

### PUBLIC SESSION

**MEETING OF THE BOARD OF DIRECTORS**  
to be held in the Seminar Room, Birmingham Women's Hospital  
on Thursday 29 January 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

**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 18 December 2008**

To APPROVE the minutes of the meeting held on 18 December 2008

**5 Matters arising from the minutes of the meeting held on 18 December 2008 (where not covered by agenda items)**

**6 Trust Chair's report**

**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

JO

2

Ref  
1/09/public/A9/v1

Enc

1

Ref  
1/09/public/A4/v1

	Framework		
<b>10</b>	<b>Datix</b> To CONSIDER the plan and progress towards implementation	JO/PT	<b>3</b> Ref 1/09/public/A10/v1
<b>ORGANISATIONAL PERFORMANCE</b>			
<b>11</b>	<b>Integrated Performance Report (including Finance Report)</b> To NOTE the Integrated Performance Report	JO TW NS	<b>4</b> Ref 1/09/public/A11/v1
<b>12</b>	<b>Monitor Quarterly Report</b> To AGREE the quarterly report for submission to Monitor	SIP	<b>5</b> Ref 1/09/public/A12/v1
<b>13</b>	<b>Establishing a Volunteer programme</b> To APPROVE a programme for the use of volunteers	NS	<b>6</b> Ref 1/09/public/A13/v1
<b>14</b>	<b>Trust Communication Strategy</b> To APPROVE the strategy	JB	<b>7</b> Ref 1/09/public/A14/v1
<b>15</b>	<b>Trust Values</b> To CONSIDER the values appropriate to the Trust	NS	<b>8</b> Ref 1/09/public/A15/v1
<b>16</b>	<b>Care Quality Commission Registration</b> To APPROVE the declarations necessary for registration under the Health and Social Care Act 2008	JO	<b>9</b> Ref 1/09/public/A16/v1
<b>17</b>	<b>Hosted Organisation – Six Monthly Update from West Midlands Cancer Intelligence Unit</b> To RECEIVE the six-monthly update and the Annual Report.	Gill Lawrence	<b>10</b> <i>To follow</i> Ref 1/09/public/A17/v1
<b>18</b>	<b>Revisions to Committee Terms of Reference</b> <b>a. Organisational Risk &amp; Governance Committee</b> <b>b. Management Board</b> To CONSIDER the changes proposed by the Committees	SIP	<b>11</b> Ref 1/09/public/A18/v1
<b>MEMBERS' COUNCIL MATTERS</b>			
<b>19</b>	<b>Report from Members' Council Chair</b>	JM	<b>Oral</b>
<b>TRUST POLICIES FOR APPROVAL</b>			
	a. Trust Risk Management Strategy	JO	<b>13</b> Ref 1/09/public/A19/v1
<b>OTHER TRUST MATTERS</b>			
<b>20</b>	<b>Sealing Report</b> To NOTE the report	SIP	<b>14</b> Ref 1/09/public/A20/v1

**ITEMS CIRCULATED BETWEEN BOARD MEETINGS**

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

- a. Foundation Trust Network newsletter
- b. Department of Health weekly bulletin
- c. Monitor letter re: Baby P

Dates of next meetings

Thursday 26 February 2009

Thursday 26 March 2009

Thursday 23 April 2009



**Unconfirmed Minutes of the  
MEETING OF THE FOUNDATION TRUST BOARD  
HELD IN PUBLIC  
in the Seminar Room, Birmingham Women's Hospital,  
on Thursday 18<sup>th</sup> December 2008**

**PRESENT:**

Judith Mackay (in the Chair)	Trust Chairman
Julie Burgess	Chief Executive
Jason Burn	Acting Commercial Director
David Draycott	Non-Executive Director
Helen Hemberg	Non-Executive Director
Jane Owen	Director of Nursing & Midwifery
Robin Rison	Non-Executive Director
Neil Savage	Director of Workforce & Organisational Development
Tim Woods	Director of Finance

**IN ATTENDANCE:** Steve Parsons Head of Corporate Affairs

**ACTION**

**FTP/1208/1 WELCOME AND APOLOGIES**

FTP/1208/1.1 The Chairman welcomed those present to the meeting.  
  
Apologies for absence were received from Professor Ian Booth and Mr Nigel Gardner.

**FTP/1208/2 QUESTIONS FROM THE PUBLIC ON MATTERS  
RELATING TO THE AGENDA**

FTP/1208/2.1 No questions relating to the business of the meeting were asked by the members of the public attending.

**FTP/1208/3 DECLARATIONS OF INTEREST**

FTP/1208/3.1 No interests were declared in any item on the agenda for the meeting.

**FTP/1208/4 MINUTES OF MEETING HELD ON 28 NOVEMBER  
2008**

FTP/1208/4.1 The minutes of the meeting held on 28 November 2008 were **APPROVED** and signed as a correct record subject to the following amendment:

FTP/1208/4.2 Helen Hemberg was present

**FTP/1208/5 MATTERS ARISING FROM THE MINUTES OF THE**

# ENCLOSURE 1

## MEETING HELD ON 30 OCTOBER 2008

FTP/1208/5.1 No matters arising were mentioned.

### **FTP/1208/6 TRUST CHAIR'S REPORT**

FTP/1208/6.1 The Chairman drew the following items to the Board's attention:

#### Times of meetings

FTP/1208/6.2 The Chairman suggested to the Board that, given the continuing pressure of business on the private sessions of the Board, it would be appropriate to move the starting time of the public session to 11am for the foreseeable future.

FTP/1208/6.3 The Board **AGREED** that future public sessions should begin at 11am. **SIP**

#### Press Coverage

FTP/1208/6.4 The Chairman tabled an outline of the press coverage enjoyed by the Trust over the previous three months, and noted that details could be provided if any Director required. She also noted that the Trust's profile was being raised, and most of the coverage was positive.

#### Knitters and Volunteers Lunch

FTP/1208/6.5 The Chairman noted that this had been a very well-attended event, and expressed thanks to Christine Peverelli for the organisation of the event.

#### Genetics Education Centre

FTP/1208/6.6 The Chairman noted that the Genetics Education Centre had won the 'One to Watch' prize in the NHS West Midlands Innovation Award, and had also been awarded the runners-up prize in the national finals. Congratulations were extended to the Genetics Team on their successes

FTP/1208/6.7 History of the Trust

The Chairman noted that the Trust had been presented with a copy of *History of the Birmingham Women's Hospital 1871- 1948*, a thesis written by Julia Lockhart who had been a midwife at the Women's Hospital.

### **FTP/1208/7 MEETING OF THE BOARD IN PRIVATE SESSION**

FTP/1208/7.1 The Chairman reported that the Board had met earlier in the day in private session, and had considered a number

# ENCLOSURE 1

of items including strategy for the neo-natal unit, an analysis of RCA incidents in maternity over the previous two years, the forward strategic plans for Clinical Genetics, progress towards the Annual Business Plan, and the transition to IFRS.

**FTP/1208/8**

## **ORAL REPORT BY THE CHIEF EXECUTIVE**

FTP/1208/8.1

The Chief Executive drew attention to the following main issues:

### NHS letter re: 'Baby P'

FTP/1208/8.2

The Chief Executive noted that David Nicholson, NHS Chief Executive, had written to all Trusts regarding this matter, and the Trust was looking at how to take the matter forward. Jane Owen commented that the letter suggested looking back to ensure past compliance, and also ensuring that training and interventions by external bodies were also appropriate. Serious cases over the last 12 months were being reviewed and would be reported to the Clinical Governance Committee. Julie Burgess noted that copies of the documents would be circulated to Directors.

**SIP**

### Private Patient Income

FTP/1208/8.3

The Chief Executive referred to the revised guidance from Monitor on this area, which was disappointing in that further restrictions had been identified. The Trust would be considering the impact of these changes and possible ways forward.

### Operating Framework

FTP/1208/8.4

The Chief Executive noted that the revised Operating Framework had been published, and would be fed into the annual planning process.

### 'Breaking Through'

FTP/1208/8.5

The Chief Executive reminded the Board that she was involved in this NHS initiative to enable BME candidates to move into senior leadership positions; part 2 of the process would take place in January.

### Shadow Health Secretary

FTP/1208/8.6

The Chief Executive reported that she had attended a dinner organised by the Foundation Trust Network with the shadow health secretary, Mr Andrew Lansley M.P.: this had included discussions on the likely impact of their policy proposals in the health arena. Foundation Trusts were seen as existing into this future, but the role of Strategic Health Authorities could change.

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## Academic Health Science Centres

FTP/1208/8.7 The Chief Executive reported that the Trust was working with other health and academic organisations within Birmingham to prepare a bid; the deadline for submitting expressions of interest was 16<sup>th</sup> January 2009, with shortlisting in February 2009 and final interviews in March 2009. The process was being led internally by Professor Kilby; an area of concern was over governance of the project, with some suggestion that not all partners would be equally involved at AHSC board level. This was the subject of ongoing discussions.

**JB**

## Healthcare Commission appeal

FTP/1208/8.8 The Chief Executive confirmed that an appeal against the 'good' rating had been submitted to the Commission and was under consideration by their technical team. She also understood that other organisations had experienced a similar issue.

## Retirement of Harry Gee

FTP/1208/8.9 The Chief Executive noted that Mr Gee, former Medical Director for the Trust, would be retiring at the end of the month and his retirement event would be held following this meeting. She took the opportunity to place on record her acknowledgement of the significant contribution he had made to the Trust's development.

## Resignation of Tim Woods

FTC/1208/8.10 The Chief Executive reported that Mr Woods had given notice consequent on being offered a position with Derbyshire Mental Health NHS Trust. Mr Woods would be leaving at the end of February, and she acknowledged his significant contribution to the Trust. Arrangements for the future were under discussion and would be considered by the Remuneration Committee.

**RemCo**

## National Nursing Conference

FTC/1208/8.11 The Chief Executive advised the Board that she had been invited to participate in a national Nursing Conference arising from the Darzi review groups.

## Shadowing work

FTC/1208/8.12 The Chief Executive reported that, since the last meeting of the Board, she had shadowed the Clinical Director for Maternity and in the Early Pregnancy Assessment Unit. She would also be shadowing a junior doctor on a twilight shift on Monday.

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FTP/1208/8.13 The Chief Executive's report was **NOTED** with thanks.

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

### **FTP/1208/9 Red Risk Register and Assurance Framework**

FTP/1208/9.1 Jane Owen presented paper 12/08/public/A9/v1, and noted that the register had been discussed at the Management Board, which had also seen a shadow form of Datix reporting and which had been encouraging. She referred to the following updated items:

- 0304 relating to Midwifery Staffing: there had been considerably more incidents than appeared in the report, and it was looked to reduce these; the real number was close to 50. A recruitment round for Band 5 midwives had recruited 16 for 22 places, all of whom were newly-qualified and on the relevant programme; the feedback to date was good.
- 0373, relating to baby tagging: this had been delaying, owing to components being in transit, and was now expected to be implemented in the new year.

FTP/1208/9.2 Robin Rison referred to 0373, and asked about confidence in the availability of replacement parts; Neil Savage noted that this was under firm review, and on-going assurances were being sought. Mr Rison also referred to 0382 (Norton Court), and enquired why it was now a red risk; Jane Owen commented that the risk had recently been re-evaluated and re-scored. Julie Burgess noted that a piece of work had been identified and was being progressed; Judith Mackay commented that this was useful and needed to be linked to strategic plans. Neil Savage noted that the appointment of the Head of Estates would be a key driver, and a paper related to estates would be coming forward in the new year, which would include options relating to Norton Court.

**NS**

**NS**

FTP/1208/9.3 The Board:

- **NOTED** the Red Risk Report and related discussion.

### **FTP/1208/10 Amber Risk Register**

FTP/1208/10.1 Jane Owen presented paper 12/08/public/A10/v1, noting that this had also been considered by the Management Board. She drew attention to the following points:

- 0364, relating to referral to treatment time limits: attention was focussed on meeting the 18-week requirements by the end of December 2008, and this would be tight owing to the unexpected inclusion of Genetics who provided about 5% drag on non-admitted patients.
- 0384, relating to a Consultant Microbiologist: a locum

**JO**

# ENCLOSURE 1

appointment had been made, and interviews for a substantive post-holder were to be held next week.

- 0391 had now been removed from this register.

FTP/1208/10.2 Robin Rison enquired whether 0391 only affected one area, and it was confirmed that this was the case at present.

FTP/1208/10.3 Judith Mackay commented that it appeared that the implementation of Datix was not being resolved. Neil Savage commented that ORAG had discussed the situation, and he had subsequently discussed with Peter Thompson and Jane Owen; a new project plan was to be established to take this forward. Jane Owen noted that there had been a need to build the system, with incident reporting being implemented first followed by other aspects of the system. The situation was being monitored with weekly updates to Executive Directors.

PT/ JO

FTP/1208/10.4 The Board:

- **NOTED** the Amber Risk Register and the related discussion.

## ASSURANCE

### FTP/1208/11 Registration with the Care Quality Commission

FTP/1208/11.1 Steve Parsons presented paper 12/08/public/A11/v1, outlining the requirements for registration with the Care Quality Commission from 1<sup>st</sup> April 2009. The Commission would be replacing the Healthcare Commission and would be taking responsibility for work relating to Healthcare Acquired Infections; from 1<sup>st</sup> April 2010, a standard registration framework under the Commission for all care organisations would be introduced. The declarations for registration would need to be agreed by the Board, and the Commission had declared a limited registration window between 12<sup>th</sup> January and 6<sup>th</sup> February 2009; therefore the Board would need to approve the declaration at its January 2009 meeting.

SIP/ JO

FTP/1208/11.2 Robin Rison enquired whether this linked to the policies to be considered later in the meeting, and Jane Owen noted that they fed in, although they were part of the ongoing timetabled update programme.

FTP/1208/11.3 The Chairman noted the request for the Board to identify useful information, and Jane Owen noted that similar information to that provided to the Healthcare Commission would be relevant. Julie Burgess noted that the Commission had been discussed at the CEO's meeting with the SHA; that discussion had noted that the relationship and powers of the Commission with other statutory bodies was still unclear, for example, HFEA.

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The Chairman asked if a risk assessment had been carried out on non-compliance with CQC requirements, and Jane Owen advised that this would carry forward from that for the Healthcare Commission.

FTP/1208/11.4

The Board:

- **NOTED** the need to register with the Care Quality Commission;
- **AGREED** that similar evidence to that required for the Healthcare Commission should be presented to the January 2009 Board meeting to support the statutory declaration; and
- **NOTED** the timetable for registration with the Commission.

JO

## ORGANISATIONAL PERFORMANCE

FTP/1208/12

### Integrated Performance Report

FTP/1208/12.1

Jane Owen introduced paper 12/08/public/A12/v1, noting that the presented figures related to October, as figures for November were not currently available due to the Board meeting one week earlier this month. Two reports (November and December) would be reviewed in January 2009.

FTP/1208/12.2

Tim Woods referred to the finance report, also related to October; the first view of November's figures was that they were not inconsistent. He wanted to spend a little time looking at non-pay issues, and then at the Directorate reports.

FTP/1208/12.3

October had shown a £96k surplus, and the accumulated surplus to that date was £693k, which was satisfactory. The surplus was however dependent on financial break-even on operations; there was extra income being generated, but non-pay costs were incurring additional spending.

FTP/1208/12.4

Non-pay costs were at £792k for the year to date, with a significant proportion (£308k) relating to the Northern Ireland genetics contract, although this was generating related income. £141k had been incurred on additional energy charges, and £343k incurred across the rest of the Trust. Gynaecology had been placed under special management measures to bring back to control and balance. Overall, the non-pay issue needed to be taken forward into the annual planning process.

FTP/1208/12.5

Looking at the Directorate-level figures, overall there was a positive position. The Maternity directorate had generated additional income through over-performance, and the question was how to re-invest the surplus generated. Gynaecology was behind plan by £481k,

# ENCLOSURE 1

spread between both income and expenditure; Mr Woods noted that the contract required between 3 and 4 patients per list, whilst the Trust was averaging close to 3. This Directorate also had issues on the non-pay side of the account. Judith Mackay asked how they compared to the 2007 year, and Tim Woods noted that it had been worse but had focussed around the CIP; this had now been addressed, and other issues had arisen. Month 7 had shown a positive outcome, although it was unlikely that the full contract could be delivered. Jane Owen also noted that this had impacted on theatre utilisation, and Tim Woods noted the need to give an appropriate positive message whilst focussing on the need to make a surplus overall.

- FTP/1208/12.6 Tim Woods noted that Neo-Natal was a success story, having experienced difficulties last year but being in surplus and achieving CIP targets during the present year; however, they were also experiencing some non-pay pressures particularly relating to nitrous oxide supplies. He noted that Clinical Support and Corporate would re-charge costs to front-line Directorates in due course, but also noted that Clinical Support was experiencing both pay and non-pay cost issues; they were seeking to have more permanent contract staff to replace agency posts. It was hoped to develop charging on a usage basis for this directorate.
- FTP/1208/12.7 Overall, Tim Woods noted that pay costs were as expected, but non-pay costs were under review; the costs of meeting infection control requirements was part of this, which would be charged back in due course. **TW**
- FTP/1208/12.8 Judith Mackay asked for an update on the Trust funds currently in the Paymaster General's Office, and Tim Woods confirmed that with the current strong cashflow, £10.2 million was currently lodged with the PGO. He intended to review the position in the future, noting that the PGO paid interest at Bank of England Base Rate, and it might be possible to get greater return at minimal risk. **TW**
- FTP/1208/12.9 Robin Rison suggested that the next Audit Committee meeting should review the underlying systems to provide assurance to the Board regarding non-pay items. On specifics, he enquired whether additional income was related to the increased non-pay spend; Tim Woods confirmed that this was largely related, and Mr Rison commented that this showed the need to identify net benefits to the Board. Julie Burgess noted that some of the income issue was a result of payment phasing with income being generated after the expenditure.
- FTP/1208/12.10 Neil Savage referred to the workforce report for October, and noted that 6 of the 10 indicators were unchanged.

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The key issue was sickness absence, for which policies would be reviewed in the new year, and improvements in KSF.

- FTP/1208/12.11 The Board:
- **NOTED** the Integrated Performance Report; and
  - **NOTED** that the November and December 2008 reports would be presented to the January 2009 Board meeting.
- Execs

## **FTP/1208/13 International Financial Reporting Standards (IFRS) adoption- Balance Sheet at 1<sup>st</sup> April 2008**

FTP/1208/13.1 Tim Woods introduced the subject, and tabled a paper (ref 12/08/public/A13/v1) outlining the required declaration from the Board. He noted that the Board had, during the private session, considered the appropriate accounting treatment for certain items, and was now in a position to make the statement required by Monitor.

FTP/1208/13.2 Mr Woods noted that the Audit Committee, and now the Board, had considered the proper treatment and effect of certain issues, particularly relating to accumulated ('rolled-over') leave and the treatment of the premises lease for the Hospital site. The external auditors had been consulted, and were content with the proposed treatments; the transitional Balance Sheet would be subject to external audit in the process.

- FTP/1208/13.3 The Board:
- **AGREED** to make the statement as set out in the tabled paper; and
  - **AUTHORISED** the submission of the statement to Monitor by 31<sup>st</sup> December 2008.
- TW

## **MEMBERS' COUNCIL MATTERS**

### **FTP/1208/14 Report from Members' Council Chair**

- FTP/1208/14.1 The Chairman reported that, at the meeting of Members' Council held on the 15<sup>th</sup> December, the Council had:
- Received a presentation on the forthcoming Neo-Natal appeal; there had been strong support for this from Council;
  - Decided that two Governors should be retired for non-attendance at meetings;
  - Decided to retain Karen Helliwell as a Governor, in light of the special circumstances;
  - Nominated Governors to be involved with the Women's Charities Committee and the Equality and Diversity Group;
  - Had addressed the timing of meetings, and also the question of quorum for Committees.
- JM/ SIP

# ENCLOSURE 1

FTP/1208/14.2 Jane Owen commented that if staff Governors became overcommitted, this could cause issues for local management which were difficult to deal with at local management level. Neil Savage felt that this was not a clear area, and should be reviewed further. Sarah Francis (a Governor in attendance), noted that as they were appointed in a voluntary capacity, Governors needed to strike a balance for doing things in their own time.

FTP1208/14.3

The Board:

- **NOTED** the report on the proceedings of Members' Council; and
- **REQUESTED** that further consideration was given to the commitment of staff Governors to additional meetings/ events. **NS/ SIP**

FTP/1208/15

## **Trust Policies for approval**

The Board considered and approved the following policies:

- Policy for the control of PVL-Associated Staphylococcus aureus (PVL-SA) infections
- Policy for the control of extended-spectrum  $\beta$ -Lactamase-Producing Gram-Negative Bacteria
- Introduction to Infection Control and Arrangements for Reporting of Infections
- Policy for the use of Gloves in the Clinical Area
- Policy for the Management of Risks Associated with Needlestick Injuries and Mucous Membrane Exposures to Blood and Body Fluids (Inoculation Injuries)

## **Dates of next meetings**

Thursday 29 January 2009  
Thursday 26 February 2009  
Thursday 26 March 2009  
Thursday 23 April 2009

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

<b>SUBJECT :</b>	Amendments to Committee Terms of Reference
<b>REPORT BY :</b>	Steve Parsons, Head of Corporate Affairs
<b>AUTHOR :</b>	Management Board Organisational Risk & Governance Committee

**CONTEXT AND BACKGROUND FOR REPORT**

The Board has established, and set terms of reference for, the Management Board and the Organisational Risk & Governance Committee (ORAG).

Both these Committees have reviewed their terms of reference, and seek Board approval for changes.

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

The Terms of Reference define the remit, role and responsibility of the Committee, and also define and delimit the delegation of powers by the Board. They form part of the structural and governance architecture, which should be complementary but separate from the management structure of the Trust.

As a newly-established Committee, ORAG has undertaken a review of its terms of reference to ensure that they properly represent the role it understands the Board wishes it to perform. It has identified additional members that should be on the Committee to enable it to properly perform its functions, and recommends that its responsibilities should also include the minimisation, as well as management, of non-clinical risks.

The Management Board has also reviewed its terms of reference, and have proposed:

- (i) a change in the week of meeting (from 1<sup>st</sup> and 3<sup>rd</sup> to 2<sup>nd</sup> and 4<sup>th</sup>)
- (ii) the inclusion of Associate Directors in the membership of the Board

If the proposed changes are approved by the Board, Management Board intends to proceed to approve formal terms of reference for its reporting groups, including the Performance Boards.

# ENCLOSURE 11

01/09/public/A18/V1

## RECOMMENDATIONS

The Board is **RECOMMENDED** to:

- a. **APPROVE** the revised terms of reference for the Organisational Risk & Governance Committee; and
- b. **APPROVE** the revised terms of reference for the Management Board.

# Birmingham Women's



## NHS Foundation Trust

### TERMS OF REFERENCE OF THE ORGANISATIONAL RISK & GOVERNANCE COMMITTEE

#### 1. Constitution

The Board of Directors ("the Board" hereby resolves to establish a Committee of the Board to be known as the Organisational Risk & Governance Committee.

#### 2. Membership

The Organisational Risk & Governance Committee shall be appointed by the Board and shall consist of:

Director of Workforce and Organisational Development (chair)  
One independent non-executive director  
Commercial Director  
Head of Corporate Affairs  
Deputy Director of Finance  
Associate Director of Workforce and Organisational Development  
Trust Risk Manager  
Head of Legal Services  
Head of Facilities  
Head of Estates  
Chair, Health & Safety Committee [currently Director of Workforce]  
Chair, Information Governance Committee [currently Damon Harris]  
Directorate General Managers

Chair of Trust (as an Ex-Officio member)

#### 3. Quorum

A quorum shall be four members.

#### 4. Attendance

Any director, whether executive or non-executive, may attend meetings of the Organisational Risk & Governance Committee.

#### 5. Secretary

The Head of Corporate Affairs, in his or her capacity as Secretary of the Trust, shall be the secretary of the Organisational Risk & Governance Committee.

#### 6. Frequency

The Organisational Risk & Governance Committee shall meet monthly between meetings of the Clinical Governance Committee.

## 7. Authority

The Organisational Risk & Governance Committee is authorised by the Board to:

- carry out any activity within its terms of reference
- request any information it requires from any employee, and all employees are directed to co-operate with any request made by the Organisational Risk & Governance Committee
- request any information it requires from the Head of Internal Audit

The authority of the Organisational Risk & Governance Committee is limited as follows:

- it is not the duty of the Organisational Risk & Governance Committee to carry out functions that properly belong to the Board itself or to other Board Committees
- material issues must be notified to the Board for consideration
- the Organisational Risk & Governance Committee may not delegate executive powers to sub-committees unless expressly authorised by the Board.

## 8. Duties

The principal duty of the Organisational Risk & Governance Committee is to raise the profile and ensure the effectiveness of the arrangements in place within the Trust for the minimisation and management of non-clinical risks to the achievement of corporate objectives. Such risks may include, for example:

- market and competitive risk
- regulatory risk (including risk of non-compliance with the terms of the Trust's Authorisation as an NHS Foundation Trust)
- health, safety and environmental risk
- ethical and reputational risk
- information security risk
- risk to business continuity

In carrying out this principal duty, the Organisational Risk & Governance Committee will:

- raise awareness of corporate governance and corporate risk management throughout the Trust
- regularly review the Trust's corporate governance and corporate risk management strategy and framework and monitor the overall level of corporate risk within the Trust, taking into account the requirements of the NHS Litigation Authority and Monitor guidance
- liaise with the Clinical Governance Committee on matters which fall within the terms of reference and responsibilities of both committees
- ensure that the Board and executive management have available to them clear, timely and intelligible corporate risk registers and other information as necessary to enable them to ensure themselves of the effectiveness of the Trust's corporate risk management arrangements and to detect and act upon changes in individual risks or the Trust's overall corporate risk profile
- receive the report of NHS Elect on its gap analysis of the Trust's risk management and assurance and monitor the implementation of any recommendations arising from the gap analysis
- carry out investigations and prepare reports as required by the Board

## 9. Reporting

The minutes of each meeting the Organisational Risk & Governance Committee shall be formally recorded by the Secretary of the Trust and shall be presented to the Board in unconfirmed form once the chair of the meeting has cleared them. The chair of the meeting shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

## 10. Review

The membership of the Organisational Risk & Governance Committee and these terms of reference may be changed only with the express approval of the Board and will be reviewed and agreed by the Board annually.

**Approved by the Board of Directors**

28<sup>th</sup> August 2008

Membership updated at October ORAG Meeting

9<sup>th</sup> October 2008

*Revision approved by the Board, 31<sup>st</sup> January 2009*

**REVIEW** ToR at April 2009 ORAG Meeting  
& Board of Directors August 2009 meeting

## **MANAGEMENT BOARD**

### **TERMS OF REFERENCE**

<b>Constitution</b>	The Board of Directors hereby resolves to establish an operational committee for the Birmingham Women's NHS Foundation Trust to be known as the Management Board.
<b>Membership</b>	Executive Directors Clinical Directors Associate Directors Representative from Birmingham University
<b>Quorum</b>	A quorum shall be at least three Executive Directors and two Clinical Directors.
<b>Attendance</b>	All Executive Directors and Clinical Directors will attend meetings as required. The Committee will be chaired by the Chief Executive.
<b>Frequency</b>	Twice per month, routinely the 2 <sup>nd</sup> and 4th Wednesday of the month, through the year.
<b>Authority</b>	The Management Board is authorised by the Board of Directors to carry out any activity within its Terms of Reference.
<b>Duties</b>	<ol style="list-style-type: none"><li>1) To be the operational decision making group on behalf of Birmingham Women's NHS Foundation Trust. For example, reviewing and making recommendations to the Board of Directors on all issues pertaining to the use of resources and patient activity</li><li>2) To make recommendations to the Board of Directors on decisions as appropriate and to inform their debate with regard to the strategic direction of the Trust</li><li>3) To performance manage the Clinical Directorates</li></ol>

# ENCLOSURE 11b

01/09/public/A18/V1

and their performance against the key targets.

- 4) To make recommendations for further action to be taken with the Clinical Directorates to improve performance.
- 5) To review the risks facing the organisation and in particular to interrogate the red risk register on a monthly basis and to make appropriate recommendations for action and to follow through those actions as required.
- 6) To ensure that the organisation makes progress against its corporate objectives, this will include discussing the appropriate way forward, identifying any hurdles to the successful achievement and making recommendations to the Board of Directors as to how the corporate objectives need to be updated or modified.

## Reporting

The minutes of the Management Board will be circulated in confidence to members of the Board of Directors. Where pertinent recommendations have been made these will be recorded within the Board of Directors minutes and referred to as “the Management Board recommends that” and full reference will be given to the Management Board minute in the Board of Directors minutes.

The Chairman of the Management Board will be expected to brief the Board of Directors on issues arising.

Revised: December 2008

JB:Management Board/Terms of Reference 2008

**Trust  
Risk Management Strategy**

**Date of Policy:** October 2007  
**Reviewed:** September 2008

**Author:** Malcolm Bowcock  
Cath Roper

**Next Review Date:** September 2009

**Policy and Procedure No: RM 4**

<b>Type:</b>	Trust Risk Management Strategy	<b>Version:</b>	3	<b>Directorate:</b>	Clinical Governance
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<b>Aim:</b>	To provide staff with guidance in managing the risks associated with caring safely for women, their families, the public and staff.
<b>Scope (who it applies to) :</b>	This policy applies to <u>all</u> employees irrespective of grade, level, location or staff group working in the Trust.

<b>Ratified by:</b>	Clinical Governance Committee
<b>Date:</b>	ORAG Management Board
<b>Final Approval by:</b>	Trust Board
<b>Date:</b>	
<b>Approval Signatories</b>	Chief Executive
<b>Implementation Date:</b>	

<b>Review and consultation process (when review required &amp; by whom):</b>	September 2008	Risk Manager
<b>Responsibility for Implementation:</b>	Chief Executive	
<b>Revisions:</b>		
<b>Date:</b>	<b>Author:</b>	<b>Description of Revision (Action by whom):</b>
September 2008	Cath Roper	Update of responsibilities, forums, titles.
November 2008	Cath Roper & Neil Savage	Update following October ORAG meeting.

#### HISTORY

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

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

This strategy sets out the Trust's approach to the management of risk. The strategy outlines management arrangements for the identification, assessment, treatment and monitoring of clinical, non-clinical and financial risk.

The purpose of this strategy is to ensure that the Trust will take all steps (reasonably practicable) in the management of all risks to service users, staff, visitors, structures, reputation and any other issue which could impact upon, or compromise the ability of the Trust to carry out its normal activities. The management of risk is therefore an integral part of the Trust's everyday business.

### **1.1 Definition of Risk Management**

*"Risk Management is the framework for systematic identification, assessment, treatment and monitoring of risk. Its purpose is to prevent or minimise the possibility of recurrence of risks and their associated consequences"*

### **1.2 Scope of the Trust Risk Management Strategy**

Safety is 'everybody's' responsibility and all Trust employees have a duty to patients and the organisation and therefore must be familiar with the content of this document, and adhere to its principles. The Strategy identifies a vision that encompasses training and risk management awareness for all staff to enable them to fulfil their responsibilities in protecting others, themselves and the organisation from risk.

Copies of the Trust and Directorate Risk Management Strategies are available to all staff on the U: drive at Policies& Procedures in the Risk Management folder.

## **2 AIMS OF THE TRUST RISK MANAGEMENT STRATEGY**

### **2.1 Philosophy.**

The Trust strives to minimise risks and maximise the quality of service to the women, families, public and staff who come under its care.

The aim of the strategy is to develop and maintain a clear and effective structure of responsibility and accountability across the whole Trust, together with clear systems for identifying and managing risks, so that all Trust employees will be able to play their part in dealing with risk, leading to measurable improvements in patient and staff safety.

The Trust recognises that the management of risk is a fundamental part of achieving excellent patient outcomes and in delivering safe, high quality patient care and satisfaction. This supports the Trust's 5th Corporate

Objective in ensuring that the Trust continues to provide and further develop high quality, safe, clinically excellent services.

It will, therefore, ensure that the management of risk is infused into the culture of the organisation and be the responsibility of all who deliver services to its patients.

This will be achieved by:

- Ensuring the strategy is implemented at local level by all groups of staff, and raising awareness of risk management, through Directorate Risk Management Strategies
- Providing guidance on how risk management is undertaken in the Trust
- Promoting the development and dissemination of researched and evidence based practice
- Fostering a culture in which staff are encouraged and supported to report risks, incidents and near misses
- Demonstrating the strengths of comprehensive risk management processes including critical incident analysis to determine system weaknesses, ensuring that lessons learnt are used to bring about service improvement
- Complying with external regulatory body requirements e.g. The NHSLA Risk Management Standards for Acute Trusts and the Commission for Health Improvement Standards for Better Health (DH 2005)

## **2.2 Objectives**

- Ensure that the management of risk is carried out in a structured manner as part of everyday business in line with the strategy
- Ensure each Directorate develops its own Risk Management Strategy that reflects risk management processes and practice within their area
- Ensure identified risks and resulting action plans are recorded and monitored within the Trust Risk Register
- Clearly identify at all levels in the Trust individual objectives, responsibilities and accountability for clinical and non-clinical risk management by inclusion within job descriptions and professional development reviews
- Empower all staff to report risk and any concerns within an open and fair culture and to be actively involved with system improvement
- Ensure that all staff receive appropriate mandatory training relevant to their role in line with the Trust Risk Management Training Needs Analysis
- Ensure integration between incidents, complaints and legal claims via discussion of regular reports at Trust wide, directorate, team and ward meetings

### **3 ROLES AND RESPONSIBILITIES**

All staff working in the Trust have an individual responsibility for risk management activities.

The following have specific roles in the risk management system:

#### **3.1 Chief Executive**

The Chief Executive has overall responsibility for an effective risk management system in the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance.

- Continuously demonstrating personal commitment and support for the promotion of risk management and an open and fair culture
- Ensuring that a risk management structure is in place to encompass all elements of risk and that a reporting framework is in operation to enable the Board of Directors to be assured that the risks, in accordance with agreed quality of service and the risks associated with the organisation, are effectively managed
- Ensuring that Executive Directors are assigned responsibilities for the management of clinical and non-clinical risks
- Overseeing the handling and monitoring of complaints and litigation claims arising from direct patient care

#### **3.2 Executive Directors**

The Executive Directors are responsible for directing the risk management system and ensuring the necessary assurance arrangements are in place through staff whom they are managerially and professionally accountable by:-

- Continuously demonstrating personal involvement and support for the promotion of pro-active risk management and clinical governance
- Setting objectives for risk management in line with the Trust's Corporate Business Plan and monitoring progress
- Ensuring managers and safety representatives within their areas of responsibility are appropriately trained in risk assessment and health and safety
- Ensuring all staff are of appropriate professional and technical competence and adequately trained for the tasks they are required to undertake
- Overseeing the handling and monitoring of complaints and litigation claims arising from direct patient care
- Ensuring that there is a robust system in place for the management of all "Red" risks bringing these to the attention of the Chief Executive and Trust Risk Manager
- Ensuring systems are in place to continue the development of Building

a Memory: Preventing harm, reducing risks and improving patient safety

- Accountable to the Chief Executive

### **3.3 Non-Executive Directors**

Non-Executive Directors will provide scrutiny and assurance to the Board of Directors by being members of the Audit Committee, Clinical Governance Committee and Risk and Organisational Governance Committee.

### **3.4 Medical Director**

In addition to the general responsibilities of Executive Directors of the Trust, the Medical Director has the following responsibilities for risk management throughout the Trust:

- Lead of the Clinical Governance Directorate
- Responsibility for delivering clinical governance in the Trust
- Lead Director with responsibility for Maternity Services
- Ensuring that systems are in place to provide an educated, skilled and competent medical staff workforce within the Trust
- Managing the strategic development and implementation of clinical risk management and clinical governance
- Meeting the clinical risk management conditions of the NHS Litigation Authority
- Ensuring the development of the Standards for Better Health
- Responsible for advising on legislation and guidance
- Responsible for bringing all “Red” risks to the attention of the Chief Executive and Trust Risk Manager
- Participate in the reporting to external organisation of “red risks”/ serious untoward incidents where appropriate.
- Ensuring root cause analyses are carried out where required and in the case of serious untoward incidents, leading the process.

### **3.5 Director of Nursing and Midwifery**

In addition to the responsibilities laid down for Executive Directors and Directors, the Director of Nursing and Midwifery shall have the following responsibilities:-

- Joint lead of the Clinical Governance Directorate
- Ensuring that systems are in place to provide an educated, skilled and competent nursing\midwifery workforce within the Trust

- Ensuring compliance with the statutory requirements of the NMC
- Working with the Medical Director in implementing and monitoring clinical governance throughout the clinical areas of the Trust and in particular overseeing the development of clinical audit
- Responsible for advising on legislation and guidance
- Professional responsibility for Heads of Nursing and Midwifery
- Ensuring the maintenance of the Standards for Better Health
- Ensuring that all “Red” risks are brought to the attention of the Chief Executive and Trust Risk Manager
- Ensuring systems are in place for the continued development of Building a Memory: Preventing harm, reducing risks and improving patient safety

### **3.6 Director of Workforce and Organisational Development**

In addition to the responsibilities laid down for Executive Directors and Directors, the Director of Workforce and Organisational Development shall have the following responsibilities:-

- Chair of the Organisational Risk and Governance Committee (ORAG)
- Working closely with Executive Directors to ensure that systems are in place to provide an educated, skilled and competent workforce within the Trust
- Ensuring compliance with the statutory requirements of professional regulatory bodies not falling under the jurisdiction of the Nursing and Medical Director
- Working with the Executive Directors in implementing and monitoring governance throughout the non-clinical areas of the Trust

### **3.7 Director of Finance**

In addition to the responsibilities of Executive Directors and Directors, the Director of Finance has responsibility for managing the strategic development and implementation of financial risk management and the security of IT systems.

### **3.8 Clinical Governance Manager**

- Ensures risk management responsibilities of staff within the Clinical Governance Directorate are undertaken
- Has line management responsibility for the Trust Risk Manager
- Has line management responsibility for the Lead Clinician for Clinical Risk
- Accountable to the Medical Director
- Is a member of the Clinical Governance Committee

### **3.9 Trust Risk Manager**

- Supports the Trust and its directorates in developing and delivering a programme of risk management in line with the Trust Risk Management Strategy
- Supports the development of the clinical and non-clinical incident reporting system across the Trust
- Project manages processes for participation in external assessment for NHSLA Acute and CNST Maternity Risk Management Standards
- Provides advice and support on Risk Management and reports as required to the Trust and its directorates
- Works with the Lead Clinician for Clinical Risk on responses including actions and learning from incidents and near misses
- Advises the Legal Services Manager of incidents with the potential for litigation and acts upon feedback from the Legal Services Manager through the litigation process
- Participates in root cause analysis as required
- Is a member of the Clinical Governance Committee
- Is a member of the Organisational Risk and Governance Committee
- Accountable to the Clinical Governance Manager

### **3.10 Consultant Lead for Clinical Risk (Trust Wide)**

- The Lead Clinician for Clinical Risk is a member of the Clinical Governance Committee and oversees management of clinical risk
- Can be consulted on any specific issues as required
- Works with the Risk Manager, Legal Services Manager and Clinical Governance Manager on outcomes and learning from incidents and near misses
- Ensures effective communication of clinical risk management in both induction and training of junior medical and nursing staff
- Participates in root cause analysis as required
- Accountable to the Clinical Governance Manager

### **3.11 Directorate Responsibilities**

Each Clinical Director is responsible for the implementation of risk management within their Directorate, supported by other professional staff with Clinical Governance / Risk Management Responsibilities. These responsibilities are defined in the individual job descriptions and in the local Directorate Risk Management Strategy. These include:

- Maternity Services Risk Management Strategy
- Gynaecology Services Risk Management Strategy
- Clinical Support Services Risk Management Strategy
- Clinical Genetics Services Risk Management Strategy
- Neonatal Services Risk Management Strategy

These strategies can be found within each Directorate and on the U: drive at Policies& Procedures in the Risk Management folder.

## **4 THE RISK MANAGEMENT PROCESS**

The management of risk across the Trust is undertaken using the following process.

### **4.1 Risk Identification**

This is the process of identifying what has happened or could happen, why and how within a supportive culture. Once a risk has been identified, it should be assessed, controls put in place and details recorded on the Trust Risk Register.

This can be facilitated through:

- Risk profiling
- Trend analysis
- Incident reporting
- Complaints and litigation
- The 'whistle blowing' policy

### **4.2 Risk Assessment**

- Risk analysis - addresses frequency and impact
- Risk Evaluation - determines priorities by comparing against criteria/standards
- Provides a score for prioritising risks by examining the likelihood of a risk happening multiplied by the severity of its consequence.

### **4.3 Risk Treatment**

This is a process of selecting and implementing appropriate options for the management of identified risk. The 2 categories of risk we use are:

- Clinical
- Corporate

### **4.4 Action Planning**

4.4.1 The Clinical Governance Committee is responsible for overseeing the following:

- Quarterly risk reports produced by the risk management team which include the number of incidents and trends. The group monitors responses and disseminates learning via the CGC Directorate Quarterly Quality Indicator reports. Where there are trends and in the case of serious incidents, RCA is used to gain an understanding of the

problems and to identify changes that need to be made. This is a multi-disciplinary process which involves operational staff and incorporates the patient perspective. Solutions are developed that are realistic and sustainable and have local ownership. The reports are collated annually in the BWH clinical annual report

- Monitoring the use of Clinical Audit across the Trust to ensure standards are met and that practice is continuously improved.
- Considering the outcomes of trend analysis from incidents through reports
- Considering the outcome of trend analysis from complaints and legal reports and delegating responsibility to the relevant persons in the directorates to produce action plans, and overseeing the implementation of these
- Considering reports of RCAs undertaken in the directorates
- Formally receiving on behalf of the Trust, external sources of learning and best practice recommendations including National Institute of Health and Clinical Excellence (NICE), Confidential Enquiry into Suicide and Homicide (CISH), National Confidential Enquiry into Patient Outcome and Death (NCEPOD), appropriate professional bodies and the Healthcare Commission
- Ensures benchmarking of our service is undertaken against these, identifying gaps, producing action plans, overseeing implementation of these
- Oversees implementation of required changes highlighted by patient surveys including the national inpatient, outpatient and maternity surveys

4.4.2 The Organisational Risk & Governance Committee is responsible for raising the profile and ensuring the effectiveness of the arrangements in place within the Trust for the management of non-clinical risks to the achievement of corporate objectives, including, for example:

- market and competitive risk
- regulatory risk (including risk of non-compliance with the terms of the Trust's Authorisation as an NHS Foundation Trust)
- health, safety and environmental risk
- ethical and reputational risk
- information security risk
- risk to business continuity

In carrying out this principal duty, the Organisational Risk & Governance Committee will:

- raise awareness of corporate governance and corporate risk management throughout the Trust
- regularly review the Trust's corporate governance and corporate risk management strategy and framework and monitor the overall level of corporate risk within the Trust, taking into account the requirements of the NHS Litigation Authority and Monitor guidance

- liaise with the Clinical Governance Committee on matters which fall within the terms of reference and responsibilities of both committees
- ensure that the Board and executive management have available to them clear, timely and intelligible corporate risk registers and other information as necessary to enable them to ensure themselves of the effectiveness of the Trust's corporate risk management arrangements and to detect and act upon changes in individual risks or the Trust's overall corporate risk profile
- carry out investigations and prepare reports as required by the Board

#### **4.5 Supporting Staff**

It is important that staff involved in serious adverse clinical events are supported appropriately as they may be psychologically traumatised. Some may find it difficult to continue working. There may be an adverse impact on their personal lives and mental health. The amount and type of support required will be determined by the individual and their line manager. However, the following support systems have been developed to address this as part of the review process for serious incidents.

- For nurses, midwives and AHPs, the clinical manager is informed to provide ongoing support in dealing with the event and to facilitate personal reflection on the event
- Consultants provide this support for medical staff, Clinical Directors for the Consultants and the Medical Director for the Clinical Directors
- The support continues throughout the investigation and formal review process and for as long as is needed
- All staff involved in serious incidents are given information about the Trust's confidential staff counseling service
- Further support may be obtained from the Occupational Health department
- If a member of staff shows signs of post traumatic stress disorder following an incident, they must be referred to Occupational Health
- If a member of staff is unable to work due to difficulties following the incident, they should be advised to consult their GP. Frequent contact must be made by the line manager so that the staff member does not feel unsupported whilst out of the Trust
- Feedback must be given to staff on the findings and actions of the investigation of adverse incidents.
- Reducing the impact on staff of formal complaints or claims by working with the PALS and legal departments and by gathering the information needed to deal with these in an appropriate manner

Identifying good practice and encouraging staff to report adverse events and near misses to provide opportunities for improvement. This approach helps overcome a possible impression that things are getting worse because more events are being reported

#### **4.6 Monitoring and Reviewing**

External Monitoring is undertaken by the NHS Litigation Authority (NHSLA) through the Clinical Negligence Scheme for Trusts (CNST) Maternity Standards assessments and the NHSLA Risk Management Standards for Acute Trusts assessments. In Addition the Health Care Commission undertakes formal review of activity through monitoring of compliance with Standards for Better Health as part of its Annual Health Check. Monitoring of serious untoward incidents is also performed by the main purchaser of the Trusts' services, South Birmingham PCT.

#### **4.7 Risk Prevention**

All areas within the Trust must be diligent in the identification and assessment of clinical and non-clinical risk, and draw up action plans to minimise the occurrence of incidents and accidents. In the event of an incident or accident occurring, the process described above must be followed in order to identify systems failure and reduce the potential for recurrence.

### **5 CURRENT POSITION**

#### **5.1 Incident Reporting Policy**

All staff have a duty to adhere to the principles of the Incident Reporting Policy (RM 12). Electronic copies are available on the U drive in the Policies and Procedures Folder, under Risk Management Policies.

#### **5.2. NHSLA Risk Management Standards for Acute Trusts & Clinical Negligence Scheme for Trusts Maternity Standards (CNST)**

All staff must be familiar with, and comply with the NHSLA Risk Management Standards for Acute Trusts and proactively work towards compliance with Level 3 status. In addition where applicable, staff must actively work to achieve the requirements of CNST Maternity Standards at Level 3.

#### **5.3. Clinical and Non Clinical Risk Assessments (Risk Register)**

The Risk Assessment Policy describes the risk assessment process i.e. the identification of actual and potential risks, and ensures adequate control measures are in place to eliminate or reduce risks to the lowest level reasonably practicable, by identifying specific responsibilities to both employer and employee and defining recognised risk assessment tools.

The Trust Risk Register Policy identifies the process by which the Trust Board reviews the organisation wide risk register.

Both policies can be found on the U: drive at Policies& Procedures in the Risk Management folder.

The purpose is to ensure that an effective system is in place for identification and control of risks to the safety of Patients, staff, visitors and the quality of service.

All managers must be familiar with the assessment tools and recording assessments on the Risk Register.

Staff must be aware of the action plans identified from these assessments within their specific area of work. Quarterly reports are produced for the Clinical Governance Committee and directorate Clinical Improvement Groups and disseminated throughout the Trust

#### **5.4 Communication and Co-ordination**

Various communication forums in the Trust enable all staff members to meet to discuss risk management issues and subsequently disseminate information to staff in all areas. These are described in Appendix 2.

#### **5.5 Staff Induction and Training**

All new employees are required to attend the Trust Induction training day on commencement of employment, followed by a flexible individualised area specific induction programme.

A Risk Management Training Matrix (Appendix 3) has been developed that describes the training required by different staff groups within the Trust. Much of the clinical training is supported by a training needs analysis that is specific for that particular area of training. These Training Needs Analyses can be found on the U Drive in the relevant clinical policy or can be accessed separately via the contents page of the Risk Management Policies Folder.

All clinical staff must attend the following mandatory training:

- Adult resuscitation as defined in Training Needs Analysis
- Infection Prevention and hand hygiene updates as defined in Training Needs Analysis
- Fire training
- Manual handling training as defined in Training Needs Analysis
- Safeguarding Children Training at appropriate level
- Blood transfusion training as defined in Training Needs Analysis
- Risk Management Training

Permanent members of the Medical Staff and Junior Doctors who work within the Trust for more than a year must attend mandatory training annually.

Health Care Assistants and non-clinical staff must attend mandatory training relevant to their roles as described in the Trust Risk Management Training matrix.

Staff working in the Maternity Directorate may need additional training. Training requirements and relevant Training Needs Analyses are identified in the Guidelines for Training for staff caring For Mothers & Babies.

## **5.6 Professional Development Plans**

All Medical, Nursing and support staff must have annual appraisals and complete a professional development plan in line with their job's KSF.

## **5.7 Recommended Best Practice Guidance**

All clinical staff have a professional responsibility to ensure they are familiar with the best practice guidance which applies to them e.g. Trust Guidelines for Professionals, Royal College of Midwives' Midwifery Guidelines, the Royal Marsden Manual of Clinical Nursing Procedures, Essence of Care etc.

Individuals producing guidelines must ensure they comply with the Guideline for Development, Distribution and Maintenance of Trust Policies 2006. Most guidelines are available electronically on the network U: drive.

## **5.8 Trust Policies**

Directorate staff must be familiar with, and adhere to the principles stipulated within Trust policies found in the file on the U: drive at Policies& Procedures.

## **5.9 Clinical Audit**

All clinical staff are required to be actively involved in clinical audit. Directorates produce Core Audit Plans on a 1 to 3 year basis prioritised according to risk assessment involving the following criteria:

- The needs of women and their families who use the Trust
- National Confidential Enquiries
- National guidance e.g. NICE guidance, Essence of Care
- Clinical Indicators of Outcomes
- Professional bodies
- Outcomes of Incident and formal reviews including action plans and changes in practice
- Complaints
- Integrated Care Pathways
- NHSLA Risk Management Standards for Acute Trusts

## **5.10 Complaint and Litigation Reports**

Quarterly reports are presented to the Clinical Governance Committee. These are disseminated throughout the directorates. In addition, the directorates produce quarterly quality indicator reports which are presented within the directorate and to the Clinical Governance Committee.

Both reports are recognised as useful resources in identifying risk which may be incorporated onto the risk register where appropriate. The reports, associated action plans and changes in practice are discussed, monitored and reviewed at the directorates' clinical improvement groups and at the directorate meetings.

## **6 Implementation and monitoring of the Risk Management Strategy**

The implementation of this strategy including associated reports, action plans and resulting changes in practice will be monitored by the Clinical Governance Committee.

### **6.1 Training on this strategy**

Staff will be informed of the principles of this strategy and all associated policies at Induction. Attendance at training will be monitored through the Trust training database.

### **6.3 Consultation**

This policy has been widely distributed via the Clinical Governance Committee.

### **6.4 Associated Policies**

This strategy relates to systems and processes detailed in various other documents and should be read in conjunction with these. The list below is not exhaustive but highlights associated policies staff must be aware of:-

- Clinical Governance Strategy
- Patient & Public Involvement strategy
- Directorate specific Risk Management strategies
- Incident Reporting Policy
- Major Incident Plan May
- Root Cause Analysis Policy and Procedure
- Raising Concerns Policy at work-Whistle Blowing Policy
- Risk Register Policy
- Risk Assessment Policy
- Infection Control Policies
- Clinical Audit Strategy
- Induction Policy
- Guideline for Development, Distribution and Maintenance of Trust Policies
- Policy & Procedures for the Verification of Registration of all Health Care Professionals

These are all available on the U: drive at Policies& Procedures.

## **7 Circulation of the Strategy**

The strategy document will be made available to all Trust members of staff. It will be accessible on the U: drive at Policies& Procedures in the Risk Management folder.

Risk Management Awareness is included in the Induction Programme for all new staff.

## **8 References**

*Risk Management in the NHS*. NHS Executive 1994

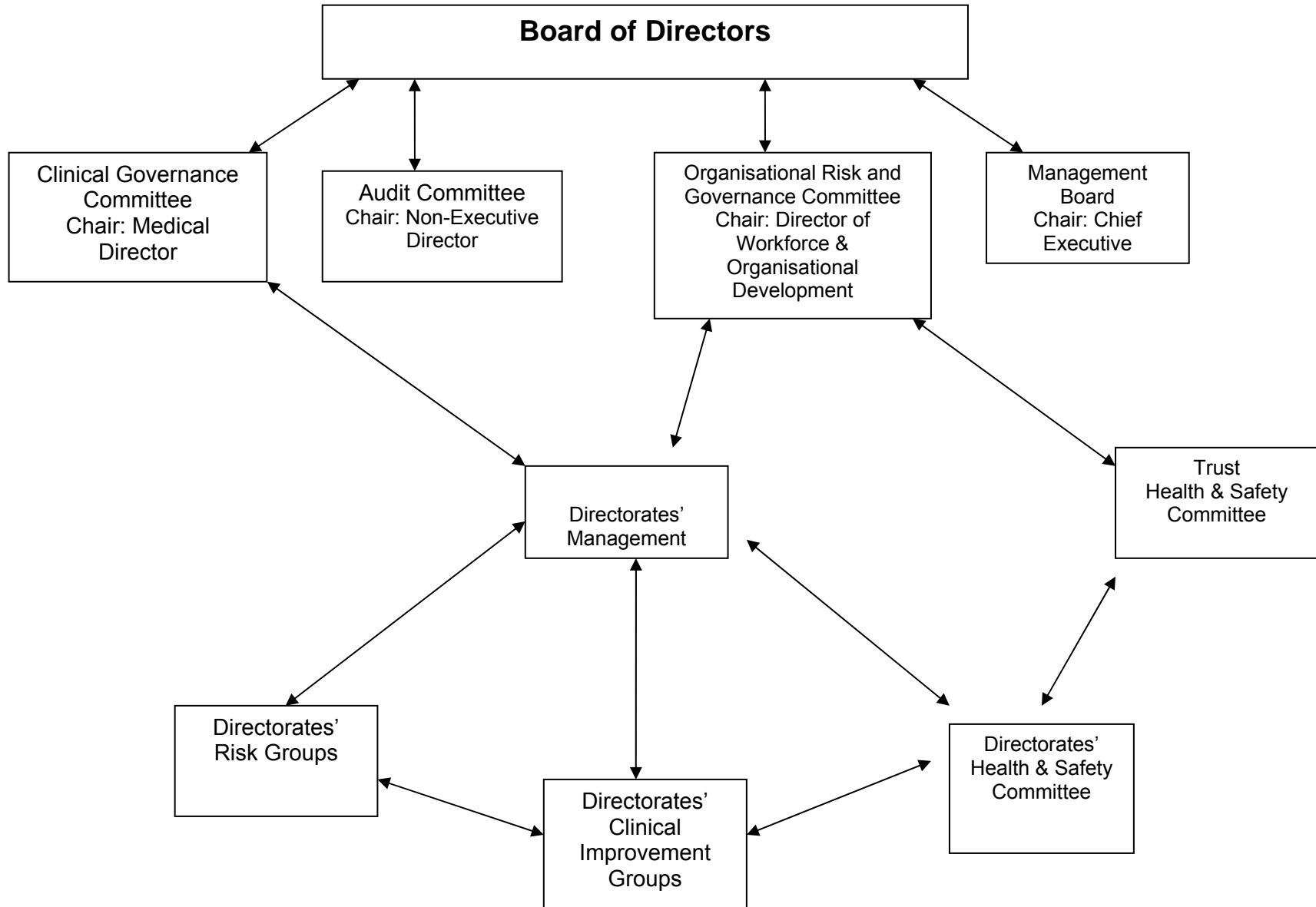
HSC 1998/ 113 A *A First Class Service. Quality in the new NHS*

HSC 1999/ 065 *Clinical Governance. Quality in the new NHS*.

Clinical Risk Management for Obstetricians and Gynaecologists - Clinical Governance Advice No 2 . RCOG January 2001

*NHSLA Risk Management Standards for Acute Trusts Standards* April 2007.  
NHS Litigation Authority

# Trust Risk Management Structure



## **Membership and Responsibilities of forums with responsibility for co-ordination and communication of Risk Management**

### **Board of Directors**

#### *Membership*

Trust Chairman

Chief Executive

Executive and non-Executive Directors

- Meetings held monthly
- Corporate Risk Register and Assurance Framework reviewed
- Policies and procedures accepted
- Clinical Governance reports received including incident reports, complaints, claims, PALS etc
- Organisational implications considered

### **Audit Committee**

#### *Membership*

At least 3 Non-Executive Directors

- Meetings held at least 3 times per year
- The Audit Committee gives the Trust Board written independent verification on the risk management systems in place in the Trust
- Reviews the establishment and maintenance of an effective system of internal control and risk management
- In particular the committee will review the adequacy of: All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board
- The structures, processes and responsibilities for identifying and managing key risks facing the organisation
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements
- The operational effectiveness of policies and procedures
- The policies and procedures for all work related fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud Services

### **Organisational Risk and Governance Group**

#### *Membership*

Director of Workforce and Organisational Development (chair)

One independent non-executive director

Commercial Director

Head of Corporate Affairs (secretary)

Deputy Director of Finance

Associate Director of Workforce and Organisational Development

Trust Risk Manager  
Head of Legal Services  
Head of Facilities  
Chair, Health & Safety Committee  
Chair, Information Governance Committee  
Any director, whether executive or non-executive, may attend meetings of the Organisational Risk & Governance Committee.

The committee will:-

- meet monthly between meetings of the Clinical Governance Committee
- raise awareness of corporate governance and corporate risk management throughout the Trust
- regularly review the Trust's corporate governance and corporate risk management strategy and framework and monitor the overall level of corporate risk within the Trust, taking into account the requirements of the NHS Litigation Authority and Monitor guidance
- liaise with the Clinical Governance Committee on matters which fall within the terms of reference and responsibilities of both committees
- ensure that the Board and executive management have available to them clear, timely and intelligible corporate risk registers and other information as necessary to enable them to ensure themselves of the effectiveness of the Trust's corporate risk management arrangements and to detect and act upon changes in individual risks or the Trust's overall corporate risk profile
- carry out investigations and prepare reports as required by the Board

### **Clinical Governance Committee**

Discusses risk management issues trust wide and considers all external reports i.e. confidential enquiries, NICE Guidance etc and reports to the Trust Board.

#### *Membership*

Medical Director (Chair)  
Director of Nursing & Midwifery (Deputy Chair)  
Lead Clinician for Clinical Risk  
Chief Executive  
Clinical Directors (or deputy)  
    Maternity  
    Gynaecology  
    Neonatology  
    Genetics  
    Clinical Support Services (Associate Director)  
Clinical Governance Manager  
Professional Leads  
    Head of Nursing - Gynaecology  
    Head of Midwifery  
    Head of Nursing -Neonatal  
Risk Manager  
Non-Executive Directors  
Representing Public and Patient Involvement

## Trust Board Observer & Scrutineer

Co-opted as necessary:

Director of Workforce & Organisational Development  
Director of R & D  
Legal Services Manager

- Meetings held monthly
- To ensure that any required actions are monitored and completed
- New and reviewed guidelines should be presented to the Committee for endorsement
- Discussion of relevant summarised adverse clinical events, risk management processes and trend analysis and related issues
- To consider key issues from, national service frameworks, implementation plans for the Confidential Enquiries (CEMACH, CISH and NCEPOD) NICE guidance and other relevant external bodies including professional bodies and the Healthcare Commission
- Discuss audit findings and action recommendations
- Receive and discuss newly endorsed guidelines and consider relevant patient information
- Meeting minutes are to be circulated

## **Directorate Groups**

*Membership*

Clinical Director

Directorate Manager

Professional Leads

Departmental Leads

Clinical Managers

Ward / departmental Managers

Reps from Clinical Governance, Risk Management, Informatics, Finance, HR. etc as required

- Meetings frequency varies according to directorate
- Organisational risk issues discussed
- Key issues from national service frameworks, implementation plans for the NICE guidance Confidential Enquiries (CEMACH, CISH and NCEPOD)
- Delegate responsibility for the above to appropriate leads to ensure that any required actions are identified, recommendations made and completed
- Risk Management issues should be standing items on the agenda with relevant discussion of summarised clinical and non-clinical events, risk management processes, trend analysis and related issues
- Minutes and other pertinent reports will be tabled and reviewed including feedback from directorate Clinical Improvement Groups
- Group meeting minutes circulated and discussed at local area meetings by the manager

## **Directorate Clinical Improvement Group** e.g. Gynaecology /ACU

### *Membership*

Clinical Director– Chair

Head of Nursing - Deputy Chair

Director of ACU

Clinical Co-ordinators

Clinical Nurse Managers

Clinical Governance Manager

Trust Risk Manager

Theatre manager

Representatives from Clinical Support- physiotherapy .

- Meetings are held four times a year
- Risk Management issues should be standing items on the agenda with relevant discussion of summarised clinical and non-clinical events, risk management processes, trend analysis and related issues
- To ensure that any required actions are completed
- To consider and implement key issues from national service frameworks, implementation plans for the NICE guidance Confidential Enquiries (CEMACH, CISH and NCEPOD)
- Discuss audit findings and action recommendations, and discuss further audits to be undertaken.
- New and reviewed guidelines should be presented for endorsement.
- Patient information relating to newly endorsed guidelines should be identified by the group and a responsible individual identified for review.
- Group meeting minutes are to be circulated and discussed at local area meetings by the manager

N.B For specific membership for each Directorate, refer to individual Directorate Risk Management Strategy.

## **Risk Group** e.g. Gynaecology /ACU

### *Membership*

Head of Nursing

Health & Safety representatives from departments

Other invited representatives from wards/ departments

- Meetings to be held monthly
- Health and safety issues raised by representatives will be discussed
- Relevant Health & Safety issues can then be taken to Trust Health & Safety committee by Head of Nursing on behalf of Group
- To ensure that any required actions are completed
- Feedback from Head of Nursing on issues discussed at directorate meeting and Trust Health & Safety Committee

## **Departmental/ Ward Meetings**

### *Membership*

Departmental / Ward Manager

Nurses

Nursing assistants

Ward Receptionists

Other staff relevant in specific areas

Invited guests

- Meetings to be held monthly
- Organisational Issues and other pertinent reports will be explored and disseminated to staff including issues from national service frameworks, implementation plans for the Confidential Enquiries (CEMACH, CISH and NCEPOD), NICE Guidance etc
- Operational issues will be discussed to improve patient experience
- Risk Management issues should be standing items on the agenda with relevant discussion of summarised clinical and non-clinical events, risk management processes, trend analysis and related issues
- Outcomes of investigation of incidents, complaints and claims relevant to the area feedback to staff to enable learning / changes in practice
- To ensure that any required actions are completed
- Staff informed of new and reviewed guidelines and of accessibility on the Trust U: drive
- Findings from audit should be discussed
- Group meeting minutes should be displayed in the appropriate departments and circulated to other interested areas

Corporate Risk Management Training Matrix

	Corporate Induction - once	Local Induction - once for all new areas	Defusion & Breakaway once only	Display screen Equipment – once only	Root Cause Analysis - once only	Diagnostic/Therapeutic Equipment (Low Risk) -once only	Diagnostic/Therapeutic Equipment (High Risk)	Risk Mgmt and Incident Reporting - induction & annual	Fire Safety - induction & annual	Patient Handling –induction & annual	Load Handling –induction & annual	Infection Prevention & Hand Hygiene - induction & annual	Adult Resuscitation Training (Video / ABLIS) induction & annual	Hospital Life Support (HLS) - induction & annual	Immediate Life Support (ILS) induction & annual	Paediatric Resuscitation - induction & annual	Neonatal Resuscitation - induction & annual	Food Hygiene (Basic) 2 yearly	Blood Transfusion Safety 3 yearly	Safeguarding Children 3 yearly	
Exec and Non Exec	√	√	FL		N			√	√				T								T
Senior Medical Staff	√	√	FL		N	√	√	√	√	T	T	T		√		T	T			T	T
Junior Medical Staff	√	√	FL			√	√	√	√	T	T	T		T	T	T	T			T	T
Line Managers	√	√	FL	N	N			√	√	T			T	T							T
Midwives	√	√	FL	N	N	√	√	√	√	T	T	T		T	T		T			T	T
Registered Nurses	√	√	FL	N	N	√	√	√	√	T	T	T		T	T	T	T			T	T
Registered AHP	√	√	FL	N	N	√	√	√	√	T	T	T		T	T	T				T	T
Biomedical Scientists	√	√	FL	N				√	√		T	T	T							T	T
Clinical Scientists	√	√	FL	N				√	√		T	T	T								T
Genetic Technicians	√	√	FL	N				√	√		T	T	T								T
Genetic Counselor	√	√	FL	N				√	√		T	T	T	T		T					T
Medical Technical Officers	√	√	FL	N				√	√		T	T	T								T
Nursery Nurses	√	√	FL			√		√	√		T	T		T		T		N	T	T	T
Health Care Assistants	√	√	FL			√		√	√	T	T	T		T		T		N	T	T	T
Other support workers	√	√	FL			√		√	√	T	T	T	T	T		T		N	T	T	T
Facilities/ancillary	√	√	FL		N			√	√		T	T	T					N	T	T	T
Admin/Clerical	√	√	FL	N				√	√		T		T			T				T	T
Contracted Staff		√																			
Non-Medical Locum staff		√																			
Medical Locum staff		√																			
Agency staff		√																			

√ = MANDATORY  
 O=OPTIONAL  
 FL=FRONTLINE STAFF  
 N = NOMINATED  
 T = Defined in TNA

# Birmingham Women's



NHS Foundation Trust

<b>SUBJECT :</b>	Revised Trust Risk Management Strategy
<b>REPORT BY :</b>	Jane Owen, Director of Nursing & Midwifery
<b>AUTHOR :</b>	Cath Roper, Risk Manager

## **CONTEXT AND BACKGROUND FOR REPORT**

The risk management strategy has been subject to a regular review, and the opportunity has been taken to update to reflect changes since the last review.

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

The revised Strategy has been updated to reflect latest learning in the management of risk in the Trust, and to reflect the revised scoring criteria adopted in preparation for the implementation of Datix risk management.

## **RECOMMENDATIONS**

The Board is invited to **APPROVE** the revised strategy

# Birmingham Women's

## NHS Foundation Trust

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

**KEY ISSUES FOR TRUST BOARD CONSIDERATION AND DECISION:**

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

<b>Seal No.</b>	<b>Date</b>	<b>Description of Document Sealed</b>	<b>Value</b>	<b>Signed By</b>	<b>Attested By</b>
32	24 <sup>th</sup> Dec 2008	Intermediate Form of Building Contract (IFC 98, as amended) E. Manton Limited	£403,544	Julie Burgess	Neil Savage

**RECOMMENDATION:**

The Board is invited to **APPROVE** the application of the Trust seal to the above agreement.

## Birmingham Women's



NHS Foundation Trust

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

### CONTEXT AND BACKGROUND FOR REPORT

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

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

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

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

### RECOMMENDATIONS

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# Combined Corporate Red Risk Register and Assurance Framework

**16/01/09**

Incident Month December

## CONTENTS

<b>Description</b>	<b>Page</b>
▪ Introduction	1
<b>Corporate Red Risk Register</b>	
▪ Assurance Framework purpose	
▪ Risk Register profiles	
▪ Trends	
▪ Corporate Objective Mapping	6-7
▪ Healthcare Commission Standards Mapping	8 -9
▪ Timeline	10
▪ Corporate red risk profile	11-17
▪ Structured assurance model	18

## Description and definitions:

### The Purpose of NHS Assurance Frameworks

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

It incorporates the following elements:

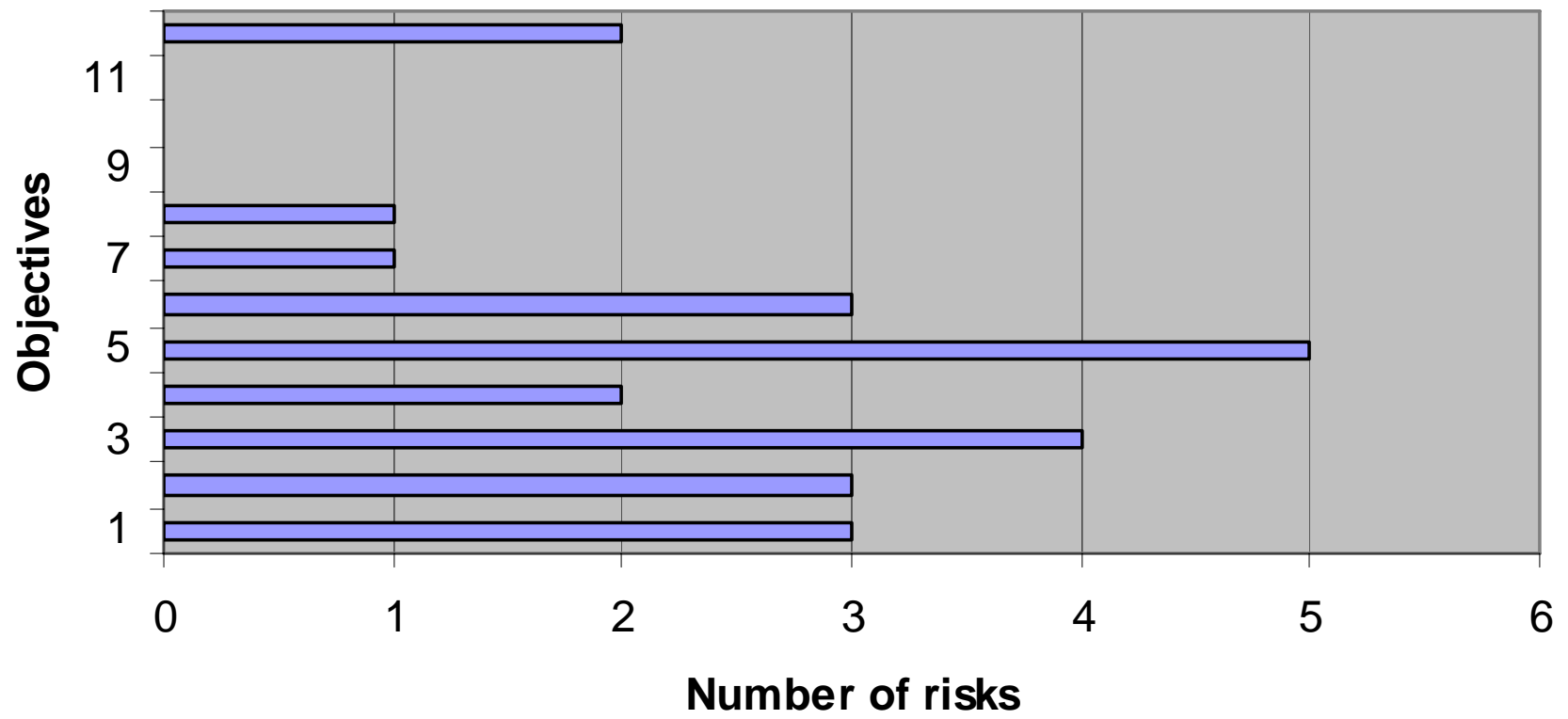
- What the organisation aims to deliver (**corporate objectives**)
- The factors which could prevent these objectives being achieved (**principal risks**)
- The significance of the principal risks (**impact**)
- The processes in place to manage those principal risks (**controls**)
- The extent to which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

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

**Distribution of Corporate Risks.**

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

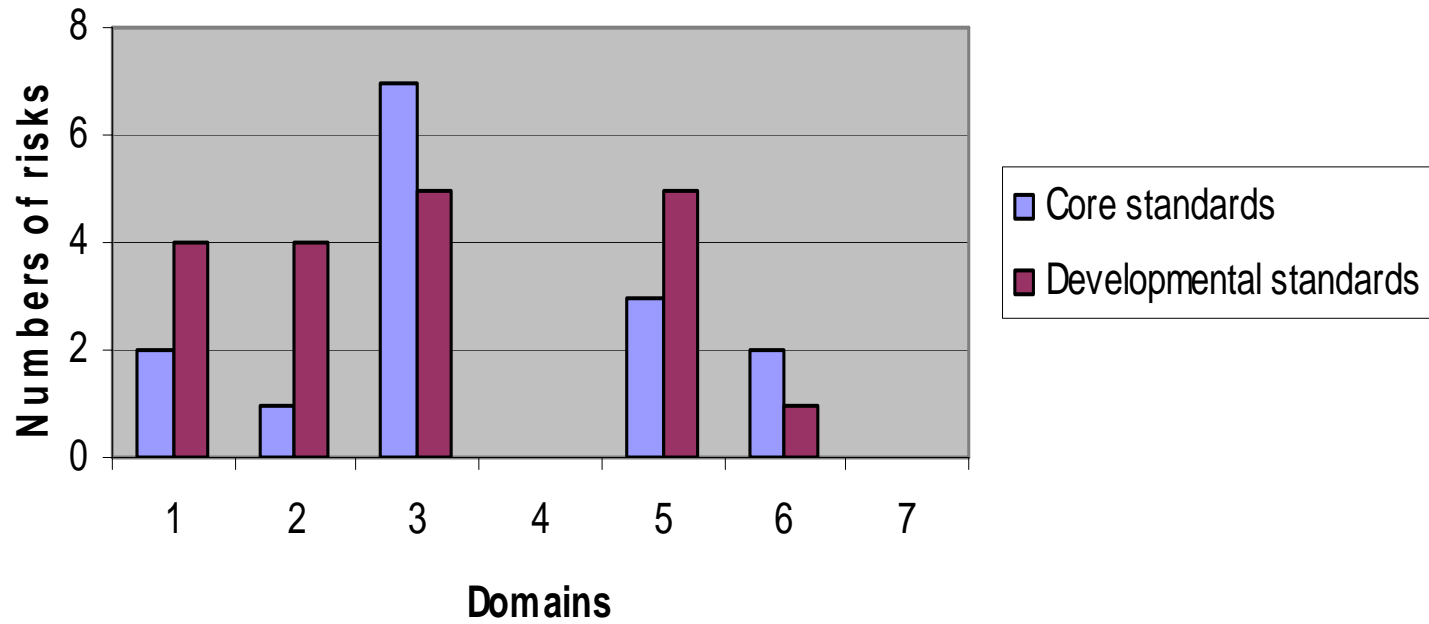
## Red Risks Mapped to Corporate Objectives



## **Corporate Objectives 2008/09**

1. We will ensure that patients and visitors are served professionally with good hotel services and facilities, excellent customer care and a welcoming environment
2. We will deliver the core performance targets and achieve an excellent rating for quality of services
3. We will deliver faster, shorter pathways and one stop care to deliver the 18 week referral to treatment target and to streamline care pathways for all our patients.
4. We will ensure that excellent standards of Infection Control and a clean environment are maintained.
5. We will ensure that the Trust continues to provide and further develop high quality, safe, clinically excellent services
6. We will continue to develop effective partnerships with all stakeholders, including our Members' Council
7. We will further develop models of care and care pathways across organisational boundaries to ensure a seamless service to patients as close to home as possible
8. To promote and expand the local and specialist services we provide to the people of the West Midlands and beyond
9. We will be an Employer of Choice recruiting and retaining and developing the best staff
10. We will make best use of our resources and achieve our financial plan
11. To further enhance our reputation for excellence in research, education and training
12. We will invest in our estate and IT infrastructure to ensure clinical care is supported and enabled by effective support services.

## Red Risks Mapped to Healthcare Commission Standards



## Healthcare Commission Standards (Standards for Better Health)

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

**Timeline for variation in Corporate Red Risk scores  
In the last 12 month period (January 2008 – December 2009)**

Risk Ref/ Date 1 <sup>st</sup> appeared on red register	Target Reduction Date	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
TRUS 0281 (Jan-05)	July 2010												
TRUS 0298 (Jun-05)	01/02/09												
TRUS 0304 (Dec-05)	30/11/08												
TRUS 0373 (Jul 07)	30/09/08												
TRUS 0374 (Sep 07)	31/11/08												
TRUS 0375 (Sep 07)	31/03/08												
TRUS 0377 (Dec 07)	31/10/08												
TRUS 0148 (Oct 08)	01/01/09										15		
TRUS 0380 (Oct 08)	31/10/08										16		
TRUS 0381 (Oct 08)	June 2009											20	
TRUS 0382 (Oct 08)	2011											20	
TRUS 0392 (Dec 08)	2011												16

1 - 3	Low risk	4 - 8	Moderate Risk	9 - 14	Significant Risk	15 - 25	High Risk
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				posts required to meet compliance.		
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- **Assurance Levels**

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

**TRUS 0304 Care could be compromised due to the lack of midwifery staff.**

The assurance with regard to implementation of the community IT programme remains uncertain.

**TRUS 0298 The potential risk of the Trust not being able to function as a Perinatal Centre due to the:  
Inadequate inappropriate building and working environment**

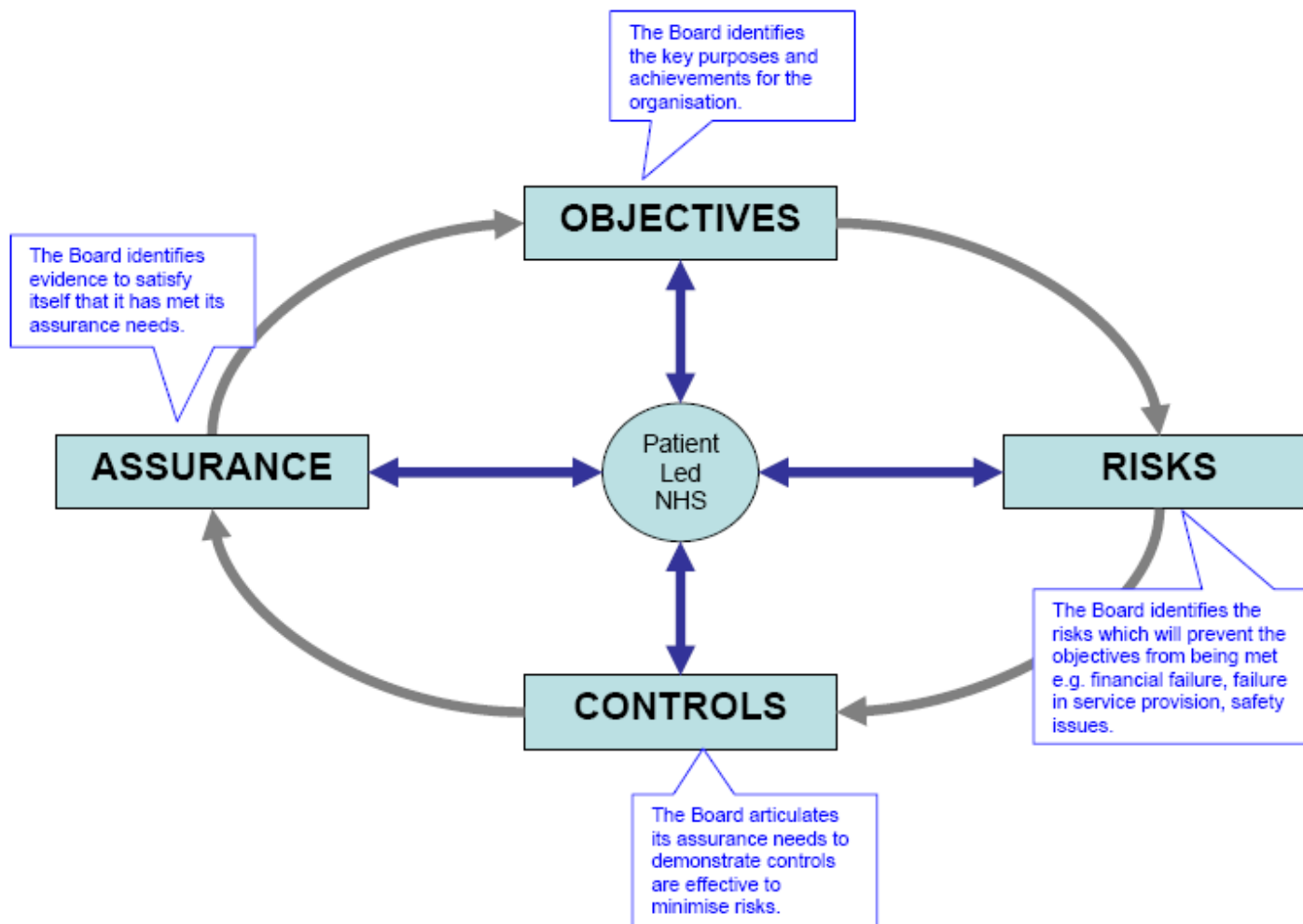
**Lack of facilities to increase cot capacity**

**Specialist nurses roles not adequately being developed and the national shortage of trained Neonatal Nurses.**

The assurance with regard to the nursing establishment remains inadequate.

**TRUS 382 Assurance with regard to the fire alarm in Norton Court is uncertain due to spare parts becoming obsolete.**

## Model for Structured Assurance



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

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

<b>SUBJECT :</b>	Datix- progress to date
<b>REPORT BY :</b>	Jane Owen/ Peter Thompson
<b>AUTHOR :</b>	

**CONTEXT AND BACKGROUND FOR REPORT**

The Board has asked to be provided with an update report on the implementation of the Datix system within the Trust.

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

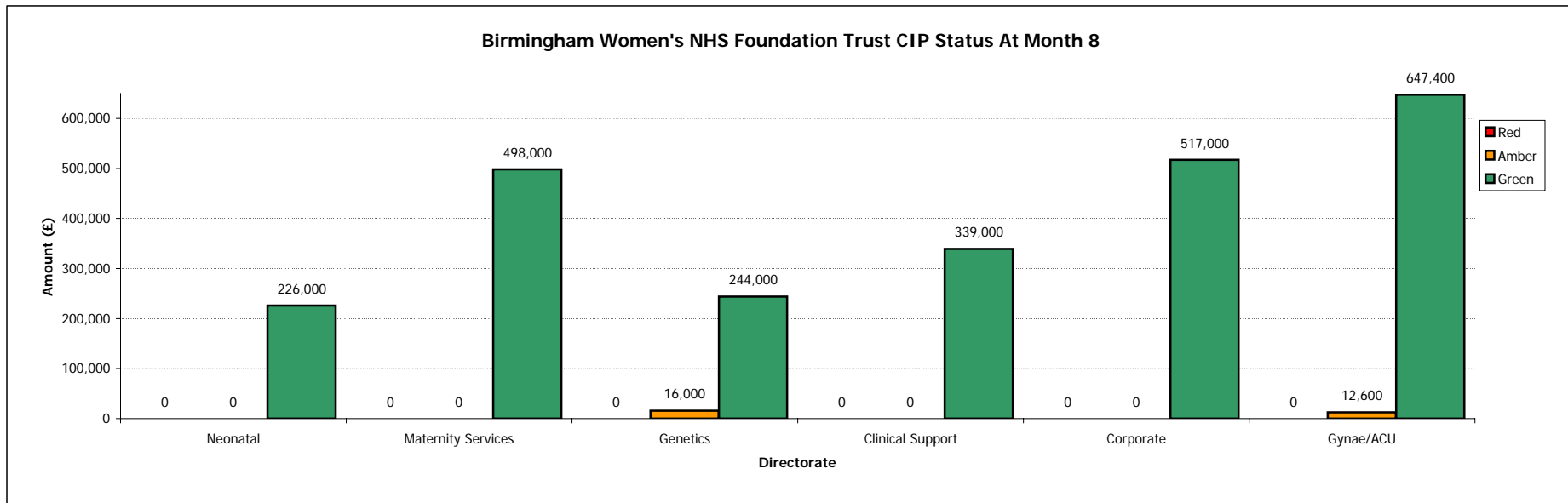
The Trust has decided to use the Datix system for the management of a number of areas around risk, including incident recording and risk register.

Concerns have been expressed as to the speed of implementation and roll-out for the system within the Trust, and the issues have been discussed in a number of forums, including Clinical Governance Committee and Organisational Risk & Governance Committee.

The project is subject to active oversight at an Executive Director level. An oral update will be provided to the Board to ensure that it receives the most up-to-date information.

**RECOMMENDATIONS**

The Board is invited to note the update on the implementation of Datix.

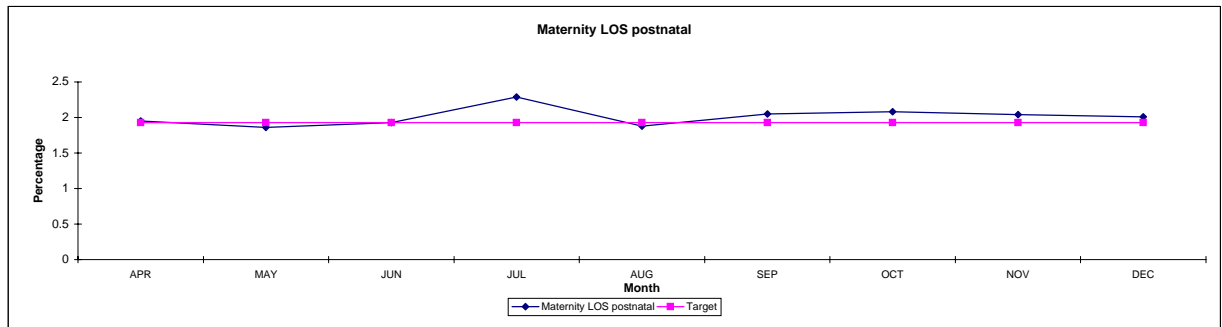


Market Trend Awareness

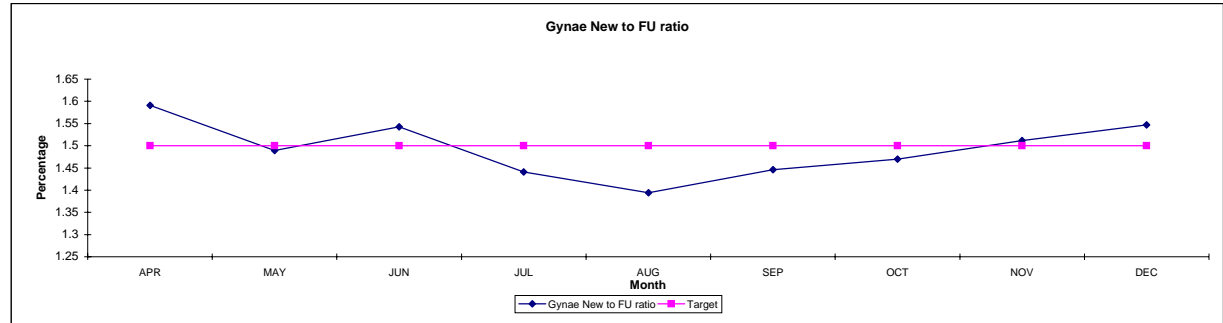
Core Standards

Productivity & Efficiency

Indicator	Target	Trend/actual	Commentary	Completion date	Lead	Risk	Impact
Maternity LOS postnatal	1.9	2.0	Slightly above the national benchmark	continue to monitor	on going	Head of Midwifery	Insufficient capacity

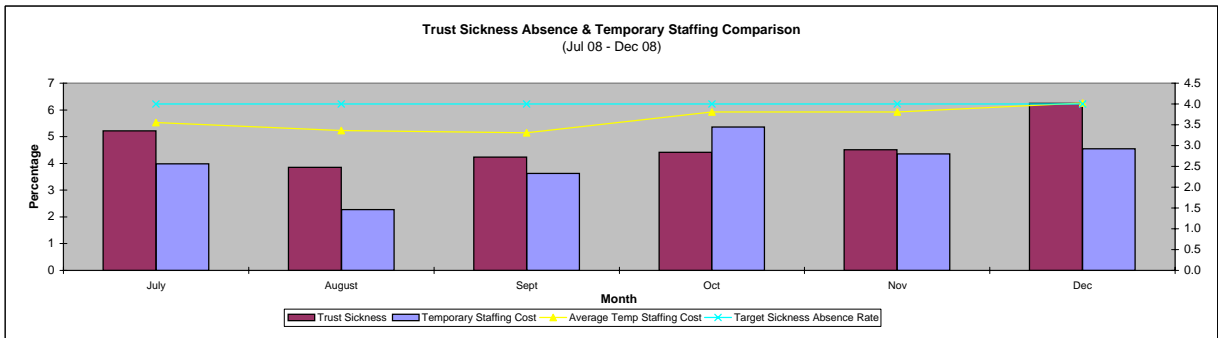


Indicator	Target	Trend/actual	Commentary	Completion date	Lead	Risk	Impact
Gynae New to FU ratio	<1.50	1.55	Increase in follow up appointments this month	monitor monthly	general manager	exceed PCT target	



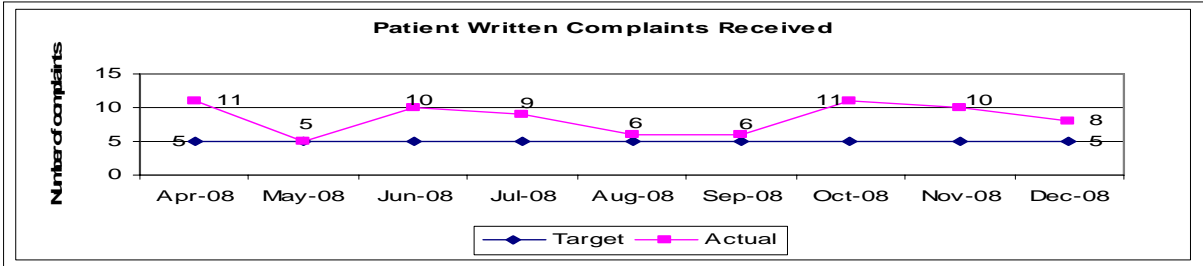
**Workforce**

Target	Trend/actual	Commentary	Action	Completion date	Lead	Risk	Impact	Impact
4.0%	6.25%	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

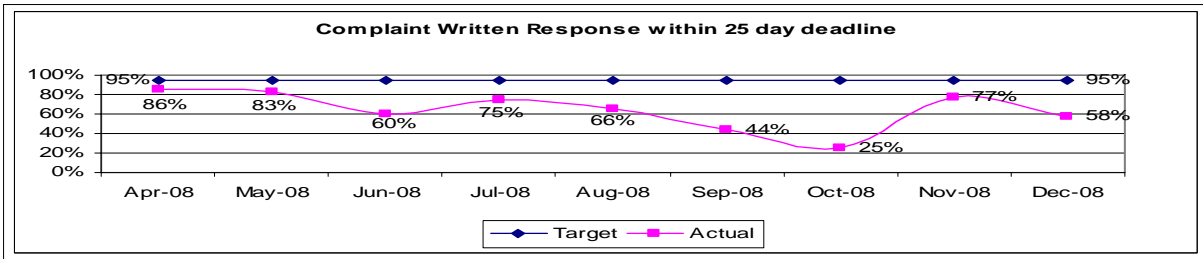


**Patient Experience**

Indicator	Target	Trend/actual	Commentary	Completion date	Lead	Risk	Impact
Complaints Received	<5	8	This is in line with the national trend				



Indicator	Target	Trend/actual	Commentary	Completion date	Lead	Risk	Impact
Response to complaint in 25 days	95.0%	58.00%	Continue as part of the early adopter programme , where timescales are negotiated with the patient				



**Foundation Status**

# Birmingham Women's NHS Foundation Trust

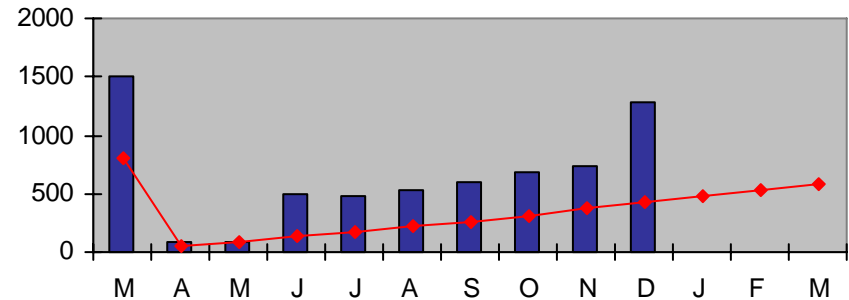
Finance Report for the Period April to  
December- 2009

# Summary Financial Position

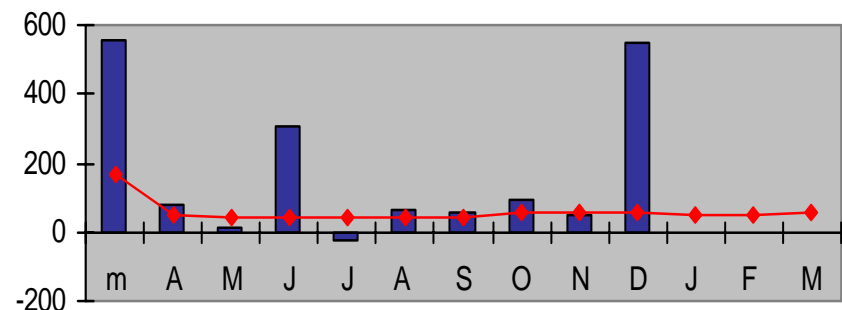
## Key Points

- This is the financial report for the first three quarters of 2009/10. The results report a net £1.2m surplus, which is £859k above plan and this converts to a Monitor risk rating of 4.
- The summary £859k variance comprises the following:-
  - A favourable £1.0m income variance;
  - An adverse £614k expenditure variance;
  - An above plan Ebitda position of 7.9%
  - A favourable £337k variance for depreciation;
  - A favourable £91k interest variance.
- In month, the net surplus was £551k for December and £46K for November.
- The planned end of year position is a surplus of £0.6m. The forecast based on the overall position remains in a range of £1,000k to £1,500k. The above plan position for December has improved the year end forecast to the higher end of this range - but not by the same degree, as the in-month improvement is one of timing rather than new income not previously included in the forecast.

**Cumulative plan, results & forecast**



**Monthly by month plan, results & forecast**



Actual Original Plan

# Income

## Key Points

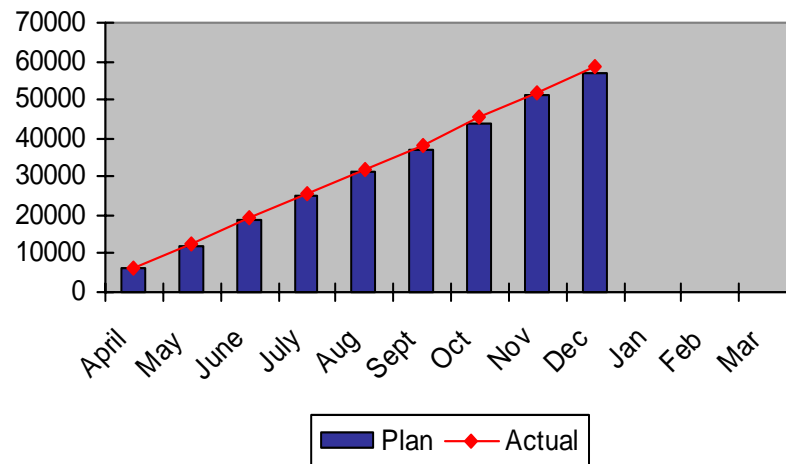
- The income received to date is £58.8m and this is £1.0m ahead of plan. There are no material changes from the activity trends reported in previous months.

## Healthcare Income

- This is £903k above plan and comprises a £516k over performance from the main PCT contracts and £443k for specialised services. The in month increase in income was due to the inclusion of the additional funding agreed with South Birmingham PCT with respect to the Community Midwifery contract. This was agreed in December and the additional midwives are now in post.

## Performance with Commissioners

- Over-performances remain with South Birmingham -£119k, Heart of Birmingham- £200K, and Birmingham North & East- £78k and Sandwell - £82k. The negative variance with Worcester of £(97)k increased only marginally from the previous report
- For Other PCTs there is a combined over performance £134k for other PCTs.



## Performance by Specialty

- Gynaecology – an adverse variance of £113k; underperformed by 217 spells. The improvement noted in previous month has continued which is good news for the Directorate and the Trust.
- Maternity- favourable £593k and 561spells. Within this position is a negative position with respect to triage. This has been factored into the plan for 2009/10.
- Neonatology -£165k favourable variance, inclusive of £150k in respect of Gloucester twins.
- Clinical Genetics- £42k positive variance and Laboratory Genetics -£129k 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 9, there was an in month improvement of movement of £135k. The main reason for this was the improvement in the pay position within Maternity, Gynaecology and to lesser extent also within Corporate Services.
- Of the year to date 872k non-pay variance, £423k is in respect of Genetics which is offset by additional contract income. Further, £210k refers to the variance within Facilities mainly from increased energy prices.
- The £239k remainder, is spread across the Directorates. However, the movement from month 8 to month 9 was a small improvement of £6k.
- This adverse position is covered within the overall financial position of the Trust, however, tighter control of non-pay is needed where this is not linked activity and/or to spending this year in order to reduce pressure in 2009/10.

- 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 7				Month 8			
£ 000s	Pay	Non-Pay	Dir'ate	Total	Pay	Non-Pay	Dir'ate	Total	
		Pay	Income			Pay	Income		
Obstetric and Fetal	-32	-15	-19	-66	-39	-22	-24	-85	
Gynaecology	-39	-117	43	-113	-2	-152	-94	-249	
Genetics	83	-308	310	85	100	-399	393	95	
Neonatal	38	-73	60	25	53	-81	72	44	
Clinical Support	-93	-89	17	-165	-123	-154	11	-266	
Facilities	-42	-141	-33	-216	-47	-172	-54	-272	
Corporate Services	124	-50	-77	-3	153	102	-87	168	
	39	-793	301	-453	96	-878	217	-565	

### Directorate Pay and non-pay variances from budget

Year to date		Month 9				Forecast			
£ 000s	Pay	Non-Pay	Dir'ate	Total	Pay	Non-Pay	Dir'ate	Total	
		Pay	Income			Pay	Income		
Obstetric and Fetal	110	-44	-19	46	185	-69	-34	82	
Gynaecology	25	-115	-122	-211	-6	-137	-139	-281	
Genetics	73	-423	348	-2	103	-562	442	-17	
Neonatal	65	-86	54	32	51	-126	22	-53	
Clinical Support	-147	-170	32	-285	-136	-265	34	-367	
Facilities	-39	-210	-70	-319	-84	-202	-94	-379	
Corporate Services	172	176	-40	307	203	-37	-216	-50	
	258	-872	184	-430	317	-1399	16	-1066	

# Cost and Efficiency Improvements

## Update on performance

### Overall Summary

- To the end of December, savings of £1,963k have been identified and verified as saved. This remains above the target of £1,1865k and directorate forecasts are in line with an end of year target of £2.5m which is in line with the plan..

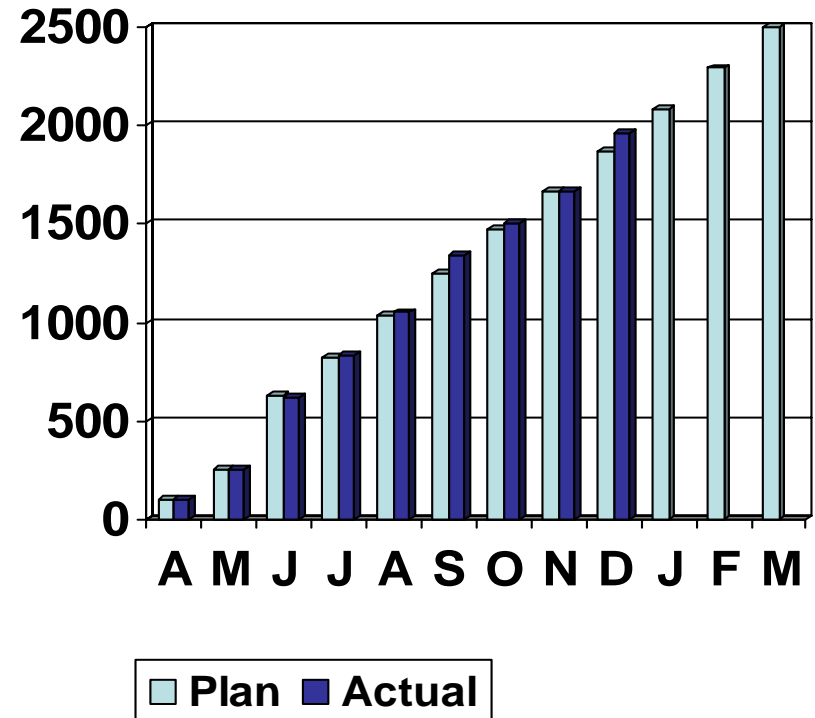
### Traffic light summary

- The CIP annual targets have been updated from the meeting held in December . There are now no red schemes which is good news. The traffic light results are ( split by the 2.5m plan):-
  - Red £ 0K
  - Amber £ 37K
  - Green £2,183K
  - Total £2,463k

There are still a number of schemes which are yet to start and these are the ones which are graded amber.

- 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

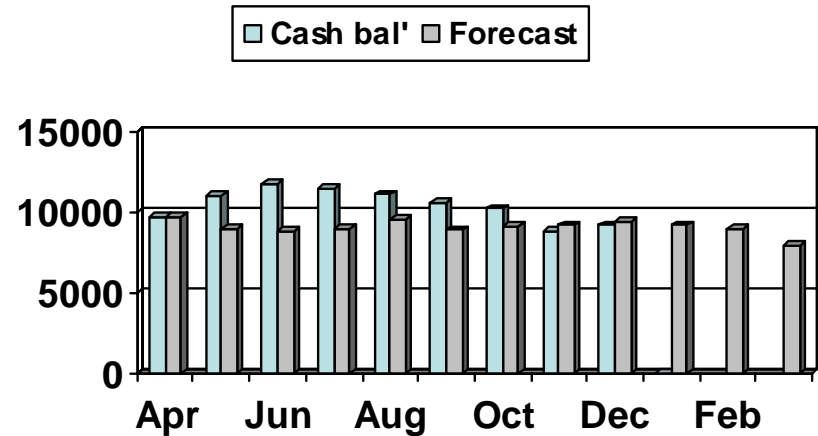


NB savings include additional income with respect to the some directorates

# Cash Flow 1

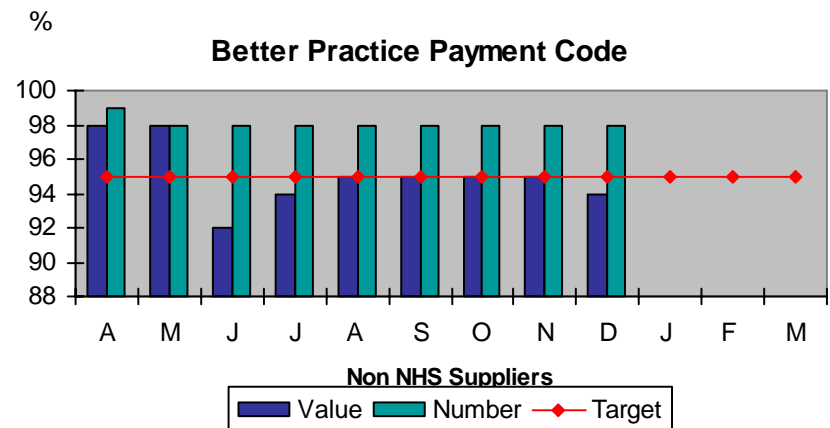
## Cash Balances

- The cash position remains strong with the balance at the end of October totalling £9.2m. ( £8.8m in November ) of which £5.1m is in respect of deferred income and accruals.
- The reduction of the cash total back to plan results from spending on the capital programme and the release of the £750k Flu pandemic monies held on behalf of the Public Health Observatory.
- As at 31<sup>st</sup> December October 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)

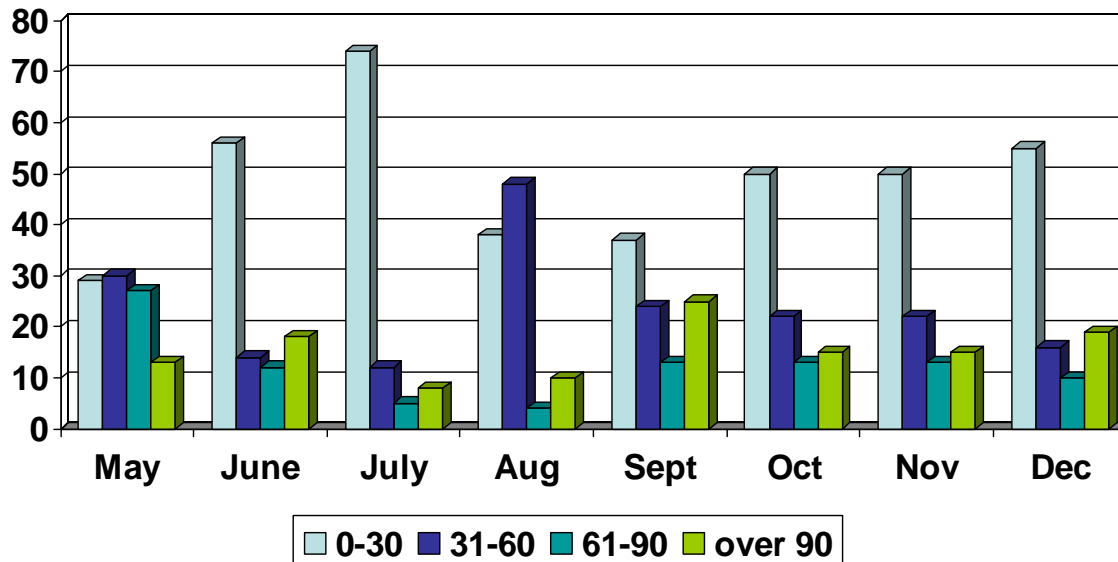
- The Better Practice Payment Code (formerly PSPP) targets NHS organisation to pay 95% of all supplier invoices within a period of not more than 30 days. Within this, the payment for local trade suppliers has been adjusted to payment within 10 days; this is in line with the Prime Minister's request to all public bodies.
- The cumulative performance by number is 98% and by value improved to the end of November but dropped slightly in December to 94%. It needs to be noted, however within this, that trade invoices by value are running at 99%.



# Cash Flow 2

## Debtors (amounts owing to the Trust)

- Total Debtors totalled £5.8m at the end of December which represents a slight rise from the previous report. Of the 5.8m, £2.8m refers to trade debtors and £3.0 to accrued income.
- In terms of aged debt information, the number over 90 days totals 19% and £450k.
- 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.

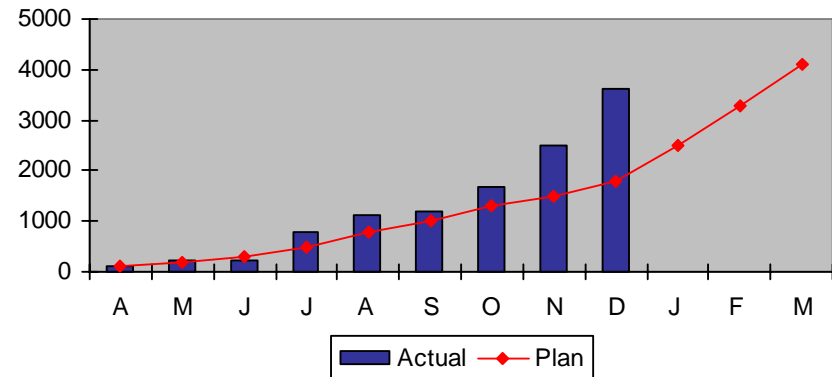


# Cash Flow 3 - Capital Spending

## 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 £3.6m is now 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

Capex Programme	Plan	Actual
Capital Equipment Replacement	500	712
Modular Theatres	-	51
Neonatal Unit Upgrade / Decant	700	192
Genetics IT	-	0
Genetics White Paper	-	(3)
PACS	-	202
Pan Birmingham Decontamination	-	181
CHP Installation	1,300	1,503
Community Midwifery IT	-	0
Replacement PCs	200	376
Baby Security System	-	0
Backlog Maintenance	500	343
Other	900	71
<b>TOTAL CAPITAL PROGRAMME</b>	<b>4,100</b>	<b>3,627</b>

# 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	£113k
Failure to deliver CIP plans fully	Red schemes & 50% amber not delivered	Low but keep under close scrutiny	Yes
Expenditure creep Unplanned & unavoidable non-pay expenses	£1,200k	High	£1,339k covered by income and pay positions.
HRG 4 - revised list of HRGs and tariffs	Currently being assessed	Definite	2009/10 impact –

# Conclusions and Recommendations

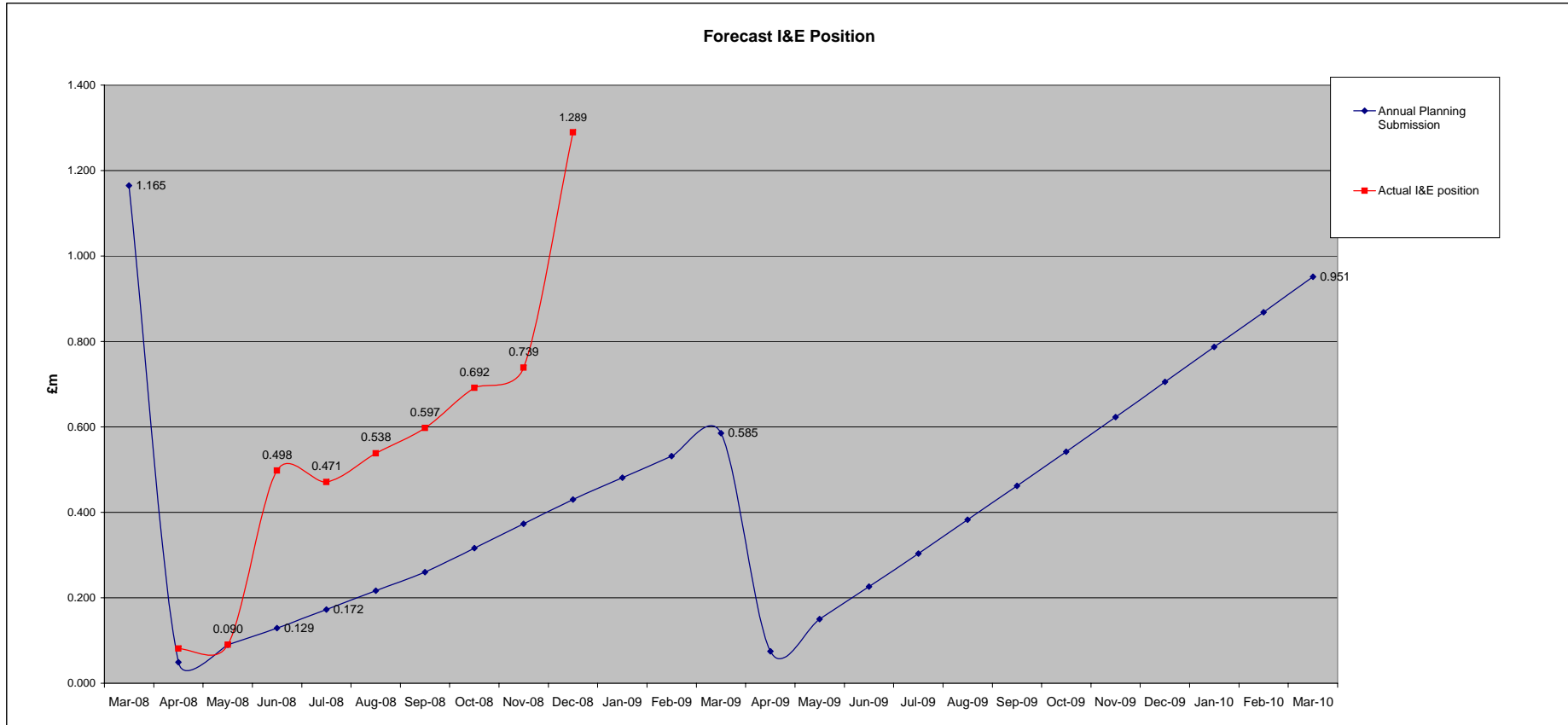
## CONCLUSIONS

1. The Trust is reporting a surplus of £1.3m. This equates to a good Monitor risk rating of 4.
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 this has improved in the December figures.
4. The financial forecast for the year has been updated and currently this shows and of year surplus in the range of £1.0m to £1.5m. The forecast based on the December performance is currently at the higher end of this range.

## RECOMMENDATIONS

- The Board is asked to consider the financial position of the Trust at the end of December 2008. These result will form the basis of the Q3 performance reports and the Q3 return to Monitor.
- These show that the Trust is continuing to forecast that it will meet its financial plan as submitted with the prospect of exceeding this, subject to the risks identified in the report which continue to be managed and mitigated.

	Mar - 08	Apr - 08	May - 08	Jun - 08	Jul - 08	Aug - 08	Sep - 08	Oct - 08	Nov - 08	Dec - 08	Jan - 09	Feb - 09	Mar - 09	Apr - 09	May - 09	Jun - 09	Jul - 09	Aug - 09	Sep - 09	Oct - 09	Nov - 09	Dec - 09	Jan - 10	Feb - 10	Mar - 10	
Annual Planning Submission	1.165	0.049	0.090	0.129	0.172	0.216	0.260	0.316	0.373	0.430	0.481	0.532	0.585	0.075	0.150	0.226	0.304	0.383	0.462	0.542	0.623	0.706	0.787	0.868	0.951	
Actual I&E position		0.081	0.090	0.498	0.471	0.538	0.597	0.692	0.739	1.289																



# Birmingham Women's



## NHS Foundation Trust

<b>SUBJECT :</b>	Integrated Performance Report
<b>REPORT BY :</b>	Jane Owen/Tim Woods/Neil Savage
<b>AUTHOR :</b>	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 31<sup>st</sup> March 2009.

The Trust overall achievement of the December targets for 18 weeks RTT should be noted.

### **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.

**APPENDIX 3**

**QUARTERLY REPORT TO MONITOR:  
EXCEPTION REPORTING**

**Exception Reporting**

The Trust reports the following matter to Monitor under the exception reporting arrangements.

**Core Standard C01a**

The Trust has been working to implement Datix as a new management tool for risks and learning. It is intended to utilise the Datix system to enable compliance with core standard C01a, by linking reporting directly to the database of the NPSA.

Owing to technical difficulties with the implementation of Datix, the Trust is currently not compliant with the required standards of reporting under C01a. The Trust has held discussions with the Healthcare Commission regarding the appropriate timetable for compliance with this core standard, and understands that the Commission regard it as satisfactory for the Trust to have achieved compliance with the standard by 31<sup>st</sup> March 2009. The Trust continues to take compliance with this standard seriously, and is committed to ensuring compliance at the earliest practical date.

**Other items of report**

**Application of 13-week target**

The Trust has, during the course of the current year, experienced a lack of clarity as to the targets applicable to the Clinical Genetics area. We therefore requested clarity from the Strategic Health Authority and ultimately the Department of Health (together with a request for clarity on the 18-week referral to treatment target. This has been previously reported to Monitor in quarterly returns.

The circular letter of 2<sup>nd</sup> November 2008 from the Department of Health indicated that Clinical Genetics was required to meet the 13-week referral to treatment target. Since that clarification, national work has been ongoing to determine the care pathway that is applicable; this is expected to report in the fourth quarter of 2008-2009. The Trust has engaged in preliminary discussions with the relevant Commissioners on how to achieve the target during the 2009-2010 year.

The current position of the Trust is being supported by the Strategic Health Authority, who are also supporting the Trust's discussions with the Healthcare Commission for mitigation on this issue in the Annual Health Check for 2009-2010.

**Counter-Fraud and Security Management Service (CFSMS) rating**

The CFSMS, in its review of provision in the Trust for the year ended 31<sup>st</sup> March 2008, gave the Trust a rating of 1. This rating has been the subject of separate correspondence between the Trust and Monitor.

Prior to receipt of the report, the Audit Committee had already reviewed the number of days allocated to the counter-fraud function, and increased them to a total of 56 days in the year. The Audit Committee has also reviewed the CFSMS report, and is satisfied that appropriate measures to improve the rating have been put in place, in the context of the Trust. The Trust is confident that there will be an improved score in the review for the year ended 31<sup>st</sup> March 2009.

**APPENDIX 4**

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

**Changes in membership of Board of Directors**

No changes in the membership of the Board of Directors have taken place during the period under review.

At its meeting on 15<sup>th</sup> December 2008, on the recommendation of the Nomination and Remuneration Committee, the Members' Council agreed to re-appoint Professor Ian Booth as a Non-Executive Director of the Trust for a further term from 1<sup>st</sup> January 2009 to 31<sup>st</sup> December 2012.

During the period, Mr Tim Woods gave notice of his resignation from the Trust consequent on having been offered another post. His exact date of demittance from office will be in the fourth quarter of 2008-2009. The Trust has agreed that Mr Jason Burn will be the Acting Finance Director.

**Changes in Members' Council**

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

- Louise Toner was appointed as a Partner Governor by Birmingham City University, *vice* Professor Filby (retired from the University).
- Cllr. Daphne Gaved was appointed to be a Local Authority Governor by Birmingham City Council, *vice* Cllr. Penny Wagg.
- Members' Council considered the position of Payal Patel (Public Constituency-Heart of Birmingham and N&E Birmingham), consequent on non-attendance at meetings (see Constitution, section 14.6). After careful consideration, Council determined not to retain Ms Patel as a Governor of the Trust.
- Members' Council considered the position of Fleur Rowlands (Public Constituency- South Birmingham), consequent on non-attendance at meetings (see Constitution, section 14.6). After careful consideration, Council determined not to retain Ms Patel as a Governor of the Trust.
- Members' Council considered the position of Karen Helliwell (Partner Governor-West Midlands Specialised Services Agency), consequent on non-attendance at meetings (see Constitution, section 14.6). After careful consideration, Council determined (by a two-thirds vote, see SO 4.11.3.3) to retain Ms Helliwell as a Governor of the Trust.

# Birmingham Women's

## NHS Foundation Trust



SUBJECT :	Report to Monitor for Quarter 3 of 2008/09
COORDINATED BY:	Steve Parsons, Head of Corporate Affairs
AUTHORS:	Tim Woods, Jane Owen, Jane Davidson

### CONTEXT AND BACKGROUND FOR REPORT

The Trust is required to submit its report for the third quarter of the 2008/09 financial year to Monitor by 31 January 2009.

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

1. Financial information for the three months from 1 October 2008 to 31 December 2008
2. Self-certification that all applicable national targets have been met during the three months from 1 October to 31 December 2008, and that plans are in place to ensure that all known targets that come into force will be met.
3. Exception reporting of any significant issues arising during the period
4. Other items requiring reporting, including changes of Governors and changes in the membership of the Board of Directors

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

The reporting requirements summarised above are addressed as follows:

1. Financial information

The required financial information is attached as Appendix 1.

2. Service performance targets

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

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

met

It is proposed that the Chairman be authorised to sign Declaration 2 on behalf of the Board. This recommendation arises from the following issue:

*Core Standard C01a*

The Trust is not currently compliant with this Core Standard, which was drawn to the attention of the Board in the context of the Annual Health Check. The Trust had discussed the issue with the Healthcare Commission, as the lead regulator on this matter, who had indicated that they would regard the Trust as compliant if compliance was achieved by 31<sup>st</sup> March 2009. The Trust remains on target to achieve compliance by this date.

Monitor have now indicated that they will regard the Trust as non-compliant with this core standard if the Trust cannot report compliance for the end of each quarter. Therefore, it is necessary to make Declaration 2 in respect of Quarter 3, as the Trust was not compliant with this standard at the 31<sup>st</sup> December 2008.

Reporting non-compliance with a single core standard gives a score of 0.4 within the Monitor scoring system. This continues to indicate a Green rating for governance.

3. Exception reporting

Core Standard C01a will be included in the Exception Report.

*18-week referral to treatment*

The Trust has been using the exception reporting section of the quarterly return to update Monitor on the position regarding the application of the 18-week referral to treatment, on which we were awaiting clarification from the Department of Health. The Department provided clarification (in a circular letter) on 2<sup>nd</sup> November 2008, and this is the first return since that clarification.

Following verification, it has been confirmed that the Trust met the requirement to have achieved the 18-week referral to treatment for 95% of patients by 31<sup>st</sup> December 2008. It should be noted that, under the guidance set by the Healthcare Commission, the Trust (in common with all other affected NHS Trusts) will be monitored monthly for compliance in January, February and March 2009.

*13-week referral to treatment*

The Departmental letter of the 2<sup>nd</sup> November 2008 also indicated that the Trust would need to comply with the 13-week referral to treatment in respect of Genetics treatments. This announcement had not been anticipated, and has affected a number of NHS Trusts.

The Trust is not currently compliant with the 13-week referral to treatment requirement. Work is ongoing at a national level to determine the appropriate structure of this pathway, and results are expected to be announced in February or March 2009. Until such pathways are determined at a national level, it is not possible for the Trust to achieve compliance with this target: however, discussions have been held with the Specialist Commissioners in preparation to achieve the target for the 2009-2010 year.

The Strategic Health Authority are supportive of the position of the Trust, and discussions have been held with the regional manager of the Healthcare Commission to allow mitigation in the Annual Health Check (also supported by the SHA).

*Counter-Fraud and Security Management Service rating*

The Trust, in respect of the financial year ended 31<sup>st</sup> March 2008, was advised in November 2008 that it had received a rating of 1 (the lowest rating) for its Counter-Fraud arrangements. This related in large part to a perceived lack of days allowed to achieve the necessary assurance. For the 2008-2009 Counter-Fraud plan, the number of days was increased to that recommended by the Service.

Monitor had been advised by the Counter-Fraud service of the rating received by the Trust, and this has been the subject of separate correspondence. In order to complete the formalities, this should also be reported on this return.

The Audit Committee have considered the report, and are satisfied that the Trust has taken appropriate measures to give reasonable assurance on Counter-Fraud matters.

Appendix 3 sets out the current situation as described above.

4. Other items requiring reporting

Appendix 4 reports:

- That Professor Booth has been re-appointed as a Non-Executive Director for the period 1<sup>st</sup> January 2009 to 31<sup>st</sup> December 2012;
- That Tim Woods has given notice of his resignation as Finance Director
- That Louise Toner has been appointed as the BCU Governor, *vice* Professor Filby
- That Cllr. Dahnpe Gaved has been appointed as the Local Authority Governor, *vice* Cllr. Penny Wagg
- That Members' Council has decided to retain Karen Helliwell as a Governor, and has also decided not to retain Payal Patel or Fleur Rowlands.

**RECOMMENDATIONS**

The Board is invited to:

- **AUTHORISE** the Chairman, on behalf of the Board, to sign Declaration 2 (as set out in Appendix 2); and
- **AGREE**, subject to such amendment as may be necessary and agreed by the Chairman and Chief Executive, Appendices 1, 3 and 4 for submission to Monitor.

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

## **Governance Declarations**

**Quarter three 2008/09 (1 October – 31 December 2008)**

NHS foundation trusts must confirm compliance with the Authorisation in relation to all items listed on page 53 of the *Compliance Framework* issued by Monitor in May 2008. No supporting detail is required unless compliance cannot be confirmed.

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

### **Declaration 1**

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

(signed) \_\_\_\_\_ on behalf of the Board of Directors

Acting in capacity as \_\_\_\_\_

### **Declaration 2**

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

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

(signed) \_\_\_\_\_ on behalf of the Board of Directors

Acting in capacity as Trust Chairman

Monitor will accept either an electronic or a hand written signature.

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

## **Governance Declarations**

**Quarter three 2008/09 (1 October – 31 December 2008)**

### **If Declaration 2 has been signed:**

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

#### **Target or Standard:**

*Core Standard C01a*

Name the healthcare target or national core standard involved.

#### **The Issue:**

*A backlog of cases to input has arisen, with the maximum outstanding number of cases being 300. Work has been undertaken to manage down the backlog within a timetable to meet the Core Standard by 31<sup>st</sup> March 2009.*

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

#### **Proposed Actions:**

*The Trust is working to achieve compliance within the Healthcare Commission timetable, which requires compliance by 31<sup>st</sup> March 2009.*

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

#### **Next Steps:**

*In consultation with the NPSA, the Trust has made arrangements to input directly into the NPSA database systems to manage the backlog.*

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

Repeat this format on additional pages as required.

# Birmingham Women's

## NHS Foundation Trust



<b>SUBJECT :</b>	Establishing a Volunteering Programme
<b>REPORT BY :</b>	Neil Savage, Director of Workforce & Organisational Development
<b>AUTHOR :</b>	Neil Savage, Director of Workforce & Organisational Development

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

This report puts forward a proposal for developing volunteering within the Trust.

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

Volunteering is well established in the majority of NHS Trusts across the country. Volunteers bring a wealth of added value to the organisations they work in. They have been shown to improve patient and staff experience, carrying out a range of functions including general "meet and greet," signposting, gardening, supporting infection control and general assistance. Following approval from the November 2008 Management Board, the Main Board is asked to support the principle of appointing of a Volunteer Co-coordinator to enable the Trust to develop its own in-house service and improve various aspects of patient experience and customer service. Supporting volunteering will also fit in with improving the Trust's position on corporate social responsibility. Failure to support volunteering will mean a missed opportunity on a range of fronts and a falling behind in terms of volunteering provision in other Trusts.

### **RECOMMENDATIONS**

The Main Board is asked to consider the recommendations within this paper and support the development of volunteering within the Trust.

## DEVELOPING VOLUNTEERING WITHIN THE TRUST

### **1. Background**

1.0 Volunteering can be defined as any activity “which involves spending time, unpaid, doing something which aims to benefit the environment or someone other than, or in addition to, close relatives.” (Compact)

1.1 Volunteering is well established in the majority of NHS Trusts across the country. Volunteers bring a wealth of added value to the Trusts they work in. They have been shown to improve patient and staff experience, carrying out a range of functions including signposting, gardening, “meet and greet”, supporting infection control and general assistance. Further examples of typical activities volunteers can carry out are attached within Appendix 1.

1.2 Supporting the recruitment of a Volunteer Service Manager will enable the Trust to develop its own in-house service and improve various aspects of customer service. Supporting volunteering will also fit in with the improving the Trust’s position on corporate social responsibility (CSR). Failure to support volunteering will mean missed opportunities and a falling behind in terms of provision compared with other Trusts.

1.3 The gross salary cost for appointing a Volunteer Service Manager is circa £16,500 per annum, based on 22½ hours per week, mid point of Band 5, with 20% on-costs. Some consideration should also be given to supporting provision of a small set-up budget followed by an annual budget to be determined following Trust approval of a volunteering policy and action plan. This would cover items such as Criminal Records Bureau checks, publicity and lanyards.

### **2. Responsibilities associated with volunteering**

2.0 Organisations owe a duty of care to volunteers through good health and safety practice. To this end organisations must take appropriate measures to ensure volunteers’ health and safety.

2.1 Volunteers do not have defined legal status in the same way that employees do, not being covered by employment legislation in the same way. This means that equal opportunities legislation does not apply to volunteers and they have no protection from unfair dismissal.

2.2 In the interests of reputation and good practice, volunteers should be given the same respect and care as employees. However, it should be clear that the organisation has a different and non-contractual relationship with them. Volunteers should be included in corporate policies such as equal opportunities, health and safety, violence and aggression. Policies relating directly to the volunteer’s relationship with the Trust, for example, those dealing with grievance and disciplinary issues, should be distinct from those for paid employees.

2.3 Clearly while volunteering is an activity undertaken with free will, with people giving their time without concern for financial gain, there are obligations on the volunteer.

2.4 The absence of a legal framework for volunteers means there is an increased need for NHS organisations to ensure good practice in the management of volunteers.

2.5 In light of this, should the Trust agree to implement a volunteering scheme, it will be essential to have a clear volunteer policy in place. This would set out a framework for volunteer involvement and responsibilities, and place these in a Trust / service delivery context. Having a volunteer policy would also demonstrate the Trust’s commitment to volunteers, and help to put in place a consistent corporate approach to volunteering.

# ENCLOSURE 6

01/09/public/A13

2.6 Having a clear policy in place is important, as volunteers will be acting on behalf of the Trust, and be seen as its ambassadors. A volunteering policy would recognise the potential range of volunteer involvement in the Trust, including input to Patient and Public Involvement exercises.

2.7 One of the first jobs of a Trust Volunteer Co-ordinator would be to consult on and develop (1) an accessible policy, and, (2) an action plan for implementing a scheme. In devising both they would be expected to involve staff, staff-side representatives, governors and service users. The policy should be ratified by the Trust and regularly reviewed alongside other related policies.

2.8 A recent "Volunteering England" report developed in partnership between the Department of Health, NHS Employers, Expert Patients Programme and NAVSM recommends that Trust volunteering policies cover the following key headings:

1. Introduction and policy statement
2. Staff-volunteer relations
3. Equality and diversity
4. Recruitment, selection, induction and training
5. Expenses
6. Support and supervision
7. Insurance
8. Vetting and Criminal record checks
9. Health screening
10. Health and safety
11. Problem-solving procedures
12. Reports to the Board
13. Recognition of volunteers
14. Confidentiality
15. Data protection

2.9 These headings highlight the broad ranges of issues needing worked through. The resulting policy would provide the Trust with a manageable volunteering framework and accompanying assurance.

### **3. The role of a Volunteer Service Manager**

3.0 A job description for a Volunteer Service Manager is attached as Appendix 2. An example of a volunteers recruiting leaflet is also attached as Appendix 3.

### **4. Summary and recommendations**

4.0 The Main Board is asked to debate the recommendations to appoint a Volunteer Service Manager within this paper, and, support in principle the development of volunteering within the Trust as outlined above.

Neil Savage  
**Director of Workforce & Organisational Development**

January 2009

# ENCLOSURE 6

01/09/public/A13

## APPENDIX 1

### EXAMPLES OF ROLES VOLUNTEERS CAN CARRY OUT IN THE NHS

From "Volunteers across the NHS: improving the patient experience & creating a patient-led service"

Administration helper/medical records assistant  
Advocacy  
Ambulance first responder  
Anti-coagulant assistant  
Artist  
Arts and crafts (knitters, blanket maker, art therapist)  
Befriending/buddying (in-patients and community)  
Benefit advice  
Birds of prey (volunteers bringing birds to children's units)  
Buggy service for outpatients with mobility problems  
Carer support  
Chapel pianist and organist  
Chapel service helpers and singers  
Chapel services names collector  
Chaplaincy lay preacher  
City guides (guides who conduct hospital tours)  
Clerical helper  
Clinic assistant (baby/well-being etc)  
Counsellor  
Curtain matcher (collecting odd curtains in hospital and putting them in pairs for re-hanging)  
Dental Complaints Service volunteer panel member  
Discharge lounge assistant  
Drama assistant  
Entertainment  
Events helpers  
Exercise to music  
Expert patient  
Feeders (for patients)  
Fish tank maintenance  
Focus groups for research  
Flower arrangers/flower care on wards  
Fundraising  
Games players (for example chess player companion)  
Garden (including pond maintenance)  
GP patient participation group member  
Governance and trustees  
Hand holders (for surgery etc)  
Home care  
Home escorts for vulnerable patients  
Hospital radio presenter and request collector  
Information/leaflet readers and checkers  
Information provider (for example in epilepsy clinic)  
Interpreter  
Interviewer

IT volunteers (database work)  
Knitters for premature babies  
Lay assessor (for the Quality and Outcome Framework)  
Letter writer  
Librarian  
Magazine delivery  
Massage and aromatherapy massage  
Medicinema  
Meet and greet/welcomer  
Musicians  
Occupational therapy activities assistant  
Packs (making up maternity packs, patient emergency toilet kits)  
PALS officer  
Pets as Therapy (PAT) dogs/animal visits  
Pastoral  
Peer educators (various projects)  
Pharmacy  
Physiotherapist assistant  
Plain language volunteers (to de-jargon written materials)  
Playroom helpers  
Post room assistant  
PPI forum member  
Print room assistant  
Reception/Information/Enquiry desk/Welcome desk  
Recruitment and selection of staff  
Recycling assistants  
Reflexologist  
Runner (of errands in and out of hospital)  
Shop helper (food, clothing etc)  
Shoppers (for patients)  
Skin camouflage  
Social events organisers/helpers  
Speech and language volunteers  
Sport companions for mental health service users (for example golf buddy)  
Sport organisers for mental health service users (for example angling groups)  
Support groups for specific health conditions  
Tea bar/café/bar  
Theatre trip companion  
Trainers (for example life saving technique)  
Therapeutic hand care  
Transport (drivers)  
Trolley service (meals, drinks, toiletries, newspapers etc)  
Visitor screening helpers  
Ward and department volunteers (various, including A&E, Outpatients, Occupational Health, X-ray etc)  
Wheelchair pushers  
Youth group helpers

## Birmingham Women's

NHS Foundation Trust

### JOB DESCRIPTION

<b>JOB TITLE:</b>	Volunteer Service Manager
<b>LOCATION:</b>	Birmingham Women's Hospital
<b>BAND:</b>	AfC Band 5
<b>HOURS:</b>	Up to 22½ per week worked flexibly
<b>DIRECTLY RESPONSIBLE TO:</b>	To be confirmed

### PRINCIPAL DUTIES:

1. To establish, develop and manage a Volunteer service throughout the Birmingham Women's Hospital.
2. To act as a focal point for all enquiries regarding Volunteering within the Trust and to identify all opportunities whereby volunteers could provide additional support to Trust services.
3. To actively recruit and support all volunteers, to ensure all relevant training is provided and standards are monitored.

### DUTIES AND RESPONSIBILITIES

#### HUMAN RESOURCES

- To establish a pool of Volunteers to provide support services to the Trust and maintain a database of all contacts.
- To ensure sufficient Volunteers are in place, with appropriate supervisory cover, through the development of rotas and the planning of 'off duty'.
- To respond to any issues raised by the Volunteers such as their duties, relationships with other staff groups and working conditions.
- To work closely with the Estates and Front of House teams. To develop a Volunteer service that will enhance the service currently provided by the directly employed staff.
- To monitor the Volunteers in terms of performance, attitude and appearance to good customer care standards are maintained at all times.
- To actively recruit Volunteers and to manage the recruitment process up to and including appointment, of all Volunteers.
- To maintain training records for all Volunteers, to monitor training needs and arrange appropriate training and refresher sessions.

#### OPERATIONAL SUPPORT

- To assist in the development of Trust wide policies, to write and implement policies applicable to the immediate service areas.
- To participate in the planning and development of new services and actively seek opportunities for Volunteers to operate.
- To liaise with other service heads regarding levels of service, ad hoc requests and quality issues.
- To develop local policies and procedures for application within the Volunteer team and to contribute towards the development of Trust wide policies
- To arrange, and to participate in, quality and environmental audits, patient surveys and ensure any recommendations are acted upon in a timely and effective manner.
- To represent the Volunteer service at relevant meetings and on particular groups both within the Trust and outside the organisation.
- To carry out any other reasonable duties as may be required to meet the needs of the service.

#### FINANCIAL

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- To be responsible as Budget Manager for the monitoring of all expenditure within the Hotel Services function ensuring a balance between income and expenditure at the end of the financial year.
- To be proactive in terms of identifying any opportunities to increase efficiency or reduce cost
- To monitor all expenditure, authorise payments, sanction expenses claims and analyse budget statements and liaise with designated Accountant to resolve any queries.

## **GOODS RECEIPT AND DISTRIBUTION**

- To monitor stock levels of all equipment and materials used within the department, to ensure orders are placed in a timely manner and that goods are received and distributed throughout the organisation.

This job description outlines the current and main duties and responsibilities of the post. Owing to the changing nature of the service, the duties and responsibilities within the posts and the obligations upon the post-holder will inevitably vary and develop. In view of this, the job description may need to be reviewed and subsequently altered. Any resulting changes will be subject to consultation with the post-holder.

## **GENERAL**

Successful candidates will be employed on Birmingham Women's NHS Foundation Trust Terms and Conditions of Service. A full copy of all Terms and Conditions may be obtained from the Human Resources Department or Programme Managers/Directors Office. All employees are required to adhere to all relevant Trust Policies and Procedures including Health and Safety, No Smoking and Alcohol and Equal Opportunities Policies.

## **Terms Equal Opportunities Policy - Statement of Intent**

Birmingham Women's NHS Foundation Trust is committed to promoting equality of opportunity for employees, job applicants and the population it serves. The Policy of the Trust is to ensure that no job applicant or employee receives less favourable treatment than another on the grounds of race, colour, nationality, ethnic origin, gender, religion, marital status, sexual orientation, responsibility for dependants, age, part time employment, political beliefs or disability, unless this is directly related to a genuine requirement of the job.

The Trust commits itself to take all steps necessary to remove any existing race or sex discrimination from its operations and to take lawful positive action to promote equal opportunities and facilities for disabled employees and other disadvantaged groups. Applicants will be considered fairly and on the basis of their ability to do the job.

## **Health and Safety**

All employees are required to comply with relevant Health and Safety legislation and the Trust's Health and Safety Policies. In accordance with sections 7 and 8 of the Health and Safety at Work Act 1974 employees must:-

- Take reasonable care of their own and others health and safety whilst at work
- Co-operate with their employer to enable the employer to comply with the Act
- Not to intentionally or recklessly interfere with or misuse anything provided in the interest of health and safety.

## **Confidentiality**

Your attention is drawn to the confidential nature of information collected within the National Health Service. The unauthorised use or disclosure of patient, client, or other personal, confidential or privileged information/data is a dismissible offence and in the case of computerised information could result in a prosecution for an offence or action for civil damages under the Data Protection Act 1984.

## EXAMPLE RECRUITMENT LEAFLET

### VOLUNTEERING AT THE TRUST

We have around XXX people volunteering at this hospital. Most of them are or were patients here or are relatives of friends of patients. Some are people who simply want to give something back and contribute to the community through giving their time and effort, supporting the hospital staff and management, the patients and ultimately the NHS.

You can volunteer in a variety of different ways:

#### **The Welcoming Service**

The welcomers are available in Outpatients to help patients and visitors and guide them to the appropriate department.

#### **The WRVS Coffee Shop**

Located in the Outpatients, it is open daily to serve light refreshments and confectionary.

#### **Newspaper Trolley**

A trolley service delivering newspapers to the bedside of all patients every morning

#### **Shop Trolley**

A shop trolley runs to all wards offering drinks and confectionary.

#### **Ward Visiting Service**

This service is valuable, especially to patients whose home is outside the area and who do not receive many visitors.

#### **Clerical Support**

Volunteers help to fill envelopes and do other general administrative duties in several departments of the hospital.

#### **Buggy Service**

Our fully trained volunteers run an internal patients transport buggy to help patients and visitors on their journey to and from the X-ray department.

#### **Gardening Club**

Volunteers aim to maintain all the flowerbeds, flower tubs and shrubberies in the grounds of the hospital.

#### **Patient Survey Team**

Volunteers carry out a questionnaire with patients awaiting discharge from the hospital.

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## **Ward Helpers**

The volunteer's role is to enhance patients' experience at mealtimes. This is done by supporting ward staff in clearing "clutter" from patient tables and generally making sure patients are ready for their meals.

## **Coffee Morning and Craft Fairs**

These quarterly social events help to keep patients and the local community in touch with their hospital.

## **Hydrotherapy Club**

As a League of Friends member and when you have finished your course of treatment, you can if you wish, join the Hydrotherapy Club.

**XXX Travel Club** arranges day trips and holidays all over the world (brochures are available).

## **Festive Cheer**

Volunteers help to dress the wards and public areas at time of various religious festivals such as Christmas or Divali. For example, a choir singing carols escorts the Christmas gifts which are given to every inpatient, who is in hospital over Christmas, receives. At Easter time, volunteers distribute Easter eggs to every patient.

**If you are interested in becoming a volunteer and want to know more, please contact:**

**Volunteer Service Manager XXX or XXX on XXX Ext XXX**

## Communication Strategy

### Action Plan

2009

	Action	Timescale	Comments	Status
<b>Corporate Actions</b>	Review all existing communications	Sept 09		<b>Complete</b>
	Review the existing communications function and identify future resource needs	Jan 09		<b>Complete</b>
	Develop new brand identity for the Trust <ul style="list-style-type: none"> <li>• Logo</li> <li>• Corporate identity guidelines</li> </ul>	Jan 09	c	
	New website <ul style="list-style-type: none"> <li>• Content</li> <li>• Design</li> </ul>	Feb 09		
	Produce Corporate Brochure	Feb 09		
	Undertake a reputation audit	May 09		
	Produce a reputation management strategy	June 09		

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	Produce a power/interest matrix	June 09		
<b>Internal Communication</b>	Introduce Intranet site	June 09	In partnership with IT	
	Review Women's Progress and investigate turning it into an e-mag for staff	Feb 09	Is WP a staff magazine or a member magazine For a one off cost of £5,000 we could have an e-mag which we could update monthly (or more frequently)	
	Introduce a 'Chair's Award'	Feb 09		
	Establish a CEO telephone hotline	Feb 09		
	Produce an induction version of Women's Progress in conjunction with HR which will be given to all new starters	March 09		
	Introduce a series of events to raise the profile of the Chair and Non-execs within the Trust including walkabouts and back to the floor days	March 09		
	Celebrate national nurses day with a special back to the floor day for managers and directors	May 12 <sup>th</sup> 09		
	BWH Birthday	July 09		
<b>External Communication</b>	Arrange media training for executive directors	March 09		
	Revise Media Policy	Jan 09		<b>Complete</b>
	Produce annual media plan	Feb 09		
	Produce guidelines for handling the media for staff	Jan 09		<b>Complete</b>

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	Contribute to the South Birmingham health magazine for the public	Feb 09		
	Introduce regular media briefings for the Chair and CEO	March 09		
	Produce a meet the experts guide to clinicians for the media	April 09		
	Invite key journalists to a dinner with key clinicians and senior managers	May 09		
<b>Stakeholder Communication</b>	Identify Key stakeholders	Dec 08		<b>Complete</b>
	Produce a monthly e-mail brief from the Chairman for stakeholders	Feb 09		
	Establish programme of formal meetings with stakeholders (MPs, OSC chair etc)	March 09		
<b>Member Communication</b>	Review the membership strategy in conjunction with the Corporate Secretary	Feb 09	Revised strategy was discussed at membership ctte on Jan 22nd	<b>Complete</b>
	Produce a welcome pack for members in conjunction with the Corporate Secretary	Feb 09	Draft welcome pack was discussed at membership ctte on Jan 22nd	<b>Complete</b>
	Review Women's Progress – is it the right communication tool for members?	Feb 09		
	Produce the first monthly members' Brief	Feb 09		
	Establish foundation pages on new internet	Feb 09		
	Establish forum for members on the internet	March 09		
	Support the Corporate Secretary in	March 09		

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	developing communication tools for Governors			
<b>Social Media (web based communication)</b>	Establish a facebook site for the hospital	Jan 09		Complete
	Monitor blogs	Dec 08	Needs to be ongoing	Complete
	Monitor Wikis	Jan 09	Needs to be ongoing	
	Make contact with photographers on Flickr who feature the hospital/trust	Dec 08		Complete
	Encourage staff to write blogs	March 09		
<b>Communication with GPs and Commissioners</b>	Produce GP liaison strategy in conjunction with commercial director	Jan 09	Draft prepared	
	Investigate feasibility of producing GP Homepage on extranet which would give them realtime information about their patients	Jan 09	Initial discussions with IT are promising but it would require investment	
	Produce electronic magazine for GPs and commissioners	March 09		

## Birmingham Women's

NHS Foundation Trust

<b>SUBJECT:</b>	Communication Strategy
<b>REPORT BY:</b>	Julie Burgess
<b>AUTHOR:</b>	Claire Austin, Interim Head of Communications

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

The Trust's last Communication Strategy was adopted in 2006. This new strategy and action plan builds on the former strategy and outlines key areas of change.

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

The Communication Strategy and Action Plan are living documents which need to adapt to the changing environment. They underpin the Trust's business objectives.

### **RECOMMENDATIONS:**

The Board are asked to discuss and approve the Communication Strategy and Action Plan.

## Birmingham Women's NHS Foundation Trust

### Communication Strategy

**2009**

This document sets out a new Communication Strategy for Birmingham Women's NHS Foundation Trust.

The strategy sets out the vision for actively communicating with, and engaging staff, patients, governors, members, the public, and other stakeholders.

The strategy:

- follows the principles contained in all recent relevant national guidance
- demonstrates clear links with the business objectives of the Trust and other associated Trust strategies
- includes an action plan
- builds on the ethos that good communication is vital, central and integral to the Trust's business and that all staff have a responsibility in this area.

The Communication Strategy does not describe communication with Governors and Members in detail as this is contained in the Membership Development Strategy and Action Plan which is currently being developed.

#### **1. AIMS**

The aims of this strategy have been designed to be consistent with the objectives for the Trust. It will:

1. Enable a two-way dialogue between the Trust, its staff, patients, members, governors, stakeholders and the local population. This will help improve the services provided.
2. Ensure staff in all NHS and partner organisations, have access to adequate information about the Trust

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3. Ensure local GPs and other health professionals have access to adequate information about new developments and the impact they will have on them and their patients.
4. Provide a recognisable identity for the Trust and the individual developments within it.
5. Enable members of the local community to become involved with the Trust.
6. Build closer relationships between partner organisations, patients, carers, public and stakeholders, providing support to patients and the public through LINKs and other means to enable them to make a difference and ensuring stakeholders such as the Strategic Health Authority, MPs and Overview and Scrutiny Committee are kept up to date with developments
7. Ensure an appropriate reporting, monitoring and communicating mechanism for Birmingham Women's NHS Foundation Trust.
8. Ensure a means of identifying and responding to negative media
9. Ensure proactive on-going communications and engagement

## 1.1 Key Messages

The Trust is currently working on defining its values and these will inform the key messages. The key messages could include:

- Birmingham Women's NHS Foundation Trust runs clinically excellent services
- Birmingham Women's NHS Foundation Trust will treat its staff, patients and the public with courtesy and respect
- Patients will be treated in a clean and safe environment
- Birmingham Women's NHS Foundation Trust will continue to make the best use of its resources and will not overspend

The Trust needs to understand better how patients wish to access healthcare, what information they will need and how they want to interact with the Trust and its staff. The Trust needs to build even more effective, active and market-focused communications to take advantage of the opportunities which are presented in the realities of choice. This document sets out a Plan for the Trust to make positive steps towards this end.

The Trust's Communication Strategy supports its business objectives and vision which describe how the Trust will continue to develop services for women and their families.

The Trust's core objectives are to:

- Continue to provide services which offer high quality access and care to our local population
- Further develop as a leading provider of specialist care
- Continuously improve the efficiency of our organisation that we make the best use of our resources
- Build upon and enhance the positive experience our patients have
- Build upon and strengthen our excellent reputation as a teaching hospital with a focus on research and development

## 2. THE STRATEGIC ROLE FOR COMMUNICATIONS

Communications needs to be at the heart of an organisation. It should be recognised at Board level and be able to contribute to policy development. Evidence from the Chartered Institute of Public Relations and the Association of Healthcare Communicators suggests that for communications to be really effective it must be at the centre of decision making where it can influence decisions before they are taken. Ideally it should report to the CEO as the communications function has an important role to play as the eyes, ears and conscience of the organisation.

MORI and Leeds Metropolitan University have both shown that organisations in which the communications lead sits on the board and reports to the CEO are more successful than those where the communications lead has a less prominent position. Some NHS organisations have already embraced the concept of having communications at the heart of their activities and others are following suit. Communications is now being seen as much more than the press cuttings and the staff newsletter. Instead it is being recognised as crucial in managing the reputation of the organisation. Responsibilities of some of the most senior communications directors in the NHS include all internal and external communication, reputation management, marketing, stakeholder relations, patient and public involvement, PALs, complaints, patient surveys, patient information, front of house staff (including receptionists and telephonists), customer care, medical illustration and graphics, training and strategic support for large projects.

Good communication should underpin an organisation's objectives and responsibility for communication should be in every job description. It is too important to be left to the 'communications team'.

Investment in communications will enable the Trust to manage its relationships with stakeholders and ensure consistency of messages and approach.

Marketing is a new discipline for the NHS and Trusts are having to adapt their communications to include marketing. Historically patients have had no choice of hospital but that is changing. All patients are now offered a choice of five providers, including one from the private sector together with all NHS

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Foundation Trusts in the country. This choice will affect the stability of Trusts as those with strong reputations, short waiting times and good clinical outcomes attract more patients to the detriment of others.

The Department of Health stresses that the NHS is beginning to have the capacity and the capability to become “truly patient led” and to deliver high quality services everywhere and at all times. Patient Choice implies positive marketing and market-based decision making, but the NHS is not a purveyor of FMCG (Fast Moving Consumer Goods) and the effort needs to be structured and focused to be relevant and productive. Patients will be persuaded by reputation, cleanliness and infection rates, outcomes and the views of their GP,

Birmingham Women’s NHSFT is bound by the national tariff and will gain from providing services and procedures which are below tariff. Any additional income can then be ploughed back into the Trust. It is important that the Trust recognises its strengths – whether it is individual services, clinicians, cleanliness or its waiting times and its weaknesses. It needs to have a strong brand which is recognised locally and nationally.

A key component of the Communication Strategy is reputation management. Reputation needs to be protected and nurtured. The Trust should undertake a reputation audit to discover what the local population thinks about its services. Perceived weaknesses can be addressed and further tracking audits can be undertaken to monitor progress.

One in four people gets their information about the NHS from someone who works in it therefore staff play a key role in how the Trust is perceived by the public.

It is relatively easy and cheap to retain customers but patients may not choose to come back if they have had a bad experience from the Trust. Most individuals will not question the clinical outcomes but they will be influenced by the ‘little things’ such as whether they can get a cup of tea when they want or whether the ward appears clean. It is important to see things through the eyes of a patient and to hear things through their ears. Trust directors should put themselves in patients’ shoes and get expert patients and current users to advise them on services. This advice should be listened to and acted upon. The Trust needs to map its key stakeholders and produce a matrix outlining the importance and influence of each. It will also need a Reputation Management strategy which will set out how the Trust’s reputation will be nurtured and protected.

The Trust’s communications and marketing objectives are:

- To establish and maintain goodwill and understanding between the Trust, its employees and external publics (Communicating)
- To take opportunities to motivate, stimulate and persuade staff and members of the public with respect to Trust’s corporate vision and patient choices (Marketing)

### 3. IMPLEMENTING THE COMMUNICATIONS AIMS

*Communication is about enabling not controlling; about sharing not owning; about giving access to information not telling.*

Good communications ensure that people feel valued and informed about what issues affect them.

As a fundamental principle all communications should be:

- Planned, consistent and targeted
- Proactive, timely and relevant
- Open, honest and credible
- Clear, concise and face to face wherever possible
- Audited and regularly reviewed

Although the Trust has started to invest in communications, it is important that good communication at all levels should continue to grow and develop. This Communications Strategy is designed to help the Trust achieve its objectives over the next three to five years. The strategy is not meant to be implemented by the communications department in isolation but to pull together all aspects of communication throughout the Trust. It supports many other activities which are the responsibility of different departments. New communications initiatives will not work in isolation.

The style which an organisation adopts, particularly in its internal communications, is fundamental to its culture and can be a key factor in the delivery of change. Therefore a proactive, sustained and powerful communications programme, which has the full support of the management team, is vital if the Trust is to achieve its strategic objectives.

The Trust will need to ensure it is in both 'receive' and 'transmit' mode and that it makes use of intelligent interpretation of data rather than just measuring amounts of data collected.

#### **3.1 Enabling two-way dialogue**

The Trust needs to build up its relationships with all its stakeholders. Historically it has been good at telling people about its activities but, in common with many other NHS organisations, it has not been as proactive in listening to what people want. The advent of 'Web 2.0' has led to more interaction with consumers and the trust will need to take advantage of the new technologies to implement active conversations with staff, patients and the general public.

It must have robust feedback mechanisms which allow staff, patients, carers, GPs, opinion formers and the general public to make their voices heard. Traditional routes, such as through complaints or PALs, need to be supplemented with new mechanisms such as online forums (Facebook, Twitter

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etc), interactive pages on the internet, regular forums for directors to meet staff and the public, surveys and feedback forms.

The Trust must enable a range of views from patients, staff and the public to be gathered and fed into the decision making process. Staff (particularly front of house staff) must be trained in customer care to ensure patients and visitors feel valued and listened to.

Once this Strategy and Action Plan are implemented members patients and visitors will:

- Be able to access enough information about Birmingham Women's NHSFT and the services it offers in their GP surgery to enable them to make an informed choice about where they wish to be treated
- Receive all the general and condition specific information they need in the most appropriate format and language
- Have access to interpreting services if required
- Be able to successfully navigate the hospital site
- Be treated in a courteous manner by every member of staff they come into contact with
- Know who to talk to, to resolve issues
- Know how to comment, complain or make suggestions
- Expect their telephone calls to be answered within three rings
- Receive a written response to letters within one week
- Receive copies of correspondence to their GP
- Be able to access general information about the Trust, and all the information which must be disclosed through the Freedom of Information Act through the website

In addition patients will all receive a patient satisfaction questionnaire which will enable the Trust to monitor its performance on a rolling basis.

## **3.2 Ensuring staff have information**

The Trust's future direction interests staff. They are keen to be kept well informed, be involved and feel they have a link with the management team. Therefore, the Trust needs to recognise this interest and take a proactive approach to internal communications along with a sustained programme of contact with the Executive and Non Executive team.

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Staff who are well informed and involved in the development of an organisation are more likely to feel motivated, affect change and strive to achieve excellence.

Two strands of communication are required. One is the encouragement of improved day-to-day communication between the Trust's staff, managers and departments. The purpose of this is to ensure people feel part of the organisation, valued and informed about what issues affect them and their work. The second is the communication of the trust's objectives to all employees, to obtain feedback from staff and to be able to consider and act upon that feedback.

It is essential that communication is not just seen as the written word. Internal communication throughout the Trust should be a bilateral process which spans across all departments and includes training, inductions, staff forums and more importantly, walking the shop floor to find out what employees want and what they think about the organisation they work for. All available methods of communication should be utilised and if the dissemination of information is done effectively a two-way dialogue will evolve.

Internal communication is not just about getting management messages across. It is also about allowing channels of communication to open up, enabling staff to be positively involved in the delivery of the Trust's objectives.

The two-way flow of information up, down and across the organisation, is essential if the Trust is to achieve its strategic objectives. Good cross communication should be the primary aim for the Trust in order to achieve an integrated workforce across geographical boundaries. Communication has to be an integral part of everyone's objectives and there must be a willingness to provide – and to seek – information at all levels throughout the organisation. Communication should not be seen in isolation – it supports every aspect of the Trust.

Once this Strategy and Action Plan are implemented Staff will:

- Receive high quality information about the Trust as part of the recruitment pack
- Receive a special induction issue of *Women's Progress*, the staff newsletter, when they start to help them familiarize themselves with the Trust
- Participate in corporate and departmental induction programmes
- Have easy access to the intranet and their own personal e-mail account either through a dedicated computer or internet cafes
- Receive copies of *Women's Progress* 6 times a year

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- Receive training in team briefing (if appropriate) and brief their direct reports every month
- Have access to, or know where to find all the information they need to perform their duties
- Be recognised for their good work and commitment through initiatives such as a Chairman's Award, Staff Recognition Awards or any other celebrating success programme
- Have access to communication/marketing training
- Be able to comment directly to the CEO through a dedicated telephone Hotline and e-mail address
- Have regular and meaningful appraisals
- Expect to have regular contact with directors who are walking the floor
- Receive an exit interview when they leave

In addition the Trust will:

- Ensure there are formal and informal mechanisms in place for the two way flow of information throughout the Trust including Team Brief, Women's Progress, the CEO's Hotline, e mail and the intranet and that all methods of communicating are regularly reviewed and audited and include communication in individual and departmental objectives

### **3.3 Ensuring local GPs have information**

GPs are crucial to Birmingham Women's NHSFT's future success. The Trust needs to invest in its relationship with GPs as a high priority. GPs must be kept informed and be able to influence the Trust's direction. A regular newsletter should be introduced as a priority and a GP liaison strategy should be produced.

Once the Strategy and Action Plan are implemented GPs will:

- be given sufficient information available, or know how to obtain it, to enable them to help their patients make an informed choice of hospital
- receive regular information from the Trust
- Be able to contact individuals in the Trust and make their views known

### **3.4 Providing a Recognisable Identity (Branding)**

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The Trust needs to define a strong and specific marketing image for itself, comprising a list of positive features and benefits for “customers”. These can include features and benefits which are present but not unique to the Trust and others which define Birmingham Women’s NHSFT in particular its good Healthcare Commission rating, its awards and accreditations.

This positive image needs to be continually held in review and adapted to incorporate improvements over time.

This image forms the core marketing image of the Trust, which then needs to be tailored for promotional messages to identified audiences (GPs, patients, staff, Engagement etc.) and in response to specific enquiries.

This “brand” would normally be associated with a unique “logo”, which can be as simple as the name of the Trust, or developed to incorporate specific images or colours. It would be unwise to move away from the NHS Brand which has a very high recognition and loyalty factor. There are strict NHS Corporate Identity and branding guidelines and while NHS Foundation Trusts do not have to abide by them it makes marketing sense to keep the NHS brand within the overall Birmingham Women’s NHSFT brand.

The Trust must ensure that all corporate literature is produced to a consistent design, is in simple language and meets the Trust’s high standards

## **3.5 Enable members of the community to become involved**

The Trust is committed to open communication with all its external partners and stakeholders. These include other NHS organisations, Politicians, opinion formers, the media, patients, non NHS partners, the general public, volunteers and the Women’s council.

External communication is not just about getting management messages across. It is also about allowing channels of communication to open enabling the public to become positively involved in the Trust. It involves managing the reputation of the Trust.

## **3.6 Build closer relationships with partners**

The Trust has many partners – other NHS organisations, Social Services and the third sector. It needs to identify each of its partners and to understand how each wishes to be communicated with. The Trust should produce a power/interest matrix which identifies each partner and how important they are to the Trust. This will enable the Trust to prioritise its communication with each.

The Trust also has a number of key stakeholders including local politicians. These will also be identified through the power/interest matrix.

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There should be a planned, annual programme for communicating and engaging with partners and stakeholders. This will include letters, face-to-face briefings, newsletters and site visits.

## 3.7 Reporting and Monitoring

Communications standards should be incorporated in directorate performance reviews.

A quarterly communications report should be presented to the Trust Board giving details of engagement coverage, stakeholder management activities, the results of communications standards from directorate performance reviews and general communications activity.

## 3.8 Media Relations

The Trust must develop its relationship with the local media. It must be more proactive in seeking coverage for events and activities and it should be able to rebut unfair and inaccurate stories quickly and firmly.

The Trust needs to undertake a planned, positive PR campaign with *The Birmingham Post and Mail* and other media outlets. A Trust the size of Birmingham Women's should be generating at least one positive news story every week. Health correspondents, district reporters and editors from across the West Midlands all need to be targeted. There should be regular press briefings with the Chairman and Chief Executive before every Trust Board meeting and regular dinners for selected journalists and clinicians. In addition the Trust should consider offering to write a weekly or monthly health column and should identify 'expert clinicians' who could be interviewed in print or on the radio about specific topics. These topics should be mapped out in an annual media plan. The plan will need to complement national events and activities including health awareness weeks etc.

The Trust does not have to rely on the media to ensure favourable publicity. It should consider printing a regular four page wrap-around supplement to a local free newspaper in conjunction with its NHS partners in South Birmingham. This supplement would be designed to look like the host newspaper and would contain a mixture of good news articles, health information and health promotion features. Trusts elsewhere in the country already commission these supplements and have seen their reputations enhanced.

The media is a hungry beast and demand for comments and spokespeople has grown enormously with the addition of new channels and 24-hour rolling news. Birmingham Women's NHSFT needs to consider how it will service media demands out of office hours. The Trust should consider whether responsibility for handling media enquiries out of hours should rest with the on-call director.

Once this Strategy and Action Plan are implemented the media will:

- be able to access general information about the Trust through the website
- Receive a timely response to their enquiries
- be able to contact a member of the Trust communications team or an on-call Director at any time of the day or night
- The Public will gain a favourable impression of the Trust from the media

### 3.9 On-going communications and engagement

This strategy is not a one-off tick box exercise. It needs to be a living document which evolves to support the Trust's changing priorities. Methods of communication which will be used to deliver the strategy are outlined in detail in the Action Plan but the key actions are:

#### 3.9.1 Staff

- **Team Brief** – needs to be revitalised
- **Women's Progress** - should be audited to ensure its content is relevant. Consideration should be given to publishing more frequently.
- **Walkabouts** – a regular, planned annual programme for executive and non-executive directors to visit all parts of the Trust, especially the Cinderella services
- **Electronic communications** – Includes Trust-wide 'all mailbox' bulletins and regular noticeboards, staff Intranet, intranet cafes, e-marketplace etc
- **Social Media** - we should be making use of Wikis, online forums, blogs and other new forms of communication
- **Other forms of communication** – Internal roadshows and promotional campaigns, corporate noticeboards, recruitment and induction information, payslip attachments, payslip messages, use of video and CD-Rom, focus groups, meetings, other publications, powerpoint presentations

#### 3.9.2 Patients and the Public

There needs to be an active engagement process with the Trust reaching out to embrace the community rather than expecting the community to come to it. The Trust's Head of Patient and Public Involvement, supported by the communications department, will be instrumental in implementing this.

- **Internet** – the website needs to be developed to provide patients and the public with a range of easy to find information about the Trust. This will include data such as details of how to get involved, copies of all public documentation, cleanliness rates etc. This should be a high priority for the Trust

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- **attendance at local meetings** – including neighbourhood watch, local area forums, religious organisations, resident associations etc.
- **Noticeboards** – make them work
- **Video, audio and CD Rom** – use of video, audio and CD-Rom will be explored to communicate with patients and the public in clear, easily understood ways and different languages.
- **Translation, Braille, large print** – Information will be provided in formats appropriate to the various audiences. All patients should have equal access to services and information should be adapted to reach all parts of the target audiences.
- **Targeted communications campaigns** – specific campaigns will be developed working in conjunction with the local communities to target specific health areas or groups of people.
- **Support and training for speakers** – ‘Champions’ will be identified who can speak about the Trust in a variety of ways and languages.

## 3.9.3 Media

- **Proactive media coverage** – the Communications team will further develop relationships with local and national newspapers, radio, television and trade press to raise the profile of the Trust and promote its achievements. The team will advise and support staff on how to maximise publicity for their work or achievements. Key journalists and health correspondents will be encouraged to meet members of staff and discuss relevant issues with members of the Trust Board and senior managers
- **Responding to the media** – all media enquiries should be directed through the communications department during office hours. A decision needs to be taken on out-of-hours cover
- **Media Training** – Media training should be offered to all key individuals if required
- **Media Monitoring** - The Communications team will provide a press cuttings service to monitor media coverage in the local, national and trade written press and where possible the broadcast press.

## 3.9.4 Stakeholders

- **Roadshows, exhibitions and conferences** – A range of communications material will be developed and maintained to support the promotion of the Trust’s objectives and activities at local, regional and national events
- **Meetings and Open days** – regular meetings and site visits will keep MPs and stakeholders informed and up to date
- **External meetings** - Members of the Trust Board and other senior managers should seek to continue to regularly attend meetings of partner and local community organisations, including the Overview and Scrutiny Committee, Local Involvement Network and Local Medical Council, to seek local involvement and promote the work of the Trust

### 3.9.5 Public Information Campaign

It is important to have a sustained public awareness campaign about what Birmingham Women's NHSFT does and stands for.

The Trust needs a corporate "brochure" and other promotional material which should state, re-inforce and illustrate the positive brand messages regarding this Trust. It is very important that the quality of the material is consistent with the (high) quality of the Trust's overall message.

Trust magazines are a positive way to build on the brand message but they will need to be reviewed and updated.

### 3.9.6 Communication Methods

- Posters
- Briefing of GPs
- Staff newsletter
- Website
- Bus advertising
- Radio advertising
- Newspaper advertising
- Street advertising
- Billboards outside the hospital
- Proactive PR campaigns
- Media Planning Calendar
- Continued communication with the groups and individuals already in contact with the Trust
- Websites (including intranets)
- Adverts in patient/community magazines
- Regular updates in Council publications
- Regular attendance at organised meetings (internal and external)
- Briefing MPs (at least quarterly)
- Regular dialogue with OSC and Links
- Team briefing for staff

Consideration will need to be given to making all material available in other languages, large print, Braille and audio. All material should be easy-read.

## 5. Conclusion

The purpose of this strategy is to set out a plan for the positive development of the Communication function over the next 12 months. It will be important to review the plan carefully and to generate any new, specific approaches in response to identified opportunities and threats.

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The Trust now needs to review its communications resource in the light of this strategy to see whether it is capable of providing the communications support that is required. It will need to review the size of the communications team and the skills of the individual members of staff.

DRAFT

# Birmingham Women's

## NHS Foundation Trust



<b>SUBJECT :</b>	"Core Values" - Developing organisational values at Birmingham Women's NHS Foundation Trust
<b>REPORT BY :</b>	Neil Savage, Director of Workforce & Organisational Development
<b>AUTHOR :</b>	Neil Savage, Director of Workforce & Organisational Development

### CONTEXT AND BACKGROUND FOR REPORT

This report puts forward a proposal for developing organisational values to support the delivery of the Trust's objectives.

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

This report proposes that Trust strategy statements as encompassed with the Mission and Vision:

- Can be seen as a promise to patients, staff and commissioners
- Should inspire, motivate and channel staff energies
- May start life in planning documents, but ultimately rest in the minds and hearts of people (rhetoric to reality), and,
- Should evoke both rational and emotional response

It suggests a way forward for developing, in partnership with staff, clearly defined organisational values that can be readily used to help the Trust deliver its objectives.

### RECOMMENDATIONS

The Board of Directors is asked to consider the recommendations within this paper and to support the further development of organisational values within the Trust.

## “Core Values”

### Developing organisational values at Birmingham Women’s NHS Foundation Trust

#### 1. Introduction

1.1 At the December 2008 Board Seminar, the following amendments to the Trust Mission and Vision Statements were agreed in principle.

1.2 The Mission Statement was amended from:

“Continue to be a leading provider of local, regional and national importance providing a specialist range of distinct, but interrelated services, delivering excellent healthcare, education, training and research, and contributing to the health and wellbeing of the people we serve”

to:

“To be the best specialist provider of Maternity, Gynaecology, Neo-natology, Fertility and Genetics; delivering excellent healthcare, education, training and research; and contributing to the well-being of the people we serve. We will aim to grow the business, but not to the detriment of clinical quality.”

1.3 The Trust Core Values Statement from the IBP (section 3.2) was originally agreed as:

“We recognize that we can only achieve our aspirations with a workforce that is motivated, well-managed and feels valued. Equally the needs of our patients and the wider healthcare community must drive everything we do. To make our vision a reality we have identified eight core values which will define our organization. For every service we provide we will continue to strive to:

- Place our patients at the centre of everything we do
- Actively involve women and their families in their healthcare and in shaping how services are delivered and developed
- Deliver high quality, creative and innovative care in the most appropriate setting.
- Work with our partners and the public to respond appropriate to the changing needs of our health community
- Attract, develop and retain the highest calibre of health professionals, managers, and other staff
- Give staff the organisational support they need to do their job well and to full involve them in developing our services
- Be open, honest and fair in the way we conduct our business
- Ensure that research and development and education and training underpin our clinical services.”

1.4 In recognition that this may not accurately describe organisational values, this was revised as a proposed Vision statement to:

“We aim to be an expert provider of high-quality healthcare. We will:

- Focus on appropriate clinical areas to achieve
- Measure our success by applying standards of clinical excellence
- Provide resources to deliver resources
- Improve clinical care through development of research and academic strategies
- Shape the workforce and organisational performance to deliver
- Achieve within a sustainable framework of value for money”

1.5 Subsequently, the Board asked for further work to be carried out to review and, where necessary, revise the core values.

## 2. Background

2.1 By means of supporting background, it can be helpful to consider that the Trust strategy statements as encompassed with the Mission and Vision:

- Can be seen as a promise to patients, staff and commissioners
- Should inspire, motivate and channel staff energies
- May start life in planning documents, but ultimately rest in the minds and hearts of people (rhetoric to reality), and,
- Should evoke both rational and emotional response

2.2 Arguably, positive patient and staff experiences are the fulfilment of the promises outlined in these statements.

2.3 A value can be defined as “a principle, standard, or quality considered worthwhile or desirable.” Values can be seen as the behaviours and beliefs we operate to manifest our Mission and Vision, to the ultimate aim of delivering our objectives and providing high quality clinical services for patients.

2.4 If the original Vision statement agreed for the Integrated Business Plan (IBP) is reviewed, the following values could be distilled:

- Patient & family centred
- Quality-focused
- Caring & compassionate
- Creative & innovative
- Responsive
- Partnership-focused
- Supportive
- Nurturing & developing

2.5 Subject to the outcome of the Staff Attitude Survey and the Medical Engagement Scale Pilot, it is proposed that, these be used as discussion starters to engage staff on the development of organisational values to assist with the delivery of the Trust’s objectives.

## 3. “Core Values” – a proposed consultation process

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3.1 Following the Board Seminar, potential consultation processes were discussed by Executive Directors. As a result, the following process is suggested for reviewing, consulting on and agreeing the future Trust organisational values:

1. Trust receives the outcome of 2008 Staff Attitude Survey and the Medical Engagement Scale Pilot - end of February 2009
2. Summary of outcomes and potential priorities are utilised to open “staff conversation” consultation meetings and formal Trust management fora. These sessions are utilised to introduce, discuss and identify staff and management priorities for the future organisational core values necessary to best deliver the Trust Mission and Vision – March / April 2009
3. Director of Workforce and Organisational Development analyses the feedback from the consultation and makes recommendations to the Staff Committee, Consultant Forum, Management Board and Board of Directors – May / June 2009
4. The agreed values are communicated, incorporated and embedded into Trust activities including Induction, Appraisal (PDR) and Performance Management processes - July 2009 onwards
5. Director of Workforce and Organisational Development reviews progress and reports back to Board of Directors – March 2010.

## 4. Recommendations

- 4.1 The Board is asked to consider, debate and agree the proposals outlined above.

Neil Savage

**Director of Workforce & Organisational Development**

January 2009

**Application for registration with the Care Quality Commission in relation to  
healthcare associated infection**

**Part 1: Details for registration.**

Name of trust: **Birmingham Women's NHS Foundation Trust**

Contact address: **Birmingham Womens Hospital  
Metchley Park Road**

**Birmingham  
West Midlands**

Email address: **jane.owen@bwhct.nhs.uk**  
(For all electronic communication with respect to this application)

**Part 2: Statement of Compliance with the proposed requirement for the  
regulation of regulated activities relating to health care associated  
infections (HCAI) that will, subject to Parliamentary approval, come into  
force on 1 April 2009.**

Requirement: A service provider in respect of carrying on of a regulated activity must, so far as reasonably practicable, ensure that patients, healthcare workers and others who may be at risk of acquiring a healthcare associated infection, are protected against identifiable risks of acquiring such an infection by the means specified in the regulations.

**Statement: The trust considers it is, and will continue to be, in compliance with this  
requirement that will, subject to parliamentary approval, come into force on 1 April  
2009.**

- Compliant**                       **Not Compliant**

**Part 3: Statement on whether the criteria set out in the Code of Practice about compliance with the regulation on HCAs are being, and will continue to be, met.**

(The supporting guidance to the Code of Practice illustrates how each of these criteria may be reliably met. Declaration of an improvement plan to strengthen systems of compliance will not necessarily be reflected in conditions being imposed on registration: this will be reserved for cases where it is considered there is a need for action to address a significant risk of the registration requirement being breached.)

<b>Criterion 1: The trust has in place and operates effective management systems for the prevention and control of HCAI that are informed by risk assessments and analysis of infection incidents</b>
<b>meets</b>
<b>Criterion 1: The trust has in place and operates effective management systems for the prevention and control of HCAI that are informed by risk assessments and analysis of infection incidents</b>
<b>meets</b>
<b>Criterion 3: The trust provides suitable and sufficient information on HCAI to patients and the public and to other service providers when patients move to the care of another healthcare or social care provider</b>
<b>meets</b>
<b>Criterion 4: The trust ensures patients presenting with an infection or who acquire an infection during care are identified promptly and receive appropriate management and treatment to reduce the risk of transmission</b>
<b>meets</b>
<b>Criterion 5: The trust gains the co-operation of staff, contractors and others involved in the provision of healthcare in preventing and controlling infection</b>
<b>meets</b>
<b>Criterion 6: The trust provides or can secure adequate isolation facilities</b>
<b>meets</b>
<b>Criterion 7: The trust secures adequate access to laboratory support</b>
<b>meets</b>
<b>Criterion 8: The trust has, and adheres to, appropriate policies and protocols for the prevention and control of HCAI</b>
<b>meets</b>
<b>Criterion 9: The trust ensures, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAI</b>

meets

**Part 4: Supplementary Information to support this application.**

Trusts may wish to record here significant information that provides additional evidence that the requirement to protect patients, healthcare workers and others from identifiable risks of acquiring an HCAI are, and will continue to be, met. This should include confirmation whether any planned action to address non-compliance in the Core Standards Declaration for 2007/08 regarding C4a, C4c and C21 has been completed, or will be by 31 March 2009. It may also include a brief comment on how well targets on the reduction of HCAI, as appropriate, are being met.

The trust has recorded zero cases of MRSA and Clostridium difficile for the last 5 years of mandatory reporting. We have also declared full compliance with the core standards C4a C4c and C21

**Part 5: Indication of willingness to receive notices by electronic communication.**

The trust is willing to receive notices with respect to this application for registration by electronic communication to the email address provided in Part 1.

(This will include any notice of proposals and the notice of decision provided by ss 26 & 28 of the 2008 Act)

**Part 6: Electronic sign off by the trust chief executive.**

Name of chief executive:

Miss Julie Burgess

Signature of chief executive .....

Date of chief executive sign-off.....

Name of person completing the electronic form:

Miss Jane Owen

It is an offence under section 37 of the 2008 Act to make a statement that is false or misleading in a material aspect in an application form

Please ensure that the form does not contain any confidential information about patients or staff.

<b>SUBJECT:</b>	Registration with the Care Quality Commission
<b>REPORT BY:</b>	Jane Owen, Director of Nursing and Midwifery DIPAC
<b>AUTHOR:</b>	Jane Owen Director of Nursing and Midwifery DIPAC

### CONTEXT AND BACKGROUND FOR REPORT

The board will be aware from the briefing paper presented to the December meeting, of the key changes relating to the care quality commission.

The Care Quality Commission (CQC) will succeed, on 1<sup>st</sup> April 2009, to the regulatory functions of the Healthcare Commission, the Mental Health Act Commission, and the Commission for Social Care Inspection. It will be a requirement for the Trust to be registered at this date; providing care without being registered will be a criminal offence. The registration at April 2009 will largely replace the current work of the Healthcare Commission on healthcare associated infection (see the *Code of Practice for the prevention and control of healthcare associated infections*.)

Care providers are required to register from 1<sup>st</sup> April 2009, the CQC has given a window to apply of 12<sup>th</sup> January to 6<sup>th</sup> February only. This application has been completed by the Director of Infection prevention and control, and now needs board approval. A copy of the completed document is attached for information. Supporting evidence is available with the Director of Infection prevention and control for review should board members wish to do so. In addition, the board should be assured that similar standards were monitored and assessed at the recent hygiene code inspection on 30<sup>th</sup> and 31<sup>st</sup> December and the trust was found to be compliant.

The CQC will assess and cross-check applications for registration during February and March 2009, if necessary contacting the Trust to clarify any items and discuss any concerns. It is expected that proposed registration classifications (including any conditions or expectations for improvement) will be notified in the second half of March 2009.

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

- The Trust is stating compliance with all criteria.
- Supporting evidence is available.

### RECOMMENDATIONS:

The Board is **INVITED** to:

- NOTE** the new registration system that will be effective from the 1<sup>st</sup> April 2009;
- NOTE** the requirement to approve an application for registration by the 6<sup>th</sup> February 2009; and
- APPROVE** the application and declaration