

PUBLIC SESSION

MEETING OF THE BOARD OF DIRECTORS
to be held in the Seminar Room, Birmingham Women's Hospital
on Thursday 26 February 2009 at 11.00am

AGENDA

- | | | | |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------------------------------------|
| 1 | Welcome and apologies
Apologies should be sent to Jackie Howell at
jackie.howell@bwhct.nhs.uk, tel 0121 627 2601 | | Enc |
| 2 | Questions from the public on matters relating to the agenda | | |
| 3 | Declarations of interest
Directors are asked to declare any interests relating to any of the items on the agenda | | |
| 4 | Minutes of the meeting held on 29 January 2009
To APPROVE the minutes of the meeting held on 29 January 2009 | | 1
Ref
2/09/public/A4/v1 |
| 5 | Matters arising from the minutes of the meeting held on 29 January 2009 (where not covered by agenda items) | | |
| 6 | Trust Chair's report
a. Process for appointment of Chief Executive | | Oral |
| 7 | Meeting of Board in private session
To NOTE that representatives of the press and other members of the public were excluded from an earlier session of the meeting having regard to the confidential nature of the business which was transacted, publicity on which would be prejudicial to the public interest. | | |
| 8 | Report by the Chief Executive | JB | Oral |
| | PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE | | |
| 9 | Red Risk Register and Assurance Framework
To CONSIDER the Red Risk Register and Assurance Framework | SIP | 2
Ref
2/09/public/A9/v1 |

ASSURANCE

- | | | |
|-----------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------|
| 10 Update on registration with the Care Quality Commission
To RECEIVE an update on the registration process | JO | Oral |
| 11 Policy approvals process
To CONSIDER a paper on changes to the policy approval process in the Trust | SIP | 3
Ref
2/09/public/A11/v1 |
| 12 Quarterly Report on Infection Control (Matron's Reports)
To RECEIVE the report | JO | 4
Ref
2/09/public/A12/v1 |

ORGANISATIONAL PERFORMANCE

- | | | |
|-------------------------------------------------------------------------------------------------------------------|-----------------|---------------------------------------|
| 13 Integrated Performance Report (including Finance Report)
To NOTE the Integrated Performance Report | JO
JaB
NS | 5
Ref
2/09/public/A13/v1 |
| 14 Freedom of Information- Annual Report
To RECEIVE the report | JaB | 6
Ref
2/09/public/A14/v1 |
| 15 Six-monthly update from the Cancer Intelligence Unit
To RECEIVE the update | G
Lawrence | 7
Ref
2/09/public/A15/v1 |
| 16 Six-monthly update from the National Genetics Education and Development Centre
To RECEIVE the update | C Cooley | 8
Ref
2/09/public/A16/v1 |

MEMBERS' COUNCIL MATTERS

- | | | |
|----------------------------------------------------------------------------------------------------------------|----|-------------|
| 17 Report from Members' Council Chair
a. Meeting of Members' Council, 16 th February 2009 | JM | Oral |
|----------------------------------------------------------------------------------------------------------------|----|-------------|

18 TRUST POLICIES FOR APPROVAL

- | | | |
|-----------------------|----|-----------------------------------------|
| a. Training Strategy | JO | 9
Ref
2/09/public/A18a/v1 |
| b. Surrogacy Guidance | JO | 10
Ref
2/09/public/A18b/v1 |

ITEMS CIRCULATED BETWEEN BOARD MEETINGS

To NOTE the following items have been circulated since the previous meeting:

- a. Action notes from January Board/ Trustee meetings
- b. E-mails regarding resignation of Chief Executive

Dates of next meetings

Thursday 26 March 2009

Thursday 23 April 2009

Thursday 28 May
Thursday 4 June (Annual Accounts)
Thursday 25 June

Birmingham Women's**NHS Foundation Trust**

**Unconfirmed Minutes of the
MEETING OF THE FOUNDATION TRUST BOARD
HELD IN PUBLIC
in the Seminar Room, Birmingham Women's Hospital,
on Thursday 29th January 2009**

PRESENT:	Judith Mackay (in the Chair)	Trust Chairman
	Professor Ian Booth	Deputy Chairman
	Julie Burgess	Chief Executive
	Jason Burn	Acting Commercial Director
	David Draycott	Non-Executive Director
	Nigel Gardner.	Non-Executive Director
	Helen Hemberg	Non-Executive Director
	Jane Owen	Director of Nursing & Midwifery
	Robin Rison	Non-Executive Director
	Tim Woods	Director of Finance
IN ATTENDANCE:	Estelle Carmichael	Associate Director of Human Resources
	Steve Parsons	Head of Corporate Affairs

ACTION**FTP/0109/1 WELCOME AND APOLOGIES**

FTP/0109/1.1 Apologies for absence were received from Neil Savage; the Chairman noted that Estelle Carmichael was representing him at this meeting.

FTP/0109/1.2 The Chairman took the opportunity to express the Board's regret that Mr Woods was leaving the Trust, and to pay tribute to his substantial contribution. He had been a safe pair of hands and had helped to provide stability to the Trust through testing times, and the Board wished him well in his new role at Derbyshire Mental Health Trust.

FTP/0109/1.3 Julie Burgess also recorded her thanks for Mr Woods' contribution, and for hitting the ground running when he joined the Trust; also for his sterling work in getting the Trust through the Authorisation process. He would be a hard act to follow.

FTP/0109/2 QUESTIONS FROM THE PUBLIC ON MATTERS RELATING TO THE AGENDA

FTP/0109/2.1 No questions relating to the business of the meeting were asked by the members of the public attending.

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Ref: 2/09/public/A4/v1

FTP/0109/3 DECLARATIONS OF INTEREST

FTP/0109/3.1 No interests were declared in any item on the agenda for the meeting.

FTP/0109/4 MINUTES OF MEETING HELD ON 18 DECEMBER 2008

FTP/0109/4.1 The minutes of the meeting held on 18th December 2008 were **APPROVED** and signed as a correct record subject to the following amendments:

- FTP/1208/6.7, Judith Lockhart who had been a Midwife
- FTP/1208/8.2, the reference is to self-assessment
- FTP/1208/12.9, Robin Rison clarified that his question related to whether expenditure on contracts had driven up non-pay spending.

FTP/0109/5 MATTERS ARISING FROM THE MINUTES OF THE MEETING HELD ON 18th DECEMBER 2008

FTP/0109/5.1 No matters arising were mentioned.

FTP/0109/6 TRUST CHAIR'S REPORT

FTP/0109/6.1 The Chairman reported that the Trustees of the Ronald McDonald House Charity had enjoyed a successful visit to the Trust; she reminded the Board that discussions were ongoing for the building of a House on the Birmingham Women's Hospital site. Julie Burgess confirmed that it had been a positive visit and the Charity was very engaged.

FTP/0109/7 MEETING OF THE BOARD IN PRIVATE SESSION

FTP/0109/7.1 The Chairman reported that the Board had met earlier in the day in private session, and had considered a number of items including progress towards objectives in the third quarter, developments in the bid for Academic Health Science Centre status, work toward the Annual Business Plan, the development of an estates strategy, work on meeting NHSLA standards, the outcome of the recent Equitable Access tender process, and commentary on the draft job role for the Chair of the Trust.

FTP/0109/8 ORAL REPORT BY THE CHIEF EXECUTIVE

FTP/0109/8.1 The Chief Executive drew the Board's attention to the following matters:

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Ref: 2/09/public/A4/v1

- FTP/0109/8.2 Foundation Trust anniversary: The first anniversary of authorisation would fall on Sunday 1st February; she thanked the staff of the Trust for their hard work in making this status a success. She also drew attention to the Trust's first-year performance scores which had been excellent throughout.
- FTP/0109/8.3 National Safeguarding Review: The self-assessment for this process was still pending, as the Healthcare Commission framework had not been provided to date. However, no issues were anticipated.
- FTP/0109/8.4 Executive Director timeout: The Executive Directors had held a timeout day earlier in January, when a number of issues were discussed, to horizon scan and identify future challenges.
- FTP/0109/8.5 Clinical Excellence Awards: The Panel had met under the Chief Executive's chairmanship, and made awards under the scheme. A report from the Panel would be presented to the Board next month. **JB**
- FTP/0109/8.6 Retirement of Mr Chan: The Chief Executive noted that Mr Chan, a senior surgeon with the Trust, would be retiring at the end of April; there would be two consequential appointments
- FTP/0109/8.7 Service of Celebration: A service to celebrate the work of the old Neo-Natal Unit would be held on 14th March in St Phillips Cathedral. Invitations for Directors had been laid on the table.
- FTP/0109/8.8 Nursing Leadership Summit: The Chief Executive reported that she had been asked to speak at this event.
- FTP/0109/8.9 Clinical Visits: a number of visits had taken place since the last Board meeting, including working alongside; a junior doctor on a twilight shift; a community midwife; Professor Gutpa in the hysteroscopy clinic and the Estates Team.
- FTP/0109/8.10 Professor Booth drew the Board's attention to the high number of national Clinical Excellence awards received in this Trust, which was both a good indicator of high quality and good for the finances (as these were funded centrally).
- FTP/0109/8.11 Jane Owen drew the Board's attention to a recent successful bid to the Burdett Trust, who were undertaking a piece of work researching the role of Nursing Directors and the amount of time spent by Boards considering clinical and patient issues. There would be interviews with key figures, and reviews of the interaction with the Board on a diagnostic basis with **Board**

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Ref: 2/09/public/A4/v1

support/ counselling for the Executive Nurse in between. Details were awaited, but Board engagement would be needed.

- FTP/0109/8.12 The Board:
- **NOTED** the items reported by the Chief Executive; and
 - **AGREED** to participate in the work of the Burdett Trust.

- FTP/0109/8.13 The Chief Executive's report was **NOTED** with thanks.

PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE

FTP/0109/9 Red Risk Register and Assurance Framework

- FTP/0109/9.1 Jane Owen presented the register (paper 1/09/public/A9/v1), noting that no items had been updated since the December report although EWTD compliance had been added for Medical Staffing; this was rated as an Amber risk at the corporate level. She also reported that a shadow register was now on Datix, with the scoring system now amended and ready to go; the next step was for ORAG to state what was needed from the register, which could then go live. Finally, she noted that the Head of Corporate Affairs would be presenting this report from February 2009.

SIP

- FTP/0109/9.2 The Chairman noted the work in presenting the report over the last 18 months, and asked what had been the main challenges; Jane Owen identified several challenges, including significant changes, moving to a new reporting system and the required level of training, achieving the Board's expectations from reporting, and ensuring risk management was embedded. Julie Burgess noted that the annual risk discussion by the Board would be scheduled shortly, and this would feed into the system. She further noted that risk management remained within the Clinical Governance department's remit, and the Head of Corporate Affairs would be reporting on corporate risk areas to the Board.

SIP

- FTP/0109/9.3 The Board **NOTED** the update on the Red Risk Register.

ASSURANCE

FTP/0109/10 Datix

- FTP/0109/10.1 Jane Owen presented paper 1/09/public/A10/v1, noting that a large amount of work was being undertaken to bring the system up to speed, and she was confident that the correct system for the Trust had been procured. Daily updates were being provided to the Medical

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Ref: 2/09/public/A4/v1

Director and the Director of Nursing & Midwifery, and the difficulties were being overcome. The problems with meeting national standard C01a, on reporting incidents, had been a focus; she was pleased to be able to report that from a backlog of 363, only 5 remained to be entered through a difficult NPSA web-based system. Peter Thompson noted that the requirement from the Healthcare Commission was to be compliant at 31st March 2009, although Monitor had taken a different view regarding quarterly reporting. The next phase of the project would be to update the project plan, and present to ORAG and Clinical Governance Committee at the end of February/ beginning of March.

PT/ JO

FTP/0109/10.2 The Chairman asked for confirmation that implementation dates were being set, and Jane Owen confirmed that they were included within the project plan.

PT/ JO

FTP/0109/10.3 The Board **NOTED** the update on progress in implementing Datix in the Trust.

ORGANISATIONAL PERFORMANCE

FTP/0109/11 INTEGRATED PERFORMANCE REPORT

Dashboard

FTP/0109/11.1 Jane Owen presented the dashboard report, and was pleased to be able to report that the Trust had achieved the targets for 18-week referral to treatment in respect of both in- and out-patients; she expressed her thanks to all the staff who had worked hard to enable this outcome, noting that the validation of data had made the difference between success and failure. This target would be monitored monthly in January, February and March, during which performance management by the PCT's would be in operation.

FTP/0109/11.2 She also noted that the 13-week target had been defined in the last quarter as including Clinical Genetics, and therefore the Trust had not been able to achieve this target in the 2008-2009 year. There had been significant re-organisation in this area, and the Trust was working with Commissioners to achieve the target.

FTP/0109/11.3 Robin Rison referred to the ongoing work in Clinical Genetics, and asked if recruitment was difficult; how many extra staff were needed? Jane Owen advised that 1 to 1½ senior staff posts had been identified, with other supporting posts; the cost was estimated at a recurrent £340k. Peter Thompson noted that this was partly dependent on the national pathway discussions, which were yet to be concluded and might not support a 13-week approach. Julie Burgess noted that Clinical

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Genetics treatments were not currently included in the Lorenzo project, but would need to be added locally, giving an additional capital cost for the Trust. **TW**

FTP/0109/11.4 Prof. Booth commented that the hypothesis for 18-week treatment had involved extra cost; was this myth or reality? Jane Owen suggested that significant investment had been needed to achieve the target, but this should level off with achievement; the re-organisation of the 20 scheduled lists had been of assistance, but the clinical staff had also improved their performance. Peter Thompson noted that this did mean that the Trust had less ability to absorb peaks and troughs in performance whilst still meeting targets.

Finance

FTP/0109/11.5 Tim Woods presented the finance report, noting that he would prepare the February report but it would be presented to the Board by Mr Burn. December had been a good month, with overachievement on income and underspending on both pay and non-pay areas; a cumulative surplus of £1.2 million was showing for the first three quarters of the financial year. Additional income from PCT's for maternity had now been confirmed and included, giving a temporary spike that would drop back in future. It was now expected that the end of year position would be ahead of forecast, indicating a Monitor rating of 4. **JaB**

FTP/0109/11.6 Mr Woods also drew attention to the strong cash position, with £9.2 million in cash, and referred to the report's commentary on the reasons why this had fallen back from the highs in the summer: better planning and drawdown for capital projects, the disbursement of funds held for flu pandemic work, and paying non-NHS creditors within 10 days rather than 30.

FTP/0109/11.7 The Chairman asked for confirmation that the CIP delivery was better than the comparable period in the previous year, and it was confirmed that improvements had been seen in each of the last 2 years, and there were no red indicators at this point: in response to a question, it was confirmed that replacement windows were included in the capital expenditure figures. Helen Hemberg referred to the inclusion of the increase in HRG4 in the figures, and questioned whether the increase in CNST should also be included; Tim Woods confirmed that this was included in the projections for 2009-2010. **TW/ JaB**

FTP/0109/11.8 Robin Rison referred to page 12 of the report, and commented that he was surprised not to see an improvement in the position for Gynaecology; Tim

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Woods noted that the Directorate was pulling back from the previous position, but the trend was not in a straight line- work was still needed, and the issues would not be solved within this year. Julie Burgess drew the Board's attention to the dashboard entry for CIP recurring/non recurring mix, which had gone to red owing to difficulties with the rebate from CNST this year against the large increase for 2009-2010 and without which this area would be on plan.

TW

Workforce

FTP/0109/11.9 Estelle Carmichael referred to the workforce section of the dashboard report, and noted that the biggest present concern was the sickness absence level which had significantly increased in December. Some of this had been shown to be related to absences not being closed on the system, but further work was also being undertaken to improve the management of sickness absence. The Director of Workforce and Organisational Development would be calling on all Directorates to formulate plans to improve sickness absence. She also referred to the KSF information presented, noting that although the recorded rate was low it was understood the actual completion rate was above 50%; the human resources department would be working through this with managers to ensure that the appropriate returns were made when appraisals were done.

NS

EC

FTP/0109/11.10 Peter Thompson referred to the reported position on sick leave, and commented that he felt less concern as there had been a period of high sickness more generally; in the hospital environment, it was important that those who were ill were not present so as to avoid cross contamination. Estelle Carmichael confirmed that the figures showed about 30% of the absence was long-term (over 4 weeks), whilst most absence was for periods under 5 days; there was also an intention to analyse the position on maternity leave and other absences.

FTP/0109/11.11 Referring back to the KSF position, Nigel Gardner asked for the reason as to the difference in reported and understood positions; Estelle Carmichael commented that formal returns to the department were not being received, and the department would be following up with directorates. Peter Thompson commented that doing appraisals was seen as a high priority, but returning the paperwork might not be.

FTP/0109/11.12 The Board:
• **NOTED** the Integrated Performance Report for December 2008.

FTP/0109/12 MONITOR REPORT FOR QUARTER 3, 2008-2009

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Ref: 2/09/public/A4/v1

- FTP/0109/12.1 The Head of Corporate Affairs presented paper 1/09/public/A12/v1, proposing the detailed return to Monitor for the third quarter of the year. He noted that, consequent on clarification of Monitor's requirements, it was proposed to make Declaration 2 owing to technical non-compliance with Standard C01a, relating to reporting incidents to the National Patient Safety Agency. Significant work had been ongoing in relation to this, and it was expected that the back-log would be resolved by the submission of the return; if this was confirmed, an appropriate amendment to the detailed return would be made. **SIP/ TW**
- FTP/0109/12.2 Subject to some identified typographical errors, the Board:
- **AUTHORISED** the Chairman to sign Declaration 2 on behalf of the Board; and **JM**
 - **AUTHORISED** the submission of the relevant documents to Monitor, subject to any appropriate amendment in respect of Standard C01a. **TW/ SIP**
- FTP/0109/13 ESTABLISHING A VOLUNTEER PROGRAMME**
- FTP/0109/13.1 Estelle Carmichael presented paper 1/09/public/A13/v1, making recommendations for the development of volunteering within the Trust. It was proposed to recruit a part-time Volunteer Services Manager, who would lead in this area; other concerns, such as appropriate policies for the use of volunteers, were being considered and would be resolved prior to full implementation; Directors noted the need for policies relating to complaints and other areas. Julie Burgess noted that this area had been promoted by the Members' Council Estates & Environment Committee, and also had the support of the Management Board. **NS**
- FTP/0109/13.2 The Board:
- **AGREED** the recommendations in the paper; and
 - **SUPPORTED** the development of volunteering in the Trust, including the appointment of a Volunteer Services Manager. **NS**
- FTP/0109/14 COMMUNICATIONS STRATEGY**
- (Claire Austin joined the Board for this item.)
- FTP/0109/14.1 The Board noted the strategy set out in paper 1/09/public/A14/v1, and was advised that it had been considered and supported by the Management Board. It built on the strategy considered by the Board in 2007, and although challenging was achievable. The Board's attention was drawn to the recently-established Facebook group, which now had 117 members. Julie

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Burgess noted that this represented a new direction for the Trust.

FTP/0109/14.2 Prof. Booth expressed some caution about involvement with Facebook, noting that harassment issues could arise for medical staff; Claire Austin acknowledged the point, but confirmed that the entries were being monitored and noted that the site was being aimed at the public rather than staff. Directors welcomed the successes in the Communications function over the last several months; Robin Rison suggested that the strategy should be tightened with entries for what would be achieved and how. Helen Hemberg noted that this was always a difficult area to manage, and suggested that the Trust needed, over time, to secure national as well as local coverage: it was acknowledged that giving out-of-hours coverage also posed challenges given the small communications team. The Chairman suggested that Claire Austin could work with Helen Hemberg to develop this further. **CA**

FTP/0109/14.3 David Draycott drew attention to the need for the business planning process to address the resourcing of the communication function, which the Board would consider in the coming months. Robin Rison noted the need for caution in offering 'experts' to the media, and the need for full training to be given. The Chairman commented that some areas could be improved, including the analysis of why and how actions would be taken; also a review of the use of technology would be useful. **JaB**
CA

FTP/0109/14.4 The Board:

- **AGREED IN PRINCIPLE** with the strategy;
- **AGREED** that the strategy should start to be implemented, pending an updated draft being presented to the Board in April or May 2009.

CA

FTP/0109/15 TRUST VALUES

FTP/0109/15.1 On behalf of Neil Savage, Julie Burgess presented paper 1/09/public/A15/v1, which arose from the discussions at the December Board seminar and subsequent discussions undertaken by the Executive team. The paper made some suggestions, which were not final proposals; they would be subject to wide discussions with interested groups within and outside the Trust. **NS**

FTP/0109/15.2 David Draycott drew attention to the need for the values to include reference to the Trust being open and inclusive, and also suggested that the Trust Board should contribute to the consultation exercise, at the relevant time. Prof. Booth noted the need for the Trust to **SIP**

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- follow the applicable equalities legislation, and it was confirmed that the relevant toolkits were followed.
- FTP/0109/15.3
- The Board:
- **AGREED**, subject to the wording being refined, the vision statement in section 1.4 of the paper; and
 - **WELCOMED** the proposed process to consult on Trust values, based on the statements in sections 3.1 to 3.5 of the paper; and
 - **REQUESTED** that the Board be given the opportunity to participate in the consultation. **NS**
- FTP/0109/16** **REGISTRATION WITH THE CARE QUALITY COMMISSION**
- FTP/0109/16.1 Jane Owen presented paper 1/09/public/A16/v1, seeking Board approval to make the necessary declarations for registration with the Care Quality Commission. She reminded the Board of the discussion at the previous meeting, and confirmed that the Trust could make the statement required by the new legislation. She also circulated a re-print of the Trust's answers to the various secondary questions on registration, as the original CQC web-site had contained an error.
- FTP/0109/16.2 The Board:
- **APPROVED** the making of the necessary statement for registration with the CQC; and
 - **AUTHORISED** the Chief Executive to sign the statement on behalf of the Trust. **JB**
- FTP/0109/17** **TERMS OF REFERENCE FOR ORAG AND MANAGEMENT BOARD**
- FTP/0109/17.1 The Head of Corporate Affairs presented paper 1/09/public/A18/v1, outlining proposed changes to the Terms of Reference for (i) ORAG and (ii) Management Board, as recommended by those Committees.
- FTP/0109/17.2 The Chairman noted that the Chair was an ex-officio Member of other Board Committees and asked whether the same should happen with the Management Board; the Head of Corporate Affairs noted that the Constitution made no provision for this, so it was a matter for the Board. Julie Burgess expressed discomfort with this idea, as the Management Board was the operational board for the Trust; although she was comfortable with non-executive Directors attending on an occasional basis, she felt the work of the Management Board would be inhibited by such an appointment.
- FTP/0109/17.3 In response to questions, the Head of Corporate Affairs confirmed that the current arrangements meant that

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whoever was Trust Chairman would currently serve on a number of Committees, which the Board had made *ex-officio* appointments, as a voting member.

FTP/0109/17.4 Referring to the delegation of powers to the Management Board, the Chairman commented that the terms of reference were all stated in terms of items coming up from the Management Board, and they should reflect a two-way communication with items being referred from the Board as well. David Draycott commented that the approach depended on what the Board wished the Management Board to do; if the Board referred an item, it was implicit that the Management Board should review and report. He also drew attention to a previous discussion about the overall scheme of delegation to Board Committees, which he suggested should be referenced in the Terms of Reference.

FTP/0109/17.5 The Board:

- **AGREED** the amendments to the terms of reference for the Organisational Risk & Governance Committee; and
- **REQUESTED** that the proposed changes to the terms of reference for the Management Board be the subject of further consideration.

**Man. Bd./
SIP**

MEMBERS' COUNCIL MATTERS

FTP/0109/18 Report from Members' Council Chair

FTP/0109/18.1 The Chairman reported that there had been limited activity since the previous Board meeting, with the various Committees of the Council meeting on their usual cycle.

FTP/0109/19 Trust Policies for approval

FTP/0109/19.1 Jane Owen presented paper 1/09/public/A19/v1, the annual review and update of the Trust's Risk Management Strategy. It was noted that Clause 3.10 should refer to 'lead clinicians'.

FTP/0109/19.2 Subject to that amendment, the Board **APPROVED** the Trust Risk Management Strategy.

FTP/0109/20 Sealing Register

FTP/0109/20.1 The Board **APPROVED** the application of the Trust Seal to the contract with E. Manton Ltd., as set out in the report at paper 1/09/public/A20/v1.

Dates of next meetings

ENCLOSURE 1

Ref: 2/09/public/A4/v1

Thursday 26 February 2009
Thursday 26 March 2009
Thursday 23 April 2009

Birmingham Women's



NHS Foundation Trust

SUBJECT :	Structure for revising the Policy for Policies
REPORT BY :	Steve Parsons, Head of Corporate Affairs
AUTHOR :	Steve Parsons, Head of Corporate Affairs

CONTEXT AND BACKGROUND FOR REPORT

The Trust's current policy process is contained within the *Guideline for the Development, Distribution and Maintenance of Trust Policies*. This is now due for regular review.

As part of this review, it is intended to move the 'policy for policies' into the standard template offered by NHSLA, thereby ensuring that their requirements for this are met. It is also intended to take the opportunity to reform the policy approval process in the Trust.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The current policy approval process, as set out in the *Guideline*, requires Trust Board to approve all policies and guidelines. This may be an inefficient use of the limited time of the Board, and also tends to delay the passage of policies unnecessarily as there are a large number of groups that consider the drafts. How much value is added by this multiple consideration is questionable.

It is proposed to adopt a new system, already in use at other Trusts, to 'grade' the level of approval for policies and guidelines:

Class 'A'-	Whole-Trust policies, strategic or otherwise important enough to require Trust Board approval. e.g. Health & Safety policy
Class 'B'-	Whole-Trust policies not requiring Trust Board approval. These will be approved by Clinical Governance Committee/ ORAG as appropriate. Most policies will fall within this category.
Class 'C'-	Policies applicable only to one Directorate. These will be approved by a Directorate policy group, and reported to CGC/ ORAG.
Class 'E'-	Policies adopted in concert with external partners. These will be subject to Class 'A' or 'B' approval, as appropriate.

ENCLOSURE 3

Ref 2/09/public/A11/v1

e.g. Safeguarding of Children policy

The revision of the 'policy for policies' will also include the requirement for all policies and guidelines to include an equality impact assessment, as required by law, together with other statutory compliance requirements such as risk assessment. It will also provide for an annual report of policy approvals to the Board.

RECOMMENDATIONS

The Board is invited to:

- a. **NOTE** the need to review the *Guideline for the Development, Distribution and Maintenance of Trust Policies*;
- b. **AGREE** to utilise the NHSLA template for the review; and
- c. **AGREE IN PRINCIPLE** to the proposed new structure for approving policies and guidelines.

Birmingham Women's

NHS Foundation Trust



SUBJECT :	Matron's 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.

These Matron 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 January 2009 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)
- Audits undertaken in the clinical areas.
- The improved results of hand hygiene audits.
- The successful migration to BBraun.

RECOMMENDATIONS

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

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

Quarterly period	Oct-Dec 2008
Directorate	Clinical Support
Matron	Gael Peters

1. Hand hygiene audit

Ward/Dept		% Score	Nurse /Midwives	Medics	AHP's	Others
Theatre	Q3	88%	89%	75%	100%	N/A
& Recovery	Q2	80%	91%	50%	N/A	100%
	Q1	100%	100%	100%	100%	N/A

This quarter has seen an improvement with the Medical staff in the recovery area which is largely attributed to the availability of hand gel at the point of care. Overall scoring is acceptable but will continue to monitor and reinforce good practice.

2. Cleaning & the environment

All areas of the Directorate have shown improvement in this quarter and the environmental walkabouts have proved to be a useful tool for ensuring all areas adhere to policies and procedures.

Work has been undertaken in updating decontamination policies, cleaning schedules and daily decontamination procedures undertaken locally.

Managers continue to enforce the uniform policy (in particular within/outside of the Operating theatres) which now has less than 1% non-compliance. This is a major achievement, and no complaints have been received regarding this since October 2008.

We will continue to monitor the cleanliness of all areas of the directorate and are submitting proposals into the Directorate Annual Plans for 2009/10 to improve/increase the cleaning/housekeeping regime in several key areas.

3. Decontamination

The Trust successfully migrated decontamination services from Synergy Healthcare to BBraun on 17th November. This work has been part of the Pan Birmingham Decontamination Project involving all Trusts in Birmingham who use decontamination services.

The BWH is the penultimate Trust to migrate to the facility in Kings Norton. We are also the only Trust tracking supplementary (single wrapped) items as we were successful in negotiating a trial for these items.

The advantages to the Trust of this service are:

- Full track and traceability of all instrument trays and supplementary items.
- The introduction of an Instrument Management System allows us to view stock levels within all areas of the Trust to ensure continuity of service (avoiding the requirement to fast track instruments). This is also a very useful tool for items that may have been stored in the incorrect place.

- Long term this will assist in instrument management and stock levels as we can increase/reduce levels as and when required in all areas of the trust according to frequency of use.
- We also have an 8 hour turnaround time (24 hours with previous supplier).

Weekly meetings with BBraun have been established to monitor any non-conformance with the contract.

A local users group is being established to identify and rectify any failures in service delivery.

The Service Review Committee (for Pan Birmingham) will monitor performance and introduce improvements to the service and the BWH has a clinical representative on this group who also acts as the Customer advisor for the other Trusts.

4. Response to recent national guidance

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

All recovery unit bed points and Radiology scanning rooms have alcohol gel available for use at the point of care staff finds this both beneficial and time saving.

5. Untoward incidents

No untoward incidents have been recorded in this period.

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

Quarterly period	Oct-Dec 2008
Directorate	Gynaecology
Matron	Jacky Cotton

1. Infection surveillance

1.1 Newly detected cases of colonisation or infection with MRSA

- 8 cases in total. Seven cases were detected at pre-op screening and deemed to have been acquired elsewhere. The remaining case was a patient who was transferred from another hospital who underwent routine screening on admission to ward as per transfer procedure

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

This was undertaken in December 2008.

Ward/Dept		% Score	Nurse /Midwives	Medics	AHP's/Others
Ward 7	Q3	70%	85%	43%	N/A
	Q2	88%	86%	100%	100%
	Q1	85%	100%	40%	100%
Ward 8	Q3	95%	100%	100%	80% (Domestics/Porters)
	Q2	82%	100%	80%	60%
	Q1	88%	89%	75%	100%

The improvement in scores for Ward 8 reflects the ongoing work of the Ward Manager in reminding staff of the need for effective hand hygiene

The reduction in compliance by all staff on Ward 7, particularly medical staff is disappointing. The Ward Manager will be working with nursing staff to improve compliance and about the need to remind medical staff to use alcohol gel available at point of care in order to improve compliance scores during Quarter 4.

3. Cleaning & the environment

Several audits have been undertaken this quarter relating to cleanliness of the patient environment including one of mattresses and pillows. Any that were no longer fit for purpose or required recovering were taken out of patient use and exchanged with those in a bay currently closed on Ward 7.

Environmental inspections have been undertaken on a regular basis in clinical areas to ensure high standards of tidiness and cleanliness are maintained. Disposable curtains are now in use in all clinical areas and window curtains have been replaced with

blinds. Problem areas in clinical departments that were identified with storage or that were difficult to keep clean have been addressed. On Ward 8 the kitchen facilities were replaced and a large shower room that was no longer required converted to a store room.

All areas underwent “decluttering” by staff of equipment/furniture etc that were either not fit for purpose or were surplus to requirements.

Preoperative Assessment and Urogynaecology transferred to Ward 2 in December as part of the Neonatal Decant plans. Several issues were raised relating to the new department and provision of clean utility room and domestic store which were speedily resolved. Additional glove and apron dispensers were ordered and installed in areas that identified deficits.

One ward routinely closes at weekends and this had usually been Ward 7. However it was identified by the Ward Managers that this did not allow for Ward 8 to have a thorough clean as it was constantly open. Consequently wards now alternate with closures at weekends which allows each area to be cleaned regularly when there are no patients present.

4. Progress against key objectives in the Annual Programme

Routine MRSA screening of all elective Gynaecology patients continues. Although the number of colonised patients this quarter was higher than previously, this seems to be largely explained by an increase in the number of ‘at risk’ patients who would have been screened previously. To date universal MRSA screening appears to have identified only a small number of unexpected MRSA-colonised patients.

5. Response to recent national guidance

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

It is planned to undertake an audit of hand hygiene provision in Gynaecology out-patients during Quarter 4.

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. During the quarter only one intervention was made (treatment with co-amoxiclav stopped).

7. Antibiotic use & risk of *C. difficile*

Posters giving guidance on the identification, diagnosis and management of *C. difficile* have been displayed in all clinical areas.

8. Untoward incidents

None

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

Quarterly period	Oct-Dec 2008
Directorate	Maternity Services
Matron	Jenny Henry

1. Infection surveillance

1.1 Newly detected cases of colonisation or infection with MRSA

- 4 cases of colonisation/infection with MRSA in mothers. All assessed as being acquired elsewhere than BWH.
- No cases of bacteraemia with MRSA.

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	Q3	95%	90%	100%	100% (Domestics)
	Q2	85%	100%	33%	67%
	Q1	67%	75%	40%	100%
Wards 3&4	Q3	100%	100%	100%	100%
	Q2	87%	95%	33%	100%/60%
	Q1	94%	92%	100%	100%

Maternity saw a significant improvement in hand hygiene by medical and midwifery staff since the last quarter. Ward 1 saw a 10% drop from 100% - 90% in midwives this may be due to newly appointed midwives to the trust. The newly appointed midwives have either attended mandatory skill drills which include hand hygiene or are booked to attend.

Infection Control is a standing item on the maternity manager agenda any issues identified are discussed and actions agreed There have also been regular ad-hoc inspections to the clinical areas by the matrons. The audit has been disseminated to the ward managers.

3. Cleaning & the environment

Over the past quarter has again seen a significant improvement in cleaning and in the environment of all areas.

1. Cleaning of medical equipment has improved and staff have fully embraced their roles and responsibilities. The general environment has been well maintained by the staff and the Estates Department.
2. Window replacements on delivery suite continue which is improving the fabric of the building and will allow windows to be cleaned.
3. During this quarter maternity reviewed its stock levels and were able to share and reduce stock which has freed up storage space.
4. The adult and baby bed and cot mattress inspection was undertaken this quarter, there were a small number of mattresses were damaged or 'bottomed out' and removed immediately from the clinical area.
5. Early in 2008 a bed audit identified that a number of beds in general would need to be replaced, an order for inpatient beds has now been placed and we await delivery.

4. Progress against key objectives in the Annual Programme

New operational guidance on MRSA screening from the DH (31 July 2008) for 'elective' and 'high risk' Maternity cases.

Maternity will meet with the ICT to discuss and agree a pathway and timescale for implementation.

This item has been added to IC risk register under green risk.

5. Response to recent national guidance

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

Hand hygiene at point of care - Hand gel was attached to the bottom of inpatient beds. Whilst we initially experienced a number of missing gel bottles when women were discharged home this has now settled.

6. Antibiotic use & risk of *C. difficile*

Posters giving guidance on the identification, diagnosis and management of *C. difficile* have been displayed in all clinical areas.

7. Untoward incidents

None

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

Quarterly period	Oct-Dec 2008
Directorate	Neonatal
Matron	Michèle Emery/ Charlotte King

1. Infection surveillance

1.1 Newly detected cases of colonisation or infection with MRSA

- ❑ 1 case in a NNU patient (asymptomatic colonisation): source uncertain.
- ❑ 5 cases in neonates on other wards (2 considered to have been acquired at BWH – see Untoward Incident section)
- ❑ No cases of MRSA bacteraemia.

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	AHPs/Others
NNU	Q3	80%	83%	83%	50%
	Q2	75%	67%	88%	N/A
	Q1	80%	76%	100%	N/A
Ward 2	Q3	100%	100%	100%	100%
	Q2	95%	100%	90%	100%
	Q1	75%	100%	50%	100%

There has been a marked improvement in compliance with hand hygiene on Transitional Care (ward 2). Staff are congratulated.

There is an improvement in performance amongst nursing staff on the NNU and this is to be encouraged although there is still a considerable short fall from the minimum standard of 95% compliance. It is disappointing to see that medical staff results have deteriorated again this quarter. These results have been shared with all staff. Graphical representation of the results is displayed within the Neonatal Unit. Hand hygiene audits are to be completed two weekly with individuals targeted when they fall short of the standard.

3. Cleaning & the environment

The NNU environment continues to be high lighted as a red risk on the Trust Risk Register. Six weekly environment audits are completed to monitor the environment to ensure that it is safe and clean. We are working closely with the Estates Department to

maintain the environment. Weekly environmental check lists are completed by shift leaders.

The decant to ward six remains on schedule with the move taking place during the last week in February or first week in March 2009.

Cleaning schedules and check lists are kept in each of the clinical rooms and their completion is monitored by the shift leaders and Matrons.

Extra domestic cover has been requested in our Annual Plans to allow an increase the frequency of cleaning particularly high dusting.

During their visit to NNU the Health Care Commission commented that we should not store clean packs on the shelves in our incubator cleaning room. We are currently trying to locate extra storage facilities to remove these packs.

4. Response to recent national guidance

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

All cots and maternal beds now have alcohol gel at the point of use as well as at sink spaces and entrances.

5. Antibiotic use

The Gentamicin audit data collection is now in progress.

6. Untoward incident

MRSA on the new Transitional Care Ward, 4-8 December 2008

MRSA was detected in mothers and babies occupying one four-bed bay as follows:

04.12.08: Caesarean section wound swab from one mother who is a Nurse at Selly Oak Hospital

05.12.08: Umbilical swab from an unrelated baby

08.12.08: Nasal swab from a further unrelated baby

Screening of all staff and other patients was undertaken in response to likely nosocomial spread of MRSA. No further cases identified.

Assessment:

Likely that the infected mother was the index case, but that spread had occurred to the two babies. It is noted that the current transitional ward is more cramped, with fewer isolation facilities, than on Ward 2. In recognition of this a policy of screening all mothers and babies admitted to the Transitional care Ward has been implemented.

Birmingham Women's



NHS Foundation Trust

SUBJECT :	Integrated Performance Report
REPORT BY :	Jane Owen/Tim Woods/Neil Savage
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

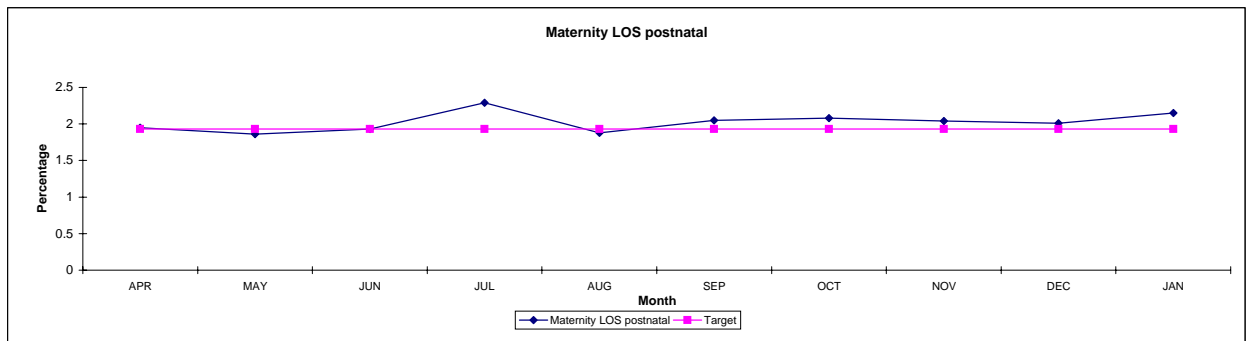
The Board are asked to consider the performance information and to be assured that this has been managed appropriately by the Executive Management Team.

Market Trend Awareness

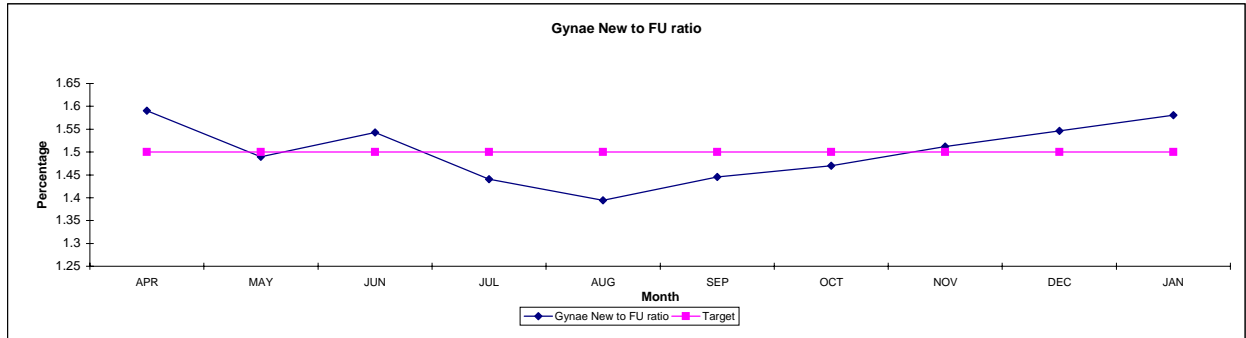
Core Standards

Productivity & Efficiency

Indicator	Target	Trend/actual	Commentary	Completion date	Lead	Risk	Impact
Maternity LOS postnatal	1.93	2.15	Slight increase this month	on going monitoring	Head of midwifery	In sufficient capacity	Delays in transfers from delivery suite leading to poor patient experience.



Indicator	Target	Trend/actual	Commentary	Completion date	Lead	Risk	Impact
Gynae New to FU ratio	<1.50	1.58	Increased follow up ratio for 2 months to be monitored closeley. The rise may be due to a new way of counting pre operative appointments	on going	General manager	exceed target	

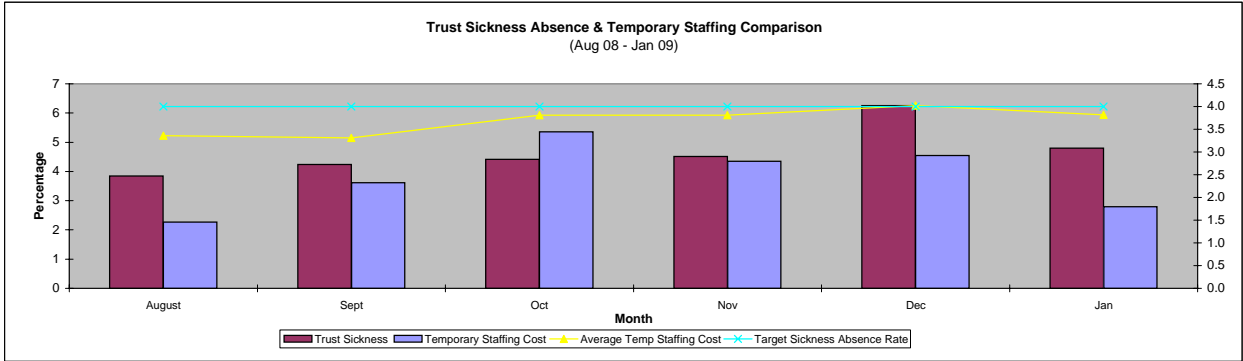


Clinical Quality

Finance

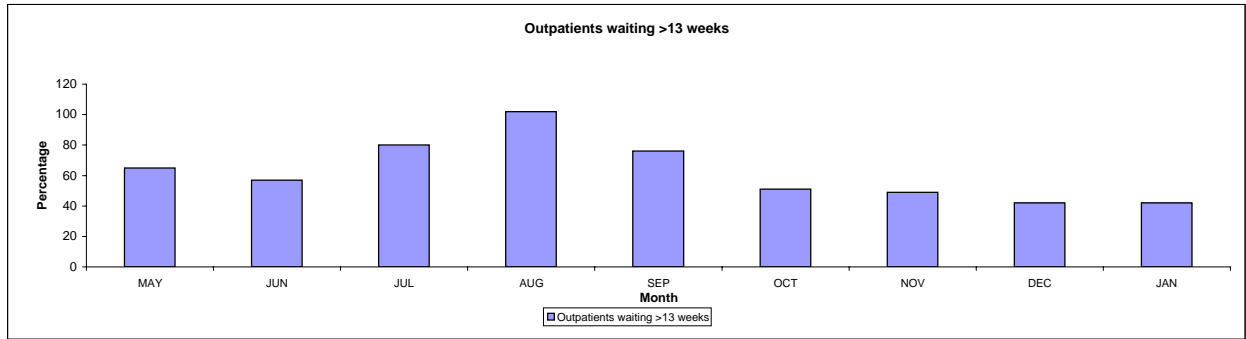
Workforce

Target	Trend/actual	Commentary	Action	Completion date	Lead	Risk	Impact	Impact
4.0%	4.80%	The table highlights the trends in absence against the national average and also provided are the trends for temporary staffing levels in order to identify any correlation.	Detailed reports have been provided to each directorate regarding sickness hotspots in order for relevant management to take place. In addition Directorate have been asked to develop improvement strategies and action plans that focus on reducing the volume of short term absences and minimise the length of absence for long term ill-health absences. The HR team will also review the flexible working and carer's leave guidance for the Trust to support effective absence management.	Monthly	Associate Director for HR	Cost/Morale/service Provision	Higher bank/agency costs.	Financial and Activity



HCC Access Targets

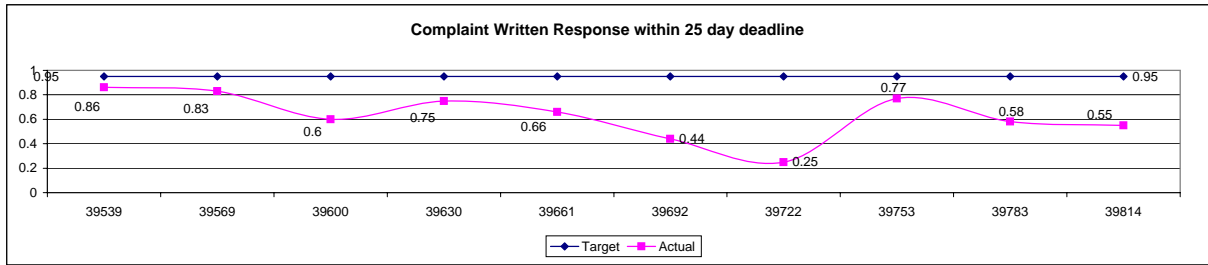
Indicator	Target	Trend/actual	Commentary	Completion date	Lead	Risk	Impact
Outpatients waiting >13 weeks	No lapses	42	There continue to be breaches in the 13 week target	On going	General manager	Poor HCC score	reputation.



Vital Signs

Patient Experience

Indicator	Target	Trend/actual	Commentary	Completion date	Lead	Risk	Impact
	95% Response within 25 days	under performing	Some timescales agreed within the individual as part of the early adopter system.	on going monitoring	Jane Owen	Failure to achieve national targets	Reputation



Foundation Status

BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE
REPORTING PERIOD : - January 09 (Period 10)

Form F1	This Month			Year To Date			Full Year Forecast		
	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's
Income (+)									
Healthcare Income	5,039	5,011	(28)	50,092	50,967	875	60,157	61,346	1,190
Private Patient Income	100	90	(10)	1,001	845	(157)	1,201	1,007	(194)
Other Income	1,371	1,282	(89)	13,141	13,342	201	15,708	16,441	733
Total Income	6,510	6,384	(126)	64,235	65,154	919	77,066	78,794	1,729
Operating Costs (-)									
Pay Costs	(4,347)	(4,299)	48	(42,803)	(42,497)	306	(51,953)	(51,714)	239
Non Pay Costs	(1,697)	(1,620)	77	(16,769)	(17,564)	(796)	(19,518)	(20,693)	(1,175)
Total Operating Costs	(6,044)	(5,920)	125	(59,572)	(60,061)	(490)	(71,471)	(72,407)	(936)
EBITDA	466	464	(1)	4,663	5,093	430	5,595	6,387	792
EBITDA % Margin	7.2%	7.3%	0.1%	7.3%	7.8%	0.6%	7.3%	8.1%	0.8%
Depreciation (-)	(303)	(265)	39	(3,034)	(2,658)	376	(3,641)	(3,190)	451
Interest (+/-)	31	11	(20)	314	385	71	377	462	85
Surplus / Deficit before dividend	194	211	17	1,943	2,820	877	2,331	3,659	1,328
Dividend (-)	(147)	(147)	0	(1,466)	(1,466)	0	(1,759)	(1,759)	0
Surplus / (Deficit) cfd	47	64	17	477	1,354	877	572	1,900	1,328

Birmingham Women's NHS Foundation Trust

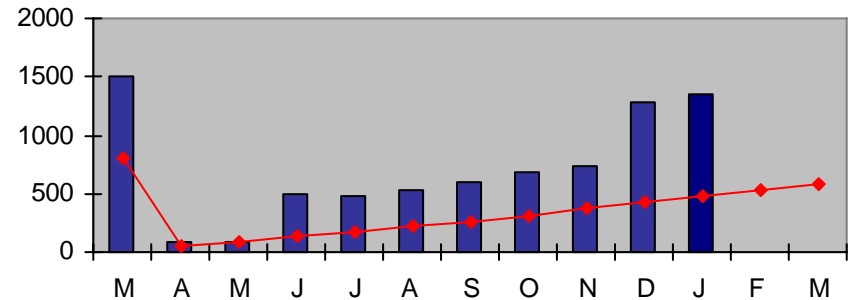
Finance Report for the Period April to
January- 2009

Summary Financial Position

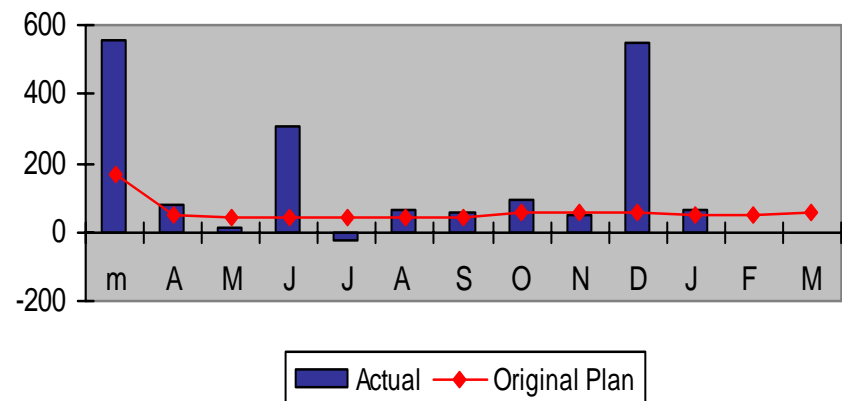
Key Points

- This is the financial report to the end of January 2009. . The results report a net £1.4m surplus, which is £859k above plan and this converts to a Monitor risk rating of 4.3
- The summary £877k variance comprises the following:-
 - A favourable £0.9m income variance;
 - An adverse £490k expenditure variance;
 - An above plan Ebitda position totalling 7.8%
 - A favourable £376k variance for depreciation;
 - A favourable but reducing £71k interest variance.
- In month, the net surplus was £64k which is £17k above plan.
- The planned end of year position is a surplus of £0.6m. The forecast based on the overall position remains in a range of £1,500k to £1,900k. The forecast may be reduced as discussions are taking place with External Audit with the view to carrying forward the £600k CNST rebate, effectively received in error in this year. This will be used to offset the £2.0m notified increase in next year's premium. The Board and Audit Committee will be kept informed on this matter.

Cumulative plan, results & forecast



Monthly by month plan, results & forecast



Income

Key Points

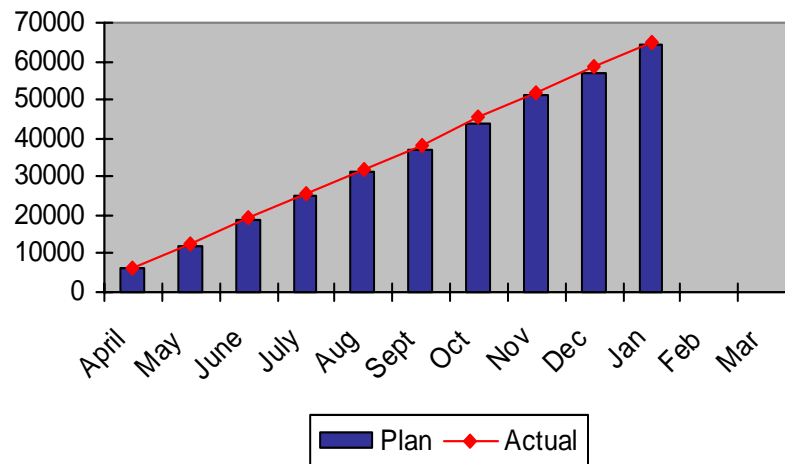
- The income received to date is £65.2m and this is £0.9m ahead of plan. There are no material changes from the activity trends reported in previous months albeit the position is a £126k reduction from the previous month which is covered below.*

Healthcare Income

- This is £875k above plan and comprises a £443k over performance from the main PCT contracts and £488k for specialised services. The in-month reduction by £28k is largely due to the position noted under PCTs below.

Performance with Commissioners

- Over-performances remain with South Birmingham -£80k, Heart of Birmingham- £254K, and Birmingham North & East- £91k and Sandwell - £83k. The negative variance with Worcester of £103k increased only marginally from the previous report
- *For Other PCTs there was an in month adverse variance of £97k. This position will be closely monitored to corroborate the initial findings that this a blip rather than an indication of a longer term trend.



Performance by Specialty

- Gynaecology – an adverse variance of £108k; underperformed by 262 spells. The improvement noted in previous month has continued which is good news for the Directorate and the Trust.
- Maternity- favourable £605k and 601spells. Within this position is a negative position with respect to triage. This has been factored into a revised the plan for 2009/10.
- Neonatology -£159k favourable variance.
- Clinical Genetics- £45k positive variance and Laboratory Genetics -£141k positive variance.

Spending Trends within Directorates

Key Points

- The tables opposite show the combined positions of pay, non-pay and directorate income variances. Healthcare income is not shown here but is included in the service line reports. This will be changed for 2009/10.
- At month 10, there was an in month movement of movement of £53k. Both pay and non-pay positions improved but this was offset by the performance of directorate income .
- The reason for the movement in directorate income is that £150k of income, so far included within the Corporate position in respect of the Education Research Centre, has been requested to be carried forward to 2009/10.
- This represents unspent monies relating to the academic year 2009 but which will be spent in the financial year 2009/10.
- The overall adverse position is covered within the financial position of the Trust , however, tighter control of non-pay is needed where this is not linked activity and/or agreed non recurrent spending. This tighter control will be carried forward to 2009/10 particularly with respect to non-pay.
- The more detailed figures behind the tables are shown on appendices f3, f4 and f5.

Directorate Pay and non-pay variances from budget

Year to date	Month 8				Month 9			
£ 000s	Pay	Non-Pay	Dir'ate	Total	Pay	Non-Pay	Dir'ate	Total
		Pay	Income			Pay	Income	
Obstetric and Fetal	-39	-22	-24	-85	110	-44	-19	46
Gynaecology	-2	-152	-94	-249	25	-115	-122	-211
Genetics	100	-399	393	95	73	-423	348	-2
Neonatal	53	-81	72	44	65	-86	54	32
Clinical Support	-123	-154	11	-266	-147	-170	32	-285
Facilities	-47	-172	-54	-272	-39	-210	-70	-319
Corporate Services	153	102	-87	168	172	176	-40	307
	96	-878	217	-565	258	-872	184	-430

Directorate Pay and non-pay variances from budget

Year to date	Month 10				Forecast			
£ 000s	Pay	Non-Pay	Dir'ate	Total	Pay	Non-Pay	Dir'ate	Total
		Pay	Income			Pay	Income	
Obstetric and Fetal	154	-60	-13	81	143	-89	-30	24
Gynaecology	29	-125	-122	-218	-15	-135	-94	-244
Genetics	50	-484	378	-56	49	-593	419	-125
Neonatal	76	-105	53	24	79	-136	32	-26
Clinical Support	-153	-167	40	-280	-180	-121	42	-259
Facilities	-73	-131	-111	-315	-103	-110	-150	-363
Corporate Services	223	276	-219	281	265	9	-280	-6
	306	-796	6	-483	239	-1175	-62	-998

Cost and Efficiency Improvements

Update on performance

Overall Summary

- To the end of December, savings of £2.0m have been identified and verified as saved. The forecast for the year remain on target to reached the £2.5m total identified at the start of the year.

Traffic light summary

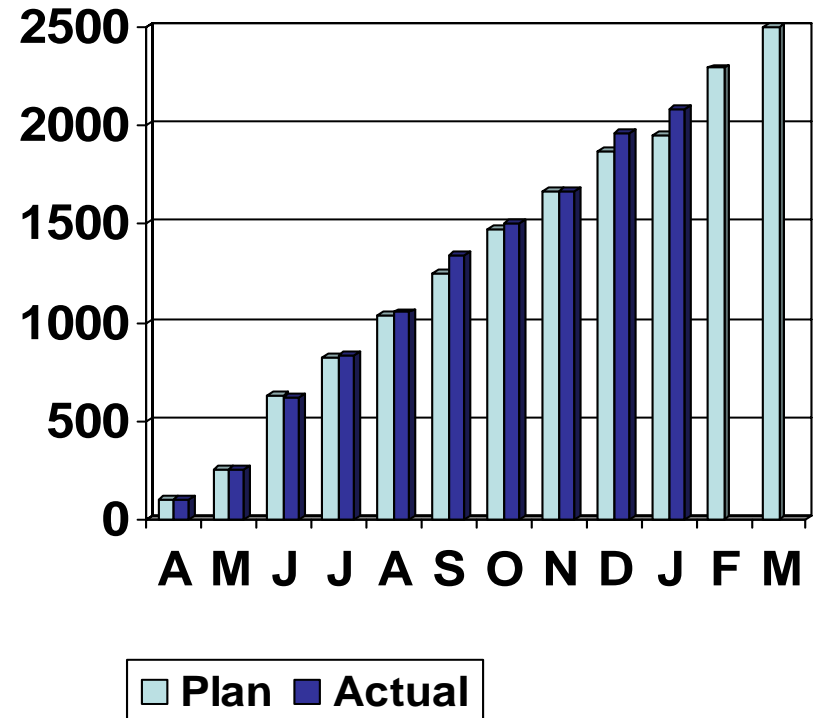
- The CIP annual targets have been updated from the meeting held in January . There continue to be no red schemes.. The traffic light results are (split by the 2.5m plan):-

- Red £ 0K
- Amber £ 37K
- Green £2,183K
- Total £2,463k

The small number of amber schemes are forecast to deliver in the final months of the year.

- The recurrent/non recurrent split is 56/44% against the plan of a 70/30%. Principal reasons behind this is that income generation schemes and the CNST rebate are regarded as non-recurrent until confirmed in an SLA. The former is now definitely non-recurrent; a 50% increase has been notified for 2009/10. This is being factored into the annual planning estimates for next year.

Savings delivery - cumulative

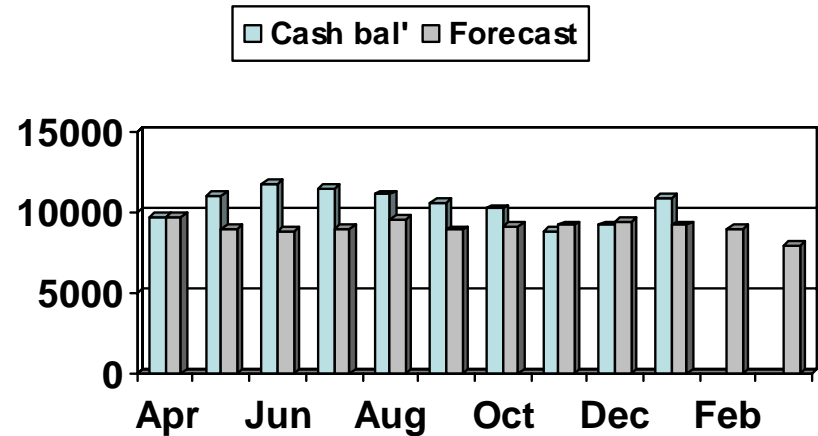


NB savings include additional income with respect to the some directorates

Cash Flow 1

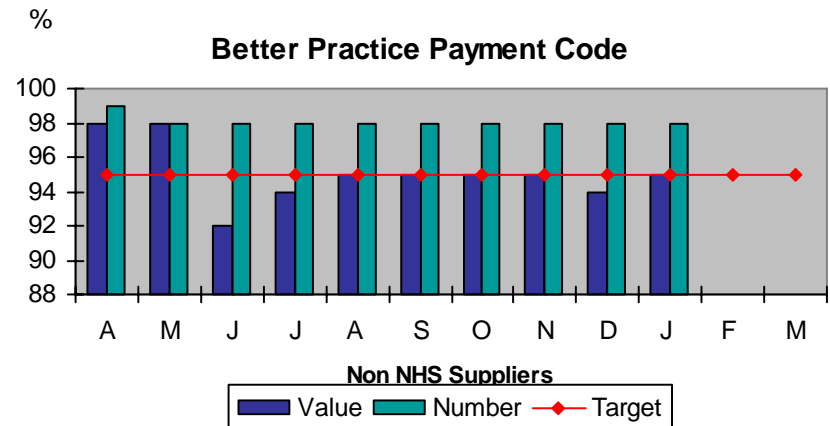
Cash Balances

- The cash position remains strong with the balance at the end of January totalling £10.8m. (£9.2m in December) of which £5.7m is in respect of deferred income and accruals.
- As at 31st January all non-operational cash remains in the Pay master General's Office account (PGO).
- As noted previously, the lower depreciation is a direct benefit of achieving FT status and as a result of undertaking a mid-term revaluation of the Estate, as reported in the annual accounts.



Creditors (money owed by the Trust)

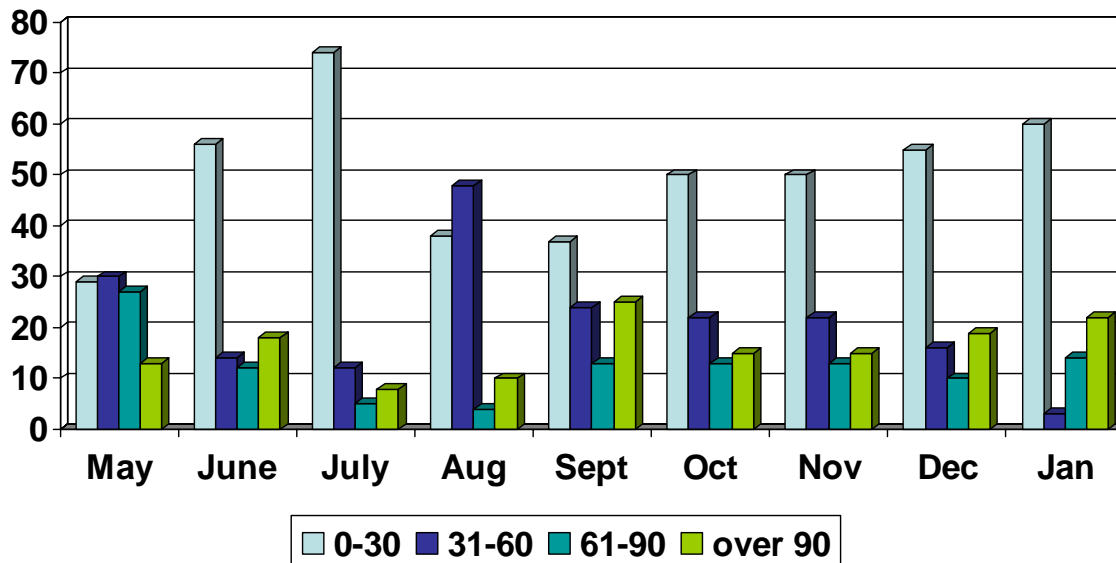
- The Better Practice Payment Code (formerly PSPP) targets NHS organisation to pay 95% of all supplier invoices within a period of not more than 30 days. Within this, the payment for local trade suppliers has been adjusted to payment within 10 days; this is in line with the Prime Minister's request to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



Cash Flow 2

Debtors (amounts owing to the Trust)

- Total Debtors totalled £3.5m at the end of January which represents a reduction from the previous report and this has lifted the cash balance as noted above. Of the 3.5m, £2.1m refers to trade debtors and £1.4 to accrued income.
- In terms of aged debt information, the number over 90 days totals 21% and £415k which is a £35k reduction on the previous month's total.
- There are no material long standing debts to be concerned about at this point. Nevertheless, the credit section and finance managers have been reminded that all longstanding debts need to be recovered or written off, as appropriate and in line with standing financial instructions.

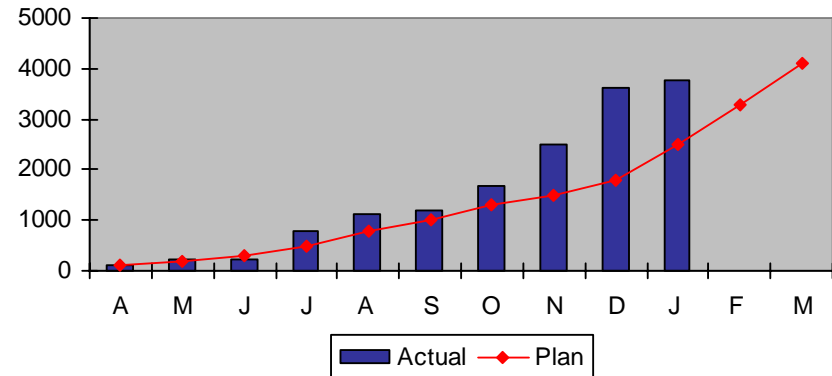


Cash Flow 3 - Capital Spending

Key Points

- The total planned spend for the year is £4.1m as recommended within the 2008/9 annual plan. The planned programme is show in the next column and the delivery of this is being managed through the Capital Development Group.
- The Group has allocated funding to the highest priorities and will continue to focus on performance managing all the agreed schemes. All schemes are progressing well.
- The year to date spend is £3.8m and is above plan. The end of year forecast remains on target.
- Thanks are due to the Capital Programme for this creditable performance and avoiding the historical end of year rush to bring schemes on line.

Monthly build up of the programme



2008/9 Capital Plan

Capital Equipment Replacement	500	738
Neonatal Unit Upgrade / Decant	700	432
PACS	0	202
Pan Birmingham Decontamination	0	107
CHP Installation	1,300	1,344
Replacement PCs	200	427
Backlog Maintenance	500	439
Other	900	34
TOTAL CAPITAL PROGRAMME	4,100	3,771

Risks

Risk	Maximum	Likelihood	Included in forecast
Challenge to income by PCTs	Circa 1% £0.6m	Low	Yes
Failure to deliver HCAI targets	Not assessed	Low	No
Failure to deliver 18 weeks	Maximum 5% penalty - £496.8k	Low but keep under review with respect to the position in Genetics	No
Elective Activity underperformance	£500k	Likely	£147k covered by general income over performance
Failure to deliver CIP plans fully	Red schemes & 50% amber not delivered	Low- CIP performance is green	Yes
Expenditure creep Unplanned & unavoidable non-pay expenses	£1,200k	High	£1,175k covered by income and pay positions.
HRG 4 - revised list of HRGs and tariffs	Currently being negotiated	Definite	2009/10 impact –

Conclusions and Recommendations

CONCLUSIONS

1. The Trust is reporting a surplus of £1.3m. This equates to a Monitor risk rating of 4.3
2. Within the overall position and as explained previously, there is a positive income variance but a negative one with respect to non-pay. This has been identified as the response to three main issues; the costs of meeting additional activity, inflationary pressures for utility charges and agreed spending above plan to invest in hospital equipment and the patient environment.
3. Whilst the higher levels of expenditure are explainable and the overall financial position is positive, there has been little financial headroom at the operational level although on the upside this has improved in both the December and January figures.
4. The financial forecast for the year has been updated and currently this shows and of year surplus in the range up to £1.9m. This will be impacted by the discussions with External Audit with respect to the £600k rebate received in this year.

RECOMMENDATIONS

- The Board is asked to consider the financial position of the Trust at the end of January 2009.
- These show that the Trust is continuing to forecast that it will meet its financial plan as submitted to Monitor with the prospect of exceeding this as indicated at conclusion 4.

Birmingham Women's 
NHS Foundation Trust

SUBJECT :	Freedom of Information Act- Annual Report
REPORT BY :	Damon Harris, Head of Infomatics
AUTHOR :	

CONTEXT AND BACKGROUND FOR REPORT

As a public authority, the Trust is required to respond to requests received under the Freedom of Information Act. This report provides an annual update on this process, for the year to December 2008

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The number of requests received has increased significantly in the year under report, from an average of 5 per month in 2007 to 14 per month in 2008.

Compliance with the requirements of the Act is a regular item at the Information Governance Group.

RECOMMENDATIONS

The Board is invited to **NOTE** the annual report.

FREEDOM OF INFORMATION ACT 2000
REQUESTS RECEIVED BY THIS TRUST JANUARY 2008 - DECEMBER 2008

1. Introduction

The Freedom of Information Act 2000 (FOIA) came into force in England and Wales on 1 January 2005, and from that date the Trust has been receiving requests for information. This document reports on requests received within the calendar 2008. Future reports will detail request activity in the previous quarter and draw the Board's attention to any issues that have arisen. The next report will be produced in April 2009 and will describe activity between January and March 2009.

This introduction highlights issues and developments. Section 2 analyses requests received during the period 1st Jan to 31st Dec 2008.

During the four years that the Act has been in force, the processing of Freedom of Information requests has become part of the Trust's administrative routine. Requests are predominantly received by e-mail and are addressed to the Trust's Freedom of Information mailbox. Requests are also regularly received by the Chief Executive's Office. All requests are processed by the Informatics Department. The Information Governance Manager leads on this activity but two other members of the team have been trained to cover in his absence. As soon as requests are received, they are logged in the requests database and an entry is placed on the intranet database (see below). The applicant is also advised that the request has been received and is being processed. The most likely Trust 'owners' of the information required to answer the request are identified and asked to supply their responses to the Informatics Department. Progress is monitored at all stages to ensure that we meet the 20 working day statutory deadline. Once the information has been received, the Information Governance Manager drafts a response (having discussed and applied appropriate statutory exemptions to part or all of the information) and communicates with the applicant.

2006 saw a doubling of requests over the first year and 2007 saw that level maintained, but in 2008 there has been a significant increase with figures tripling from 2007. The current average is now 14 requests per month compared to 5 in 2007, although there are seasonal peaks and troughs. Requests often contain multiple questions (and not always on the same subject) and hence can involve several sections of the Trust and shared service partners to provide the requested information.

A report on Freedom of Information activities and developments is a standard item on the

bi-monthly Information Governance Group agenda. For instance, the Information Governance Manager scans decisions issued by both the Information Commissioner and the Information Tribunal, and reports on those of significance to NHS activity - e.g. in 2008 there were several decisions concerning the release of health records of deceased patients.

The Trust's Publication Scheme (available via the web site) is routinely maintained. In 2004, the Trust developed a Publication Scheme (a guide to information routinely published and made available to the public) based on the Model Publication Scheme for the NHS.

2. Analysis of requests received January 2005– December 2008.

2.1 Total requests received to date

Month	No. of requests
Total 2005	34
Total 2006	63
Total 2007	66
Total 2008	173
Grand total	336

2.2 Applicant categories – 2008

Requestor Type	Count	% of total
Unknown	52	30%
MP	35	20%
Commercial	31	18%
Media - Newspaper	21	12%
Media - TV	8	5%
Media - Journal	8	5%
Political Party	4	2%
Media - Press Agency	3	2%
Charity	3	2%
Student	2	1%
Higher Education	2	1%
Solicitors	1	1%
Political Organisation	1	1%
NHS -StHA	1	1%
NHS - Other	1	1%

2.3 FOIA complaints received 2005-2008

Complaint Type	No. of Complaints 2005-2008
From Applicant to Trust Complaints Procedure	0
From Information Commissioner to Trust	1 -

Grand Total	0
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3. Recommendation

That Trust Board receives and notes this report.

Damon Harris
Head of Informatics
21 January 2009

Birmingham Women's

NHS Foundation Trust



SUBJECT :	West Midlands Cancer Intelligence Unit- 6-monthly update
REPORT BY :	
AUTHOR :	Steve Parsons, Head of Corporate Affairs

CONTEXT AND BACKGROUND FOR REPORT

The Trust acts as the host organisation for the West Midlands Cancer Intelligence Unit (CIU). As part of the governance arrangements for CIU, the Board is provided with an update on CIU activities every six months.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Annual Report of the CIU is also presented for the information of the Board.

RECOMMENDATIONS

The Board is invited to note the six-monthly update and annual report from CIU.

West Midlands Cancer Intelligence Unit

WMCIU Strategic Objectives 2008/09		
NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
1.	To ensure the current and future financial viability of the WMCIU	<ol style="list-style-type: none"> 1. Business plan for cancer registration and breast and cervical screening QA functions for 2008/09 prepared taking into account uncertainties over future funding levels, the financial implications of the WMCIU reorganisation and actual 2007/08 expenditure 2. Robust 3 year plan in place for the use of the underspends accumulated in the budgets for the breast and cervical screening QA and cancer registration functions, taking into account uncertainties over future funding levels 3. Sponsorship obtained and delegate fees charged wherever possible for training activities (workshops, study days, annual conferences) run by the WMCIU for external health service professionals 4. Full funding secured to cover the costs of national and regional non-core research and audit projects managed by WMCIU and appropriate funding obtained from UKACR /NCIN central monies to cover work carried out to support joint UKACR initiatives 5. Financial implications for the WMCIU of the Birmingham Women's NHS Foundation Trust's move to Foundation Trust status evaluated and appropriate action taken
	Update January 2009	<ol style="list-style-type: none"> a) Business plan prepared but discussions with the Trust are ongoing to ensure full accuracy of the plan. b) Contracts with the Department of Health West Midlands Office for funding in 2008-2009 have now been signed, and funding has begun to flow through. Discussions have started with the DoH Regional Office regarding longer-term arrangements. c) Birmingham University have given indications that they would like to see the Unit moved out of the current location in the Public Health Building. The Trust has a legal lease with the University, with over 80 years remaining on the term, and a repayment of premium clause which would require the University to pay back approx £1.2M to the Trust. d) 3 year plan agreed with GO for the use of existing underspends implemented; with office building work completed and 2 year fixed-term information and intelligence team staff appointed. Review of data quality and computing team staffing requirements being undertaken as part of preparations for the Senior Executive Team 2008/09 objectives and planning away day on 17 February 2009. e) Additional funding secured from National Cancer Intelligence Network (NCIN) to support the WMCIU's role as lead cancer registry for breast cancer and bone and soft tissue sarcoma and from the NHS Breast Screening Programme for the development of a national all breast cancers report combining data for screen-detected and symptomatic breast cancers.

West Midlands Cancer Intelligence Unit

NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
2.	<p>To consolidate the WMCIU's relationships with key stakeholders in order to maximise the opportunities presented by the Cancer Reform Strategy to use cancer registration and screening QA data to improve cancer services within the West Midlands and at National level</p>	<ol style="list-style-type: none"> 1. National Cancer Registration Advisory Group (NCRAG), UK Association of Cancer Registries (UKACR), NHS Breast and Cervical Cancer Screening QA Directors and National Health GIS related meetings attended and good relationships with other member organisations established and maintained 2. Good working relationships maintained with key regional groups, e.g. Regional Observatory, Wider Public Health Group, West Midlands Public Health Observatory, Specialised Services Cancer Steering Group, Cancer Peer Review Zonal Reference Group, Cancer Network Directors and Network Site Specific Groups 3. Opportunities to work with the Commissioning Business Support Agency at the West Midlands SHA identified and exploited fully through full contributions to the Health Improvement Quarterly Performance Improvement Reports and other initiatives 4. Full contributions made to the development of the Regional Public Health Information Network and opportunities to work with the Specialised Services Commissioning Group at the West Midlands SHA identified and exploited fully 5. Strategic developments within the WMCIU's cancer registration function agreed and monitored at twice yearly meetings of the Cancer Registration Steering Group 6. Strategic developments within the WMCIU's breast and cervical screening functions agreed via regular meetings with the SHA screening lead 7. Active contributions made to the development and implementation of the National Cancer Intelligence Network
	<p>Update January 2009</p>	<ol style="list-style-type: none"> a) Strategic direction of the cancer registration overseen by the WMCIU Cancer Registration Steering Group under the chairmanship of Dr Jami Rao at the GO; with Jason Burn replacing Ann Gibbs as the BWFT representative. b) Strategic development of the screening QA functions overseen through regular meetings with the SHA screening lead, Rowena Clayton. c) Regular meetings in place with director of WMPHO and GL member of WMPHO Steering Committee and vice versa. Twice yearly meetings with Cancer Network Directors continued. d) New national NCIN Clinical Reference Groups established for each cancer sites with WMCIU represented on breast cancer and bone and soft tissue sarcoma groups. Good working relationships established with the chairs of each group (Martin Lee (UHCW) for breast cancer and Rob Grimer (ROH) for bone and soft tissue sarcoma). d) Links established with Commissioning Business Support Agency and the new Quality Observatory at the SHA to ensure that data held by the WMCIU contribute to the development of World Class Commissioning and to the quality improvement programme recommended in the Darzi review.

NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
4.	<p>To carry out cancer registration and data quality activities in line with the requirements of the new National Cancer Intelligence Network; ensuring that the cancer registry peer review measures are achieved and that the WMCIU contributes to national initiatives intended to monitor and improve cancer registration data quality</p>	<ol style="list-style-type: none"> 1. Routine cancer registration data provided to ONS and other external organisations (e.g. other cancer registries and the Childhood Cancer Research Group) by agreed deadlines 2. UKACR Performance Indicators exercise co-ordinated on behalf of the UKACR executive and WMCIU data submitted to agreed deadlines 3. UKACR Registration Subgroup chaired and activities of QA, Coding & Classification and Training Working Groups overseen and monitored 4. Quarterly and annual checks carried out to monitor data quality 5. Work undertaken to ensure that the training needs of staff who code, collect and/or use cancer data in NHS Trusts diagnosing and treating WM residents are addressed 6. WMCIU's cancer registration service assessed against the cancer registry peer review measures and changes and improvements implemented as required
	<p>Update January 2009</p>	<ol style="list-style-type: none"> a) Routine cancer registration and quarterly data quality activities undertaken; with data provided to ONS, the UKACR Performance Indicators exercise, the national Cancer Information Service by the required deadlines. b) Internal and external oncology training programme provided to staff in the WMCIU, provider Trusts and cancer networks; with excellent feedback from participants. c) WMCIU's performance against cancer peer review measures discussed at Cancer Registration Steering Group meeting on 4 November 2008. The WMCIU's performance exceeded that of the UK as a whole the majority of the measures. The only measures not achieved were: <ul style="list-style-type: none"> • Colorectal cancer staging: 69% vs 74% required • Type of growth: 83% vs 85% required • Death certificate only (DCO) cases: 12.4% vs 3% required <p>The Steering Group agreed that the standard for the colorectal cancer staging measure is flawed as it should exclude from the denominator cases where Dukes stage is inapplicable.</p> <p>The Steering Group agreed that accurate information on type of growth could not be obtained for over 4000 cases with a non-specific morphology code, most of which were diagnosed via imaging or cytology.</p> <p>The problem with DCO cases has been addressed from 2007 onwards by sending requests for further information directly to GPs. Preliminary data indicate that the DCO rate for 2007 cases will be well within the national standard.</p>

NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
5.	<p>To further improve the timeliness, completeness and comprehensiveness of the WMCIU's cancer registration database by continuing to develop electronic data transfer and automated cancer registration; taking maximum advantage of the new provisions relating to electronic cancer data transfer in the NHS Standard Contract for Acute Services and the 2008/09 Operating Framework for the NHS in England</p>	<ol style="list-style-type: none"> 1. Work undertaken with West Midlands cancer networks and PCTs to ensure that the provisions relating to electronic cancer data collection in the NHS Standard Contract for Acute Services are agreed and implemented with all cancer service providers 2. Mechanisms agreed to enable timely access to electronic feeds of CWT, Hospital Episode Statistics (HES), multi-disciplinary team (MDT) databases and patient lists, structured and coded pathology reports, the Radiotherapy Dataset (RTDS), e-prescribing drug therapy data, National Cancer Audit Support Programme (NCASP) databases (e.g. DAHNO, LUCADA, NBOCAP) and professional clinical audit databases (AUGIS, BAUS) to improve case ascertainment and to supplement and extend the data obtained from existing sources 3. Additional systems implemented to create 'initial cancer registrations' from electronic data feeds (death certificates, pathology reports, MDT databases, cancer waiting times (CWT) data) within 4 months of diagnosis 4. Manual cancer registration processes modified and streamlined to ensure the availability by January 2009, of 'first episode registrations' containing diagnosis and treatment data for cases diagnosed in January 2008
	<p>Update January 2009</p>	<ol style="list-style-type: none"> a) Visits to all acute Trusts providing cancer registration data undertaken with cancer network representation and action points to improve the timeliness and completeness of data provision agreed. Follow up visits to each trust will take place in 2009/10. b) Major issues in historic data provision by four Trusts were identified and action points agreed. Interventions by PCT commissioners will be sought in 2009/10 where data provision has not improved. c) Automated cancer registration (ACR) progressing well; with electronic processing of death certificates, pathology reports and radiotherapy and chemotherapy databases established. d) HES and CWT data linkage projects progressing well and download of contract dataset data recently provided by CBSA. e) Access to HES data for 2007/08 and mortality data for 2006 and 2007 delayed due to confidentiality concerns; the latter following changes in responsibility for ONS since April 2008. f) ONS-HES-linked data for breast cancer and bone and soft tissue sarcoma including ONS data up to 2004 provided as part of NCIN-funded project; but cancer registration-HES linked data up to and including 2006 data still awaited. The lack of this more to date data is seriously compromising what the WMCIU can achieve as the lead cancer registry for these tumour sites. This will be raised at the next NCIN Clinical Reference Group meeting on 10 March 2009

West Midlands Cancer Intelligence Unit

NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
6.	<p>To develop and expand the information available to stakeholders in order to monitor the quality of cancer service provision within the West Midlands and at National level and to further develop the WMCIU's research profile</p>	<ol style="list-style-type: none"> 1. Cross-unit information and intelligence team established with site-specialised teams leading on the provision of information and intelligence for each cancer site, with work plans for each team agreed and accommodation changes completed 2. Provision of data in response to <i>ad hoc</i> information requests streamlined and new formats agreed to ensure that appropriate, concise and timely intelligence is provided and that national peer review targets are achieved; with protocols for all information provision activities developed and maintained 3. The WMCIU's role within the NCIN as the national lead registry for breast cancer and bone and soft tissue sarcoma established with programmes of work for each cancer site agreed and implemented and the implications of the 2012 vision documents for breast and bone and soft tissue sarcoma assessed and action plans devised as necessary 4. Programmes of work agreed with external stakeholders to maximise the use of cancer registration data to improve cancer services within the West Midlands. To include: <ul style="list-style-type: none"> • routine reports for cancer networks containing incidence, mortality and survival data, and diagnosis and treatment referral pattern data for individual cancer sites • gynaecological cancer and breast cancer reports containing clinical outcome measures • collaborative studies with the CBSA to explore how cancer registration and screening QA data can be combined with contract datasets to assess the quality of and improve cancer services 5. Screening status classifications derived for all West Midlands colorectal cancers using methodology based on that developed for breast and cervical cancers 6. Content of West Midlands local electronic Cancer Information Service (CIS) reviewed and content modified so that it is consistent with and/or complements the cancer registration data available on the national CIS and the screening QA data available via quarterly and annual reports 7. Work undertaken with the WMPHO and other agencies to provide data relating to deprivation and ethnicity to support improvements recommended in the Public Health white paper and with PCTs, the HSE and the HPA to investigate potential cancer clusters 8. Complex geographic analyses identified, developed and applied to address key public health policy needs, and specialist expertise provided to health service and other professionals in collaborative research projects which can be published as internal reports, conference presentations and peer reviewed publications 9. WMCIU website reviewed and updated on a regular basis with fact sheets on funnel plots, upper GI cancers and gynaecological cancers added in 2008/09 10. Joint studies undertaken with clinicians, other cancer registries and academic institutions with work taken through to peer reviewed publications and oral and poster presentations regional, national and international meetings 11. External grant awarding bodies investigated and where appropriate applications for funding made with full financial work up of all pay and non pay costs

West Midlands Cancer Intelligence Unit

NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
	<p>Update January 2009</p>	<ul style="list-style-type: none"> a) Cross-unit information and intelligence team established with site-specialised teams and information managers meeting regularly to agree consistent protocols and procedures. New information assistants receiving appropriate training for their roles b) WMCIU's role within the NCIN as the national lead registry for breast cancer and bone and soft tissue sarcoma being established with programmes of work for each cancer site to be agreed at meeting on 10 March 2009. c) First three cancer network reports on stomach, oesophageal and pancreatic cancer circulated to cancer networks and discussed with PBCN NSSG. Further reports for colorectal cancer and head & neck cancers to be completed by 31 March 2009. d) Breast cancer clinical outcome measures report based on BCCOM and cancer registration data published and circulated to networks and NSSGs. e) Collaborative studies with CBSA discussed and initial data download received. f) WMCIU role in Bowel Cancer Screening QA delayed until 2009. Screening histories project for bowel cancer cases will therefore begin in 2009/10. g) Local CIS updated with new PCT geographies and 2006 cancer incidence data. Review of overall content taken forward into 2009/10. h) Ethnicity and cancer work with WMPHO is being incorporated into an NCIN project with first meeting on 5 February 2009. i) New PCT and cancer network population data provided by health GIS service to support the national Cancer Information Service. Project of the impact of radiotherapy services on the NHS carbon footprint being taken forward at national level.

West Midlands Cancer Intelligence Unit

NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
7.	<p>To monitor and improve the quality of the region's breast and cervical screening programmes by supporting service re-organisation and professional development, by organising workshops, seminars and study days and by undertaking service evaluation through QA team visits, the production of outcome measures, and the development of new methods to assess service quality</p>	<ol style="list-style-type: none"> 1. Support provided for West Midlands breast and cervical screening service re-organisation 2. West Midlands breast and cervical screening service evaluation undertaken through the collection, validation and dissemination of routine annual and quarterly monitoring data 3. Rolling programmes of West Midlands breast and cervical screening QA team visits completed, additional <i>ad hoc</i> visits undertaken as required and recommendations followed up promptly 4. Workshops, seminars and study days organised to support professional development for West Midlands breast and cervical screening services staff and to disseminate information concerning the quality of the services provided 5. Breast EQA, gynaecological EQA and technical EQA schemes in place and operated to the required national standards 6. National guidance on invasive cervical cancer audit and on breast interval cancer review implemented across West Midlands breast and cervical screening services 7. Screening status classification derived for all women with in situ and invasive breast cancer and invasive cervical cancer diagnosed since the introduction of the NHS cancer screening programmes in the West Midlands, screening status classifications transferred to the WMCIU's cancer registration database in line with the National SLA and data used to interpret incidence, mortality and survival trends and to compare the outcomes for screen detected and symptomatic cancers 8. Specific studies undertaken to examine and improve the quality of the services provided by West Midlands breast and cervical screening services
	<p>Update January 2009</p>	<ol style="list-style-type: none"> a) Support provided during the establishment of the City, Sandwell and Walsall Breast Screening Service and to the review of Worcestershire Breast Cancer Services. b) Routine service evaluation undertaken for both screening programmes through data collection and QA visits; EQA schemes overseen as required and workshops, seminars and study days organised as planned. c) National guidance on invasive cervical cancer audit and on breast interval cancer review implemented d) Screening status classifications complete to 2007 for cervical cancer and to 2006/07 for breast cancer. National workshop on interval cancers being organised on behalf of the NHS Breast Screening Programme in March 2009. e) Various studies being undertaken in conjunction with breast and cervical cancer specialists throughout the region.

NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
8.	To support service re-organisation in the region's breast and cervical screening programmes to facilitate the successful implementation of the changes specified in the Cancer Reform Strategy	<ol style="list-style-type: none"> 1. Programme for the extension of the NHS Breast Screening Programme to women aged 47 to 73 planned 2. Programme in place to ensure that by 2010 all breast screening services have a digital mammography unit within their assessment capability 3. Plans in place to ensure that surveillance of women at high risk of breast cancer is undertaken by the NHSBSP in accordance with NICE guidance 4. Action taken to increase participation in cervical screening of women aged 25 to 35 and to reducing variations in coverage between PCTs 5. Programme in place to ensure that by 2010, all women receive their cervical screening test result within 14 days 6. Standards including 31 days to treatment and 62 days from referral (or equivalent) to treatment implemented and arrangements for monitoring in place for cancers diagnosed through the NHS Breast and Cervical Screening Programmes 7. The implications of the 2012 vision documents for breast and gynaecological cancer and screening assessed and action plans devised as necessary
	Update January 2009	<ol style="list-style-type: none"> a) Warwickshire, Solihull & Coventry BSS screening women aged 47-49 as one of six national age extension pilots. Evaluation of 'state of readiness' of other services including digital assessment capacity undertaken, but further guidance now awaited from DH before other services can expand. b) Region-wide cervical screening coverage campaign undertaken in conjunction with PCTs. Analysis of impact is being undertaken, with early indication of increased screening activity in most areas. The project was shortlisted for HSJ award. c) Regional working group established to plan service reorganisations required to meet 14 day turnaround times for cervical samples. d) Further guidance still to be issued on arrangements that need to be in place for monitoring 62 day waiting times standards for screening women but preliminary processes in place in all services.

West Midlands Cancer Intelligence Unit

NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
9.		<ol style="list-style-type: none"> 2. External funding secured to support the continuation of all three national breast cancer audit projects 3. Publication containing ABS at BASO audit data for screen-detected breast cancers detected in 2006/07 produced and distributed at the 2008 ABS at BASO meeting and the audit of 2007/08 cases planned and implemented 4. Results of the Sloane Project disseminated in newsletters and an annual report, data completeness improved through the exploration of new data sources, oral presentations given and peer reviewed papers published and action plan developed to implement the additional work proposed in the new 3 year research funding awarded by the Breast Cancer Research Trust. 5. Results from the BCCOM audit disseminated in newsletters and an annual report, oral presentations given and peer reviewed papers published 5. Next stages of the BCCOM audit planned taking into account the opportunities opened up by the establishment of the UK Cancer Intelligence Network for the WMCIU to become the national lead registry for breast cancer by the establishment of the National Cancer Intelligence Network
	<p>Update January 2009</p>	<ol style="list-style-type: none"> a) External funding obtained from the NHSBSP, Breakthrough Breast Cancer, the Breast Cancer Research Trust and the National Cancer Intelligence Network to secure all three projects for a further 3 years. b) 2006/07 ABS at BASO audit data booklet published and data presented at national ABS meeting in June 2008 and at various other national and international conferences and meetings. The 2007/08 audit is proceeding as planned with data to be presented at the ABS annual meeting on 17/18 March 2009. c) Sloane project newsletter and annual report published together with 3 peer-reviewed papers. Sloane data have been presented at various national and international conferences and meetings and there will be a session on the Sloane Project at the 2009 ABS meeting in March 2009. Plans for the use of the BCRT funding have been agreed by the Sloane Project Steering Group, these included the appointment of a Sloane Project Analyst post. d) Results from the BCCOM audit have been disseminated in newsletters and an annual report, and oral presentations given. A paper on the project has been submitted for publication. e) Links have been established between the BCCOM Project Team and the Clinical Effectiveness Unit in the Royal College of Surgeons which is carrying out the National Mastectomy and Breast Reconstruction Audit. Joint analyses of ONS-HES linked breast cancer data are being undertaken. f) Further work on the BCCOM project will be agreed at the BCCOM Steering Group meeting on 5 February 2009 and at the NCIN Breast Cancer Clinical Reference Group meeting on 10 March 2009.

West Midlands Cancer Intelligence Unit

NO.	DESCRIPTION OF AGREED OBJECTIVES	AGREED ACHIEVEMENT MEASURES
9.	To ensure that robust human resources policies and procedures are in place to encourage the development of WMCIU staff within a culture that promotes equality and value diversity	<ol style="list-style-type: none"> 1. PPR appraisals undertaken for all WMCIU staff and personal development plans, Knowledge & Skills Framework (KSF) outlines and training programmes agreed with and subsequently monitored for each person 2. Concerns raised by WMCIU staff relating to the Trust's equality and diversity policies (including Disability Equality, Employment Equality [Religion or Belief], Equal Opportunities and Harassment & Bullying policies) in the culture and environment of own professional activities inside and outside the WMCIU acted upon and resolved
	Update January 2009	a) Annual and six-monthly PPR reviews undertaken for all staff and personal development plans, Knowledge & Skills Framework (KSF) outlines and training programmes agreed. Short-term objectives agreed for new staff prior to full PPR and FSF discussions in April and May 2009 when 2009/10 objectives for WMCIU have been agreed.
10	To ensure the promotion, monitoring and maintenance of best practice in health and safety and data confidentiality and security within the WMCIU	<ol style="list-style-type: none"> 1. All WMCIU staff acting in accordance with the requirements of the Data Protection Act and WMCIU and UKACR confidentiality policies 2. Any incidents or concerns regarding health and safety and data confidentiality and security inside and outside the WMCIU acted on and resolved 3. Full review undertaken by Identifiable Data Release (IDR) group of all areas where confidential (patient identifiable or potentially identifiable) data are used or transferred (within and outside the WMCIU) to ensure that all releases are documented on the WMCIU's confidential data registers 4. Measures developed to reduce the use of patient identifiable data in professional activities inside and outside the WMCIU 5. Roll out UKACR Patient Information Leaflet to all West Midlands acute Trusts and deal effectively with all enquiries from cancer patients that are received
	Update January 2009	a) WMCIU confidentiality policy being reviewed and updated version will be published in February 2009

Birmingham Women's



NHS Foundation Trust

SUBJECT :	NHS National Genetics Education and Development Centre- 6-monthly update
REPORT BY :	
AUTHOR :	Steve Parsons, Head of Corporate Affairs

CONTEXT AND BACKGROUND FOR REPORT

The Trust acts as the host organisation for the NHS National Genetics Education and Development Centre. As part of the governance arrangements for CIU, the Board is provided with an update on the Centre's activities every six months.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The Board should be aware that the Trust is re-tendering to host the Centre for a further period.

RECOMMENDATIONS

The Board is invited to note the six-monthly update and annual report from the Centre.

NHS NATIONAL GENETICS EDUCATION AND DEVELOPMENT CENTRE

Paper for February 2009 Trust Board meeting

The NHS National Genetics Education and Development Centre (NGEDC) is now into its fifth year of funding from the Department of Health. The last six months have been a period of consolidation and dissemination of our work with the NHS and Universities. This report will highlight a few of the activities which have been undertaken by the team during the last 6 months.

Medicine

There have been a number of NGEDC initiatives within medicine, The work with the Royal College of General Practice includes a 'Train the Trainers' course for GPSPR educators, an on-line e learning course, a book 'Genetics in Primary Care Practice' and a series of articles for InnovAit, the GP trainee journal. All of these have been developed to support the Genetics Statement within the new GP curriculum which was developed in collaboration between the RCGP and NGEDC.

Nursing

We have been working with Birmingham City University, Derby University and Canterbury University specifically looking at ways to integrate genetics within busy undergraduate curricula. The Centres role is in facilitating educators to feel confident in delivering genetics and to support them by developing resources to use in their teaching. We have also been working with specific post-graduate nursing groups such as haemophilia and oncology looking at the education and training required to enable them to achieve specific genetics skills (competences) in practice.

Pharmacogenetics

Professor Alain Li Wan Po, Professional lead for Pharmacy was an invited speaker at a conference ***Celebrating Ehrlich's Nobel Prize Centenary***, in Nuremberg last October 2008. He spoke on Pharmacogenomic Targeting of Paul Ehrlich's Magic Bullet. A series of factsheets explaining the core concepts of pharmacogenetics for non-specialists are now available on the website.

Conference

The Centre held its conference ***Impact of knowledge about the human genome on clinical practice*** on the 15th October in Birmingham with sessions on:

- Effective use of technology for learning
- End-to-end services for patients and families
- Genetics and the cancer reform strategy
- Genetics education: patients' perspectives

and interactive workshops on

- Incorporating the Centre's resources to support genetics learning outcomes

- Teaching genetics: mind your language
- Using patient stories to enhance your teaching and learning of genetics
- Where does genetics fit into clinical practice and how can I support it?

Over 120 participants from clinical practice and education attended and the conference report shows that they evaluated the conference very positively, particularly the interactive sessions with the NGEDC team.

Taking a Family History Series

The Family History series includes a template tool for drawing the common symbols, a booklet with advice and suggestions on questions to ask to build a complete pedigree picture and a set of PowerPoint slides for use in education and learning. This pack was recently awarded both a West Midlands and National Innovation award which will be utilised to develop the next series on interpreting the Family History.

Birmingham Women's 
NHS Foundation Trust

SUBJECT:	Safeguarding Children Training Strategy
REPORT BY:	Jane Owen
AUTHOR:	Elaine Giles – Lead Nurse/ Midwife Safeguarding Children/Vulnerable Adults. Mike Hocking – Named Doctor.

CONTEXT AND BACKGROUND FOR REPORT

- To advise Management Board of the reviewed and updated Safeguarding Children Training Strategy.

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

- Implementation of a more robust reporting system of staff who do not attend training.
- Note an improved system of the provision of training for medical staff & how this is recorded and monitored.
- To note the inclusion of mandatory training in the 'Common Assessment Framework'.
- To note the changes to the some of the competency levels for some staff groups.

RECOMMENDATIONS:

- To note & approve this updated strategy.

Safeguarding Children Training Strategy



**Birmingham Women's Health Care NHS Trust
2009-2010**

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Child Protection Training for Safeguarding Children – Everyone’s Responsibility

1. Introduction and background:

1.1 The Department of Health 2006 states in ‘What To Do If You Are Worried a Child Is Being Abused (2003)

“All those who come in contact with children and families in their everyday work, including people who do not have a specific role in relation to child protection, have a duty to safeguard and promote the welfare of children.”

Lord Laming, in his report in to the death of Victoria Climbié, wrote:

“I strongly believe that in future, those who occupy senior positions in the public health sector must be required to account for any failure to protect vulnerable children from deliberate harm or exploitation. The single most important change in the future must be the drawing of a clear line of accountability, from top to bottom, without doubt or ambiguity about who is responsible at every level for the well-being of vulnerable children”

1.2 The Training Strategy reflects the commitment of Birmingham Women’s NHS Foundation trust to enable every member of staff employed by the Trust to have an awareness of the need to safeguard children.

2. Aim:

The aim of this strategy is to meet the training needs of all staff who work either directly with families, young people and children or who in the course of their work have contact with adults who may be carers/ parents.

3. Strategy development:

The strategy is underpinned by the following legislation and guidance, which should be read in conjunction with this document:

- Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate document. (2006)
Safeguarding Children and Young People
- The Children Acts 1989 and 2004
The Children Acts 1989
The Children Acts 2004
- Working Together to Safeguard Children 2006
Working Together to Safeguard Children 2006
- Standards for Better Health C2
Standards for Better Health C2
- Framework for the Assessment of Children in Need and their Families 2000
Framework for the Assessment of Children in Need and their Families 2000

- The Victoria Climbié Inquiry Report 2003
The Victoria Climbié Inquiry Report 2003
- What To Do If You Are Worried a Child is Being Abused (Department of Health, May 2006)
What To Do If You Are Worried a Child is Being Abused (Department of Health, May 2006)
- Every Child Matters: Green Paper 2003
: Next Steps 2004
: Change for Children 2004
- Every Child Matters: Green Paper 2003
Every Child Matters: Green Paper 2004
Every Child Matters: Change for Children 2004
- Domestic Violence Crime and Victims Act 2004
Domestic Violence Crime and Victims Act 2004
- National Service Framework for Children, Young People and Maternity Services (2004)
National Service Framework for Children young People and Maternity Services
- Learning from Serious Case Reviews (DH, 2006)
Learning from Serious Case Reviews
- Child Protection Companion (Royal College of Paediatricians & Child Health, 2006).
Child Protection Companion
- Birmingham Safeguarding Board Policies & Procedures 2007
BSCB PROCEDURES

4. Core Standards for Training:

In order for training to be effective, the following core set of values has been agreed.

5. Management and organisational commitment to training:

- The Chief Executive and Board of Directors has a responsibility to ensure that all staff receive the appropriate level of training to enable them to fulfill their duties and responsibilities as an employee in safeguarding children.
- The Trust should ensure that sufficient resources are available for training to be accessed and delivered to Trust employees.

- Safeguarding Children training is a **mandatory requirement** and the implementation of the strategy is an important component of clinical governance. Professional updating, **every 3 years**, will be required for all staff regularly involved in Safeguarding children issues.

6. Target groups:

This training strategy is aimed at all trust employees who have a degree of involvement with children and families.

7. Equal Opportunities:

- The training will respect and endeavor to acknowledge equal opportunities.
- Each session will be designed to reflect the specific training needs of different groups of employees and reflects diversity within the Trust employees.

8. Implementing the training programme:

- The training accessed will incorporate the principles of adult learning and the learning cycle. This will endeavor to focus the employees on reflection, professional responsibility/accountability and provide an opportunity for personal development.
- The training to be delivered will be evidence-based and recognise a variety of different training methods, which take into account the different learning styles of the group.
- The training will endeavor to identify and manage emotional responses that safeguarding children training can evoke.

9. Booking Procedure:

- Attendance and approval should be sought from your line manager before you apply for a place on a training session to ensure there is adequate cover in your absence.
- A study leave form should be completed and given to your line manager in order that your training record is up to date.
- Training places should be booked by contacting Social Care secretary, Deborah Dearn, ext 4016.
- If you are unable to attend a booked training session please find a replacement or inform the relevant trainer that you are unable to attend.
- Confirmation will be sent 2 weeks prior to the course date.
- Incidents of non-attendance will be reported to the relevant line manager.

- A reminder will be sent 3 months prior to an update being required.

10. Audit and Evaluation:

- A record of attendance will be on Oracle Learning Management (OLM) made and certificates provided.
- Each training course will have aims and objectives
- All training will be evaluated
- Trainers will evaluate and analyse the feedback from sessions
- Training needs analysis will be undertaken annually
- A comprehensive review of the training programme will be undertaken annually

11. Overview of training for safeguarding children:

The following Safeguarding Children training matrix identifies the appropriate level of training required.

Health workers have a responsibility to demonstrate that, appropriate to their role, they are competent in safeguarding children and that they maintain their knowledge and competence.

Managers have a responsibility to ensure that staff have accessed the appropriate level of training for their role.

Safeguarding Children Training Matrix

Training Levels	Aims	Content of Safeguarding Children Training
Level One Awareness	To raise awareness for the need of protection of children from abuse	<ul style="list-style-type: none"> ▪ Basic instruction on how to refer either directly or via manager to safeguard children to appropriate agency ▪ Local Policies/Procedures ▪ Roles and Responsibilities ▪ Sources of advice/support
Level Two Awareness <i>Recognition and Referral</i>	To ensure staff have the necessary skills and knowledge in safeguarding children. Ensure staff are trained in accordance with ACPC guidelines and national local policy	<ul style="list-style-type: none"> ▪ What is abuse and how to recognize it ▪ Legislation/guidance referral ▪ Lord Laming recommendations ▪ Barriers to Recognition Process/thresholds and for referral ▪ Confidentiality ▪ Sharing of information ▪ Record Keeping ▪ Interagency working Framework for Assessment ▪ The unborn child
Level Three Awareness <i>Direct work in protecting children</i>	To ensure that relevant staff who work with children are aware of the legal framework and their professional role and responsibilities	<ul style="list-style-type: none"> ▪ Working together ▪ Child Protection Conferences ▪ Core groups child protection plans ▪ Record Keeping – legal aspects ▪ Multi-agency assessment ▪ Legal powers ▪ The Children Act ▪ Risk factors in child protection work ▪ Substance misuse and its affect on parenting capacity ▪ Domestic Violence and the impact it has on children

Training Levels	Aims	Appropriate Staff Groups to Attend	Essential For	Content of Safeguarding Children Training
Level Four Awareness <i>Assessment and Investigation</i>	To ensure that Specialist Nurses/Doctors give support and advice to other staff appropriately	Child Protection Named Doctors/Nurses. Specialist Practitioner in Safeguarding Children	Essential for: Specialist Nurses for Safeguarding Children, Named Doctors/Nurses in Child Protection, Line Managers	<ul style="list-style-type: none"> ▪ Supervision and support in child protection ▪ Accountability and responsibility in regards protecting children ▪ Decision making ▪ Dealing with conflict to find appropriate resolutions ▪ National conferences re safeguarding children ▪ Risk management/clinical governance issues in safeguarding children ▪ Human Rights ▪ Safeguarding Boards ▪ Serious Cases and Part 8 Review recommendations ▪ Multi-agency Public Protection Panels roles and responsibilities ▪ Commission for Health Improvements ▪ Common Assessment Framework

Training must be updated every 3 years.

Level 1 training comprises of written information in the form of the Safeguarding Children leaflet which will be distributed to all staff every 3 years.

Level 2 comprises of ½ day training

Level 3 is full day training

‘Staff are required to work through each level to achieve the desired competency’.

13. Training Requirements 2009-2010

DEPARTMENT/ STAFF GROUP	LEVEL OF TRAINING
Named Professionals	4
MIDWIFERY	
All practicing midwives	3
Midwifery assistants	2
NEONATAL SERVICES	
All nursing/ midwifery staff	3
Nursery Nurses	2
Health Care Assistants	2
GYNAECOLOGY	
All nursing staff	1
MEDICAL STAFF	
Consultant Paediatricians	3
Paediatricians (finishers)	3
All obstetricians	1
GENETICS	
All staff	1
ACU	
All staff	1
SUPPORT SERVICES	
Radiography	1
Physiotherapy	1
All other staff	1
CLERICAL SUPPORT	1
CHAPLAINCY	2
STAFF COUNSELLOR	1
PALS	
All staff	1
Link Workers	2
Interpreters	1
CHIEF EXECUTIVE	2
DIRECTOR OF NURSING & MIDWIFERY	3
EXECUTIVES/ DIRECTORS	1
ADDITIONAL STAFF	Consult with Safeguarding Lead/ Named Dr

N.B:

- The Trust has given consideration to the training undertaken by paediatricians and have decided that upon completion of training should have attended Level 3.
- A record of Obstetricians receipt of the Safeguarding Children Leaflet will be taken by the Educational Learning Centre and given to Deborah Dearn to ensure the data is recorded on OLM.

14. CAF Training:

Information and current training availability is available on the CAF website:

COMMON ASSESSMENT FRAMEWORK

DEPT/ STAFF GROUP	TRAINING COMPETENCY LEVEL	MANDATORY	OPTIONAL
MIDWIFERY STAFF			
All Community Midwives – Band 6 upwards.	1½ day multi – agency course	√	
All Band 7's	1½ day multi-agency course	√	
	Lead Practitioner Training		√
All other midwives	Awareness raising – BWH based	√	
NEONATAL STAFF			
All community NN Nurses	1½ day multi-agency course	√	
All Band 7's	1½ day multi-agency course	√	
All other nursing/ midwifery/ Nursery Nurses	Awareness raising – BWH based.	√	

15. Inter-agency training:

All other inter-agency training is optional.

BSCB TRAINING INFORMATION

16. Additional training:

The following training will be provided by the Safeguarding Team or alternative providers. It is optional but is recommended.

- Substance Misuse.
- Mental health.
- Domestic abuse.
- Teenage pregnancy.
- FGM.

Staff should contact Social Care Secretary, Deborah Dearn: ext 4016.

Birmingham Women's 
NHS Foundation Trust

Subject:	Guidance for the Care of Women Involved in Surrogacy Arrangements
Report by:	Jane Owen Director of Nursing, Midwifery & Operations
Author:	Elaine Giles Lead Nurse/Midwife for Safeguarding Children

Context and background for report

Following further consultation with the Trust's solicitors and the Local Authority, section 7.3 has been amended. This has taken into consideration the threshold for referral to social services and confidentiality in respect of patient information.

Key issues for the Board of Director's consideration and decision:

The Board of Directors are asked to review and approve this guidance.

Recommendations:

Approve the guidance.

**GUIDANCE FOR THE CARE OF
WOMEN
INVOLVED IN SURROGACY
ARRANGEMENTS**

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
Children

Authors: Elaine Giles
Lead Nurse/Midwife Safeguarding

Type:	Guidance for the Care of Women Involved in Surrogacy Arrangements	Version:	1	Directorate:	Corporate
		Ref:			

Aim:	To provide staff with guidance for managing situations whereby a couple are involved in surrogacy arrangements
Scope (who it applies to) :	This guidance applies to <u>all</u> employees irrespective of grade, level, location or staff group.

Ratified by:	Clinical Governance Committee
Date:	5.12.2008
Final Approval by:	Board of Directors
Date:	
Approval Signatories	Director of Nursing/ Midwifery: Medical Director: Supervisor of Midwives
Implementation Date:	
Review and consultation process (when review required & by whom):	Lead Nurse/ Midwife for Safeguarding Children/ Vulnerable Adults
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
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1. Introduction:

1.1 What is Surrogacy?

A surrogacy arrangement is one in which one woman ("the Surrogate Mother") agrees to bear a child for another woman or a couple ("the Intended Parent(s)") and surrender the child at birth.

There are two types of surrogacy:

- Partial surrogacy;
- Full surrogacy.

Partial surrogacy

The Surrogate Mother provides the egg. The egg is then fertilised (either naturally or through artificial insemination) by either the intended father or a sperm donor.

Full surrogacy

The Surrogate Mother has no genetic link with the child but gestates embryos usually created from the eggs and sperm of the Intended Parents (or where applicable, donor eggs and/or sperm).

1.2 What is the legal position?

Surrogacy is not prohibited by law. However, surrogacy through commercial arrangement is illegal (in accordance with section 2 Surrogacy Arrangements Act 1985) and therefore it is an offence for an individual or agency to act on a profit - making basis to organise or facilitate a surrogacy arrangement for another person. Any persons or organisations who organise or facilitate a surrogacy arrangement must do so on a non - commercial basis.

Surrogate Mothers can however receive reasonable expenses from the Intended Parents, such as for maternity clothing, insemination and IVF costs and costs of travelling to and from hospital. More examples can be found in 'Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation 1998' available on the Department of Health website.

Staff should be alert to any third parties (i.e parties outside of the Surrogate Mother and Intended Parents) who may be acting illegally on a profit - making basis. Should staff become suspicious that the parties are involved in a commercial arrangement, they should contact the Lead for Safeguarding Children for further advice and guidance.

1.3 Are surrogacy arrangements legally enforceable?

The Courts have held that a surrogacy arrangement is not a legally binding contract and therefore, an arrangement between the Surrogate Mother and the Intended

Parents is not enforceable. Either party are therefore free to change their mind at any time.

2. Pre-birth

2.1 Ante- natal care

It is important to recognise that the Trust's duty of care is to the Surrogate Mother to provide maternity services. The Trust owes no duty to the Intended Parents.

All applicable ante-natal care should be provided to the Surrogate Mother in the usual way. The Intended Parents can be involved in this process provided that the Surrogate Mother consents to this. The Trust should facilitate this so far as is practical.

The Surrogate Mother has the right to make all decisions relating to her ante-natal care. It is important to remember that the child is not recognised as a "person" until birth and therefore, the rights of the mother should take precedence over the interests of the unborn child. No one else can make decisions on her behalf.

Due to the legal complexities, health professionals should advise women involved in surrogacy arrangements that they may wish to seek the expert advice of a lawyer (DOH, 2008).

2.2 Antenatal Screening

Infectious diseases

The British Medical Association in their paper "*Considering Surrogacy? Your questions answered*" (2007) highlight that parties should consider screening for HIV or hepatitis (or other applicable transmittable disease) prior to conception.

Where treatment has been provided in a licensed clinic, the eggs and the sperm to be used will be tested for HIV, hepatitis and other transmittable diseases.

However, with self insemination, there will be a risk of transmission of infection to the Surrogate Mother. It is therefore important that the Surrogate Mother is counselled of this risk and offered testing accordingly. The guidance also recommends that the intended father is tested prior to the insemination.

What if the Surrogate Mother tests positive for a transmittable disease?

Should the Surrogate Mother be identified as having a transmittable disease, staff are prohibited from sharing this information with the Intended Parents or other third party without the consent of the Surrogate Mother. To do so would be a breach of patient confidentiality.

The Surrogate Mother should however be counselled of the risks of transmission of infection to the child and any recommended steps at birth to minimise the risk of transmission, in the usual way.

Ante-natal screening for foetal abnormality

The Surrogate Mother should be offered all applicable ante-natal screening tests for abnormalities. Staff should only perform tests that the Surrogate Mother has consented to. The Intended Parents have no authority to demand testing that the Surrogate Mother does not consent to.

Should an abnormality be identified in the unborn child, staff should not share this information with the Intended Parents or other third party without the consent of the Surrogate Mother.

3. Termination of pregnancy

A Surrogate Mother has the right to a termination (provided her circumstances fall within the standard legal framework for abortion). The Intended Parents have no right to prevent a termination taking place. The Intended Parents should not be informed about a termination unless the Surrogate Mother has given her consent for this information to be shared.

4. Mental Capacity of the Surrogate Mother to make decisions

Should staff have any concerns regarding the mental capacity of the Surrogate Mother to make decisions about her pregnancy, a formal assessment of capacity should be performed (staff are advised to follow the Trust's consent policy). In the event that the Surrogate Mother lacks capacity to make a particular decision, treatment should be given having regard to the best interests of the Surrogate Mother – however, staff are advised to consult the Trust's Lead on the Mental Capacity Act prior to administering non-emergency treatment in such circumstances.

5. Birth planning

A Surrogate Mother and the Intended Parents will often sign up to a written agreement (for example, the organisation, COTS, provide a template agreement and guidance on the issues this may include). This agreement usually sets out the preferred method of delivery, who will hold the baby after delivery and who will make decisions about the child's welfare etc. Staff should be aware that these agreements are not legally binding and should be used as a guide as opposed to a binding agreement.

In the absence of a pre-prepared written agreement, staff should work with the Surrogate Mother and, where possible, the Intended Parents (in so far as the Surrogate Mother consents to their involvement) to develop an agreed birth plan. This will assist in ensuring a workable and clear plan is in place relating to e.g. the preferred method of delivery, attendance at delivery, who the baby will be passed to at birth, use of drugs during delivery etc. However, whilst it is clearly beneficial for

these discussions to take place with the Intended Parents, final decisions about delivery must be made by the Surrogate Mother.

The Surrogate Mother, with the advice of healthcare professionals where appropriate, will make the final decisions both during and immediately after the pregnancy. Where, following birth, the Surrogate Mother delegates responsibility for the child to the Intended Parents, this should be written clearly in the medical notes. Further details of how responsibility passes to the Intended Parents can be found in paragraph 7.2 of this Policy.

It is important to remember that even where a birth plan has been agreed in advance (either within the unit or a formal written agreement drawn up independently by the parties), the Surrogate Mother can change her mind at any time.

6. Confidentiality

The Surrogate Mother's confidentiality should be respected at all times. This means that no information about the Surrogate Mother or the unborn child should be shared with the Intended Parents or any other third party without the consent of the Surrogate Mother.

Whilst a breach of patient confidentiality can be justified in certain circumstances, such circumstances are limited and are subject to strict criteria. As noted above, where staff become suspicious of a commercial arrangement, they should contact the Lead for Safeguarding Children for further advice and guidance.

7. The baby following birth

7.1 What is the legal status after Birth?

7.1.1 The Legal Mother

The Surrogate Mother is the "carrying" mother and therefore, in law is the legal mother of the child at birth. This applies even where there is full surrogacy and the Surrogate Mother has no genetic link to the child.

7.1.2 The Legal Father

(a) Where the Surrogate Mother is married

If the Surrogate Mother has a husband, he is deemed to be the legal father of the child at birth unless he can prove he did not consent to the surrogacy process.

(b) Where the Surrogate Mother is unmarried

Where the Surrogate Mother is unmarried, the intended father will only gain parental responsibility for the child once he is named as the father on the birth certificate. At this point he becomes the legal father of the child. The

General Register Office makes no distinction between births that have arisen by way of self-insemination or by IVF at a licensed clinic. Once named on the birth certificate, the intended father shares parental responsibility with the Surrogate Mother.

The Intended Parents, if married, can then apply for a Parental Order. This will transfer all legal rights over the child to the Intended Parents and relinquish the legal rights of the Surrogate Mother. There are other methods of obtaining legal parentage such as adoption. The Intended Parents should seek legal advice when seeking to obtain a Parental Order or adopt the child.

For further details regarding the registration of the birth, see section 8.3 of this Policy.

(c) Where the intended father dies

Where the sperm of the intended father, or an embryo created with his sperm, is used after his death, that man will not be treated as the father of the child.

7.2 How do the Intended Parents become the legal parents of the baby?

7.2.1 Heterosexual couples

In order for the Intended Parents to become the legal parents of the baby, they must either apply to adopt the baby or apply for a Parental Order. This is true even if both the Intended Parents are the genetic parents of the baby.

It is important to realise that whilst a Surrogate Mother and/or the Intended Parents may wish responsibility for the child to pass to the Intended Parents at birth, the Surrogate Mother remains legally responsible for the baby until a Parental Order has been confirmed or the baby has been legally adopted by the Intended Parents. The Intended Parents have no formal legal rights over the baby until this time.

7.2.2 Same sex couples

The Civil Partnership Act 2004 set up a framework to allow same sex couples to achieve legal recognition of their relationship. Civil partners may apply to adopt the child or apply for a residence order. Currently however, civil partners cannot apply for a Parental Order.

7.2.3 Foreign Intended Parents and British surrogate

If neither Intended Parent is domiciled in the UK, they will not be eligible to apply for a Parental Order. Adoption would therefore be the only available option to obtain legal parenthood.

7.3 Care of the baby in the postnatal period

As the Surrogate Mother is the legal mother at birth, the baby cannot be removed from the hospital by the Intended Parents without her consent. Staff should ensure they have written consent from the Surrogate Mother before handing over the baby and that this is done, wherever practicable, in the presence of the Surrogate Mother and the Intended Parents. Staff should consider whether the Duty Social Worker should be informed of the Surrogacy arrangement to ensure that both the Surrogate Mother and the Intended Parents are able to receive support and advice in the post natal period where appropriate.

The intended mother should not be admitted as a patient of the Trust in order to provide care for the baby.

7.4 What happens if there is a dispute between the Intended Parents and the Surrogate Mother?

The Trust should attempt to work with the Surrogate Mother and the Intended Parents at all times. Should a dispute arise, the Surrogate Mother's wishes should be respected at all times and staff may wish to consider contacting the Lead for Safeguarding Children for further advice and guidance.

If the Intended Parents attempt to remove the baby from Trust premises against the Surrogate Mother's wishes, staff should consider informing the Police, subject to the consent of the Surrogate Mother.

Should staff have any concerns about the welfare of the baby, staff should follow standard procedures in terms of risk assessment, involvement of other appropriate agencies as well as invoking child protection procedures (if applicable).

8. What if the Intended Parents change their minds?

If the Intended Parents change their minds about taking the child, for example, if their circumstances have changed or if the child is born physically or mentally disabled and they feel unable to take on the responsibility, the Surrogate Mother (and her partner if she has one) will be legally responsible for the child.

In the event that the Surrogate Mother also refuses to take on the responsibility, social services should be contacted in the usual way.

8.1 What if the Surrogate Mother changes her mind?

If the Surrogate Mother changes her mind and wishes to keep the baby, the Trust must respect her wishes. In this situation, the Courts will usually allow her to keep the baby. If there is disagreement between the Surrogate Mother and the Intended Parents, the Lead for Safeguarding Children should be contacted.

8.2 What if the child becomes ill and is in need of treatment?

Where possible, decisions about the baby's treatment should be made jointly, by the Surrogate Mother and the Intended Parents in conjunction with the health professionals.

In most circumstances, the Surrogate Mother will hand over responsibility to the Intended Parents on an informal basis, at birth. However, the Surrogate Mother remains legally responsible for the baby until a Parental Order has been confirmed or the baby has been legally adopted by the Intended Parents. The Intended Parents have no legal rights over the baby until this time.

The BMA, in their "Considering Surrogacy" guidance, state that provided the baby has been "passed" to the Intended Parents by the Surrogate Mother, responsibility for decision making should pass to them.

Therefore, where a Surrogate Mother informs staff that she has handed over responsibility for the baby to the Intended Parents, staff should consult with the Intended Parents in respect of decision making and seek their consent to procedures accordingly.

Staff should request that the Surrogate Mother records in writing that she is delegating responsibility for the baby to the Intended Parents. Whilst the Surrogate Mother cannot surrender or transfer any part of her responsibility to the Intended Parents without the permission of the court, she can arrange for some or all of it to be met by one or more person acting her behalf (i.e. the Intended Parents). This arrangement is not however legally binding.

Therefore, as a matter of law, even where the Surrogate Mother has delegated the care of the baby to the Intended Parents, this does not mean that she relinquishes all legal rights or responsibilities to the baby or that the Intended Parents automatically assume the legal right to make decisions about the baby.

As a matter of law the Surrogate Mother has parental responsibility at birth and therefore, has the legal right to consent/refuse treatment on behalf of her child. This is the position until the Intended Parents have obtained a Parental Order/adoption proceedings are finalised.

In the event of a dispute between the Surrogate Mother and the Intended Parents, it is the Surrogate Mother who has parental responsibility in law to consent/refuse treatment on behalf of the child (subject to the usual test of best interests).

Should a dispute between the Surrogate Mother and the Intended Parents arise, staff are advised to contact the Lead for Safeguarding Children for further advice.

8.3 Registering of a Surrogate Child

The law requires a birth to be registered within 6 weeks.

8.3.1 Where the Surrogate Mother is married

If the Surrogate Mother is married, she and her husband will be named on the birth certificate as the parents.

If the husband of the Surrogate Mother writes a letter stating that he did not give permission for the arrangement, the intended father can be named as the father.

8.3.2 Where the Surrogate Mother is unmarried

If the Surrogate Mother is unmarried and the intended father is present when the birth is registered, he may be named as the father on the birth certificate and thus obtain parental responsibility. This is true whether the birth came about by self-insemination or by IVF at a licensed clinic. The Intended Parents will need to obtain a Parental Order to become the legal parents. The birth can then be re-registered to show the Intended Parents as the parents of the child.

In both cases the baby can be given the Intended Parents surname.

9. Sources of advice and support.

- Lead Nurse/ Midwife for Safeguarding Children
- Supervisor of Midwives
- Line Manager

10. Auditable Standards

References

- Considering Surrogacy? Your questions answered (2007) The British Medical Association: London.
- COTS Surrogacy in the UK. www.surrogacy.org.uk
- www.hfea.gov.uk
- Department of Health, 2008: email dhmail@dh.gsi.gov.uk
- The Adoption & Children Act 2002