policy, as well as documenting the occurrence in accordance with the Incident Reporting Procedure.

7.5 The Trust has to balance its ability to deliver effective care and treatment with the needs of the patients. There may be circumstances in which it would be reasonable to withhold treatment from violent and abusive patients. This will always be as a last resort to ensure the safety and security of employees.

8. Maintaining services to patients

8.1 If the perpetrator of a violent incident is a patient requiring further treatment or care from staff, arrangements must be made by the responsible manager to endeavour to provide this without any further risk to staff. This action will include:

- informing patients of the Trust's policy regarding violence and aggression to staff
- ensuring that all staff, including those working for the PCT, FHS providers and NHS Trusts, who may come into contact with the perpetrator of a violence incident are made aware of the possibility of further violence and of the steps being taken to prevent this
- making arrangements for home visits and clinic appointments so that staff are protected such as visits being made by staff working in pairs, clinic appointments at specific times of the day, clinic appointments in the presence of a security officer.

8.2 If the responsible Manager considers that safe arrangements cannot be made then they must notify the Director of Nursing and Midwifery/Medical Director.

8.3 The Director of Nursing and Midwifery/Medical Director will confirm the action to be taken.

9. The Legal Position

9.1 In determining what action can be taken against abusive members of the public or visitors, the first point to consider is who is allowed on the Trust's premises i.e. lawful visitors.

9.2 If an out–patient/day patient becomes threatening and violent towards staff then the most senior person may decide to ask them to leave Trust's premises. If they refuse to leave the Police must be contacted to assist.

9.3 If a patient/relative/visitor or carer becomes threatening and violent, towards staff, in the patients/clients own home, and then the employee should leave immediately.

9.4 The decision to either provide the treatment in other premises or to withdraw treatment must be made by the Directorate Manager in consultation with the Director of Nursing and Midwifery/Medical Director.

9.5 Withholding treatment will ***ONLY*** be appropriate where violent and abusive behaviour is likely to:

- Prejudice any benefit the patient might receive from the care or treatment.
- Prejudice the safety of those involved in giving the care or treatment.
- Lead the member of staff offering care to believe that he/she is no longer able to undertake their duties properly.
- Prejudice the safety of other patients present at the time.
- Results in damage to property inflicted by the patient or as a result of containing them.

9.6 It will be inappropriate to withhold treatment/care from the following:-

- Patients, who in the expert judgment of a relevant clinician are not competent to take responsibility for their action e.g. an aggressive individual, who becomes violent as a result of an illness or injury.
- Mentally ill patients who may be under the influence of drugs and/or alcohol.
- Patients who, in the expert judgement of a relevant clinician, requires urgent emergency treatment.
- Other than in exceptional circumstances, any patient under the age of 16.

9.7 The withholding of treatment is time limited for a period of no more than 12 months with review every 6 months. However, the sequence of warnings and repeated withholding of treatment will recommence following further violent and abusive incidents.

9.8 Incidents of aggression or abuse by a member of staff will be dealt with in accordance with Trust disciplinary procedures.

10. Support for Staff

10.1 The Trust acknowledges that there may be occasions when staff may be affected physically or emotionally following a violent incident. Managers need to be aware that individuals will need active support and possibly counselling, especially after the incident and on returning or resuming work. This is particularly important given the potential impact of stress on the employee's current or future health.

10.2 Professional counselling can be arranged through the Trust's Occupational Health Services, if required. The Trust also employs an independent counselling service which staff can access confidentially.

11. Monitoring

11.1 The Trust's Health and Safety Committee is responsible for monitoring and reviewing the implementation of this policy and for receiving reports from the Risk Manager regarding all violent or abusive incidents and the actions taken or planned as a result.

11.2 Key Performance Indicators for implementation of the policy are:-

- Evidence of staff attending relevant training, identified as part of the risk assessment process.
- Evidence that Service/Departmental risk assessments have considered workplace violence and aggression.
- Evidence of local procedures for the prevention and management of violent and aggressive incidents.

12. References

- The Health and Safety at Work etc Act 1974 (HSW Act)
- The Management of Health and Safety at Work Regulations 1999
- The Reporting of Injuries, Diseases and Dangerous Occurrences
- Regulations 1995 (RIDDOR)
- www.hse.gov.uk
- Safety Representatives and Safety Committees Regulations 1977 (a)
- The Health and Safety (Consultation with Employees) Regulations 1996 (b)

Managers Checklist **Appendix 1**

The following should be considered when identifying the risks of Violence, abuse and harassment to staff. This list is not exhaustive.

- Unpredictable and unremitting workloads which often lead to fatigue and a diminished ability, both to identify at an early stage and to subsequently cope with potentially violent situations.
- The need to provide cover for nights, weekends and changeover periods between shifts.
- Individuals must not be left isolated for long periods, nor should junior or inexperienced staff have to cope alone, especially in situations where there is a recognised potential for violence, or where patients (and/or friends and /or relatives) may take advantage. See also Lone Worker Policy.
- Where there is a well established risk, an agreed minimum number of appropriately qualified staff should be on duty at any one time. Where appropriate, nursing staff will be designated to a patient who requires "special" observation.
- Attention should be taken in relation to any reduction/cessation of anti-psychotic drugs or alcohol withdrawal and an appropriate psychiatric opinion sought.
- As part of the risk assessment process, identify the training needs of their staff, with regard to violence and aggression.
- Lone Working.

Preventative Measures **Appendix 2**

The following should be considered to keep the likelihood of violence and aggression as low as possible:

1. Keep patients and visitors informed particularly in situations of acute distress and/or long waiting periods.

2. Keep staff informed: Information about clients/patients who are being cared for within different services/departments must be communicated in both written and verbal form. Particularly when:
   - New members of staff are involved.
   - New patients are admitted.
   - Change in the patient's medical/physical state, medication, behaviour of moods.
   - Known violent patients/clients being transferred /referred. In these situations staff should check the transfer/referral letter and obtain additional information prior to working alone.
   - Where domiciliary visits are made to patients/clients with a known or suspected history of aggressive or violent behaviour. (See Lone Working TSP)

3. Environment:
   Individuals may be anxious or apprehensive about unfamiliar surroundings or procedures.
   It is important that the workplace environments and surroundings are subject to risk assessment. This is equally important in the domiciliary setting as well as in the clinic/health centre.
   - Employees should pay particular attention to layout of ALL rooms including those in domiciliary settings where they provide care/treatment. E.g. Employees are nearer the door than patients; removal of items which could be used as a weapon, if there is a known risk.
   - Panic alarms are easily accessible.
   - Procedures should be devised AND implemented for staff to follow in the event of the panic alarm being sounded and a drill conducted at least once annually.
   - Reception staff should never be left isolated.
   - Ideally clinic rooms cannot be accessed without passing by Reception.
   - As far as possible one person should not open or lock up premises alone in darkness.
   - When clinics are in use out of main office hours, staff should use clinic rooms in close proximity to each other.
   - Never enter a location if there is ANY doubt about personal safety. E.g. if the person answering the door gives cause for concern or the patient is not in.
   - Remain aware of the domiciliary environment. E.g. escape routes in case problems arise.
   - Follow occupants in when entering houses and other buildings.

4. Arrange for patients/clients to be seen at a clinic/health centre rather than at home, if at all possible.

5. Arrange for another member of staff or a reliable relative of the patient/client to be present during the visit. E.g. if a member of staff is vulnerable to sexual harassment while visiting a member of the opposite sex.

6. Providing a taxi, if appropriate in areas where cars may be vandalised, or staff have to go through unsafe areas to make visits.

7. Training
It is important that staff are equipped with the skills and techniques which will enable them to deal with potential or actual violent incidents confidently and competently. Training in the prevention and management of violence and aggression must be made available to ALL front line staff who come into contact with patients/clients and relatives and regularly updated.

Comment: We must be clear about how this is provided, what it should contain and who should received the training before the policy should be implemented.

Assessment may identify additional training needs in methods to diffuse aggression and methods of physical control.

Training should include:

- Interpersonal skills
- Prevention and continual assessment of risk
- Managing aggression and de-escalation techniques.
- Conflict resolution training as identified by Counter Fraud and Security Management Services.

Appendix 3

FLOWCHART of action to take following ALL violent or abusive incidents

INCIDENT

- Document the incident in accordance with the Incident Reporting Policy completing all relevant sections on the same day
- If the individual affected *" feared for their own safety"* contact the relevant Locality/Service/Departmental manager, operational manager or on-call manager immediately

SERVICE/DEPARTMENTAL MANAGER

- All incidents in which the individual affected *"Feared for their own safety"* will be classed as Major and therefore subject to a full Root Cause Analysis
- Enable affected individual to access counselling if required.
- Inform the relevant Directorate Manager or on call manager

DIRECTORATE MANAGER

- In cases where a member of staff is the perpetrator, instigate the disciplinary procedure
- In the case of a patient or member of the public being the aggressor, identify if a letter is required (Stage 1 or 2) WITHIN 2 WORKING DAYS

HAS THE AGGRESSOR BEEN INVOLVED IN A SIMILAR INCIDENT BEFORE? (if a patient or member of the public is the aggressor)

NO

- Implement Warning Stage 1 if appropriate (Appendix 4)

√ Letter 1 to go within 5 WORKING DAYS
√ Letter 2 to go within 5 WORKING DAYS

YES

- Implement Withdrawing Services Stage 2 if appropriate (Appendix 6)

√ Letter 3 to go within 5 WORKING DAYS
√ Letter 4 to go to GP within 5 WORKING DAYS

Appendix 4

WARNING STAGE 1

1. An incident form must be completed by each member of staff involved ensuring all relevant fields are completed in accordance with the Incident Reporting Policy.

2. The Directorate Manager will prepare letters 1 and 2 and obtain the signature of the Chief Executive prior to posting WITHIN 5 WORKING DAYS with a copy of the policy, pages 1-10, attached.

3. A copy of the letters should be sent to the PCT Clinical Governance Lead

4. Review the incident with area/service/departmental manager, the appropriate Directorate Manager, the Director of Nursing Services/Medical Director and the PCT Clinical Governance Lead.

5. The full process must be recorded in the patient's care documentation.

6. This procedure to be used for every occasion an incident has occurred.

7. Any patient behaving unlawfully will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will prosecute perpetrators of crime on or against Trust property, assets and staff.

Clinical Review Checklist **Appendix 5**

The Birmingham Women's NHS Foundation Trust has a duty to provide a safe and secure environment for patients, staff and visitors. Violent or abusive behaviour will not be tolerated, and decisive action will be taken to protect staff, patients and visitors.

Those patients who, in the expert judgement of the relevant clinician, are not competent to take responsibility for their actions, will not be subject to this procedure. In the event of inappropriate behaviour by a patient, and following careful review by the appropriate Directorate Manager, the Director of Nursing Services/Medical Director and the PCT Clinical Governance Lead, the Withdrawing Services Stage 2 can be instigated.

Review to include (please delete)

♦ Is the patient/relatives known to have a history of violence?
Yes/No

♦ Is the patient suffering from a medical condition to cause him/her to be violent?
Yes/No

♦ If yes, what? …………………

♦ Has the patient suffered from a previous head injury?
Yes/No. If Yes insert date injury occurred…………..

♦ Is the patient suffering from mental illness?
Yes/No

♦ Does the patient have a history of alcohol abuse?
Yes/No

♦ Does the patient have a history of drug abuse?
Yes/No

♦ Agreement that the Alert Code is to be used
Yes/No

Comments / action:

WITNESSES FOR THE TRUST

(Initiator of Procedure)

NAME……………………………… NAME………………………….…..

DESIGNATION …………………… DESIGNATION………………………

Signed …………………………….. Signed ………………………………..

Date ……………………………….. Date……………………………………

Appendix 6

WITHDRAWING SERVICES STAGE 2

1. The decision to withdraw treatment must be taken by the Director of Nursing and Midwifery Services/Medical Director and the relevant Directorate Manager. This does not preclude the relevant clinician discharging a patient who no longer requires care in the normal manner.

2. The Medical Director/Director of Nursing and Midwifery must inform the patient's GP of the exclusion and the reasons for it.

3. The patient must be informed that they may challenge an exclusion using the established complaints procedure.

4. The Chief Executive must be informed by the Executive Director involved in the decision and will dispatch written confirmation to the patient's home WITHIN 5 WORKING DAYS.

5. The Medical Director/Director of Nursing and Midwifery must also inform the PCT Clinical Governance Lead in accordance with the Incident Reporting Policy. A detailed record of the rationale for exclusion and of any alternative arrangements for care should be kept in the patient's health records.

6. It is essential that all premises where health care services are provided are informed of the exclusion and reminded of the actions to take if the individual enters the premises to access services and responsibility for this lies with the Clinical Governance Lead at the PCT.

7. If an excluded individual returns in any circumstances the police should be called immediately. The Trust will subsequently seek legal redress to prevent the individual from returning to Trust property.

8. Such exclusion will last for a maximum of one year, subject to alternative care arrangements being made. The provision of such arrangements will be pursued with vigour by the relevant Directorate Manager.

9. Any patient behaving unlawfully will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will prosecute perpetrators of crime on or against Trust property, assets and staff.

Letter 1

Letter to the Aggressor - Warning Stage 1
(This letter is for guidance. Additional information may be added BUT DO NOT omit.)
Date
Re: Relatives
Relatives: address
Relatives: date of birth
Relatives: hospital number
Dear

I write further to your unacceptable behaviour in xxxxx. (Insert Clinic / ward/ address of where violence took place) on (insert date) xxxxxxxxxxx and to confirm to you that the Trust will be applying its Prevention and Management of Violence, Abuse and Harassment Policy & Procedure. This is in respect of your actions on these premises on this date.

The staff in xxxxx(insert Clinic/.Ward/ address of where violence took place) felt extremely threatened by your behaviour, which put themselves [and other patients and visitors] at risk. Birmingham Women's NHS Foundation Trust strives to provide a high standard of care to all patients, and your behaviour will not be tolerated in any area of the Trust or against any of its staff.

The Trust has followed the conditions outlined in its Policy which addresses individuals who are violent and abusive. This means that:
- Incident forms have been completed by staff,
- A letter will be sent to your GP advising them of this incident
- A record of this incident will be placed on your/ your relative's* records.

Should you on any occasion in the future fail to comply with the expected standards of behaviour detailed in the accompanying leaflet the Trust will have no alternative but to * withdraw services and / or make a full report to the Police.

Your GP would also be advised in order that your/ your relative's treatment can be provided in a more appropriate setting.

If you have any queries, or require any further information please contact me.

Yours sincerely

J.Burgess
Chief Executive
Birmingham Women's NHS Foundation Trust.
Note: A COPY OF THE SAFETY PROCEDURE SHOULD BE ATTACHED.
* delete as appropriate.

Letter 2
(This letter is for guidance. Additional information may be added BUT DO NOT omit.)
Letter to GP – Warning Stage 1

GP's name and address
Date
Re: Patient's
Patient's address
Patient's date of birth
Patient's hospital number

Dear
The above individual is currently receiving treatment at xxxxx (insert Clinic/Ward/address of where violence took place)

In order to protect the *environment/ other patients/ members of staff*, it has been necessary to instigate the Warning Stage procedure for individuals who are violent and/or abusive.

This Warning Stage requires the Trust to:
- Complete the appropriate incident forms,
- Issue a written warning to the patient about their behaviour.
- Issue a letter to you their GP advising them of this incident.
- Place a record of the incident on their care records.

If the patient continues to behave in a violent and threatening manner the Trust will withdraw all services for a maximum of 12 months.

This will also involve their immediate exclusion from the Trust premises and /or a full report made to the Police.

If you have any queries, or require any further information please contact me.

Yours sincerely

J.Burgess

Chief Executive
Birmingham Women's NHS Foundation Trust.
Note: A COPY OF THE SAFETY PROCEDURE SHOULD BE ATTACHED
*delete as appropriate

Letter 3
Letter to the Aggressor - Withdrawing Services Stage 2

(This letter is for guidance. Additional information may be added BUT NOTHING omitted.)

Date
Re: Relatives
Relatives: address
Relatives: date of birth
Relatives: hospital number

Dear

I write further to your repeated unacceptable behaviour in xxxxx (insert Clinic/Ward/ address of where violence took place) on (insert date) xxxxxxxxxxx and to confirm to you that the Trust will be applying its Prevention and Management of Violence, Abuse and Harassment Policy. This is in respect of your actions on these premises.

The staff in xxxxx (insert Clinic/.Ward/address of where violence took place) felt extremely threatened by your behaviour, which put themselves [*and other patients and visitors] at risk.
(insert details of this behaviour)
Birmingham Women's NHS Foundation Trust strives to provide a high standard of care to all patients, and your behaviour will not be tolerated in any area of the Trust or against any of its staff.

The Trust has followed the conditions outlined in its Policy which addresses individuals who are violent and abusive. This means that: [add to this list as necessary]

- Incident forms have been completed by staff,
- You have already received a written warning about your behaviour
- A report has been made to the Police.
- A record of this incident will be placed on your/ your relative's records.

The decision has therefore been taken to withdraw all clinical services involved in your care for **a maximum of 12 months**. Your GP has also been advised in order that * your/your relatives care can be provided in a more appropriate setting.
You may challenge an exclusion using the established complaints procedure.

Yours sincerely

J.Burgess
Chief Executive
Birmingham Women's NHS Foundation Trust.
• delete as appropriate

Letter 4

Letter to GP - Withdrawing Services Stage 2

(This letter is for guidance. Additional information may be added BUT NOTHING omitted.)

Date
Re: Relatives
Relatives: address
Relatives: date of birth
Relatives: hospital number

Dear

The above individual is currently receiving treatment at xxxxxx(insert Clinic/Ward/address of where violence took place)

They have been involved in a subsequent violent and abusive incident for which the Trust has followed the conditions outlined in its Policy which addresses individuals who are violent and abusive. This means that:

- A written warning has been issued
- Incident forms have been completed by staff,
- You have been informed of previous incident(s)
- A report has been made to the Police.

As a result of their behaviour, the Trust has withdrawn all services for a maximum of 12 months.

If you have any queries, or require any further information please contact me.

Yours sincerely

J.Burgess
Chief Executive
Birmingham Women's NHS Foundation Trust.

SUBJECT :	First Aid Policy
REPORT BY:	Neil Savage Estelle Carmichael
AUTHOR :	Catherine Roper Risk Manager

CONTEXT AND BACKGROUND FOR REPORT

The First Aid Policy has been written to provide clear information to employees in line with Health and Safety legislation. There was no policy previously.
It has been discussed and agreed by the Health and Safety Committee.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board are asked to consider and approve the policy.

RECOMMENDATIONS

First Aid Policy

Date of Policy: **June 2008** **Author: Catherine Roper**
Reviewed:

Next Review Date: **June 2011**

Type:	First aid Policy	Version: Ref:	1	Directorate:	All, Trust Wide

Aim:	To provide guidance for all staff in the provision of first aid, in line with Health and Safety legislation.
Scope (who it applies to) :	This policy applies to all employees irrespective of grade, level, location or staff group.

Ratified by: Date:	Health & Safety Committee Clinical Governance Committee Management Board
Final Approval by: Date:	
Approval Signatories	Chief Executive
Implementation Date:	

Review and consultation process (when review required & by whom):	June 2011 Risk Manager
Responsibility for Implementation:	

Revisions:		
Date:	Author:	Description of Revision (Action by whom):

HISTORY

Review date:		Effective from:	
Effective to:			
Action Required by Trust/Dept			

Distribution methods:	All staff via Global email, Global U Drive, Intranet Please note that the electronic version of this document on U Drive is the only version maintained. Any printed copies may not necessarily contain latest updates and should be compared to the version on the U Drive.

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1. Policy Statement

1.1 It is possible that staff, contractors or members of the public may suffer injury or sudden illness on Trust premises. It is essential that they receive prompt and appropriate care and attention to save lives and prevent minor injuries becoming major ones.

1.2 As the Trust does not provide Accident and Emergency services it will be necessary for other appropriately trained staff to provide first aid.

1.3 This policy sets out the Trust's commitment to this aim and the responsibilities and arrangements in place to ensure it is implemented.

2. Background

2.1 Although a high proportion of staff working in the Trust are already skilled in dealing with first aid emergencies, it is necessary to clarify who is responsible for providing such care, in what circumstances and what support will be available, including equipment.

3. Definitions

3.1 First Aider
This means individuals who have undergone an HSE approved training course in administering first aid at work and hold a current *First Aid at Work Certificate*. They will only give treatment for which they have been trained.

3.2 Appointed Person
When the first aid needs risk assessment identifies that a first aider is not necessary, the minimum requirement is to appoint a person that takes charge when someone is injured or falls ill (including calling an ambulance if required) and looks after first aid equipment. They will only give treatment for which they have been trained. All trained nursing and medical staff are considered 'Appointed Persons'.

3.3 Nominated Person
This means staff in either of the above 2 categories are responsible for managing injury or ill-health in staff and others on Trust premises.
In clinical areas there should be a number of staff who are able to assume this responsibility. However, non clinical areas may need to specifically allocate the responsibility (including deputies and out-of-hours provision). In these cases, the Nominated Staff will be designated either 'First Aider' or 'Appointed Person'.

4. Roles and Responsibilities

4.1 In order to ascertain that it would be possible to provide first-aid response to emergencies at all times, including the use of peripatetic (mobile) staff if necessary, the Directorate Management team shall ensure that:-

- Ward/Department managers carry out local risk assessment to determine local needs for first-aid provision
- each ward/department has nominated staff to manage injury/ill health emergencies

- appropriate training is provided for the nominated staff
- there is provision of appropriate first-aid equipment/facilities where necessary
- there is effective local management of first-aid equipment/facilities
- effective recording of incidents/treatment given takes place
- staff are aware of the arrangements in their workplace

4.2 All Managers must ensure the effective implementation of this policy.

4.3 Ward/Department Managers must ensure:-

- risk assessment is completed to determine local needs
- appropriate First Aider/Appointed Persons are nominated
- adequate provision and maintenance of First Aider/Appointed Persons training
- adequate provision and management of equipment/facilities
- the names of nominated persons and the location of First Aid equipment are displayed
- staff are aware of the local arrangements

4.4 Nominated Staff must:-

- provide care of injuries and ill-health in accordance with training and capabilities
- document a complete record of treatment and incidents
- take charge/assist those in charge of emergency situations
- maintain first-aid equipment/facilities
- ensure any incident and treatment given is recorded on an Incident Report form
- maintain personal competence to the required standard

4.5 All staff must:-

- take reasonable care for themselves and others
- co-operate with the implementation of this policy

5. Risk Assessment

5.1 First aid risk assessment will be carried out by Ward/Department Managers in accordance with Trust Policy.

5.2 The assessment will determine what measures should be taken to ensure the effective implementation of this policy in their workplace.

5.3 Key considerations in such assessments will include:

- workplace hazards and risks
- the size of the department
- the department's history of accidents
- the nature and distribution of the workforce
- the remoteness of the site from emergency medical services
- the needs of travelling, remote and lone workers
- employees working on shared or multi-occupied sites

- public access
- annual leave and other absences of first aiders and appointed persons.

5.4 Further advice on completing such a risk assessment can be found in the HSE leaflet *'First Aid at Work – Your Questions Answered' (INDG214).*

6. Training

6.1 In most areas the presence of trained nursing/medical staff will ensure adequate provision of nominated staff and no further training will be necessary.

6.2 Where this is not the case, the following training may be appropriate following risk assessment:

- First Aid at Work Certificate

A four day HSE-approved training course, refreshed every three years. Given the proximity to nursing and medical staff at all sites, there will be little requirement for this type of training. However, some exceptions may occur where there is a job requirement or a risk assessment indicates the need.

- Emergency First Aid Training

A four hour training course including what to do in an emergency (e.g. CPR, care of the casualty, control of bleeding). An annual update training session is necessary. This training is appropriate for Appointed Persons in non-clinical areas.

6.3 All staff will be made aware of first aid provision as part of their Health and Safety awareness training.

7. Equipment/Facilities

7.1 In close proximity to nursing/medical services basic equipment and facilities will be readily available.

7.2 In areas where a risk assessment requires local arrangements then a first-aid kit must be kept readily available.

7.3 The contents of a first aid kit will be based on the risks in the area concerned but as a guide should contain:

- one leaflet giving basic advice on First Aid at Work
- twenty individually wrapped sterile adhesive dressings (assorted sizes) appropriate to the work environment (which must be detectable for the catering industry);
- two sterile eye pads, with attachment;
- 4 individually wrapped triangular bandages;
- 6 safety pins;
- 6 medium sized individually wrapped sterile unmedicated wound dressings (approx 12 cm x 12 cm);
- 2 large sterile individually wrapped unmedicated wound dressings (approx 18 cm x 18 cm);
- 1 pair of disposable gloves

7.4 Additional items that may be required and, as identified by the risk assessment, should be stored close by e.g. protective clothing, eye irrigation fluid.

7.5 Any items in the first aid box that have passed their expiry date or appear unfit for purpose should be disposed of safely.

7.6 Tablets and medication must not be kept in the first aid box.

7.7 The contents of kits must be checked regularly, restocked after use and maintained by a Nominated Person.

7.8 All first aid boxes must have a white cross on a green background.

8. Recording Treatment

8.1 All treatment given by First Aiders/Appointed persons must be recorded on the Incident Report form along with full details of the incident including:-

- date, time and place of incident
- name (and job role if working at the time) of the injured or ill person
- details of the injury/illness, how it occurred and what first aid was given
- what happened to the person immediately afterwards (for example went home, went back to work, went to hospital)
- name and signature of the first aider or person dealing with the incident.

9. Monitoring and Audit

9.1 Monitoring of all aspects of this policy will be included in the rolling Health and Safety audit programme.

10. References

www.HSE.gov.uk

SUBJECT :	Display Screen Equipment Policy
REPORT BY :	Neil Savage Estelle Carmichael
AUTHOR :	Catherine Roper Risk Manager

CONTEXT AND BACKGROUND FOR REPORT

The policy has been revised and updated to ensure that it reflects current Health and Safety requirements.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board are asked to consider and approve the policy.

RECOMMENDATIONS

Display Screen Equipment Policy

Date of Policy: 2002

Author: D Halliley/Occupational Health and Safety Dept. UHB

Reviewed: September 2008

Next Review Date: September 2011

Type:	Policy for the safe use of Display Screen equipment	**Version: Ref:**		**Directorate:**	All, Trust wide

Aim:	To provide guidance for all staff in the safe use of display screen equipment
Scope (who it applies to) :	This policy applies to all employees irrespective of grade, level, location or staff group.

Ratified by: Date:	Health & Safety Committee Clinical Governance Committee Management Board
Final Approval by: Date:	
Approval Signatories	Chief Executive
Implementation Date:	

Review and consultation process (when review required & by whom):	September 2011 Risk Manager
Responsibility for Implementation:	

Revisions:		
Date:	**Author:**	**Description of Revision (Action by whom):**
September 2008	C Roper	

HISTORY

Review date:	September 2011	**Effective from:**	
Effective to:			
Action Required by Trust/Dept			
Distribution methods:	All staff via Global email, Global U Drive, Intranet Please note that the electronic version of this document on U Drive is the only version maintained. Any printed copies may not necessarily contain latest updates and should be compared to the version on the U Drive.		

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1 Background

The Health and Safety (Display Screen Equipment) Regulations came into force in 1993 and were later amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002. The Regulations promote the need for an ergonomics approach in assessing and reducing the risks of injury associated with the use of Display Screen Equipment (DSE).

2 Policy Statement

The Trust recognises the Health and Safety (Display Screen Equipment) Regulations 1992, the Health and Safety (Miscellaneous Amendments) Regulations 2002 and the need to provide a safe environment for its employees, volunteers, contractors, visitors and patients, as far as is reasonably practicable. This Policy is concerned with all aspects of usage, including posture and furniture, visual factors, breaks, environment and training. It is intended to minimise health risks, in particular, the incidence of work related upper limb disorders.

The Trust intends to:

- Assess the risks associated with Display Screen Equipment use
- Take appropriate action to reduce such risks.

3.Definitions

3.1 Display Screen Equipment (DSE):

Any alpha-numeric or graphic display screen, regardless of the display process involved including:-

- conventional (cathode-ray tube) display screens
- other types such as liquid crystal or plasma displays used in flat-panel screens
- touchscreens
- other emerging technologies
- display screens mainly used to display line drawings, graphs, charts or computer-generated graphics
- screens used in work with television or film pictures
- non-electronic display systems such as microfiche

DSE in both office and non-office (eg clinical area) environments are included.

3.2 A Display Screen Equipment user is a person who fulfils most or all of the following criteria:

- is dependent on DSE to do their job
- has no discretion on the use of DSE
- needs significant training and skills
- uses DSE for an hour or more at a time
- uses DSE more or less daily
- needs rapid input and output of information
- has high levels of attention and concentration

3.3 Workstation:

The assembly comprising:

- Display screen equipment
- Any optional accessories to the display screen equipment
- Any disk drives, telephone, modem, printer, document holder, work chair, work desk, work surface or other item peripheral to the display screen equipment
- The immediate work environment around the display screen equipment

3.4 Work Area:

The area defined by line management responsibility.

4. Responsibilities

4.1 Employees must:

- read and comply with this policy and any local procedures for Display Screen Equipment use in their work area.
- complete a DSE Self-Assessment Form (available on U:\Risk Management\Risk Assessment Forms)
- inform their line manager of any difficulties or concerns they have with Display Screen Equipment use in their work area.
- report all incidents relating to Display Screen Equipment to their line manager.
- report all incidents relating to Display Screen Equipment using the Trust Incident Reporting procedures.
- advise their line manager of any change in circumstances, which will require a review of their Display Screen Equipment work, workstation and work area.

4.2 Employees classed as DSE users must:

- attend a “Healthy Working with Computers” training session and put the training into practice.

4.3 Clinical Directors and Directorate Managers shall co-ordinate Display Screen Equipment issues by ensuring that:

- adequate numbers of staff are trained in the DSE risk assessment process
- risk reduction action-plans are drawn up.
- action plans are prioritised and progressed.
- resources for action plans are allocated in the annual business plan.
- resources for eyesight testing (and corrective lenses, where applicable) are allocated in the annual business plan.

- all DSE users attend a “Healthy Working with Computers” training session within two months of their start date .

4.4 Line managers shall:

- identify employees who are DSE users.
- request that a DSE assessor carries out an assessment for DSE users as necessary
- ensure that all agreed action plans are progressed.
- ensure that all DSE users receive adequate training as detailed in 6.2
- maintain records of all training
- ensure that working activities are such that DSE users are able to take frequent short breaks from screen work
- ensure that all Display Screen Equipment incidents are reported and investigated in accordance with the Trust Incident Recording Policy and Procedures.
- issue the appropriate form to Display Screen Equipment users who request an eye sight test (Appendix 1).
- ensure that any member of staff reporting health problems that may be attributable to the use of DSE is promptly referred to the Occupational Health Department.

4.5 DSE Assessors shall:

- attend appropriate risk assessment training.
- ensure risk assessments are carried out and reviewed in accordance with Health and Safety (DSE) Regulations and retain documentation in the work area.
- prepare prioritised action plans.

4.6 Contract staff or others persons carrying out Display Screen Equipment work for the Trust will be requested to:

- Read, and comply with information in, the Trust leaflet on Healthy Working with Computers.
- Report all incidents relating to Display Screen Equipment to the appropriate line manager.
- Report all incidents relating to Display Screen Equipment using the Trust Incident Reporting procedures and forms.

4.7 The Human Resources Department will provide training for all staff and managers as required.

5.Risk Assessment

5.1 Risk assessments will be carried out and documented using the Trust Risk Assessment Form available at U:\Risk Management\Risk Assessment Forms\Display Screen Equipment Assessment Form.doc

5.2 Risk assessments will consider:

- changes of activity, work routines and breaks for users
- whether workstations and equipment comply with minimum requirements
- optimum set up of the workstation including:
  - adequate lighting, including adequate contrast with no glare or reflections
  - noise minimisation
  - comfortable temperature and humidity
  - reduction of radiation to negligible levels
  - software which is appropriate to the task and user, provided feedback on system status with no secret monitoring
  - window coverings
  - adjustable, readable, glare/reflection free screen with no flicker
  - usable, adjustable, detachable, legible keyboard with adequate space in front of the keyboard to support hands and wrists
  - glare-free work surface with adequate space for all necessary arrangements
  - adequate leg room and clearance under desk
  - chair with adjustable height and back support

5.3 Display Screen Equipment assessments should be reviewed annually or sooner if any of the following occur:

- there are changes in the individual's capability
- there are major changes to hardware, software or work furniture
- there is a substantial increase in DSE work intensity or duration
- the workstation is relocated or the work area is modified
- research findings indicate a significant new risk

6. Training

6.1 All new DSE users (including contract and agency) shall receive training in healthy working with computers within two months of their start date.

6.2 User training shall include:

- health risks/effects of computer work
- optimum set-up of the workstation - good/bad practice, ergonomic features, e.g. chair comfort, undesirable features, e.g. reflection and glare
- good posture and keyboard technique

- the need to take advantage of breaks and changes in activity
- special characteristics of software
- legislative requirements and workers' rights
- the assessment checklist
- information regarding eyesight testing
- organisational arrangements for bringing problems and symptoms to the attention of the manager.

6.3 Assessors training shall be in accordance with the *Management of Health and Safety at Work Regulations 1992* and include:-

- DSE legal requirements
- health conditions related to poor use of DSE
- entitlement to eyesight testing and arrangements
- giving feedback recommendations to users

7 Monitoring

7.1 The line manager will maintain an up to date record of the following for monitoring purposes:

- list of Display Screen Equipment users
- Display Screen Equipment risk assessments and action plans including DSE Self-Assessment Forms

7.2 The Human Resources Department will provide Directorate Managers with attendance details of DSE training.

8 References

The Health and Safety (Display Screen Equipment) Regulations 1993
Health and Safety (Miscellaneous Amendments) Regulations 2002
www.HSE.gov.uk

Appendix 1

Eyesight Examination Form

DSE Users' form for Eye Sight Examination / Corrective Appliance Provision
* This form is only valid at a branch of Scrivens Optical & Hearing Ltd with a Birmingham Postcode address

About the individual

Name of employee…………………………………………………………………….

Date of birth ………………………………………….

Job title …………………………………………………………………….

Department ……………………………………………………………………..

Department Cost Code……………………………………………………………………

About the computer task

When working at the computer, about how far are the individual's eyes from:

The screen………….……………………….. Centimetres

The keyboard……………………………….. Centimetres

The work documents……………………….. Centimetres

Please indicate if the individual does any work that requires the following:

Focusing on small details / text yes / no

Visual work in low light yes / no

Other difficult visual task yes / no

Signatures

Authorising manager's name…………………………………………..

Authorising manager's signature………………………….……. ……….Date…….……….

Individual's signature……………………….…….. …………………….Date…….……….

This is a 2 page form

DSE Users' form for Eye Sight Examination / Corrective Appliance Provision

* This form is only valid at a branch of Scrivens Optical & Hearing Ltd with a Birmingham Postcode address

This part to be completed by the Optician at Scrivens*

Name of employee…………………………………………………..

Department…………………………………………………………..

Department Cost code ………………………………………………

I have examined the above patient in accordance with current professional guidelines relating to the ophthalmic criteria required to evaluate suitability for DSE work and recommend that s/he:

- Does not require corrective lenses
- Requires corrective lenses for normal use which may or may not be used for DSE work
- Requires corrective lenses incorporating a correction specifically for DSE work only.

(Cost to the employer is the equivalent to the cost of a basic appliance, ie basic frame and prescribed lenses, including the DSE correction within bifocal/varifocal spectacles – cost of £……………based on price agreement, reviewed June 2008)

A further examination, for DSE purposes should be carried out in ……. months.

Additional comments:

Signed: …………………………………..……… Date: ………………

Practice Address (Official stamp):

This is a 2 page form

ENCLOSURE 15

Subject:	Policy for the Emergency Protection of a Child Following Birth
Report by:	Jane Owen
Author:	Elaine Giles

Context and background for report

Following incidents reported both nationally and locally of babies being removed from their mother's care unlawfully it was identified that a policy was needed to inform staff of the process that must be followed.
The policy has bee adopted by all agencies involved in this process.
The policy has been through Clinical Governance Committee on 3rd October 2008.

Key issues for trust board consideration and decision:

Management Board are asked to review and approve this policy.

Implications:

Financial:	
Human Resources:	
Healthcare:	
National Policy/ Legislation:	√
Standards for Better Health	
Local Delivery Plan:	
Diversity Impact:	
Legal	√
Environmental	
Corporate Objective Number	

Recommendations:

Approve the policy.

Policy for the Emergency Protection of a Child Following Birth

Signed by:

……………………………… ……………………………………………..

Jane Owen — **Director of Nursing and Midwifery**

Peter Thompson — **Medical Director**

…………………………….

Supervisor of Midwives

Date of Policy: October 2008
Date of next review: October 2011

Authors: Elaine Giles

Type:	Policy for the Emergency Protection of a Child Following Birth	Version: Ref:	1	Directorate:	

Aim:	To provide staff with guidance for managing situations whereby a child has to be protected from harm following birth.
Scope (who it applies to) :	This policy applies to all employees irrespective of grade, level, location or staff group.

Ratified by: Date:	
Final Approval by: Date:	
Approval Signatories	Director of Nursing/ Midwifery: Medical Director: Supervisor of Midwives
Implementation Date:	October 2008
Review and consultation process (when review required & by whom):	October 2011 Lead Nurse/ Midwife for Safeguarding Children Partner agencies
Responsibility for Implementation:	Director of Nursing/ Midwifery

Revisions:		
Date:	Author:	Description of Revision (Action by whom):

HISTORY

Review date:		Effective from:	
Effective to:			
Action Required by Trust/Dept			

Distribution methods:	Hard copies to all policy folders, Global email, Global U Drive, Intranet

1. Introduction:

There are circumstances where it is unsafe for a baby to be in the care of its mother following birth.

A Child Protection Plan, which requires clear decision making, planning and implementation, is the means by which the baby is kept safe. This Policy outlines the process by which a Child Protection Plan is carried out and the circumstances in which a baby may be removed from a mother's care.

The Local Authority takes the lead in Child Protection Planning but it shares the responsibility with the Agency Partners for ensuring all staff act within the law.

2. Removal of a baby from its mother:

A baby can only be separated from its mother in very limited circumstances. A baby should not be removed from its mother unless:

- The mother explicitly, and with full understanding, agrees to that separation and the child is accommodated under Section 20 of the Children Act 1989; or
- There is a Court Order authorising separation. This may be an Emergency Protection Order under section 44 of the Children Act 1989, or an Interim Care Order under section 38 of the Children Act 1989; or
- The baby is taken into Police Protection under section 46 of the Children Act 1989; or
- There is a real and immediate risk to the baby of significant harm by a parent or carer and removal is necessary to protect the safety of the baby. Where a child is removed in these circumstances, it should only be seen as an interim measure and the Police or the Local Authority will need to seek a Court Order as a matter of urgency if the child is to be kept from its mother.

A separation of mother and baby outside of the circumstances set out above is unlawful and could be in breach of Article 8 of the European Convention on Human Rights Act.

3. The Decision Making Process:

The factors determining the need to remove a baby at birth may be numerous and will often be based upon information available from many different agencies. Fortunately, this is not an action that occurs frequently as such interventions can interfere with the bonding process between mother and baby and reduces the benefits to a baby's health that breast feeding can provide (Masson et al, 2004).

In most situations, concerns regarding an unborn child will be shared at a pre-birth Child Protection Conference, which will produce a detailed Child Protection Plan to address the risk of significant harm when the child is born.

Children's Services holds lead responsibility for the decision whether to remove a child following birth. It will make this decision in consultation with other agencies, and this consultation should always include the Local Authority's legal department.

4. Responsibility of Health Professionals When Attending a Pre-Birth Child Protection Conference:

The health professional in attendance must obtain from the Conference a clear statement of whether there is a Child Protection Plan and, if so, what that plan is.

If the Child Protection Plan includes the removal of the child from the mother, it must also state clearly -

- Whether the local authority intends to seek a Emergency Protection Order (EPO) or Police Protection; and/or

- Whether the mother has signed a Section 20 agreement, agreeing for the child to be accommodated by the Local Authority.

Following the pre-birth Child Protection Conference the health professional will inform the Lead Nurse/Midwife for Safeguarding Children (LNMSC) of the outcome.

5. Action planning:

The Local Authority response is to develop an effective action plan. Following a pre-birth Child Protection Conference, if the child is subject to a Child Protection Plan, the core group must establish a clear process for sharing information and agree a plan of action for implementation of the Child Protection Conference Plan.

The Child Protection Conference should give careful consideration to the membership and frequency of the core group. The agencies involved in the planning process will normally be Health, Children's Services and the Police.

The LNMSC will ensure an up to date 'alert' is distributed, as appropriate, internally and/or to bordering, regional units and West Midlands Ambulance Service. Distribution of national alerts is the responsibility of the Local Authority.

The social work team manager, in consultation with the LNMSC, must convene a planning meeting at least 6 weeks before the estimated date of delivery (EDD). The purpose of this meeting is to agree a plan ("the Child Protection Birth Plan") which includes:

- Contact between the parents and the baby
- Breast feeding

- Risk management
- Specific agency responsibilities

The Child Protection Birth Plan must allow for the possibility of the baby being born outside normal office hours – e.g. evening, weekend, Bank Holiday - or being born at home, or at a neighbouring hospital. This must include effective communication with the Emergency Duty Team to ensure a robust out-of-hours response to secure the safety of the baby. This responsibility lies with the Local Authority.

The Child Protection Birth Plan must state clearly that removal of the child without the mother's consent may require a court order. If the mother has consented to the removal, the plan must state that she can withdraw this at any time, and a copy of the signed consent ("the section 20 agreement") must be attached to the plan.

Every effort will be made to engage the parents in the decision making process and planning for the child's protection, seeking their cooperation in the process.

6. Implementation:

When the woman presents in labour and her child is subject to a Child Protection Plan, midwifery staff will consult the Child Protection Plan and alert the relevant professionals immediately.

If the child protection plan requires that the baby will be separated from the mother immediately, the baby can be accommodated on another ward until transfer to the community, **provided the relevant authority from the Court or the parents has already been sought. No baby should be removed from their mother unless one of the criteria set out in Section 2 of this Policy can be met.**

In those cases where an Order has been granted by the Court, e.g. Emergency Protection Order, Interim Care Order, or the child is subject to Police Protection, the social worker will provide copies of such Orders which will be filed in the hospital records. Section 20 agreements signed by the parent/s should also be included in the records.

Ongoing contact between the parents and the child is the responsibility of the Local Authority. The hospital may be able to assist in short term supervision for no longer than 3 hours. This will require specific agreement.

The social worker holds responsibility, through the core group process, for the detailed arrangements and implementation of the Child Protection Plan.

7. Discharge from hospital:

At the time of transfer from hospital, if the baby is not to remain in the parents' care, a discharge plan must be agreed between the social worker who will be collecting the baby and hospital staff.

The Local Authority must provide a car seat to transport the baby safely.

The social worker must have on their person the appropriate form of identification. Midwifery staff will not allow the baby to leave the hospital with anyone who does not carry appropriate identification.

The social worker must provide the following information to the Hospital staff:

- Name and address of carer where the baby is to be discharged
- General Practioner's name, address and phone number
- Health Visitor (if known)

Hospital staff must inform the social worker of any health issues relating to the baby, including:

- Feeding requirements
- Health issues
- Birth marks/ blemishes identified prior to discharge
- Follow up appointments
- Community midwifery visiting

8. Actual or attempted removal of a baby from hospital, contrary to the child protection plan:

If there is any attempt by a parent to remove a child, contrary to the child protection plan and without the permission of the Local Authority, the health professional must contact the police by dialling 999 in order to minimise the risk of significant harm. The health professional must also contact:

- Hospital security
- Lead Nurse/ Midwife for Safeguarding Children
- Named social worker/ Emergency DutyTeam
- Maternity Directorate Manager / Head of Midwifery
- Out of hours contact hospital cover and the operational manager

In any other situation where there is no immediate child protection plan for the child, but there are concerns of significant harm, health staff must initiate child protection procedures.

References:

Birmingham Safeguarding Children Board Policies and Procedures 2006

Children Act 1989, sections 20, 38, 44, 46

Human Rights Act 1998, section 8.

Masson, J; Winn Oakley, M; Pick, K (2004). Emergency Protection Orders, School Of Law Warwick University.

Working Together to Safeguard Children 2006.

R (G) v Nottingham City Council, 2008

Associated policies:

Safeguarding Children, BWH, 2008

Birmingham Safeguarding Children Board Child Protection Procedures, June 2007.

ENCLOSURE: 16

Agenda Item : 24

Month : October 2008

Subject: Non Medical Prescribing Policy

Report by: J Owen, Director of Nursing and Midwifery

Author: Mr H Gee, Chairman, Drugs and Therapeutic Committee

Context and background for report

This Non Medical Prescribing policy has been written to provide clear guidance and information to non medical employees who have the appropriate training and have been assessed as competent to prescribe. There is no previous policy.

Key issues for trust board consideration and decision:

The Board are asked to consider and approve the policy.

Non Medical Prescribing Policy

Date of Policy: September 2008

Author: Mr H Gee, Chairman,
Drugs and Therapeutics Committee

Next Review Date: September 2011

Type:	Policy for non medical prescribing within BWFT	Version: Ref:	1	Directorate:	Neonatal Directorate

Aim:	To provide guidance for staff concerning non medical prescribing within the Trust
Scope (who it applies to) :	This policy applies to approved, named individuals who have successfully completed approved training.

Ratified by: Date:	Drugs and Therapeutics Committee Management Board Trust Board
Final Approval by: Date:	Julie Burgess, Chief Executive
Approval Signatories	
Implementation Date:	October 2008
Review and consultation process (when review required & by whom):	September 2011 Drugs and Therapeutics Committee
Responsibility for Implementation:	Neonatal Services Directorate

Revisions:		
Date:	Author:	Description of Revision (Action by whom):

HISTORY

Review date:	September 2011	Effective from:	
Effective to:			
Action Required by Trust/Dept			

Distribution methods:	Global U Drive Members of Drugs and Therapeutics Committee

Non-Medical Prescribing

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1. Background

The NHS Improvement Plan, Putting People at the Heart of Public Services and Creating a Patient Led NHS (Department of Health June 2004, March 2005) identifies that patients should have increased choice and access to a wider range of services. This includes increasing the range of healthcare professionals who can prescribe drugs to patients.

Improving roles in a more flexible workforce is a further objective of the NHS Improvement Plan. Non-medical prescribing utilises the skills of the NHS workforce, improves access to medicines for the patient and enables patients to receive timely episodes of care delivered by the most appropriate healthcare professional.

2. Implementation

These guidelines have been developed by UHB Non-medical Prescribing Group (NMPG) in line with guidance from the NHS West Midlands Stakeholder Steering Group for Non Medical Prescribing and approved by UHB Medicines Management Advisory Group (MMAG). As an affiliated body, the Birmingham Women's Drugs & Therapeutics Committee has adopted this guidance with appropriate modifications.

These guidelines are intended to ensure that the implementation of Independent Non-medical Prescribing (INMP) and Supplementary Prescribing (SP) by Registered Healthcare Practitioners at BWH is supported by a clear set of principles and arrangements.
The document will be circulated to:

- Non-medical Prescribers (NMPs) at BWH
- Student and applicants of a non-medical prescribing course
- Designated Medical Practitioners
- Clinical Directors
- Heads of Nursing

A link to these guidelines will also be available on the Trust intranet.

3. Principles

A number of different qualifications and documents exist which permit the administration or supply of medication without a prescription from a medical practitioner. (Appendix 1. explanatory notes).
However, the key principles of non-medical prescribing are:

- An improvement in patient care.
- Better use of time by the doctor, AHP, nurse or pharmacist and the patient.
- A clarification of professional responsibilities with patient safety being paramount.

NB: The flexibility of supplementary prescribing is not compatible with the formalities required under Part IV of the Mental Health Act 1983. Therefore the prescribing of medicines for any patient detained under the Act remains the responsibility of the Responsible MEDICAL Officer and therefore non-medical prescribing may not be permitted at all.

4. Training and Approval to Practice

4.1 Eligibility to Access Non-Medical Prescribing Training

a) Registered* Nurses, Pharmacists, Radiographers, Physiotherapists, Podiatrists or Chiropodists working in a role where there is a need to prescribe as a supplementary prescriber and where they will have the opportunity to work in partnership with a designated medical practitioner (DMP) to prescribe in accordance with a Clinical Management Plan (CMP).

or

b) Registered Nurses or Pharmacists working in a role where there is a need to prescribe as an independent prescriber where the nurse or pharmacist is competent to assess, diagnose and make treatment decisions for the patient and where the nurse or pharmacist works autonomously from a doctor, seeing patients independently.

In addition to **a** or **b** above, all registered healthcare practitioners must also have:

- Ability to study at level 3 (degree level)
- At least 3 years post registration clinical experience or part time equivalent (with exception of pharmacists who require at least 1 year post registration clinical experience or part time equivalent)
- Access to a medical prescriber who is willing to contribute to and supervise 12 days of learning practice
- Access to prescribing budget
- Support from their employer for continuing professional development (CPD)
- Nurses and Allied Healthcare Professionals (AHPs) should have prior competencies in the therapeutic area/s in which they will prescribe**

Doctors who are to act DMPs (in support of supplementary prescribers) or medical supervisors (supporting potential independent prescribers during their training) will be offered information from the trust prior to commencement of supervision.

* Professionals must be either: first level Nurses registered with the Nursing and Midwifery Council (NMC), Pharmacists fully registered with the Royal Pharmaceutical Society of Great Britain (RPSGB) or Radiographers, Physiotherapists, Podiatrists or Chiropodists fully registered with the Health Professions Council (HPC).

**Training courses for a non-medical prescribing qualification do not include clinical training in the specialist area in which the NMP will be prescribing.

4.2 Application for Training (see flow chart Appendix 2)

- Applicants must fulfil the legal criteria for eligibility to prescribe.
- Applicants, managers and, where appropriate, DMPs must complete the West Midlands NHS Application for Non-medical Prescribing (see appendix 3).
- Applicants for the supplementary prescribing course must provide evidence, within the application form, of DMP agreement to contribute to and supervise the applicant's 'learning in practice' element of training.
- Applicants must provide evidence of ongoing CPD.
- Applications for training and approval to practice will be reviewed by the Drugs & Therapeutics Committee. Only applications considered appropriate will be approved. Applicants and their supporting Consultant may be requested to attend for interview or provide additional information at the discretion of the D & T Committee.

4.3 Approval to practice within Birmingham Women's Hospital (see flow chart Appendix 4)

Trust support for a non-medical prescriber's role will be gained through approval of the Approval to Practice Form (see appendix 5) by the D & T Committee. The area of service provision that the prescriber can work within will be set out in the Approval to Practice Form, and a copy will appear in the staff member's personal file and Knowledge and Skills Framework (KSF) portfolio.

An Approval to Practice Form must be completed and submitted in the following circumstances:

- All BWH staff who have an NMP qualification and wish to practice as a non-medical prescriber.
- Non-medical prescribers currently approved to practice within the trust who wish to change or add to their areas of practice.
- Supplementary prescribers whose DMP has left the trust and a new DMP has been identified.
- All BWH staff who have gained an NMP qualification but who have not prescribed for 1 year or more. These individuals must complete a period of at least 3 months supervised practice* in their specialist area before submission of the form (see below).

Non-medical prescribers approved to practice will receive a letter (Appendix 6) together with a copy of the approved Approval to Practice form.

D & T Committee will be informed of all newly approved prescribers at BWH through completion of the form set out in Appendix 7.

Non-medical prescribers new to the Trust who have gained the qualification elsewhere or those who wish to provide a service under a SLA will be required to submit evidence of previous education, training and competence (eg. Knowledge and Skills Framework (KSF) portfolio) together with the Approval to Practice Form to the D & T Committee.

* If a NMP has not prescribed for over one year, following discussion with the Clinical Director and Clinical Line Manager, they must under go at least 3 months supervised practice consisting of mentorship from either a medical or non-medical prescriber in their specialist area.

4.4 Register of NMPs approved to practice at BWH

Once a non-medical prescriber has received approval to practice their name, areas of practice and signature will be entered on to the BWH register held by the Pharmacy Departments. An electronic register will be available through the Trust intranet which in addition, will include a list of drugs or types of drugs the NMP is permitted to prescribe, the name of the DMP or supporting Consultant and any other relevant information.

4.5. Trust Limitations to Prescribing

The Approval to Practice Form (appendix 5) will include the list of drugs which may be prescribed by a non-medical prescriber. Should the NMP wish to expand the area in which he/she prescribes, the Line Manager should explore any further clinical training or experience

that may be required to support this prescribing. Before this new area can be included in their professional duties, a revised Approval to Practice form should be submitted to NMPG.

It is the responsibility of the non-medical prescriber to ensure that they prescribe in line with all other BWH policy.
For example:

- **New drugs to the Trust** - BWH may impose restrictions on the prescription of drugs new to the Trust through the Procedure for the Introduction of New Drugs or Formulary Changes.
- **Unlicensed drugs or drugs prescribed "off label/ license"**- BWH may impose restrictions and NMPs must always prescribe these drugs against a clinical management plan.

All NMPs have responsibility for accepting professional accountability and clinical responsibility for their prescribing practice, working at all times within their clinical competence and with reference to their regulatory body's professional standards.

5. Prescribing, dispensing/ administration process

5.1 Prescribing

All non-medical prescribers must:

- conform to BWH Medicines Policy.
- inform each patient of their qualification to prescribe, ensuring the patient understands the scope of their practice relevant to the patient's care.
- have access to a current British National Formulary (BNF) when prescribing.
- prescribe only on BWH prescription forms.
- enter the department concerned on all prescriptions submitted to UHBFT pharmacy departments and use the appropriate suffix INMP (independent non-medical prescriber) or SP (supplementary non-medical prescriber) to denote their prescribing status (this may vary for a prescriber in different situations) should be appended to their signature on all paper written prescriptions.
- only prescribe drugs which have been approved by the D & T Committee by the process above.
- Never prescribe outside restrictions imposed on the prescription of drugs by D & T Committee, its advisory groups or any other BWH controlled document.

5.2 Dispensing

- Prescriptions must be checked against the Pharmacy register of approved NMPs before dispensing. Pharmacy will only dispense NMP prescriptions written by individuals on this register.

- NMP pharmacists must ensure that their prescriptions are clinically screened or dispensed by another pharmacist and are not dispensed by themselves. However, non-medical prescribers may prescribe and supply pre-packed and pre-labelled medication in situations which have been risk assessed and approved through the D & T Committee prior to prescribing. Approval will only be granted where this improves patients' access to medicines and there is minimal risk.

5.3 Administration

- NMP prescriptions require the same checks before administration as those written by a medical practitioner (see BWH Medicines Policy).

- Where possible non-medical prescribers should avoid administering drugs which they have prescribed unless administration by the prescriber improves patients' access to medicines.

6. Record keeping

Records of all patient consultations must be made in the patient's medical notes. Copies of letters filed in the record or on the Patient Administration System (Lorenzo) detailing the consultation may be used to meet this requirement for out-patients.

All professionally held records must be stored in a secure manner in a locked file, drawer or cupboard. All staff must follow the BWH Confidentiality Policy in relation to patient records.

7. Continuing Professional Development (CPD)

All non-medical prescribers have a professional responsibility to keep themselves abreast of clinical and professional developments. They will be expected to keep up-to-date with best practice in the management of conditions for which they may prescribe. NMP should be discussed at Personal Development Review (PDRS)/ KSF and any training needs identified through CPD.

To maintain high standards of prescribing practice a Trust Non-medical Prescribing Forum will be available via UHB to update all prescribers and share good practice on the principles of prescribing and medicines management. An attendance certificate will be issued.

Newly qualified non-medical prescribers or those recently transferred to the trust will be encouraged to participate in a 'buddy' system whereby they regularly meet with an established prescriber, preferably working in a related clinical area.

NMPs may be asked to provide evidence of relevant CPD and prescribing practice annually.

Any industrial sponsorship received for training and education must be reported in accordance with the Trust Standing Financial Instructions.

8. Ordering and receiving investigations

All investigations, including laboratory tests, ordered by NMPs must be requested under the name of the consultant responsible for the patient's care.

9. Clinical Governance and Audit

All NMPs must ensure they have read and understood BWH Medicines Policy and any BWH controlled documents relevant to their area of practice, available on the trust intranet.
Those who prescribe Controlled Drugs must be fully aware of the section of the Home Office's Misuse of Drugs Regulations dealing with the storage of Controlled Drugs, the Health

Act 2006 and the Controlled Drugs (Supervision of Management and Use) Regulations 2006 (introduced as a result of the Shipman enquiry).

NMPs should consider taking out their own professional indemnity insurance, for example through membership of their own professional body. However, the BWH will provide indemnity for all members of staff working within the terms and conditions of their contract with the Trust.

Each NMP must ensure there is a system for audit, relevant to their practice, in place and available for review. All audit must be logged with the Clinical Governance Directorate and must address:

- Incidents
- Complaints
- Continuing competence
- Adherence to clinical management plans
- Appropriateness of prescribing

10. Incident reporting

Adverse incidents should be recorded on a clinical incident form in accordance with BWH policy.
All adverse drug effects should be reported according to guidance from the Committee for the Safety of Medicines (CSM) using the Yellow Card system, copies of which can be found at the back of a current BNF or by completing the form on-line at www.mhra.gov.uk .
The bulletin "Current Problems in Pharmacovigilance", issued by the MHRA and the CSM, contains advice and information on drug safety issues. The bulletin is produced four times a year and NMPs must consult the bulletin as a matter of routine. Copies are available from the CSM's website, which can be found on www.mhra.gov.uk .

References

Department of Health – **National Service Framework for Mental Health. 1999**

Department of Health – **The NHS Plan. 2000**

Department of Health – **The NHS Improvement Plan, Putting People at the Heart of Public Services. June 2004**

Department of Health – **Creating a Patient-Led NHS Delivering the NHS Improvement Plan. 2005**

Department of Health – **Supplementary Prescribing by Nurses, Pharmacists, Chiropodists/Podiatrists, Physiotherapists and Radiographers within the NHS in England- A guide for implementation. May 2005**

Department of Health – **Improving Patients' Access to Medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England. 2006**

Department of Health – Medicines Matters – **A Guide to current mechanisms for the prescribing, supply and administration of medicines. July 2006**

Appendix 1.

EXPLANATORY NOTES

The mechanisms available for the prescribing, supply and administration of medicines are:

- Patient Specific Directions
- Patient Group Directions (PGDs)
- Specific exemptions covering supply or administration - as contained in medicines legislation
- Nurse Independent Prescribing
- Pharmacist Independent Prescribing
- Supplementary prescribing by nurses, pharmacists optometrists, physiotherapists, radiographers and chiropodists/podiatrists

Patient Specific Direction: "a written instruction, from a doctor, dentist, nurse or pharmacist independent prescriber, for medicines to be supplied or administered to a named patient."
In primary care, this might be a simple instruction in the patient's notes. Examples in secondary care include instructions on a patient's ward drug chart.
As a Patient Specific Direction is individually tailored to the needs of a single patient, it should be used in preference to a Patient Group Direction (PGD) wherever appropriate.

Patient Group Directions: "a written instruction for the supply or administration of a **licensed** medicine (or medicines) in an identified clinical situation."
A PGD is drawn up locally by doctors, pharmacists and other health professionals and must meet certain legal criteria. Each PGD must be signed by a doctor or dentist, as appropriate, and a pharmacist, and approved by the organisation in which it is to be used, typically a PCT or NHS trust.
PGDs can only be used by the following registered healthcare professionals, acting as named individuals:- **nurses, midwives, health visitors, paramedics, optometrists, chiropodists and podiatrists, radiographers, orthoptists, physiotherapists, pharmacists, dietitians, occupational therapists, prosthetists and orthotists, and speech and language therapists.**
Each PGD has a list of individuals named as competent to supply/administer under the direction.
More detailed advice on PGDs is available from the National Prescribing Centre website at www.npc.co.uk , and in *Health Service Circular (HSC) 2000/026 Patient Group Directions [England only]*, available from www.dh.gov.uk/publications. National template PGDs are accessible via the National Electronic Library for Health website at www.nelh.nhs.uk.

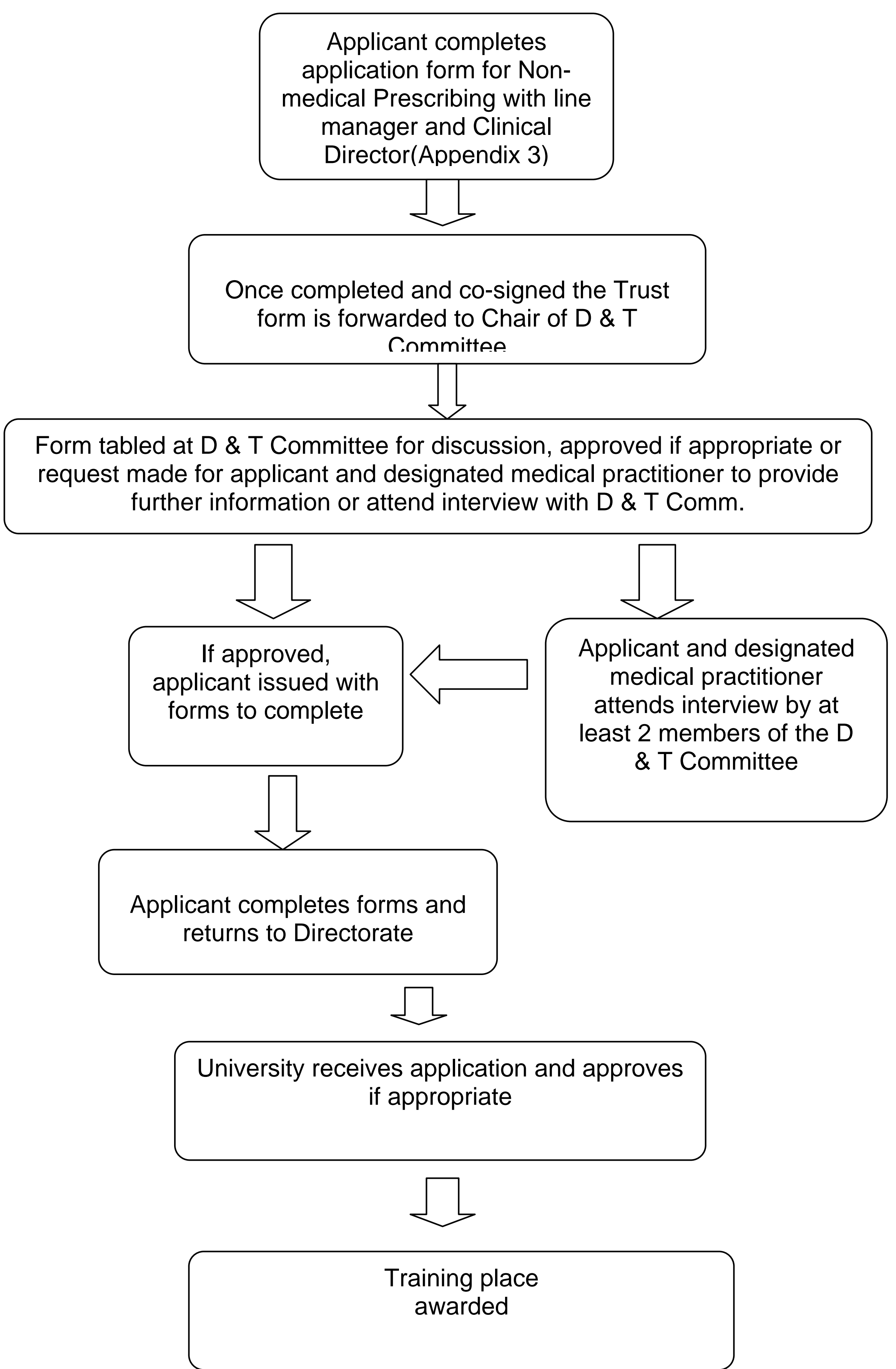
'Specific exemptions' in medicines legislation:
A number of health professions – for example, **midwives, chiropodists/ podiatrists, optometrists, paramedics** – have specific exemptions in medicines legislation to supply or administer medicines. Provided the requirements of any conditions attaching to those exemptions are met, a PGD as outlined above is not required. For example, registered chiropodists/ podiatrists have exemptions under medicines legislation for parenteral administration of a number of prescription only medicines (POMs), including bupivacaine and lidocaine.

Nurse and Pharmacist Independent Prescribing:
Nurses and **pharmacists** with an independent prescribing qualification may prescribe any **licensed** medicine for any medical condition that a nurse or pharmacist prescriber is competent to treat. Nurses but not pharmacists may prescribe some Controlled Drugs. It allows virtually any licensed medicine in the British National Formulary (see part XVIIB(ii) of the Drug Tariff) to be prescribed.
All registered nurses, midwives, specialist community public health nurses and pharmacists may train to be Independent Prescribers. However, the DH Guide to Implementation and the Nursing and Midwifery Councils (NMC) Standards of Proficiency for nurse and midwife prescribers state that nurses put forward for prescribing training must have at least three years' post-registration experience. Pharmacists should have at least one years' experience following registration.
The training for nurses and pharmacists is spread over a period of six months with a higher educational institute (HEI), and consists of at least 26 days training and 12 days learning in practice. A designated medical practitioner must supervise the student and provide support. Nurses who successfully complete the HEI's programme must register their prescribing qualification with the NMC before they can apply to UHBFT for approval to prescribe in the Trust. Pharmacists must similarly register their qualification with the RPSGB see www.rpsgb.org.uk
For further information visit www.nmc-uk.org.

Supplementary prescribing:
Registered **nurses, pharmacists**, **physiotherapists, chiropodists/podiatrists, radiographers** and **optometrists** may train for a supplementary prescribing qualification.
Supplementary prescribing is a **voluntary prescribing partnership** between the independent prescriber (doctor or dentist) and supplementary prescriber, to implement an agreed patient-specific clinical management plan (CMP), with the patient's agreement.
Following agreement of the CMP, the supplementary prescriber may prescribe any medicine for the patient that is referred to in the plan, until the next review by the independent prescriber. There is no formulary for supplementary prescribing, and no restrictions on the medical conditions that can be managed under these arrangements.
Supplementary Prescribers may prescribe **Controlled Drugs** and **unlicensed medicines** in partnership with a doctor, where the doctor agrees within a patient's CMP. The training for supplementary prescribing is incorporated into Nurse and Pharmacist Independent Prescribing. Many HEIs are offering the supplementary prescribing elements of the course as multi-disciplinary training for nurses, pharmacists, and AHPs, which the professions have found valuable. The exception is optometrists, who follow a programme more specific to the eye.
All professional groups must register their supplementary prescribing qualification with their regulatory body before beginning to prescribe.

Appendix 2.

Flow chart for process for approval to train as an NMP.



Appendix 3.

APPLICATION FORM FOR NON-MEDICAL PRESCRIBING

University[1]________________________________**Start Date**__________________

Part time ☐ *Full Time* ☐ *Taught Course* ☐ *E- Learning* ☐
Supplementary ☐ *Independent* ☐ *Other* ☐ *(specify)…………………*

All sections must be completed

Section 1 - Details of Applicant

Name

Profession **Nurse/ Midwife (specify)……………………………**

AHP (profession)………………………..

Job Title

Contact Details	**Work**	**Home**
Address **Postcode**		
Telephone No		
Mobile No		
Email		
Tick preferred correspondence details.		

Name of Employing Organisation

Section 2- Professional Eligibility

Nurses

Are you a 1st level registered nurse/midwife/specialist community public health nurse currently on the NMC Register? – please specify area of practice.____ Yes / No

____

Do you have at least 3 years or equivalent relevant post qualification experience? Yes / No

NMC PIN Number Expiry Date

[1] See Appendix 1 for list of Universities & Courses within NHS West Midlands

Allied Health Professionals

Professional Group: ………………………………………………………….

Area of Practice: …..

………………………………………………………………………………………………

Do you have at least 3 years or equivalent relevant post qualification experience?

HPC Registration Number Expiry Date Yes / No

CRB Checks – All Professional Groups

Do you have a current enhanced CRB (Current Employer and issued in last 3 years) Yes / No

Has an enhanced CRB been applied for? Yes / No

Please State Professional Qualifications Attained

Awarding Body	Level	Year	Subject	Result	Place of Study

Supporting information (additional qualifications, professional experience likely to facilitate prescribing)

Have you registered or commenced and partially completed a non medical prescribing course previously? Yes* / No

* If yes please give reasons for **not** completing the course

Nurses Only

Please provide evidence of your ability to study at degree level

I have completed a health/clinical assessment course (or specialist equivalent)? Yes* / No

**please check this has been included in your supporting information or give details*

If **No** have you been assessed competent by your employer in clinical assessment and diagnosis prior to being put forward for this course (see professional regulations for guidance re competence)

Please give details and ensure section below is completed and signed.

As the applicants manager/ supervisor I confirm that the applicant is competent in clinical assessment & diagnosis and is a suitable candidate for non medical prescribing (NB this may be achieved by internal assessment of competence or completion of an appropriate health/clinical assessment course.)

Name Title/Position

Signature Contact Details

Section 3 - Requirements for Prescribing

Please provide reasons for your application for a prescribing course. **a) How will your ability to prescribe maximise benefit to the patient?** (role/service delivery benefit, expected changes to clinical pathway, timeliness of provision, effectiveness, impact on patient journey/experience, improved access to medicines)
b) How will your ability to prescribe benefit your organisation? (service improvements, financial improvements, skills utilisation, capacity improvements)
c) Please provide details of the service you intend to prescribe in? (For Nurses - Candidates are required to have worked for a minimum of 1 year[2] the area they will be prescribing within. Please indicate range of medication that you anticipate will be prescribed.
Are Patient Group Directions a realistic alternative to supplying or administering the items to be prescribed? It not please explain why? Yes ☐ No ☐

[2] One year equates to full time, those working part time will need to evidence experience which equivalent to 1 year full time

Section 4 – Designated Medical Practitioner Arrangements

Eligibility Criteria for becoming a Designated Medical Practitioner (DMP) AA

Further information for supervisors is available on the DH website

Are you a registered medical practitioner who:

(i) has normally had at least 3 years recent clinical experience for a group of patients/clients in the relevant field of practice.

YES ☐ NO ☐

and are you:

(ii) (a) within a GP practice and is either vocationally trained or is in possession of a certificate of equivalent experience from the Joint Committee for Post-graduate Training in General Practice Certificate (JCPTGP):

YES ☐ NO ☐

Or

b) is a specialist registrar, clinical assistant or a consultant within a NHS Trust or other NHS employer.

YES ☐ NO ☐

and have you:

(iii) support of the employing organisation or GP practice to act as the DMP who will provide supervision, support and opportunities to develop competence in prescribing practice YES ☐ NO ☐

and have you

(iv) some experience or training in teaching and or supervising in practice

YES ☐ NO ☐

If not an Approved Training Practice/Institution, then please outline your experience of teaching, supervision and assessment of students.

Agreement by Designated Medical Practitioner for Supervision of Applicant

Name of Medical Supervisor (PLEASE PRINT)

Please tick GP ☐ Consultant ☐ Specialist Registrar ☐ Clinical Assistant ☐ Other ☐

Speciality

Work Address

Postcode Telephone Number

Email Address

I confirm that I have agreed to supervise, support and assess the applicant for a minimum of twelve days (90 hours) in the development of their prescribing role during clinical placement.

Signature* Date

* See Guidance notes appendix 2

Section 5 – Trust Approval

Line Manager
Please confirm the following
The applicant has agreement to be release from practice to attend non medical prescribing course and has appropriate medical supervision. Yes / No

The area of non medical prescribing activity is linked to core service provision Yes / No

If the service is time limited or pilot project /service please give details:

On qualification the applicant will have access to prescribing budget & other practical requirements for prescribing. Yes / No

On qualification the on-going CPD requirements of the prescriber will be supported. Yes /No

I confirm that non medical prescribing is included in the applicants Job Description or a letter of empowerment to prescribe within the Trust will be appended to the JD. Yes /No

Name (please print)

Job Title

Trust

Address

Email Telephone Number

Signature* Date

* See Guidance notes appendix 2

Funding
The Applicant would wish to apply for a NHS West Midlands funded place Yes / No
If No (or you have been informed that funding is not available) please give details of your funding source.

Trust Non Medical Prescribing Lead

Trust Non-Medical Prescribing Lead agreement that there will be access to a prescribing budget and a benefit to patient services by training this nominee.

Name (please print) Trust

Address Telephone Number

Signature* Date

*See Guidance notes appendix 2

Applicant (Student) Agreement

I agree to communication between NHS West Midlands Strategic Health Authority, My Employer, Prescribing Lead for my Trust and the University that I am attending to discuss any aspect of my attendance and progress on the prescribing course. I also agree to undertake Continuing Professional Development on completion of this course.

I have read & agree to comply with the guidance notes attached in appendix 2

Signature of applicant* Date

* See Guidance notes appendix 2

PLEASE RETURN FORM TO THE NON MEDICAL PRESCRIBING LEAD(Chair of Drugs & Therapeutics Committee)

FOR YOUR TRUST

For office use only

Approved for attendance on the course Yes ☐ **No** ☐

Signature **Date**

Version 1 Draft 12

List of Approved University Courses (Appendix 1 to NMP Application)

Nurse and AHP Prescribing Training:

Coventry University	Dawn Court Faculty of Health & Life Sciences Department of Nursing, Midwifery, & Health Care Priory Street Coventry CV1 5FB Telephone: 024 7688 7688 d.court@coventry.ac.uk
Worcester University	Pauline Wooliscroft/Jane Perry Institute of Health & Social Care Henwick Grove Worcester WR2 6AJ Telephone: 01905 855147 Jane.perry@worc.ac.uk P.woolliscroft@worc.ac.uk
BCU	Sarah Eades/Debra Sprague Department of Community Health & Social Work Room 407 Baker Building BCU Birmingham Franchise Street Perry Barr Birmingham B42 2SU Telephone: 0121 331 6005 Sarah.Eades@uce.ac.uk Debra.Sprague@uce.ac.uk
Wolverhampton University	Helen McCarthy Watson School of Health Maryseacole Building MH 214, Molineux Street Wolverhampton WV1 1SB Telephone: 01902 518638 hmwatson@wlv.ac.uk
Staffordshire University	Katharine Hardware Faculty of Health & Sciences Blackheath Lane Stafford ST18 OAD Telephone: 01785 353766 K.Y.Hardware@staffs.ac.uk

Pharmacist Prescribing Training:

Keele University	Jacqui Kinsey Prescribing Studies Course Manager School of Pharmacy Department of Medicines Management Keele University Staffordshire ST5 5BG Tel: 01782 584201 j.kinsey@keele.ac.uk

See relevant section for conditions of signing non medical prescribing application form

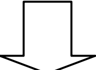
Applicant
Will inform course leader and line manager of known days of absence such as AL, SL during course dates prior to course commencing. Will attend all course dates at university as required. Prior to starting course has met with supervisor and discussed learning objectives and methods for supervision Attends all supervisory sessions with medical supervisor as required. Where possible an experienced non medical prescriber should work alongside the student and the designated medical practitioner to provide support and guidance as appropriate. For midwives this should include the lead midwife for education. Completes requirements of course within allocated time period. If the candidate interrupts their studies for independent prescribing, the programme must be completed within the requirements of your registering body and the regulations of the university. For nurses if assessments are not completed within 12 months from the start, the candidate must undertake the entire programme again including all the assessments. For Pharmacists RPSGB and university regulations apply. Once qualified informs line manager and lead for non medical prescribing immediately. Intends to prescribe within area of work and competence once qualified. All registrants must record their prescribing qualification, for nurses within 12 months of successfully completing the course. Other Healthcare professionals have a duty to comply with their registering bodies regulations. Attends regular inhouse CPD support mechanisms once qualified. Provides feedback on the course to manager and lead person Mentors and supports colleagues undertaking the course at later date. Participates in local steering group and work to develop supporting policies. Candidates should be aware of national and local policies in relation to prescribing. For Pharmacist applicants additional information will be required to meet RPSGB requirements these fo will be provided by the university.
Line manager
Agrees the appropriateness and suitability of candidate application and ensures the candidate is able to apply the prescribing principles to their area of practice. Understands the candidate must have 3 years experience as an appropriately registered health professional (2 years in the case Pharmacist and Optometrist) and the year preceding the application has been working in the clinical area in which they intend to prescribe (for part timers, it's the equivalent of 3 years experience and 1 year in relevant clinical area). Nurse applicant must have completed a module in diagnosis and physical assessment before accessing the prescribing programme or provided evidence as outlined by the university of competence in history taking, physical assessment and diagnosis relevant to clinical area in which you are working. Applicants should not be put forward until they first demonstrate ability to diagnose in their area of speciality (should be identified through CPD reviews within the work setting) see professional regulations guidance Understands and accepts the requirements for candidate attendance at university and with medical supervisor. Agrees with choice of medical supervisor. The designated medical practitioner must be sufficiently impartial to the outcome for the student and should not be the same individual as the person sponsoring the student to undertake the programme.

Where possible an experienced non medical prescriber should work alongside the student and the designated medical practitioner to provide support and guidance as appropriate. For midwives this should include the lead midwife for education. Confirms Trust policies/procedures and clinical governance infrastructure and professional indemnification processes are in place to support non medical prescribing. Effective policies for record keeping must be in place to ensure records are accurate, comprehensive, contemporaneous and accessible by all members of a prescribing team. Evaluates experiences of candidates and provides feedback to lead person. Provides opportunity for CPD. All registrants must record their prescribing qualification within 12 months of successfully completing the course. (This may vary between professional groups – individuals, have a duty to comply with their registering bodies regulations)
Designated Medical Practitioner
Meets Department of Health requirements for supervision. Provides the required supervision in terms of time and content. Agrees learning contract and objectives with each student. Attends the induction session at university at least once or seeks further guidance from the university. Provides appropriate learning experiences. Takes responsibility for signing off competencies. Is responsible for ensuring he/she has time to supervise effectively. The designated medical practitioner must be sufficiently impartial to the outcome for the student and should not be the same individual as the person sponsoring the student to undertake the programme. The medical supervisor would be expected to work in collaboration with other support systems for students including the personal tutor. Where possible an experienced non medical prescriber should work alongside the student and the designated medical practitioner to provide support and guidance as appropriate. For midwives this should include the lead midwife for education. The assessment of clinical practice should occur where possible with an experienced non medical prescriber who can ensure application to specific areas of professional practice.
Non Medical Prescribing Lead
Confirms Trust policies/procedures and clinical governance infrastructure and or professional indemnification processes are in place to support non medical prescribing. Agrees appropriateness of candidate selection. Agrees and is involved in selection process. Agrees that the medical supervisor is appropriate. Maintains database of all prescribers. Represents Trust at meetings such as NHS West Midlands Non Medical Prescribing Stakeholder Steering Group. Knows the content of curriculum and attends University curriculum group meetings to feedback evaluation, concerns etc. Is available for candidate one to one support.

Appendix 4.

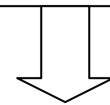
Approval Process for Non-medical prescribers (NMPs) to commence prescribing within BWHFT

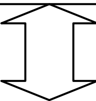
Successful completion of non-medical prescribing course/ New Prescriber in Trust.



Submission to **D & T Committee** of:

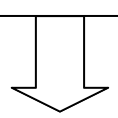
- Approval to Practice form
- documentary evidence of qualification and registration





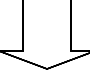
Application approved

Application not approved– returned to applicant with rationale

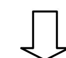


D & T Committee awards Trust approval to prescribe

- Approval to Practice form signed, copied to NMP.
- Original held by D & T Comm. Chair
- Authorisation letter to prescribe sent (2 copies).



NMP signs and dates letters and sends one copy to Pharmacy. **Authorisation to prescribe** commences from date of signing.



D & T Comm. informed of:

- name of new prescriber
- area of practice
- drugs prescribed
- name of supporting clinician/s

UHB Pharmacy informed

Appendix 5. Birmingham Women's Hospital NHS Foundation Trust Approval to Practice Form

NB. This form must be completed in full in capitals and submitted to the Non-medical Prescribing Group together with a copy of the entry into the respective professional register which has been signed clearly by the non-medical prescriber.

FULL NAME……………………………………………………………………………………………..................

PROFESSION……………………………………………………………………………..……………………….

PRESCRIBING QUALIFICATIONS………………………………………………………………...……………

PROFESSIONAL REGISTRATION NO. (eg. NMC / HPC)………………………………...………………

INDEPENDENT PRESCRIBER ☐ **SUPPLEMENTARY PRESCRIBER** ☐

Tick relevant box/es and if appropriate mark other N/A

APPROVED TO PRESCRIBE FOR; (EG GROUP OF PATIENTS OR SPECIALTY)

………

SITE ………………………………………………………………………………...................

RESPONSIBILITIES OF POST & RELEVANT EXPERIENCE OF POST HOLDER

………

………

DESCRIPTION OF DRUGS TO BE PRESCRIBED:
DRUG NAME OR THERAPEUTIC CLASSES OF DRUGS:
………

………

………

………

………

………

………

***NB. Qualification as a non-medical prescriber (NMP) does not confirm competency in the speciality concerned. Courses DO NOT include specialty specific clinical training. The CSL MUST be confident in the NMP's clinical competency before signing.**

*__CSL (PRINT NAME)__……………………………………………………………………………………..

***CSL (SIGNATURE**)………………………………………………………………………………………

SIGNATURE OF NON-MEDICAL PRESCRIBER ……………………………………………………………..

CONTACT NO. / BLEEP NO. …………… **DATE**……………………………………………

Approved by Chair of Drugs & Therapeutics Committee, Birmingham Women's NHS Foundation Trust

Date………………………………………………..

Name ………………………………………………Signature……………………………………………………..

Appendix 6.

Dear……………………………

Re: Confirmation of BWH authorisation to prescribe as a
Supplementary* and /or Independent* Prescriber *delete as applicable

Congratulations on achieving your prescribing qualification and Trust Authorisation

I can confirm the following:

- Your list, of anticipated therapeutic classes of medication to prescribe, has been approved
- you have provided us with a sample of your signature
- you have provided documentary evidence of your registration and qualification

As a Trust non-medical prescriber it has been agreed that you will only be authorised to prescribe within your clinical specialty or area of expertise as outlined in your Approval to Practice Form. Should you wish to change the approved list or status, a new Approval to Practice Form must be submitted to the Non-medical Prescribing Group.

It is expected that you will adhere to the Trust Non-medical Prescribing Guidelines and Trust Medicines Policy at all times.

Please date and sign both copies of this letter to demonstrate that you agree to the terms outlined within it. Return one copy to the Chair of the Drugs & Therapeutics Committee and retain the other copy for your records. You are authorised to prescribe from the date this signed letter is received by the Committee Chair.

Yours sincerely,

On behalf of the
D & T Committee
Birmingham Women's NHS Foundation Trust

Non-medical prescribers signature…………………………………

Date…………………………………………………………………………………….

Appendix 7.

Birmingham Women's NHS Foundation Trust.
Non-Medical Prescribers Approved by D & T Committee to Prescribe Date x to Date x.

Prescribers Name:………………………………………………………………………………
Independent/Supplementary Prescriber?:...
Area/Speciality:………………………………………………………………………………..
CSL:……………………………………………………………………………………………….
*DMP or supporting Consultant (if not CSL):………………………………………………………..
Medicines approved to prescribe:……………………………………..
……………………………………………………………………………………………………......
……
……
……
……
Any other information:………………………………………………………………………………
……………………………………………………………………………………………………..

Prescribers Name:………………………………………………………………………………
Independent/Supplementary Prescriber?:...
Area/Speciality:………………………………………………………………………………..
CSL:……………………………………………………………………………………………….
*DMP or supporting Consultant (if not CSL):………………………………………………………..
Medicines approved to prescribe:……………………………………..
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Any other information:………………………………………………………………………………
……………………………………………………………………………………………………..

Prescribers Name:………………………………………………………………………………
Independent/Supplementary Prescriber?:...
Area/Speciality:………………………………………………………………………………..
CSL:……………………………………………………………………………………………….
*DMP or supporting Consultant (if not CSL):………………………………………………………..
Medicines approved to prescribe:……………………………………..
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……
……
Any other information:………………………………………………………………………………
……………………………………………………………………………………………………..

Appendix 8.

Example Audit Tool and Audit Guidance.

Non Medical Prescribing Audit Form		
Patient Demographics		
Gender	Male	Female
Age		
Primary Diagnoses		
Co-morbidities		
Allergies/Sensitivities		
Name of patients consultant		
Number of medications the patient is taking		
Concomitant medications the patient is taking		
Drugs prescribed by the non medical prescriber: Include supplementary and extended independent prescribing		
Use of off label/unlicensed medication:		
Adverse Events & Outcome:		
Reasons for referral back to Independent prescriber & Outcome:		
Cost of your prescribing		
Issue or concerns relating to prescribing for the patient		

Considerations for writing up your audit report

Log your audit with the clinical governance directorate.

Provide the following details:

- Background information on your speciality and the impact you feel that non medical prescribing has had.
- The total number of patients you have prescribed for
- The time period of the audit (e.g. six months from June - December 07)
- The mean age and age range of the patients that you have prescribed for
- Log and comment on the range of comorbidities (is this what you expected?)
- Comment on polypharmacy, the mean number of drugs that your patients are taking and the percentage of patients taking 4 or more drugs
- Comment on the share of non medical prescribing by the doctors you work with
- Comment on any risk factors that you have identified for your specialty, does there appear to be a consensus approach and evidence based practice? Could lessons be learned by presenting your audit findings?
- Could you develop a specialty based drug formulary?
- Give a conclusion and submit your audit report to the non medical prescribing group so that it can be shared with other non medical prescribers within the Trust.

ENCL 16

Non Medical Prescribing Policy

Date of Policy: 2008 **Author: H. Gee**

Next Review Date: September 2011

Type:	Policy for non medical prescribing	Version: Ref:		Directorate:	All, Trust wide

Aim:	To provide guidance on non medical prescribing training and regulation
Scope (who it applies to) :	This policy applies to all employees irrespective of grade, level, location or staff group.

Ratified by: Date:	Drugs and therapeutics Committee 8.10.08 Clinical Governance Committee Management Board
Final Approval by: Date:	
Approval Signatories	Chief Executive
Implementation Date:	

Review and consultation process (when review required & by whom):	September 2011 Chair of D& T
Responsibility for Implementation:	Clinical Directors

Revisions:		
Date:	Author:	Description of Revision (Action by whom):
September 2008	H. Gee	

HISTORY

Review date:	September 2011	Effective from:	
Effective to:			
Action Required by Trust/Dept			
Distribution methods:	All staff via Global email, Global U Drive, Intranet Please note that the electronic version of this document on U Drive is the only version maintained. Any printed copies may not necessarily contain latest updates and should be compared to the version on the U Drive.		

Annual health check 2007/08 - Performance of Birmingham Women's NHS Foundation Trust

Summary

Based on our assessment for 2007/08, Birmingham Women's NHS Foundation Trust provided a good quality of service to patients but failed to maintain the excellent standard of performance it achieved in the previous year. In 2005/06 the trust provided a good standard of performance. This trust has gained foundation status during 2007/08. Foundation trusts are assessed in a different way to other trusts. It has been excellent at managing its finances.

The trust was not one of those chosen to receive an inspection over the summer.

In a recent survey of trusts in England, patients rated this organisation as 'satisfactory' in terms of their overall experience.

Overall performance

The overall performance rating is made up of two parts: 'use of resources', which looks at how effectively a trust manages its financial resources; and 'quality of services', which is an aggregated score of performance against national standards and targets. The below tables summarise the three years of the annual health check.

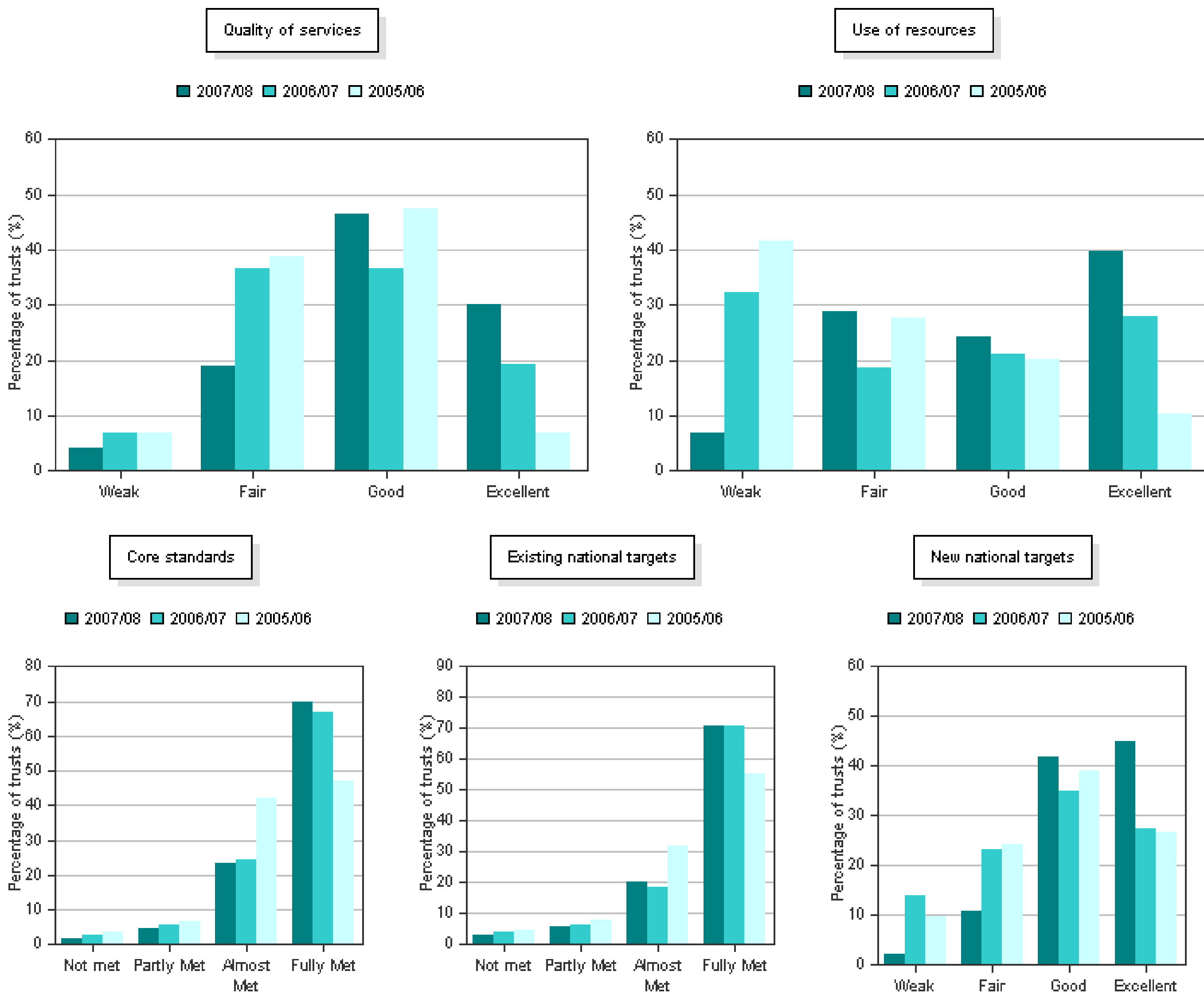
	2007/08	2006/07	2005/06
Quality of services	GOOD	EXCELLENT	GOOD
Use of resources	EXCELLENT	FAIR	FAIR

Components of quality of services

	2007/08	2006/07	2005/06
Core standards	FULLY MET	FULLY MET	ALMOST MET
Existing national targets	ALMOST MET	FULLY MET	FULLY MET
New national targets	EXCELLENT	EXCELLENT	GOOD

Overall peformance of acute trusts

The graphs below show the overall performance of all acute and specialist trusts for the two parts of the overall performance ratings, as well as for the three components of quality of services, over the three years of the annual health check.



Core standards performance

Every NHS trust in England is responsible for ensuring that it is complying with the Department of Health's core standards. As part of the annual health check, we ask all trusts to assess their performance against the core standards and to publicly declare the information. The tables below present Birmingham Women's NHS Foundation Trust's performance in the seven key areas of health and healthcare over the three years of the annual health check.

Safety

	2007/08	2006/07	2005/06
C01a - incidents - reporting and learning	NOT MET	NOT MET	COMPLIANT
C01b - safety alerts	COMPLIANT	COMPLIANT	COMPLIANT
C02 - safeguarding children	COMPLIANT	COMPLIANT	NOT MET
C03 - NICE interventional procedures	COMPLIANT	COMPLIANT	COMPLIANT
C04a - infection control	COMPLIANT	COMPLIANT	COMPLIANT
C04b - safe use of medical devices	COMPLIANT	COMPLIANT	COMPLIANT
C04c - decontamination	COMPLIANT	COMPLIANT	COMPLIANT
C04d - medicines management	COMPLIANT	COMPLIANT	COMPLIANT
C04e - clinical waste	COMPLIANT	COMPLIANT	COMPLIANT

Clinical and cost effectiveness

	2007/08	2006/07	2005/06
C05a - NICE technology appraisals	COMPLIANT	COMPLIANT	COMPLIANT
C05b - clinical supervision	COMPLIANT	COMPLIANT	COMPLIANT
C05c - updating clinical skills	COMPLIANT	COMPLIANT	COMPLIANT
C05d - clinical audit and review	COMPLIANT	COMPLIANT	COMPLIANT
C06 - partnership	COMPLIANT	COMPLIANT	COMPLIANT

Governance

	2007/08	2006/07	2005/06
C07a and c - governance	COMPLIANT	COMPLIANT	COMPLIANT
C07b - honesty, probity	COMPLIANT	COMPLIANT	COMPLIANT
C07e - discrimination	COMPLIANT	COMPLIANT	COMPLIANT
C08a - whistle-blowing	COMPLIANT	COMPLIANT	COMPLIANT
C08b - personal development	COMPLIANT	COMPLIANT	COMPLIANT
C09 - records management	COMPLIANT	COMPLIANT	COMPLIANT
C10a - employment checks	COMPLIANT	COMPLIANT	COMPLIANT
C10b - professional codes of conduct	COMPLIANT	COMPLIANT	COMPLIANT
C11a - recruitment and training	COMPLIANT	COMPLIANT	COMPLIANT
C11b - mandatory training	COMPLIANT	COMPLIANT	COMPLIANT
C11c - professional development	COMPLIANT	COMPLIANT	COMPLIANT
C12 - research governance	COMPLIANT	COMPLIANT	COMPLIANT

Patient focus

	2007/08	2006/07	2005/06
C13a - dignity and respect	COMPLIANT	COMPLIANT	COMPLIANT
C13b - consent	COMPLIANT	COMPLIANT	COMPLIANT
C13c - confidentiality of information	COMPLIANT	COMPLIANT	COMPLIANT
C14a - complaints procedure	COMPLIANT	COMPLIANT	COMPLIANT
C14b - complainants discrimination	COMPLIANT	COMPLIANT	COMPLIANT
C14c - complaints response	COMPLIANT	COMPLIANT	COMPLIANT
C15a - food provision	COMPLIANT	COMPLIANT	COMPLIANT
C15b - food needs	COMPLIANT	COMPLIANT	COMPLIANT
C16 - accessible information	COMPLIANT	COMPLIANT	COMPLIANT

Accessible and responsive care

	2007/08	2006/07	2005/06
C17 - patient and public involvement	COMPLIANT	COMPLIANT	COMPLIANT
C18 - equity, choice	COMPLIANT	NOT MET	COMPLIANT

Care environment and amenities

	2007/08	2006/07	2005/06
C20a - safe, secure environment	COMPLIANT	COMPLIANT	NOT MET
C20b - privacy and confidentiality	COMPLIANT	COMPLIANT	COMPLIANT
C21 - clean, well designed environment	COMPLIANT	COMPLIANT	NOT MET

Public health

	2007/08	2006/07	2005/06
C22a and c - public health partnerships	COMPLIANT	COMPLIANT	COMPLIANT
C22b - local health needs	NOT APPLICABLE	COMPLIANT	COMPLIANT
C23 - public health cycle	COMPLIANT	COMPLIANT	COMPLIANT
C24 - emergency preparedness	COMPLIANT	COMPLIANT	COMPLIANT

Existing national targets performance by indicator

Our assessment of existing national targets looks at whether this trust is maintaining the levels of service set through the Department of Health's 2003-2006 planning round. We use sets of performance indicators to measure the targets. In the 2007/08 annual health check we used a total of 36 indicators across the different trust types to measure performance against existing national targets. Most of those targets are measured by one performance indicator, with the remainder being measured by two indicators.

The levels of performance against the indicators for this trust are detailed below.

Indicators

	2007/08	2006/07	2005/06
Total time in A&E: four hours or less	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
All cancers: two week wait	ACHIEVED	ACHIEVED	ACHIEVED
Rapid access chest pain clinic: two week wait	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Revascularisation: three month wait	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Cancelled operations and those not admitted within 28 days	UNDER ACHIEVED	UNDER ACHIEVED	UNDER ACHIEVED
Thrombolysis - 60 minute call to needle time	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Information in place to support choice	FAILED	ACHIEVED	ACHIEVED
All cancers: one month diagnosis to treatment	ACHIEVED	ACHIEVED	ACHIEVED
All cancers: two month GP urgent referral to treatment	ACHIEVED	ACHIEVED	ACHIEVED
Inpatients waiting longer than 26 weeks	ACHIEVED	ACHIEVED	ACHIEVED
Outpatients waiting longer than 13 weeks	ACHIEVED	ACHIEVED	ACHIEVED

Note: Data from the last three years has been presented in the table above. However, annual amendments to indicator constructions and scoring thresholds have sometimes taken place.

New national targets performance by indicator

Our new national targets assessment looks at the targets outlined in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 - 2007/08*. As for existing national targets we use sets of indicators to measure performance against the targets. In the 2007/08 annual health check we used a total of 59 indicators to measure performance against the new national targets. Some new national targets are measured by one performance indicator, with others being measured by up to four indicators.

Indicator level performance for this trust is detailed below.

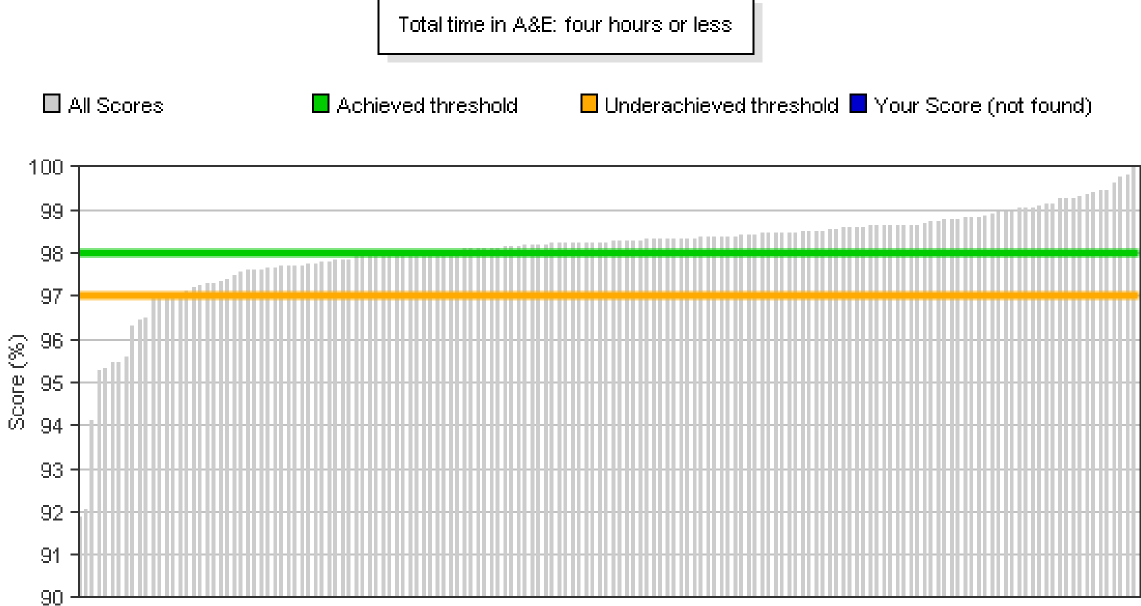
Indicators

	2007/08	2006/07	2005/06
Participation in audits	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Smoking during pregnancy and breastfeeding initiation	ACHIEVED	ACHIEVED	ACHIEVED
Access to genito-urinary medicine clinics within 48 hours	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Experience of patients	SATISFACTORY	SATISFACTORY	SATISFACTORY
Emergency bed days	DATA NOT AVAILABLE	DATA NOT AVAILABLE	ACHIEVED
Waiting times for diagnostic tests	ACHIEVED	ACHIEVED	ACHIEVED
Clostridium difficile data quality	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE
MRSA bacteraemia	ACHIEVED	ACHIEVED	ACHIEVED
Data quality on ethnic group	ACHIEVED	ACHIEVED	ACHIEVED
Compliance with guidelines concerning self harm	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE
Information, screening and referral for drug misusers	ACHIEVED	ACHIEVED	FAILED
Referral to treatment time milestones	ACHIEVED	NOT APPLICABLE	NOT APPLICABLE
Compliance with guidelines concerning obesity	UNDER ACHIEVED	NOT APPLICABLE	NOT APPLICABLE

Note: Data from the last three years has been presented in the table above. However, annual amendments to indicator constructions and scoring thresholds have sometimes taken place.

Focus on selected target indicator

The graph below shows how Birmingham Women's NHS Foundation Trust has performed in comparison with all other acute trusts for the selected target indicator in 2007/08.



Summarised performance of other annual health check assessments

The following assessments have also been carried out during the first three years of the annual health check. Our reviews and studies look at whether NHS trusts are delivering high quality care and treatment, and achieving value for money.

	2007/08	2006/07	2005/06
Medicines management			FAIR
Maternity		FAIR PERFORMING	

Useful links and glossary

The documents below provide further information on the annual health check:

- Performance ratings 2007/08 - including links to national overview report and regional summaries
- More information on core standards
- More information on existing national targets
- More information on new national targets
- Annual health check 2007/08 frequently asked questions
- Information on NHS patient surveys

Glossary of terms:

Core standards

Fully met: This score means that a trust met all of the core standards set by Government by the end of the assessment year. A trust can only receive this score if it declares no more than four failings during the year. These failings must have been corrected by the end of the year.

Almost met: This score means that a trust met almost all of the core standards set by Government.

Partly met: This score means that a trust met many of the core standards set by Government. However, it was not able to demonstrate that it had met a number of standards.

Not met: This score means that a trust did not meet several of the core standards set by Government.

Compliant: This score means that a trust's board determined that it had met a standard during the assessment year, without any significant lapses.

Insufficient assurance: This score means that a trust's board was unclear as to whether there had been one or more significant lapses during the assessment year in relation to a standard.

Not met: This score means that a trust's board was clear that there had been one or more significant lapses in relation to a standard during the assessment year.

Declaration adjusted / Qualification: This score means that a trust received a follow up inspection at the end of the assessment year and had its declared compliance level adjusted, or qualified, based on the findings of our inspection.

Existing and new national targets

Fully met: This score means that a trust performed consistently well for the existing national targets assessment.

Almost met: This score means that a trust performed well for many aspects of the existing national targets assessment.

Partly met: This score means that a trust performed poorly for some aspects of the existing national targets assessment.

Not met: This score means that a trust generally performed poorly for the existing national targets assessment.

Excellent: This score means that a trust performed well beyond the minimum requirements and the reasonable expectations for the new national targets assessment.

Good: This score means that a trust performed above the minimum requirements and the reasonable expectations for the new national targets assessment.

Fair: This score means that a trust performed in line with the minimum requirements and the reasonable expectations for the new national targets assessment.

Weak: This score means that a trust performed below the minimum requirements and the reasonable expectations for the new national targets assessment.

Achieved: This score means that a trust performed to a high level for this aspect of the targets assessment.

Underachieved: This score means that a trust performed below the required level for this aspect of the targets assessment.

Failed: This score means that a trust performed poorly for this aspect of the targets assessment.

Not applicable: This score means that this aspect of the targets assessment did not apply to this trust. As a result, this trust was not assessed against it.

Data not available: This score means that this aspect of the targets assessment did apply to this trust, but the relevant data were not available. This was not the fault of the trust, so it was not assessed against it.

Data not returned: This score means that this aspect of the targets assessment did apply to this trust, but the relevant data were either not returned or were of insufficient quality for the purpose of this assessment. As a result, this trust was awarded the lowest score, equivalent to a fail.

Target: This is an expectation of the NHS set by Government, which is to be achieved by a specific date.

Indicator: This is what we use to measure performance against a target. Often this will be a one-to-one relationship (in other words, one target is measured by one indicator), but sometimes we use more than one indicator to assess performance against a target.

Indicator construction: This is the detailed information that we publish about an indicator, which outlines the data and the method we will use to assess performance.

Scoring threshold: This is what we use to determine the required level of performance for an indicator. For each indicator, we use thresholds of performance to decide whether an organisation has 'achieved', 'underachieved' or 'failed'.

Quality of services assessment

Excellent: This score means that a trust received the highest score of either 'fully met' or 'excellent' for all applicable assessments that contribute to the overall quality of services score.

Good: This score means that a trust received at least the second highest score of either 'almost met' or 'good' for all applicable assessments that contribute to the overall quality of services score.

Fair: This score means that a trust has performed adequately, in that it has not received the lowest score of 'not met' for either core standards or existing national targets. However, it has not performed sufficiently well across the applicable assessments that contribute to the overall quality of services score to score any higher.

Weak: This score means that a trust received the lowest score of 'not met' for either core standards or existing national targets.

Use of resources assessment

Excellent: This score means that a trust performed very well. Management arrangements operated effectively, and financial targets were met for at least the last two years.

Good: This score means that a trust performed well in regard to its financial arrangements, and met its financial targets for at least the last two years.

Fair: This score means that a trust performed adequately in regard to its financial arrangements.

Weak: This score means that a trust performed poorly in regard to its financial arrangements.