Birmingham Women's NHS
NHS Foundation Trust

PUBLIC SESSION

MEETING OF THE BOARD OF DIRECTORS
to be held in the Seminar Room, Birmingham Women's Hospital
on Thursday 28 May 2009 at 11 am

Only urgent items have been included on the agenda.
For the assistance of the Board, Directors are requested to raise detailed questions with the presenting Director before the meeting in the first instance.

AGENDA

			Enc
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 23rd April 2009** To APPROVE the minutes of the meeting held on 23 April 2009		**1**
5	**Matters arising from the minutes of the meeting held on 23rd April 2009 (where not covered by agenda items)**		
	a. Annual Healthcare Declaration- commentary from the Birmingham Safeguarding Board	JO	**2**
6	**Trust Chair's report**	IB	
7	**Meeting of Board in private session** To NOTE that representatives of the press and other members of the public are expected to be excluded from a later session of the meeting having regard to the confidential nature of the business which is scheduled to be transacted, publicity on which would be prejudicial to the public interest.	IB	

8	**Report by the Chief Executive**	JB	**Oral**
	PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE		
9	**Red Risk Register and Assurance Framework** To RECIEVE the Red Risk Register and Assurance Framework	SIP	**3**
10	**Implications of Mid-Staffs and Birmingham Children's Hospital HCC reports** To- a. RECEIVE a report of the discussions at Management Board, Clinical Governance Committee and the Committees of Members' Council; and b. CONSIDER the implications from these reports for this Trust.	JO/ PT	**4**
	ASSURANCE		
13	**Statutory Accounts for the year ended 31st March 2009** To APPROVE and SELF-CERTIFY the accounts for submission to Monitor and laying before Parliament, including Quality Accounts	JaB	**5** **To follow**
	a. Report and recommendation from the Audit Committee *KPMG and Parkhill in attendance*	RR	**Oral**
	ORGANISATIONAL PERFORMANCE		
14	**Annual Plan 2009-2010 (3-year forecast plan)** To AGREE the Annual Plan for submission to Monitor; and To AGREE the required self-certifications	JaB	**6** **To follow**
	MEMBERS' COUNCIL MATTERS		
16	**Report from Members' Council Chair**		**Oral**
	a. Election Results	SIP	**Tabled**
	TRUST POLICIES FOR APPROVAL		
	a. Dignity and Respect at Work Policy – Managing Bullying and Harassment in the Workplace	NS	**7**
	b. Retirement Policy	NS	**8**
	c. Policy for reducing the risks associated with	JO	**9**

Intravenous devices

SEALING REPORT SIP **10**

To NOTE the Sealing Report

ITEMS CIRCULATED BETWEEN BOARD MEETINGS

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

a. Action Notes
b. Information re resignation of Chairman
c. Information re HCC reports

Dates of next meetings

Thursday 25 June 2009
Thursday 30 July 2009
Thursday 27 August 2009

ENCLOSURE 1

Ref:

Birmingham Women's NHS
NHS Foundation Trust

Unconfirmed Minutes of the
MEETING OF THE FOUNDATION TRUST BOARD
HELD IN PUBLIC
in the Seminar Room, Birmingham Women's Hospital,
on Thursday 23rd April 2009

PRESENT:	Judith Mackay (in the Chair)	Trust Chairman
	Professor Ian Booth	Deputy Chairman
	Julie Burgess	Chief Executive
	Jason Burn	Interim Finance Director
	David Draycott	Non-Executive Director
	Nigel Gardner.	Non-Executive Director
	Helen Hemberg	Non-Executive Director
	Jane Owen	Director of Nursing & Midwifery
	Robin Rison	Non-Executive Director
	Neil Savage	Director of Workforce & Organisational Development
	Peter Thompson	Medical Director
IN ATTENDANCE:	Steve Parsons	Head of Corporate Affairs

ACTION

FTP/0409/1 WELCOME AND APOLOGIES

FTP/0409/1.1 No apologies for absence were received

FTP/0409/2 QUESTIONS FROM THE PUBLIC ON MATTERS RELATING TO THE AGENDA

FTP/0409/2.1 No questions relating to the business of the meeting were asked by the members of the public attending.

FTP/0409/3 DECLARATIONS OF INTEREST

FTP/0409/3.1 No interests were declared in any item on the agenda for the meeting.

FTP/0409/4 MINUTES OF MEETING HELD ON 26th MARCH 2009

FTP/0409/4.1 The minutes of the meeting held on 26th March 2009 were **APPROVED** and signed as a correct record subject to the following amendment:

- Neil Savage was present

FTP/0409/5 MATTERS ARISING FROM THE MINUTES OF THE

MEETING HELD ON 26th MARCH 2009

Knitting Group

FTP/0409/5.1 Jane Owen confirmed that, having consulted the Infection Control officer, it had been confirmed that the knitting produced fro the hospital could continue.

FTP/0409/6 TRUST CHAIR'S REPORT

HCC report into Mid-Staffs/ BCH

FTP/0409/6.1 The Chairman reported that, following the discussion at the previous meeting of the Board, two strands of work were ongoing to feed back to the Board at the May meeting; she had written to all Governors with summaries of the reports, and the Committees of Members' Council were all considering lessons to be learnt through the current round of meetings.

FTP/0409/6.2 The Chairman also advised the Board that Monitor had published a consultation draft of guidance for Governors in the discharge of their responsibilities; this would be reviewed and any suggestions reported to the Board and Members' Council. **SIP** Monitor had also published research into self-certification by Boards, which would be circulated to Directors. **JB/ SIP** Both of these items would need to be addressed to provide assurance and to ensure appropriate Board-level debate and challenge on clinical matters.

Process of appointing a Chief Executive

FTP/0409/6.3 The Chairman noted that feedback on the recent process had been received, and had been positive; she recorded particular thanks to Governors for their involvement in the process.

FTP/0409/7 MEETING OF THE BOARD IN PRIVATE SESSION

FTP/0409/7.1 The Chairman reported that the Board had held a private session earlier in the day, during which they had considered the progress reports for the fourth quarter of 2008-2009; they had also received a presentation from the Ronald McDonald House Charity regarding a proposal to build accommodation on site for the parents of babies undergoing treatment in the Trust.

FTP/0409/7.2 The private session would be continued, when it was expected that the Board would consider the annual budget and three-year plan; a Root Cause Analysis; the Trust's academic strategy; objectives for the year 2009-2010; progress on the NNU; involvement in an IT early adopter programme; and investment opportunities that

were under active consideration.

FTP/0409/8 ORAL REPORT BY THE CHIEF EXECUTIVE

The Chief Executive drew the Board's attention to the following matters:

Circulation of Papers

FTP/0409/8.1 The Chief Executive apologised to the Board for the difficulties in circulating papers prior to this meeting; this had largely been driven by the meeting occurring earlier in the month than usual, owing to the Monitor return being due on the usual meeting date. She suggested that the Board considered, in the light of experience, whether this was a necessary precaution.

FTP/0409/8.2 Mr Rison thanked Julie Burgess for the explanation, and commented that the Non-Executive Directors had little time to review the papers; he felt her suggestion was compelling. Jane Owen noted that it might be helpful to move non-urgent items off the Board agendas for April and May, given the other pressures of business at these times. **JM/ JB/ SIP**

FTP/0409/8.3 The Board **AGREED** that all Board meetings (bar December) should be held on the last Thursday of the month. **SIP**

Care Quality Commission

FTP/0409/8.4 The Chief Executive reported that, in accordance with the provisions of the Health Act, the Care Quality Commission had issued the Trust with an unconditional licence to operate. She noted that the full registration system would be operational from April 2010, and that 21 Trusts had conditions imposed, including 4 Foundation Trusts.

Appeal against HCC Score

FTP/0409/8.5 Jane Owen reported that, after the previous Board meeting, the Trust had been advised that its appeal against a score of 'good' in this exercise had been dismissed. However, the CQC had indicated that they would not be reviewing the relevant data in future.

Risk assessment by 'Concordat' authorities

FTP/0409/8.6 The Chief Executive drew the Board's attention to a risk assessment of the Trust (undertaken on a desktop basis) by various statutory authorities acting under 'concordat' arrangements. The Trust had been advised of the outcome of this review, with the only concern

identified being in relation to Counter-Fraud: this area had since been addressed. The letter would be circulated, and might also be relevant to Members' Council. **JB**

Specialist Commissioners- Designated Services

FTP/0409/8.7 Julie Burgess advised the Board that the Specialist Commissioners had issued a consultation document regarding designated services, which had been considered by the Management Board. The Management Board had identified a number of queries to be taken up with the Commissioners: when these were resolved, it was intended that the Management Board would make recommendations to the Board. **Man Bd**

FTP/0409/8.8 The Chief Executive's report was **NOTED** with thanks.

PATIENT EXPERIENCE AND IMPROVING CLINICAL PERFORMANCE

FTP/0409/9 Red Risk Register and Assurance Framework

FTP/0409/9.1 The Head of Corporate Affairs presented the Red Risk Register report, noting that this was the first month that the report had been produced from Datix. It had been intended to have available a live link to the database to assist the Board with individual queries, but technical issues had made that impossible for this meeting. Julie Burgess noted that all risks had been reviewed and updated by the relevant risk owners, and she took assurance from this.

FTP/0409/9.2 Robin Rison enquired why the risk of a lack of estate structure was continuing, and Neil Savage commented that this related to the SLA arrangements that were now being wound up with the transfer of Estates back into the Trust. Mr Rison also referred to the Norton Court risk, and Mr Savage confirmed that a condition survey was being arranged which would form the basis of deciding how much assurance was available. **NS**

FTP/0409/9.3 Ian Booth asked if it was possible to 'embed' the supporting information in the report; it was confirmed that this was not possible from the system, but consideration would be given to getting web-based access for the Non-Executive Directors. **SIP**

FTP/0409/9.4 The Board **NOTED** the report.

FTP/0409/10 AMBER RISK REGISTER

FTP/0409/10.1 The Head of Corporate Affairs presented the Amber Risk Register, and it was noted that a piece of work was

planned to ensure that all risks were addressed on the register via a gap analysis.

FTP/0409/10.2 The Board **NOTED** the Amber Risk Register.

FTP/0409/11 NHS CONSTITUTION

FTP/0409/11.1 Neil Savage presented paper 4/09/public/A11, noting that the recommendations were aimed at embedding the NHS Constitution into the Trust's work. There was now a much clearer separation between rights and aspirations in the Constitution, although some legal rights were clearly extended. Although it did not have direct legal force, the Health Bill proposed to require Trusts to 'have due regard' to the Constitution in providing services. The proposed actions were set out in the attached action plan, and included the nomination of a Non-Executive Director 'Champion'.

FTP/0409/11.2 Julie Burgess commented that the NHS Constitution had been given a low-key launch, but was important and would be increasingly drawn upon by the public, for example in their contact with PALS. David Draycott was unclear about its impact, as there was nothing in it to differ from and it was largely embedded in other documents; in taking it forward, it would be necessary to show how it positively impacted service delivery. The Chairman noted that this could be considered to fall within the role of the Senior Independent Director; the Chief Executive commented that the Constitution would be relevant to complaints and grievances, and the Trust may need to link the two. She confirmed that Mr Savage would be the lead Executive Director in this area, and that there would be some slippage on the plan given other matters.

FTP/0409/11.3 The Board:

- **NOTED** the report and action plan; and
- **AGREED** that, subject to discussions between himself and Mr Savage, Mr Draycott should be nominated as the Non-Executive 'Champion'. **NS/ DD**

ASSURANCE

FTP/0409/12 *STANDARDS FOR BETTER HEALTH*: APPROVAL OF ANNUAL DECLARATION

FTP/0409/12.1 Jane Owen introduced paper 4/09/public/A12 confirming that the declaration to be made had been considered by the Clinical Governance Committee, which had confirmed that the evidence had given assurance for making a declaration of full compliance with the standards. She drew the Board's attention to the electronic evidence-base introduced this year, which

supported the recommendation for a declaration; in particular, she noted that the Trust had now achieved full compliance with standard C01a.

FTP/0409/12.2 The Board's attention was drawn to the third-party commentaries also circulated, which had been helpful; particular note was given to the commentary on behalf of the Members' Council, which reflected their experience of the Trust. One expected commentary, from the Birmingham Safeguarding Board, was outstanding and would be pursued. The local LINks were not in a position to participate in the process for this year, as they had only recently been established.

FTP/0409/12.3 Nigel Gardner noted the great improvement in the evidence-gathering process, which supported the Board's decision; the Chairman commented that Members' Council could make a significant input into this area. Mr Thompson noted the significantly more positive commentary from South Birmingham Primary Care Trust than in previous year although it appeared confused as the Trust had no cases of *C Difficile* over the past several years.

FTP/0409/12.4 The Board:

- **APPROVED** the declaration for the Annual Health Check; and **JB**
- **AUTHORISED** the Chief Executive to submit the declaration to the Care Quality Commission.

FTP/0409/13 CHANGES TO ORGANISATIONAL COMPLAINT HANDLING

FTP/0409/13.1 Jane Owen introduced paper 4/09/public/A13 and reminded the Board that the Trust had been an early adopter for the new-style system of complaints that had come into force following the winding-up of the Healthcare Commission. Deadlines were no longer set centrally and could be negotiated with the complainant, there was no a greater emphasis on local resolution, as unresolved complaints would be referred directly to the Health Service Ombudsman; accordingly, the various leaflets and policies would be revised in order to reflect these statutory changes. **JO** Jane Owen also noted that the new procedures were intended to provide a smooth process for the complainant, with particular emphasis being on there being a single point of contact and, for complaints affecting several organisations, one lead organisation taking responsibility for co-ordination and provision of a response. This would be a big learning process for the Trust, and the Trust would continue to provide full quality control of the process through the Medical Director, Director of Nursing and the Chief Executive.

FTP/0409/13.2	Professor Booth enquired if possible legal cases of clinical negligence remained outside the process: Jane Owen reported that there was a lack of clarity on this in the official guidance, although some informal advice had been received that complaints and legal issues could proceed in parallel. Some Trusts had offered compensation on that basis, but the NHSLA was declining indemnity as the case had not been settled through their procedures. A detailed paper would be submitted to the Clinical Governance Committee, but the current intention was to retain previous practice.	**JO/ PT**
FTP/0409/13.3	The Board: • **NOTED** the changes in legislation relating to the handling of complaints; and • **AGREED** the actions proposed in the paper.	
FTP/0409/14	**ANNUAL STAFF ATTITUDE SURVEY**	
FTP/0409/14.1	Neil Savage introduced paper 4/09/public/A14, noting that a list of proposals had been made arising from the results of the survey. He drew the Board's attention to the areas of the survey showing the Trust performing well, set out in section 3.1 of the paper, and those for improvement in section 3.2. There had been a good rate of return at about 56%, and for the next survey it was intended to ask all staff to complete the survey. The Board was asked to approve the action plan attached to the paper.	**NS**
FTP/0409/14.2	David Draycott asked for clarification as to whether the proposed improvements in communication would be both up and down, and this was confirmed. Prof. Booth noted that bullying had been an issue in previous surveys; Neil savage confirmed that it had not appeared as a significant issue in this survey- experience indicated that staff were more likely to experience bullying or harassment from patients or relatives. The focus groups, which would look at this issue, would report back in October.	**NS**
FTP/0409/14.3	Robin Rison enquired whether Directorate-level results were available, and if they informed Directorate proposals; it was confirmed that detailed Directorate breakdowns were available and provided for comment. These had not shown any noticeable outliers.	
FTP/0409/14.4	The Board: • **NOTED** the results of the 2008 Staff Survey; • **RECOGNISED** the importance of the staff survey going forward to identify areas for improvement; • **STATED** that an objective for the forthcoming year was to have a high profile for organisational	

development which would address many of the issues identified; and
- **AGREED** the proposed Action Plan.

ORGANISATIONAL PERFORMANCE

FTP/0409/15 INTEGRATED PERFORMANCE REPORT

FTP/0409/15.1 Peter Thompson presented the dashboard, noting that most areas were showing an improvement over the course of the year.

FTP/0409/15.2 Neil Savage presented the workforce indicators in detail, and noted the following points:

- The sickness absence had improved; comparative data for March was not yet available for national or the West Midlands. The department had been providing considerable support to managers in managing sickness;
- KSF was showing progress for both the creation of outlines and appraisals.

FTP/0409/15.3 Peter Thompson referred back to the dashboard, and drew the Board's attention to the information on HCC targets; on referral to treatment within 13 weeks, although there had been some breaches there was a 90% success rate. Owing to the nature of the service, the outpatient target effectively acted as the target for Genetics.

FTP/0409/15.4 Robin Rison referred to the 'shared breaches' in cancer referrals, and asked if the Trust was 'shadowing' the referral with other Trusts; Peter Thompson confirmed that this was not part of the national process, but was undertaken where possible. Julie Burgess noted that although tracking was undertaken, the Trust could not insist on another Trust meeting the target; the receiving Trust may not be so affected, as this Trust had a very small absolute number of patients in these tracks. Sarah Francis (a Governor present) commented that this linked to the issue of effective partnerships highlighted in the HCC report on Birmingham Children's Hospital. **JO**

FTP/0409/15.5 Jason Burn presented the financial report, and noted the following points:

- The predicted Monitor risk rating was 4.1, and the Trust was £725k up on plan;
- EBITDA was above plan at 7.59%
- The in-month deficit for month 12 was largely accounted for by the £600k carry-forward of CNST premium, as previously discussed;

- Recent changes to market rates had led to a slight over-performance in some areas; the Board noted the timing issues that were affecting the Clinical Support SLA's
- There had been a slight over-performance on CIP's

FTP/0409/15.6 Peter Thompson noted it would be useful for the Month 12 report to show the end-of-year position, and it was agreed that this would be reviewed. In response to a question, it was confirmed that the movement in CNST cancelled the unexpected income earlier in the year, so 'levelling out' the position; it was confirmed that the treatment was still under discussion with KPMG. **JaB**

FTP/0409/15.7 Robin Rison noted that the CAPEX figures were 10% above budget and suggested that details should be provided to the Board; it was confirmed that these changes had been through the Capital Development Group, but more detail could be provided to the Board next month. **JaB** Helen Hemberg referred to the CIP's, and enquired what the feeling of Directorates was on these; it was reported that the Directorates were pleased with performance, and now had more acceptance of the need to deliver on CIP's. Julie Burgess commented that it was vital to shift CIP's from transactional to transformational, and that some Directorates were further along this journey than others. Robin Rison suggested that, for the future, consideration could be given to a greater focus on the immediate month whilst retaining some annual forecasting. This could be discussed further outside the meeting. **JaB/ RR**

FTP/0409/15.8 The Board **NOTED** the Integrated Performance Report.

FTP/0409/16 QUARTER 4 RETURN TO MONITOR

FTP/0409/16.1 The Head of Corporate Affairs presented paper 4/09/public/A16 noting that it was proposed to made Declaration 2 out of an abundance of caution; this was because the Department of Health had not defined the target rate for completing cancer referral to treatment in 62 days, and the Trust had shared breaches in the period. The proposed return also updated Monitor on the position of the Trust on the 13-week referral to treatment targets, and advised of changes in the Board and Members' Council.

FTP/0409/16.2 Robin Rison suggested that, in conversations with Monitor, it should be stressed that the Trust had a very small number of patients under the 62-day target and therefore the position might be statistically unreliable. **JaB/ JO/ SIP**

FTP/0409/16.3 The Board:

- **APPROVED** the draft submission to Monitor for the

fourth quarter of 2008-2009; and
- **AUTHORISED** the Chairman to sign Declaration 2 as set out in the papers.

FTP/0409/17 IFRS BALANCE SHEET, YEAR ENDED 31ST MARCH 2008

FTP/0409/17.1 Jason Burn presented paper 4/09/public/A17 noting that the Board was now requested to self-certify the balance sheet after review by KPMG as auditors. He drew the Board's attention to one lease issue where there was a difference of opinion with the auditors; it had been confirmed that these differences should not affect the self-certification.

FTP/0409/17.2 Robin Rison commented that he had discussed the position regarding the lease with Mr Burn, and had suggested a further conversation with KPMG; Mr Burn confirmed that this was a useful suggestion. The accounting treatment in question had gone back for a number of years, and had not previously been identified. **JaB/ RR**

FTP/0409/17.3 The Board **AGREED** to make the self-certification as set out in the papers.

FTP/0409/18 SIX-MONTHLY UPDATE FROM WM PUBLIC HEALTH OBSERVATORY

FTP/0409/18.1 The Board **NOTED** the report that had been submitted.

MEMBERS' COUNCIL MATTERS

FTP/0409/19 TRUST POLICIES

FTP/0409/19.1 Julie Burgess referred to the proposed Raising Concerns at Work policy, and noted that this was an important development; she felt that if it had been in place for dealing with a recent difficult issue, it would have been very useful to resolve the matter. This was supported by David Draycott, who had also been involved in resolving the issue; it was noted that the policy would also feed into the NHS Constitution and the forthcoming Dignity at Work policy.

FTP/0409/19.2 The Board **APPROVED** the following policies:
- Reporting Concerns at Work (whistleblowing)
- Policy for new clinical procedures
- Incidents Policy
- Root Cause Analysis policy

FTP/0409/20 SEALING REPORT

FTP/0409/20.1 The Board **NOTED** the Sealing Report.

FTP/0409/20.2 Julie Burgess noted that the formal documentation from the Specialist Commissioners relating to the 2009-2010 contract was still outstanding Although the finance and activity levels and relevant points had been agreed, the formal contract had yet to be received by the Trust. The Chief Executive had raised this with the Director of the Specialist Commissioners.

Dates of next meetings

Thursday 28 May 2009
Thursday 25 June 2009
Thursday 30th July 2009
Thursday 27th August 2009

Birmingham Safeguarding
Children Board
Silvermere Centre
Silvermere Road
Sheldon
Birmingham
B26 3XA

Tel: 0121 464 2612
Fax: 0121 303 8427

28th April 2009

Julie Burgess
Birmingham Women's NHS Foundation Trust
Metchley Park Road
Edgbaston
Birmingham
B15 2TG

Dear Julie

Re: Trust Declaration against the Standards for Better Health 2008 / 2009

I am writing in response to your invitation for the Birmingham Safeguarding Children Board to comment on the Birmingham Women's NHS Foundation Trust declaration of compliance with the standards for Better Health issued in July 2004, which sets out 24 Core Standards. The commentary from the Birmingham Safeguarding Children Board appertains to the period 1st April 2008 to the 31st March 2009.

The Birmingham Safeguarding Children Board has a statutory responsibility for ensuring that organisations work together effectively to safeguard and promote the well being of children and young people in Birmingham. However, the Board's primary role is to evaluate the effectiveness of partnership arrangements, with the particular focus on child protection and all other aspects of safeguarding.

The Birmingham Safeguarding Children Board welcomes the opportunity to comment on the trust compliance with the Core Standards and in formalising our response the Board has taken into account;

The Health Commission Guidance which sets out the role of Local Safeguarding Children Board in commenting on the Trust's performance as part of the Annual Health check 2008 / 2009.

The Safeguarding Children Board has specifically concentrated on assessing evidence of compliance with Core Standard C2 *"Healthcare Organisations Protect Children by following national child protection guidelines within their own activities and in their dealings with other organisations".*

The Trust has contacted the Birmingham Safeguarding Children Board sharing the draft declaration and seeking formal feedback on performance against the Core Standards. The Birmingham Safeguarding Children Board welcomed the opportunity to comment on the document. This consultation process provides reassurance that Child Protection is a priority and that the Trust are able to demonstrate compliance with this standard.

I would be most grateful if you could ensure that the Board's commentary is included within the Trusts Annual Health Declaration.

My final observations do not form part of the Annual Health Declaration, but look ahead to next year to see how we can improve the consultation process. The Board want to be in a position to provide a timely and comprehensive contribution to the Annual Health check. Birmingham Safeguarding Children Board will continue to focus on the core standards that directly impact on Safeguarding and promoting the wellbeing of Children and Young People.

The Board have an established Quality Assurance and Audit Sub Group which will be responsible for liaising with Health Trusts to assist in compiling the draft declaration. Birmingham Safeguarding Children Board will seek evidence in the following areas:

- The Trusts engagement and representation within the Birmingham Safeguarding Children Board structure.
- The Trusts engagement and representation in the Health Professionals Advisory Group, chaired by Doctor Geoff Debelle.
- The outcome of OFSTED evaluations of Individual Management Reports submitted by the Trust in relation to Serious Case Reviews.
- That the Trust have fully implemented Serious Case Reviews recommendations.
- Audits of front line practice to ascertain compliance with 'Lessons Learnt' from the Serious Case Review.
- That the Trust training programme includes mandatory child protection training for those staff who have regular contact, work regularly or have particular responsibility for safeguarding children and young people.

The Healthcare Commission Annual Health check will be incorporated into the Quality Assurance and Audit Sub Group work programme from 2009 -2010 to ensure that the Board are in a position to provide commentary on the Trust's Performance in this important area.

If I can be of any further assistance please do not hesitate in contacting me.

Yours sincerely

Simon Cross
Business Manager
Birmingham Safeguarding Children Board

c.c.: Roz Alstead, Chair Quality Assurance & Audit Sub Group
Safeguarding Lead – Elaine Giles

ENCLOSURE 2

Ref: 4/09/public/A9

Birmingham Women's NHS
NHS Foundation Trust

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

CONTEXT AND BACKGROUND FOR REPORT

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

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

Owing to the short session of the Board this month, it was agreed that only new Red Risks would be drawn to the attention of the Board. No new red Risks have been identified this month.

RECOMMENDATIONS

The Board is invited to:

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

CURRENT RED RISKS

ID	Title	Opened	Review date	Risk Type	Risk Subtype	Adequacy of controls	Manager
92	Ability to maintain delivery of a radiology service to the Trust	08/05/2009		Clinical	Multi	A	Gary Cockayne
89	CPA Accreditation	02/04/2009	02/05/2009	Clinical	Multi	I	Gary Cockayne
4	Trust not being able to function as a Perinatal Centre	01/07/2005		Clinical	Clinical	A	Michele Emery
8	Neonatal Unit capacity	01/03/2005	31/12/2010	Clinical	Clinical	A	Michele Emery
9	Lack of midwifery staff	12/10/2006		Clinical	Clinical	A	Jenny Henry
10	Delivery of category 1 caesarean section within 30 minutes	28/08/2007	29/05/2009	Clinical	Multi	A	Gary Cockayne
3	Norton Court	14/10/2008	08/04/2009	Corporate	Multi	I	Pam Cooper
51	Medical Staffing-EWTD by August 09	02/01/2009		Corporate	Multi	U	NeilSavage
54	DATIX and risk management records	02/03/2009	27/03/2009	Corporate	Multi	A	Peter Thompson
6	Delivery of Trust Down's Screening Service	13/12/2007		Corporate	Multi	A	Gary Cockayne
83	Cancer waiting times - Gynaecology	12/03/2009	14/04/2009	Corporate	Multi	I	Masoud Afnan
13	13 week Waiting List Targets	01/07/2007		Corporate	Financial	A	Val Davison

ENCLOSURE

Birmingham Women's NHS
NHS Foundation Trust

SUBJECT :	Review of Two recent Healthcare Commission reports.
REPORT BY :	Jane Owen & Peter Thompson
AUTHORS :	Jane Owen & Peter Thompson

CONTEXT AND BACKGROUND FOR REPORT

The board are aware that the Healthcare Commission has recently published significant and high-profile reports following investigations into two Trusts:

a. Birmingham Children's Hospital NHS Foundation Trust (BCH)
b Mid-Staffordshire NHS Foundation Trust (Mid-Staffs)
Since the publication of these reports management board have discussed the findings and any lessons to be learnt for BWNFT.

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

The relevant themes emerging from both reports can be grouped into the following categories:

HCC BCH

Capacity and demand issues at BCH could be similar with Maternity

Developing new services, interventional radiology

Pressure on theatres, eg fetal med and increasing LSCS

Governance and Partnership working with UHB

Mid Staffs HCC

Board reporting, comparative data, failure to learn from complaints and incidents

Staffing levels

Mid Staffs Alberti

Population planning/capacity see above

Auditing mortalities

Maintain equipment replacement programme

Staffing levels see above

RECOMMENDATIONS

To discuss the assessment of recommendations in Appendix 1 and determine what, if any, changes need to be made to minimise risk to BWNFT and to ensure robust reporting and board assurance.

We would strongly recommend that the previously suggested unannounced visits by board members to the clinical areas, is reconsidered and implemented.

The letter from Dr Moyes 05/05/09 clearly states Monitor's expectations of Board actions and discussions. It is recommended that the board address these specifically.

Implications of Mid-Staffs and Birmingham Children's Hospital HCC reports

The board are aware that the Healthcare Commission has recently published significant and high-profile reports following investigations into two Trusts:

a. Birmingham Children's Hospital NHS Foundation Trust (BCH)
b Mid-Staffordshire NHS Foundation Trust (Mid-Staffs)

Since the publication of these reports and the follow - on "Alberti" report, the management board (with members of the clinical governance committee) have discussed the findings and any lessons to be learnt for BWNFT.A précis of all recommendations and BWNFT status relating to them can be found in Appendix 1. The report from Dr Colin Thome and letter from Dr Moyes was received after the discussions at management board but have been factored into this report.

a. Birmingham Children's Hospital

The HCC investigation into BCH was as a result of media reports (from information released as a result of a request under the Freedom of Information Act to University Hospitals Birmingham) of a breakdown in relations between BCH and certain consultants. The report is very different from Mid Staffs. and is not classed as an investigation. However, the concerns raised in relation to the delivery of patient safety and clinical service, in the context of partnership arrangements between BCH and University Hospitals Birmingham, will be of relevance to this Trust. The report from BCH has many direct applications to our neonatal and fetal medicine services as any babies cared for with surgical conditions will have their care affected by any shortcomings in care at BCH.

b. The independent report regarding Mid Staffordshire from the Healthcare Commission was finally published on March 18th 2009. Though many of the findings relate specifically to A&E some are readily transferable to any acute trust.

The relevant themes emerging from both reports can be grouped into the following categories:

HCC BCH

- Capacity and demand issues at BCH could be similar to those within Maternity services. At BCH one of the main problems was one of capacity and obtaining beds for children who required their care. At BWH we presently have a situation where capacity within maternity is an issue. At this time we have mitigated against this risk by implementing a capping system for maternity bookings which is biased

towards local residents and patients with complex conditions requiring specialist care. Commissioners have been involved in these decisions. In addition we have capacity problems in neonatology with our bed occupancy rate being well above the recommended 80%. This is mitigated by functioning as part of a network.

- Developing new services, interventional radiology

Interventional radiology is an increasingly important sub specialty which is under represented across Birmingham. Its use for patients of BWH would include;

1. Possible use in neonates, which would be performed at BCH
2. Use as an elective procedure in adults at UHB, or any other unit that we negotiate with.
3. Emergency treatment of haemorrhage. This is increasingly recommended in college guidelines and would need liaison with UHB. At present we have no such agreements.

- Pressure on theatres, eg fetal med and increasing LSCS

One problem at BCH was access to theatres for surgical cases requiring surgery at a specialist centre. At BWH we have pressure on our theatres in Obstetrics to allow the elective caesarean sections to be performed and to allow the less predictable usage of these theatres by the specialist tertiary services of fetal medicine.

- Governance Communication and Partnership working with UHB

As with BCH we have close relations with consultants at UHB and to a lesser extent BCH themselves. We also have an interdependency with other units. There are potentially similar problems of governance faced by consultants who work across Trusts at UHB/BCH and BWH as there were between UHB and BCH. Our Clinical Geneticists are also working in units across the region and few have honorary contracts. These collaborations would be expected to increase over time with;

1. Opening of the neonatal surgical beds
2. Increased complexity of care of ill patients
3. Opening of UHB A and E on the QE site

The report identified issues of communication between management and clinicians and a culture of lack of trust. This is not seen as a problem here and there are systems in place to provide opportunities for feedback. A recent independent survey of medical staff within the Trust showed that on a medical engagement score we ranked as a medium performing Trust. These results have only just been received in the Trust and will be debated at the Board in more detail at a later date.

Mid Staffs HCC

- Board reporting, comparative data, failure to learn from complaints and incidents

The board must ensure that the data it receives both fulfils statutory requirements and allows the Board to meaningfully contribute to improvement in patient care.

- Staffing levels

Staffing levels, especially in Maternity and Neonatology are below standards that have been set by Royal Colleges, and have been debated previously at Board level. In mitigation the Board has previously approved expansion of the workforce moving towards these standards. In addition both executives and the directorate managers have lobbied the PCT and worked closely with them to secure investment in staffing. Funding for posts relies on support from the commissioners who have a responsibility to commission safe services.

Mid Staffs Alberti

- Population planning/capacity, see above

- Auditing mortalities

Mortalities have been reviewed in Obstetrics for many years, with National Confidential Enquiries going back to 1952, only 3 years after the inception of the NHS. Our hospital mortalities are published in the annual clinical report and stillbirths form part of our Annual Quality Accounts.

- Maintain equipment replacement programme

At BWH we have an affective equipment replacement programme, however this may be placed under pressure with the changing economic climate predicted for the public sector.

- Staffing levels see above

Conclusion

The board need to consider the emerging themes and decide what changes if any need to be implemented to minimise any risks for BWNFT. In particular, current reporting and levels of assurance, clarity regarding the trust's strategic direction and corporate objectives and the method used to disseminate them

throughout the organisation. It will also be important to reflect on the recent staff survey results in the context of strong leadership and management turnover, as organisational culture and professional development opportunities were seen as key at Mid staffs.

There are clearly similar issues of partnership working with UHB, for BWNFT and governance of these arrangements needs to be robust.

Recommendations

The board needs to consider and discuss all of the above points and the recommendations in appendices 1 and 2. In addition we would strongly recommend that the previously suggested unannounced visits by board members to the clinical areas, is reconsidered. The infection control task force have found these invaluable not only to provide strong clinical leadership but also to see first hand the clinical environment. Those governors who have taken part have also found it very informative.

The letter from Dr Moyes 05/05/09 clearly states Monitor's expectations of Board actions and discussions. It is recommended that the board address these specifically as well as consider the other points raised by management board, and this paper. Dr Moyes recommendations are in Appendix 2

J Owen

Director of Nursing

P Thompson

Medical Director

15th May 2009

Appendix 1

Recommendations	Source	Relevance to BWNFT As a possible weakness
The trust, with relevant commissioners, needs to ensure that it actively monitors the demand and capacity for children's services, including information about those patients it has not been able to admit.	HCC/BCH	Yes particularly maternity
The trust needs to review its strategies and policies to improve its management of admissions and beds, and ensure that staff throughout the trust keep to these. It also needs to work with its consultants to ensure that patients needing urgent care are admitted in a timely manner.	HCC/BCH	Yes particularly maternity
The trust and commissioners of paediatric tertiary services must continue to work actively to manage the demand and provision of paediatric services at the trust.	HCC/BCH	Yes particularly maternity
The trust needs to review the way it organises capacity and prioritises cases within theatres, to ensure that patients requiring urgent and emergency surgery gain access to theatres in a timely manner. Interventional radiology is a form of radiology in which minimally invasive procedures are performed using 'image guidance'. Some of these procedures are carried out for purely diagnostic purposes; others as part of treatment.	HCC/BCH	No
The trust needs to urgently agree a clear plan to ensure that it has the capacity and systems in place to provide sufficient and timely access to elective and emergency/out-of-hours interventional radiology.	HCC/BCH	Yes
The trust must urgently ensure that it provides, for all renal transplants and neurosurgery, an appropriate and sustainable level of support within theatres at all times. This needs to be informed by discussions with the surgeons involved about the standards of support required from theatre staff.	HCC/BCH	Yes in pressure on theatres
There should be clarity between the trust, UHB and UHB consultants regarding what the	HCC/BCH	Yes particularly

UHB consultants will provide in terms of the specialist paediatric service, and what standard of support and equipment these consultants need in order to enable them to provide that service		maternity
The trust needs to review urgently the arrangements for Hospital at Night with senior clinical staff, to ensure that any outstanding concerns have been properly addressed. However, consultants from UHB, who worked at the trust only part of the time, told us that they did not often complete incident reporting forms, but preferred to raise any concerns either verbally or by email/letter to different people in the trust. We were told that this was due to a lack of an agreed procedure as to how and where UHB consultants should raise concerns regarding their work at the trust. Consultants at UHB working at the trust on honorary contracts are Healthcare Commission: Summary of the intervention at Birmingham Children's Hospital NHS Foundation Trust **22** contracted to follow the trust's local policies and procedures. This includes following procedures for governance and mechanisms for reporting of that trust.	HCC/BCH	Not hospital at night but otherwise relevant
The trust must agree, together with relevant consultants and its commissioners, a clear plan setting out actions being taken to ensure that craniofacial patients will be treated at the appropriate age and that any delays will be minimised.	HCC/BCH	No
The trust must develop better, formal communication with UHB consultants undertaking work at the trust, to ensure that any concerns are identified and addressed in a timely manner, and that the views of these consultants are formally incorporated into the trust's arrangements for governance.	HCC/BCH	Yes
Job plans that take account of the time spent by UHB consultants at the trust need to be developed by UHB. The trust needs to clarify and agree with UHB the level of input it requires from UHB staff, including time to enable more involvement of consultants in the clinical governance and management structures at the trust. Once the job plans are developed, the trust should be involved in the appraisals and professional development of these consultants	HCC/BCH	Yes
The trust and UHB, with the support of the commissioners, must agree on and implement a model of care delivering high-quality paediatric services, in line with the	HCC/BCH	No

requirements of Monitor, the independent regulator of foundation trusts. Monitor must ensure that both trusts play their part in implementing this new model of care		
Action by the board The trust's board must ensure that there is a systematic means of monitoring rates of mortality and other outcomes for patients. This information should inform the board's discussions about the quality of services at the trust, and also inform action taken to improve outcomes for patients. More generally, the trust's board needs to reflect on its arrangements for overseeing the quality and safety of clinical care within the trust. In particular, how the trust: • Develops and promotes an open, learning culture. Recommendations • Collects and reports information accurately, both internally and externally, and in sufficient detail. • Identifies and mitigates risks to the safety of its patients. • Identifies correctly, and then reports, Investigates adequately and learns from serious incidents and unexpected deaths. • Learns from, and ensures that necessary improvements are made following incidents, near misses and complaints. • Engages clinicians and develops effective clinical audit. • Considers and acts on the views and experiences of patients who use the trust's services.	HCC/Mid Staffs	Yes
A&E department Recent improvements to the emergency department must be sustained and extended to ensure that the service is safe, that it meets the needs of patients, and that the department is adequately staffed and equipped at all times.	HCC/Mid Staffs	No
Staffing and capacity The trust must continue the work it has started to recruit additional nursing and medical staff, to ensure that care provided to patients throughout the trust, including at night and	HCC/Mid Staffs	Yes

at weekends, is safe and keeps to accepted standards. The trust needs to review the training and supervision of its nursing staff and junior doctors, to ensure that they are undertaking appropriate roles, are confident and clear about the expectations placed on them, and are receiving all necessary support. The trust must ensure adequate availability of theatre sessions to ensure that it is able to handle demand in an emergency without delay, and has an effective means of determining which cases requiring emergency surgery should receive priority. The trust must ensure that there is adequate access for clinical staff to advice and support from medical staff in the critical care (intensive care) service, and ensure this is independent of the availability of beds in the critical care unit.		
Standards of care The trust must ensure that its medical and nursing staff deliver basic aspects of care, such as reviewing patients on a regular basis, monitoring their condition, and identifying and managing any complications that may arise. The trust must ensure that there is timely review of patients by senior doctors. In the light of specific findings in this report, the trust needs to audit its arrangements for and, where appropriate, equipment used in relation to: medication (particularly on admission and for patients who are 'nil by mouth'); the resuscitation of patients; non invasive ventilation; cardiac monitoring; and anticoagulation.	HCC/Mid Staffs	Yes
National recommendations Analysis undertaken in this and other trusts* shows worrying variations across the NHS in the quality of coding of clinical outcomes, and variations in the extent to which statistical information is used to monitor the quality	HCC/Mid Staffs	Yes

of local services and inform decisions at a senior level within NHS trusts. This is of concern in a modern, information driven health service where the interpretation and use of data is a fundamental means of improving clinical care. We recommend formally that all NHS trust boards have access to comparative data on outcomes for patients, including mortality, that is accurate, complete and as up-to-date as possible. While recognising the challenges in ensuring that mortality rates are accurate and expressed in a way that does not cause unnecessary alarm among patients, or lead to unhelpfully risk-averse behaviour among clinicians, we believe that mortality rates can be published in a meaningful way to help patients to make informed choices about the quality of clinical care. Boards of NHS trusts need to be focused at all times on the safety and quality of the services provided to patients. This includes having information available to boards that properly captures the experience of patients, so that non-executives can scrutinise and challenge the care received by patients. The NHS and appropriate professional and educational bodies need to examine why the experience of patients on general wards in trusts that we have investigated continues to be of a poor standard, and take urgent action to improve the quality of nursing care in these areas. PCTs need to develop more effective mechanisms to learn about the quality of care, the actual experience of patients and the outcomes of care in services that they commission, and give more priority to this aspect of commissioning. The NHS needs to ensure effective handovers when reorganisations and mergers occur, so that information on services is transferred effectively to the new organisation.		
In the medium term the needs of the local population should be clearly enumerated by the PCT and the Acute Trust and these should be reflected in the 5-year strategy for the Foundation Trust. The focus should be on what can be done safely and well by the Trust and what should be left for other Trusts to do.	Mid Staffs Alberti	No
An Urgent and Emergency Care Board should be established forthwith to ensure appropriate care and services for all those with an urgent or emergency need. This	Mid Staffs Alberti	No

should be a joint enterprise involving the PCT, Mid Staffordshire Foundation Trust, ambulance trust, patients/public and other relevant partners.		
An emergency care directorate should be established in the Trust encompassing all acute specialties with responsibility for the rapid, effective delivery of care from the patient's admission throughout the whole of the patient's care pathway to discharge.	Mid Staffs Alberti	No
Regular, timely audits should be put in place for all patients who die in hospital	Mid Staffs Alberti	?Yes
Two additional emergency physicians (A&E consultants) should be appointed in the medium term.	Mid Staffs Alberti	No
Protocols for common conditions should be introduced in A&E.	Mid Staffs Alberti	No
The use and role of the Clinical Decision Unit should be reviewed in the near future.	Mid Staffs Alberti	No
Equipment deficiencies in the Emergency Admissions Unit and on the medical wards should be reviewed and appropriate purchases made.	Mid Staffs Alberti	No
The Trust should allow direct admission of suitable patients to the Emergency Admissions Unit, once patient flows have been improved.	Mid Staffs Alberti	No
A new model of care for medical patients who are admitted should be implemented which provides for much earlier consultant contact.	Mid Staffs Alberti	No
Lengths of stay on the Emergency Admissions Unit should be limited to 48 hours. The institution of a short-stay ward should be considered.	Mid Staffs Alberti	No
The Trust should not pursue the development of a hyper-acute stroke service	Mid Staffs Alberti	No
Care of the elderly services should be enhanced and a care of the elderly network established across primary, secondary and community care.	Mid Staffs Alberti	No
The future of acute "general" surgery at the Trust needs careful and urgent consideration.	Mid Staffs Alberti	No
There is currently a bare minimum of nursing staff on the main medical wards (wards 10, 11 and 12). This should be increased as soon as possible to 6 trained nurses per day-	Mid Staffs Alberti	Yes

time shift on ward 10 and 3 on wards 11 and 12 for the day time shifts.		
The complement of nurses in the Trust who provide care to patients in the emergency care pathway should be increased and the training of nurses and other ward workers enhanced.	Mid Staffs Alberti	Yes
Plans should be put in place forthwith to improve bed management with a bed management team and early review of ALL patients in the hospital on a daily (7 days) basis.	Mid Staffs Alberti	Yes
The intermediate care capacity in the community should be reviewed with the PCT and increased if necessary.	Mid Staffs Alberti	No
More use should be made of real-time patient questionnaires.	Mid Staffs Alberti	Yes
A member of the Board should be given responsibility as patients' champion and (s)he or another Board member should have the same role specifically for older people.	Mid Staffs Alberti	No
Patient/public representatives should be included on all Board committees and sub-committees	Mid Staffs Alberti	Yes
The PCT should build quality and outcome measures into their commissioning and performance management arrangements with the Trust.	Mid Staffs Alberti	No
Clinical governance arrangements should be enhanced with strong Board level support	Mid Staffs Alberti	No
The future of acute "general" surgery at the Trust needs careful and urgent consideration.	Mid Staffs Alberti	No

Appendix 2

Dr Moyes letter is quoted below with specific questions he poses highlighted in bold

There are a number of issues to emerge specific to foundation trusts that every Board and every Board of Governors ought to consider very carefully. I would highlight the following:-

1. It now seems clear that the Board of Directors at Mid Staffordshire agreed to reductions in expenditure which led to significant reductions particularly in nurse staffing levels, without a clear understanding of the likely operational impact on patients and without the monitoring and reporting mechanisms to enable the Board to understand this impact and to take early action to remedy unintended or unacceptable consequences. **Could this happen in your hospital**? Going forward, there can be no doubt that public expenditure will become very tight from 2011-12 and that expenditure on health cannot be exempt from that. **So, if in future you are implementing programmes of cost cutting, do you understand the operational consequences and do you have the means to monitor them and adjust your plans where appropriate?**

2. The Board did not appear to have sufficient information about complaints from patients and carers, or from staff. Nor did they appear to interrogate such information as they had to establish whether specific complaints or trends in complaints contained evidence that might point to serious failings in the quality of service to patients and therefore in the running of the hospital. **Does your Board get the detail of information it needs on complaints by patients, carers and staff? If not, why not and what are you doing about it? How do you handle this information and what lessons do you draw from it?**

3. **The Governors** of the hospital appear not to have called the Board to account, perhaps because they were not provided with the information they need to do so, and did not have a clear enough understanding of the very considerable powers in the hands of Governors. The draft guidance that Monitor has recently published for consultation[1] attempts to set out clearly what are the statutory responsibilities of the Governors and how they might be expected to discharge these. Have the Governors of your hospital considered this and discussed it? To discharge their responsibilities in the way our guidance suggests, Governors need the co-operation of the Board of Directors. This includes providing them with the information they need to make the judgements that they are entitled to make and providing them with advice and resources where this is appropriate. Has your Board of Directors and your Board of Governors considered this together and agreed on the support the Board will provide to the Governors to discharge their responsibilities? Are you making sure that this is happening in practice?

4. Clinicians in Mid Staffordshire Hospital do not appear to have spoken out sufficiently frequently and strongly and, if they did, they appear not to have been able to ensure that their voices were heard by the Board of Directors and the Board of Governors, despite there being staff representatives on the Board of Governors. This isn't simply about whether the Trust did or did not have a whistle-blowing policy. It's about **the culture of the organisation and whether It encouraged open and frank**

discussion of perceived failings and potential solutions at every level in the organisation; and it's about whether the Board of Governors recognise their crucial role in calling the hospital to account and the very powerful levers they have to remedy deficiencies through their ability to appoint and remove the Chair and Non-Executive members of the Board of Directors. In considering this aspect of the report by the Healthcare Commission and Professor Alberti and Dr Colin-Thome, I would strongly encourage you not just to focus on policies but to **find ways of establishing whether the culture of your organisation fosters the kind of open dialogue that is essential if deficiencies are to be identified and tackled effectively**. And I would encourage you as Chair of the Board of Governors to lead a debate on how the Governors can be an effective channel to ensure that the Board has a realistic picture of how the quality of its services are viewed by its patients, its staff and the general public it serves.

5. Dr Colin-Thome's report in particular deals with aspects of contract management by the Primary Care Trust and performance management by the Strategic Health Authority before Mid Staffordshire became a foundation trust. These are not matters for Monitor and therefore I do not wish to comment on them. But clearly going forward you should expect commissioners to want to take steps to satisfy themselves that the services they are commissioning from your hospital are satisfactory in all respects. Commissioners are entitled to do that and foundation trusts are under a legal duty to co-operate with other NHS bodies, which includes commissioners. So I would encourage you to have a **constructive dialogue with your commissioners about the information they need to obtain the assurance they need to discharge their responsibilities to the public they serve**.

ENCLOSURE

Agenda Item:

Month: May 2009

Birmingham Women's NHS
NHS Foundation Trust

Subject:	Dignity and Respect at Work Policy – Dealing with Harassment and Bullying in the Workplace
Report by:	Neil Savage, Director of Workforce and Organisational Development
Author:	Estelle Carmichael, Associate Director of Workforce

Context and background for report

The Trust must ensure that staff feel able to report incidents of bullying and harassment and therefore the policy has been reviewed in order to streamline the process.

The policy is a good practice requirement and evidence for this procedure and its implementation are required for Standards for Better Health and NHS Litigation Authority assessments.

Key issues for trust board consideration and decision:

The policy sets out the responsibilities of the organisation in ensuring that staff feel able to report incidences of harassment and/or bullying. The previous policy was due to be updated in 2007 and the lessons learned from historical investigations by staff and comments from the Trust Staff-side have been used to inform the development of the new policy.

The Dignity and Respect at Work Policy – Dealing with Harassment and Bullying in the Workplace has been streamlined to ensure a fair and consistent process and to provide clear and supportive reporting lines for staff.

This is now a 'standalone' procedure which can be used by any member of staff to report harassment and/or bullying by another member of staff.

The key changes in the new policy are:

- Further Development of the 'Contact Officer' role;
- Clear definitions of unacceptable behaviour; and
- Focus on resolving the issues at the information stage in the first instance;

The procedure has been discussed with the Trust's Joint Negotiating Committee and Management Board, for review and approval prior to being presented to the Board of Directors.

Recommendations:

The Board of Directors are asked to **ratify** the policy.

Birmingham Women's NHS
NHS Foundation Trust

Dignity and Respect at Work Policy

Dealing with Harassment and Bullying in the Workplace

DRAFT VERSION

IMPLEMENTATION DATE: June 2009

REVIEW DATE: May 2011

Type:	Policy	Version: Ref:	DRAFT	Directorate:	Human Resources

Aim:	To ensure that all staff are treated with dignity and respect, and where this is not the case that action is taken to change inappropriate behaviour.
Scope (who it applies to) :	Applies to all Staff and Staff-side representatives working for or with the Trust and its employees

CONTENT

References:	BWHCT Bullying and Harassment Policy Gloucester Dignity & Respect at Work Policy Single Equality Scheme	
Appendices:	Appendix 1 Appendix 2 Appendix 3 Appendix 4 Appendix 5 Appendix 6 Appendix 7	Dignity and Respect At Work Policy – Summary Document Harassment or Bullying: Employee Complaints Form Harassment or Bullying: Investigation Guidance Harassment or Bullying Report Outline Policy Communication/Training Plan Internal & External Sources Of Information/Advice Equality Impact Assessment
Ratified by: **Date:**	Board of Directors	
Final Approval by: **Date:**	Trust Board	
Approval Signatories	Chief Executive	Staff Side Chair
Implementation Date:	June 2009	

Review and consultation process (when review required & by whom):	March 2009 – Deputy Director of Workforce and OD April 2009 – Review and discussion with Staff side May 2009 – Review and approval of Management Board
Responsibility for Implementation:	Deputy Director of Workforce and OD

Revisions:		
Date:	**Author:**	**Description of Revision (Action by whom):**
March 2009	Estelle Carmichael	Review and Updated Policy
Equality Impact Assessment:	**No significant negative impact** Potential Adjustments are outlined within the procedure	
EIA Completed by:	Estelle Carmichael	

HISTORY

Review date:	May 2009	**Effective from:**	01 June 2009
Effective to:	31 May 2011		
Action Required by Trust/Dept			

Distribution methods:	Global email, Global U Drive

Dignity and Respect at Work Policy

1. INTRODUCTION

1.1 Birmingham Women's NHS Foundation Trust is firmly committed to ensuring that staff at all levels work in a supportive working environment, free from harassment and bullying. It is recognised that harassment can be a serious problem which, through the creation of a threatening or intimidating work environment, can interfere with job performance, reduce the quality of service provided, undermine job security and cause serious stress leading to health problems.

2. POLICY STATEMENT

2.1 The Trust is committed to ensuring that all staff are treated with dignity and respect, and where this is not the case that action is taken to change inappropriate behaviour, and to provide support to individuals experiencing harassment. To make sure this is the case the Trust will ensure that:

- All staff, service users, members of the public, and other individuals working alongside Trust staff, understand the standards of behaviour expected of them
- The Trust Board, managers, staff and trade unions have a clear understanding of their responsibilities for tackling harassment at work
- Individuals experiencing harassment are encouraged to raise concerns or complaints, and that procedures are in place to ensure they are resolved to the satisfaction of the individuals concerned
- Staff have confidence in the ability of the Trust and its managers to prevent harassment, and that when it occurs incidents are dealt with fairly and without delay.

3. SUPPORTING LEGISLATION

3.1 There is a plethora of statutory requirements that the Trust must recognise and respond to in addressing bullying and harassment. This includes, but is not limited to the following:

- Sex Discrimination Act 1975 (updated 1986)
- Race Relations Act 1976
- The Race Relations (Amendment) Act 2000
- Race Relations Act 1976 (Amendment) Regulations 2003
- Disability Discrimination Act 1995
- Employment Equality (Sexual Orientation) Regulations 2003
- Employment Equality (Religion and Belief) Regulations 2003
- Human Rights Act 2000
- Rehabilitation of Offenders Act 1974
- Protection from Harassment Act 1997
- Health and Safety Act 1974

4. REFERENCES

4.1 This policy complements the following Trust documents, which should be read in conjunction with this policy:

- Single Equality Scheme
- Disciplinary Policy
- Grievance Procedure
- Raising Concerns at Work Procedure
- Violence and Aggression Policy

5. SCOPE

5.1 This policy applies to all employees employed within the Trust, individuals registered with the Bank, locums, individuals on honorary contracts, work experience and Hospital Volunteers. Each employee carries personal responsibility for their own behaviour in relation to this policy.

5.2 The Trust recognises that bullying and harassment has a wider application than the employees of the Trust. Service users, members of the public, voluntary organisations, public sector organisations, employees from other employing organisations, individuals on work experience placements, contractors and suppliers are expected to conform to the standards set by the Trust. The Trust will require organisations with which it has service contracts to have operational policies in place that do not conflict with the principles or procedures in this document. Where these standards are not met appropriate action will be taken by the Trust after the proper investigations have taken place.

5.3 Managers are expected to take action as appropriate to incorporate the principles of this policy into working and contractual arrangements.

6. RESPONSIBILITIES

6.1 RESPONSIBILITY OF THE TRUST BOARD

As an employer the Trust will:

- Treat all complaints of harassment and bullying seriously and sympathetically
- Deal with all complaints of harassment confidentially, protecting the harassed person and all other staff involved where possible.
- Wherever possible encourage an informal or mediated resolution of difficulties without starting formal procedures
- Offer support and advice to staff that are being harassed or bullied at work, or indirectly affected by the impact of such behaviour on other colleagues
- Offer training to staff that have been found to be responsible for harassment or bullying
- Monitor confidentially all reported incidents of harassment and bullying at work. This will include number of cases; type of cases; duration of cases; decisions made and follow up mechanisms used. We will report on unexplained increases in harassment or bullying as appropriate.

6.2 Managers

All managers have a responsibility for leading and setting standards of behaviour which are appropriate for a healthy working environment and consistent with the Trust's policies and procedures. Managers have specific obligations to ensure that:

- Staff are aware of this policy and reflect it in their behaviour.
- They take action if they witness inappropriate incidents or behaviours whether or not a complaint has been made.
- They operate the procedure for dealing with complaints swiftly, fairly and confidentially.
- Their own managerial style does not stray into bullying behaviour.

Managers must also:

- Ensure Human Resources are informed of all incidents, whether formal or informal, for monitoring purposes.
- Seek advice from Human Resources after receiving a formal complaint.
- Consider an employee's complaint in a fair and reasonable way.
- Ensure documents are provided in a timely way.
- Ensure notes are taken of any meeting relating to an incident.

6.3 Staff

Employees are expected to foster a working environment in which every employee, patient, and member of the public is treated with equal respect and dignity.

All employees are expected to contribute to dealing with and preventing harassment and bullying through their own self awareness, and through supporting colleagues who suffer harassment.

6.4 Human Resources

The Director of Workforce and Organisational Development will have the responsibility for the implementation of this policy.

The Human Resources Team will be responsible for ensuring that procedures are managed fairly and consistently across the Trust.

- The Human Resources team will provide training, guidance and support to line managers on all aspects of the operation of this policy.
- A Human Resources representative will be likely to attend all formal meetings (given due consideration to circumstances).
- An appropriate level of professional Human Resources advice given the circumstances of each case. This may be HR Adviser, HR Manager, Associate Director or Director.

6.5 Contact Officers

6.5.1 The Contact Officers provide an informal, confidential and independent resource to staff employed by Birmingham Women's NHS Foundation Trust.

6.5.2 The service is intended to offer support and informed advice to members of staff who are experiencing or think they are experiencing harassment or bullying. The service is also available for the alleged perpetrators of harassment and bullying.

6.5.3 Posters are displayed around the hospital with details of the Contact Officers names and how to reach them. You can also telephone Staff Support on 4788 for a list of Contact Officers.

7. DEFINITION OF BULLYING AND HARASSMENT

7.1 What is Bullying?

7.1.1 Bullying is defined as 'offensive, intimidating, malicious, insulting or humiliating behaviour, an abuse or misuse of power or authority which attempts to undermine an individual or group of employees and which may cause them to suffer distress.'

7.1.2 Bullying is a form of harassment and as such is prohibited under this policy.

7.1.3 Whilst it is not possible to list all forms of bullying, it is intended that the following examples should enable both employees and managers to identify incidents of bullying behaviour:

- Derogatory remarks
- Insulting or aggressive behaviour
- Insensitive jokes or pranks
- Ignoring or excluding an individual
- Persistently setting unrealistic work deadlines, in relation to other employees within the department
- Constant and persistent public and private criticism
- Substituting responsible tasks with menial or trivial ones
- Constantly undervaluing effort
- Withholding necessary information
- Shouting at employees to get things done
- Repeated shouting or swearing
- Spreading malicious rumours
- Refusing to delegate
- Knowingly destroying a relationship between other people
- Deliberately impeding work performance
- Overtly praising people causing other individuals or groups to feel belittled
- Physical attacks

7.1.4 Employees who are bullied often feel vulnerable and isolated and may suffer a loss of self-esteem and confidence, which makes it difficult for them to complain. Increases in anxiety, low mood and sleeplessness can be other symptoms of bullying. Inevitably, this will create an intimidating working environment and will interfere with job performance.

7.1.5 Bullying may also be unlawful in relation to the Protection from Harassment Act 1997. In line with this legislation, individuals who persistently bully colleagues can face fines, restraining orders or imprisonment. Failure to control bullying at work can also lead to claims of unfair or constructive dismissal.

7.1.6 It is recognised that an integral part of a line manager's responsibilities is the need to make their employees aware of instances where their job performance is below the required level. This is not to be confused with bullying.

7.2 What is Harassment?

7.2.1 The legal definition of harassment is:

> *"Where, on prohibited grounds, A engages in unwanted conduct which has the purpose or effect of violating B's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for B. Conduct will be regarded as having these effects if, having regard to all the circumstances, including particularly the perception of B, it should reasonably be considered as having such effect."*

7.2.2 As such, harassment is unwanted conduct, which affects the dignity of men and women at work. This may be based on age, sex, race, religion or belief, mental or physical disability, nationality, sexual orientation, gender reassignment or some other characteristic.

7.2.3 Harassment can be persistent or be an isolated incident, and can occur at an individual or organisational level. At an individual level, individuals or groups may be harassed by a colleague(s), managers, service users, and harassment can occur between people of the same sex or the opposite sex. At an organisational level harassment can occur when the policies, procedures and criteria for decision-making have the effect of discriminating against people.

7.2.4 When assessing whether harassment has taken place, the main question to consider is whether the individual has been treated in a detrimental way on improper grounds. It can result in the recipient feeling threatened, humiliated or patronised; it can create an intimidating working environment, interfere with job performance, undermine job security, and cause avoidable demoralisation and absence.

7.2.5 Harassment at work may in certain circumstances be unlawful, in relation to the terms of the Sex Discrimination, Race Relations, Sexual Orientation, Religion or Belief and Disability Discrimination Acts. It may lead to direct or indirect discrimination in recruitment and selection, training and promotion procedures, and failure to control harassment may also lead to claims of unfair and constructive dismissal.

7.2.6 The current definition of harassment as applied to sexual orientation, religion or belief and race and ethnic or national origin is "unwanted conduct that violates people's dignity or creates an intimidating, hostile, degrading, humiliating or offensive environment".

7.2.7 The following are some examples of behaviour/activities that might constitute harassment:

- Unwanted and/or deliberate physical conduct/contact, or gestures which are of a sexual nature (i.e. touching, standing too close, leering, coercing sexual intercourse, abuse or assault).
- Display, distribution or transmission of written materials or images of a Sexually or racially offensive nature and cause offence (i.e. Sexually Suggestive or pornographic pictures, writing, suggestive or offensive pictures, images, insignia, objects, videos, books, e-mails, internet pages).
- The use of demeaning or degrading language (i.e. Embarrassing remarks, innuendoes, lewd comments, sexual, racial or cultural jokes, derogatory name-calling, jibes or abusive, threatening or insulting words).
- Speculation about a person's private life and sexual activities.
- Requests for sexual favours, including threat of dismissal, loss of
- Promotion if requests are not met.
- Intimidation of an individual (i.e. Exclusion from conversations, isolation, unjustified supervision).
- Frequently asking for comments on racial, religious or disability issues from an individual who is a member of a religious or racial group or has a disability.

8. DEFINITION OF DISCRIMINATION

8.1 It is unlawful to discriminate on the grounds of sex, race, disability, religion or belief and sexual orientation. Acts of discrimination can occur in three main ways:

8.1.1 Direct Discrimination

This takes place when one (or more) person(s) is treated less favourably than others in the same circumstances

8.1.2 Indirect Discrimination

This form of discrimination takes place when a requirement or condition of employment, promotion or aspects of service delivery is applied equally and appears to be fair, but can be shown to have an adverse impact on an individual or group by placing them at a disadvantage, and the reasons for this cannot be justified.

8.1.3 Victimisation

This form of discrimination takes place when a person receives less favourable treatment because they have made a complaint, or it is suspected that they have made a complaint, or if they have or are going to provide evidence about an act of discrimination.

9. HANDLING COMPLAINTS OF BULLYING OR HARASSMENT

9.1 The Trust will not tolerate any form of bullying and harassment and will investigate all complaints, whether the harasser is an employee, service user, relative, or contractor. The Trust will ensure that all complaints will be treated sensitively, confidentially, thoroughly and in a timely manner. All employees who have been bullied or harassed can expect action to be taken on their behalf and support from the Trust.

9.2 Any person employed by the Trust who considers that they have been subject to bullying or harassment from an employee of the Trust may pursue the matter through the Trust's Incident Reporting Procedure, Grievance Procedure or this Policy. Where an employee considers they have been bullied or harassed by a patient or visitor, they may pursue the matter through the Trust's Tackling Racial Harassment by Service Users or through the Trust's Incident Reporting Scheme. The Trust has a 'Zero Tolerance' approach to patients or visitors who are violent or abusive in any way to our employees, and has the right to refuse treatment, remove them from the premises, and report them to the police.

9.3 Where a complaint of bullying or harassment is received from a member of another employing organisation naming an employee from the Trust, the Trust will co-operate with the investigation that may be conducted by that organisation and will also conduct its own investigation into the matter.

9.4 Informal Procedure

9.4.1 In some instances, it may be enough for the employee who has been subject to harassment or bullying to raise their concerns directly with the person concerned. Individuals may be unaware that their behaviour or actions are unacceptable or intimidating and bringing these issues to their attention may be sufficient to stop inappropriate behaviour. Employees who feel able to approach the person concerned directly, may wish a colleague or trade union representative to accompany them at the meeting. Where appropriate, training or support will be provided to enable individual members of employees to revise their behaviour and/or actions.

9.4.2 It should be recognised that not all employees will feel comfortable to raise their concerns directly with the person concerned. In such circumstances staff should be encouraged to approach their line manager who will be able to speak to the person concerned on their behalf.

9.4.3 Managers should agree with the employee raising the complaint a timescale by which their concerns will be raised with the individual concerned. This should be no longer than four weeks from the date the original complaint was raised.

9.4.4 Managers who are advised of complaints of bullying or harassment should make a diary note and write to the employee who experienced the harassment or bullying to confirm the outcome of their actions.

9.5 Formal Complaints Procedure

9.5.1 Employees should follow the formal complaints procedure outlined below when the informal complaints procedure has failed to rectify the problem, or where the problem is sufficiently serious. Employees may also opt to use the formal complaints procedure rather than the informal procedure if they choose.

9.5.2 All formal complaints must be reported using the Dignity at Work – Monitoring Form (Appendix 2).

9.5.3 Employees who wish to make formal complaints regarding bullying or harassment should raise these with their line manager, in relation to complaints regarding their colleagues, or their line manager's manager in respect of complaints relating to their line manager.

9.5.4 It is recognised that employees may find it difficult to raise concerns through the line management structure and they may, therefore, choose to raise their concerns with the appropriate Directorate General Manager or Head of Profession. Employees within the Human Resources Department who wish to make a complaint outside the line management structure should contact a Directorate General Manager.

9.5.5 A manager who has received a formal complaint should agree with the employee concerned a date by which investigations into their complaint will be completed. The employee should be kept informed on a regular basis of the progress of the investigations.

9.5.6 Where the complaint is complex and involves a number of people, a manager who has received equal opportunities training will be appointed to investigate the complaint. This can also be a Human Resources Manager. This may involve interviewing the person against whom allegations have been made, the employee making the complaint and any relevant witnesses. The Investigating Officer will report to the appropriate responsible manager, who will decide whether disciplinary action will be taken against the alleged harasser. A disciplinary hearing will be arranged where appropriate within 21 working days, in accordance with the Trust's Disciplinary Procedure.

9.5.7 The Chair of the disciplinary panel set up to consider allegations of bullying or harassment must have received equal opportunities training. In cases of sexual harassment, the disciplinary panel should comprise both men and women. In cases of racial harassment, at least one member of the disciplinary panel should be a member of an ethnic minority group, if at all possible.

9.5.8 In circumstances where there is clear evidence of a consistent or sustained pattern of bullying and harassment will, given due regard to the circumstances, constitute gross misconduct, and will be dealt with in accordance with the Trust's Disciplinary Procedure.

9.5.9 The employee making the complaint and the person against whom allegations have been made will be advised of the outcome of the investigation. Where cases progress down a disciplinary route the employee making the complaint will be advised that a disciplinary hearing is being held, but will not be advised of the specific outcome, i.e. the disciplinary sanction, due to the right of the alleged harasser to confidentiality.

9.5.10 Managers who are advised of complaints of bullying or harassment in accordance with the formal procedure, should complete and return a monitoring form to the Human Resources Department (see Appendix 1)

9.5.11 Further advice and guidance may also be sought from the Human resources Department, Occupational Health Department or Union Representatives.

9.6 Appeals

9.6.1 Either party will have the right to appeal and appeals will be dealt with under the Trust's Grievance appeals procedure. The complainant may appeal if they consider that the process of investigation and subsequent application, or not, of the disciplinary procedure has been unfairly or poorly carried out or agreed. No appeal is allowed to the complainant against the perceived severity or leniency of any disciplinary action taken. The alleged harasser may appeal if they consider that the process of investigation or subsequent application of the disciplinary procedure has been unfairly or poorly carried out or agreed. (The alleged harasser will of course have the right to appeal against any formal disciplinary action taken in accordance with the Trust's Disciplinary Procedure.)

9.7 Vexatious or Frivolous Complaints

9.7.1 A vexatious complaint is one which is raised maliciously in bad faith, whether or not this is in the context of another procedure, such as the disciplinary procedure. For example, a complaint may be considered vexatious where it is based on deliberate misrepresentations or untruths, with the malicious intent of causing harm to the person against whom the complaint is made.

9.7.2 Similarly, the raising of a series of unjustified or frivolous complaints, or a number of complaints simultaneously against many different people, may be considered vexatious.

9.7.3 The Trust takes all complaints seriously, but will not tolerate the behaviour of anyone who maliciously raises a complaint they know to be false. Vexatious complaints may result in the implementation of the Disciplinary Procedure. The advice of the HR Team should always be sought.

9.7.4 However, employees should not be deterred from raising a genuine complaint in good faith, and all complaint will be investigated fully.

10. REVIEW

10.1 The policy will be reviewed on any changes to legislation which affect this policy. The Employment Policy Review Group will review the policy to ensure that it is achieving its aim, that it is up to date, complies with legislation and that the benefits to the Trust and its employees are being realised.

11. RECORDS AND MONITORING

11.1 To ensure that the implementation of this Policy does not have an adverse impact and in response to the requirements of the Race Relations (Amendment) Act, the Disability Discrimination Act 2005, Employment Equality (Religion or Belief) Regulations 2003 and Employment Equality (Sexual Orientation) Regulations 2003, and the Employment Equality (Age)

Regulations 2006, the Trust will monitor the impact of this policy and take remedial action when necessary to address any unexpected or unwarranted disparities; and monitor the workforce and employment practices to ensure that the policy is fairly implemented.

11.2 The success of this policy, and the actions taken to tackle harassment at work, will be closely monitored by:

- Recording all reported incidents of harassment, whether or not they result in formal complaints
- The Trust Board receiving a report every 12 months describing the level and nature of harassment at work, the likely impact, and recommendations for further action
- Measuring the degree of confidence that staff have in the ability of the Trust to effectively tackle harassment at work through the annual staff attitude survey

12. FURTHER GUIDANCE

12.1 To ensure that staff and managers understand their responsibilities, and that the Trust provides a working environment free from harassment, a summary guide is provided in a separate document (Appendix 2). Copies of this guide are available from the Human Resources Department and the Trust U: / drive.

APPENDICES

Appendix 1	Dignity and Respect at Work Policy – Summary Document
Appendix 2	Harassment or Bullying: Employee Complaints Form
Appendix 3	Harassment or Bullying: Investigation Guidance
Appendix 4	Harassment or Bullying Report Outline
Appendix 5	Policy Communication/Training Plan
Appendix 6	Internal & External Sources of Information/Advice

Appendix 1

DIGNITY AND RESPECT AT WORK POLICY
SUMMARY DOCUMENT

POLICY STATEMENT
Birmingham Women's NHS Foundation Trust is committed to ensuring that all employees are able to seek, obtain and hold employment without bullying or harassment.

The Trust is committed to ensuring that all employees are treated with consideration, dignity and respect irrespective of their gender, race, age, disability, sexual orientation, colour, marital status, religion or belief, ethnic or national origin, HIV status, political affiliation, trade union membership and gender reassignment.

The Trust wishes to promote a culture where employees have a happy and fulfilling environment in which to work. The Trust will not tolerate any form of harassment or bullying behaviour, which threatens groups or individuals, for whatever reason or motive.

What is Harassment?
Harassment is defined as 'where, on prohibited grounds, A engages in unwanted conduct which has the purpose or effect of violating B's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

Conduct will be regarded as having these effects if, having regard to all the circumstances, including particularly the perception of B, it should reasonably be considered as having such effect'.

What is Bullying?
Bullying is defined as 'offensive, intimidating, malicious, insulting or humiliating behaviour, an abuse or misuse of power or authority which attempts to undermine an individual or group of employees and which may cause them to suffer distress'.

Your Responsibilities
All employees have a personal responsibility to carry out their duties and behave at all times in accordance with the principles of this policy. Employees must not harass/bully, coerce others to harass/bully, nor victimise individuals who make complaints of harassment/bullying or provide information for investigation.

Employees have a duty to report any instances of harassment/bullying, actual or suspected, occurring within the Trust whether by colleagues, service users, visitors or contractors.

Advice and Contact Points
If you have any worries about how you are being treated at work, independent confidential advice can be sought from any of the following:
Human Resources Department
Trade Union Representatives
Staff Counselling Service
Contact Officers
Other Agencies (please see appendix 6 of the Dignity at Work Policy)

This is a summary from the Dignity at Work Policy. Copies of the full Policy and Guidelines can be obtained from U: // drive, the HR Department, or your Union Representative.

Appendix 2

DIGNITY AT WORK - MONITORING FORM

This form must be completed when a complaint of discrimination, harassment or bullying reaches the stage when a formal procedure is initiated.

The form must be submitted to Human Resources

Name of complainant: _____

Workplace: _____

Telephone No: _____

Email Address:_____

Details of Complaint:
Describe briefly your complaint of harassment or bullying

How have you fulfilled the informal procedure? (see Dignity at Work Policy).
Please give details.

Are there any other details you wish to be considered at this stage?

Signature of Complainant: …….

Date: ……..

Appendix 3

DIGNITY AT WORK: INVESTIGATION GUIDANCE

The following notes are intended as an aide memoire for investigating manager's

DETAILS OF INCIDENT(S)
Use the questions below to ask the complainant, and to detail the complaint.
Please describe in your own words what your complaint is

- Describe what has happened, when it happened, where it happened, and who has been involved.
- Did anyone witness what happened?
- If another employee witnessed the complaint, are you willing, if necessary, for them to be a witness?
- Has this kind of incident (or another kind you think may be related to it) happened to you before, in your work with the Trust? If so, describe what, when and where.
- Have you taken any informal action as part of the process e.g. talked to colleagues, talked to the person harassing you, taken advice? Give details.
- Explain to the complainant that it will be necessary to talk to other members of staff and to summarise in writing to the person they are complaining about the detail of their complaint.
- Detail any support offered
- Detail any support arrangements
- Detail any problems
- Details if all other informal discussion before the formal interview should be noted in the formal assessment report.

INTERVIEWS WITH OTHER WITNESS(ES)

- Give names and details of arrangements for interview
- Describe what has happened, when it happened, where it happened, and who has been involved.
- Has this kind of incident (or another kind you think may be related to it) happened to you before, in your work with the Trust? If so, describe what, when and where.
- For all parties – detail any support offered/detail any support arranged/detail
- Any problems.

ACTION CHECKLIST

1. Complainant's interview completed
2. Summarise complaint in writing and inform all parties directly concerned
3. Interview main parties involved
4. Offer and arrange support for all parties
5. Interview additional parties involved (these people do not need full summary of complaint)
6. Complete investigation report
7. Follow up to main parties detailing outcome

Appendix 4

EXAMPLE INVESTIGATION REPORT

Title Page including
Investigating Officer and Job title
Human Resources Representative and Job title

BACKGROUND
(a) Give brief details of when the complaint was received and when the meeting was convened.
(b) List and attach as appendices any background documents, signed statements etc

NATURE OF COMPLAINT
Briefly outline the issues that the complainant is concerned about and what forms the body of the complaint

INVESTIGATION
Here detail the action you have taken in conducting this investigation:
Interviews that have taken place with the people involved i.e. interviews that have taken place with staff to verify elements of the complaint.
Anyone you were unable to contact.
Any paperwork you have examined, for example timesheets, minutes of meetings etc.

CHRONOLOGICAL BACKGROUND
Here give full details of when and what happened, who was involved, any action that was taken, what the outcome was, how the people involved felt and perceived the situation, etc.

Begin with the date and a brief sentence summary of what happened before, explaining the situation more fully (if necessary)

EXAMINATION OF THE COMPLAINT
Here use the information given in Section 2 (Nature of the Complaint) and examine each point separately.

Describe the 'Evidence Presented by (name of complainant)

Then give your 'comment' on this using any appropriate information from your investigation.

CONCLUSION
Having conducted a full and independent assessment/investigation of the complaint I have concluded that:
Detail your conclusions from the results of your assessment/investigation.

RECOMMENDATIONS
Detail your recommendations for future action

SIGNATURES
Signature of Investigating Officer
Signature of Human Resources Representative
Date

Appendix 5

Dignity at Work Policy and Procedure
Communication/Training Plan

Purpose of the Communication and Training Plan	**To ensure that managers, staff and trade union representatives are aware of the Dignity at Work Policy and Procedure**
Target group(s) for Communication or Training	▪ All Trust employees
Target numbers	▪ All Trust employees.
How will the communication or training be carried out?	▪ Intranet ▪ Awareness raising sessions ▪ Trust News ▪ Team Briefing
Communication/ training delivery	▪ Internal expert team
Funding	▪ Existing resources
Measurement of success Learning outcomes and/ or objectives	▪ Compliance with document ▪ Improved management of allegations
Review effectiveness – Learning Outputs	▪ Evaluation ▪ Review of further communication or training needs
Start & completion date of communication/training plan	▪ To be confirmed
Support from Directorates	▪ Planning the communication/ training ▪ Advertising and collecting nominations ▪ Training and review

Appendix 6

INTERNAL & EXTERNAL SOURCES OF INFORMATION/ADVICE

Internal Sources include:
Staff Counselling Service, Contact Officer and Occupational Health
Please contact the staff counselling service (extn.: 4788) for details of these support services.

The following organisations/websites provide useful information and advice.
The Trust does not take responsibility for the availability, or content, of the advice or information offered.

Equality and Human Rights Commission
Head Office Tel: 020 3117 0235
Helpline: 0845 604 6610
Website: www.equalityhumanrights.com

Lesbian and Gay Switch-Board
Tel: 020 73695767

Stonewall
(Campaigning organisation for lesbian, gay, bisexual and transgender issues)

Tel: 020 7881 9440
Website: www.stonewall.org.uk

The Andrea Adams Trust
(A national charity committed to raising awareness of bullying. Also provides support for people being bullied and directs them to sources of help and remedy)
Tel/Fax: 01273 704900
Website: www.andreaadamstrust.org

The UK National Workplace Bullying Advice Line
Tel: 01235 212 286
Website: www.successunlimited.co.uk

Health and Safety Executive
Website: www.hse.gov.uk
Info Line: 08701 545 500

Appendix 7

Birmingham Women's NHS
NHS Foundation Trust

Equality Impact Assessment

Assessment Details

Directorate:	Workforce and OD
Department / Team:	Human Resources
Assessor Name and Job Title:	Estelle Carmichael, Deputy Director of Workforce and OD
Name of Policy/Function[1], Service, Plan, SLA, Function, Contract or Framework:	Dignity at Work Policy (Dealing with Harassment and Bullying in the Workplace)
Is this a new policy or function?	New ☐ Existing ☒ UPDATED
Date Started: 01/Feb/2009	**Date Completed:** 07/May/2009
Associated Policies/Functions?	The Dignity at Work Policy compliments the following Trust documents, which should be read in conjunction with this policy: ▪ Single Equality Scheme ▪ Disciplinary Policy ▪ Grievance Procedure ▪ Raising Concerns at Work Procedure ▪ Violence and Aggression Policy
Summary of Impact Assessment Outcome	**Adverse Affects: Found** ☐ **Not Found** ☐
Who is responsible for implementing actions?	
Review Date:	07 May 2009
Signed: *Estelle Carmichael*	**Date:** 07/05/09

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

Impact Assessment Summary

Policy/Function:	
Positive Impacts *(Note the groups affected)* The policy contains guidelines for managers to follow to ensure appropriate support is provided to staff who report bullying or harassment in the Trust. The procedure has been developed to ensure that staff are able to reasonably report incidences of harassment and/or bullying.	**Negative Impacts** *(Note the groups affected)* It is important to note that failure to follow the procedural guidelines may highlight bias or discrimination in the application of the procedure.

Additional Information and Evidence:

- Staff, whose first language is not English, will have access to interpreters, should they require the service, when reporting harassment or bullying within the Trust.
- Staff with visual impairments, may request that written responses are recorded on to audio tape or CD.
- Staff with hearing impairments, may request the attendance of a sign language interpreter and/or a loop system. Alternatively, they may submit their concern in writing.
- Staff with mobility impairments will be able to request to meet in a ground floor, or other mutually agreed accessible room.
- Staff who require any adjustments not indicated in the above list should ensure that the person they are reporting the harassment or bullying incident(s) to is aware of the adjustments that they require.
- Requesting an adjustment within the guidelines of the Equal Opportunity legislation and/or good practice, should not preclude an individual from reporting harassment or bullying within the Trust.

Recommendations:
Line Managers/Investigating Managers and Staff-side Officers should, as a matter of course, ask staff if they require any adjustments to be made to support them in both the informal and formal stages of the process.

Assessor Name:	Estelle Carmichael
Assessor Job Title:	Deputy Director of Workforce and OD
Date Completed:	07/05/09

Policy/Function Description

What is the aim of purpose of the Policy/Function?	To ensure that all staff are treated with dignity and respect, and where this is not the case that action is taken to change inappropriate behaviour.
Who is intended to benefit from this policy/function? And in what way? *(incl. Staff/Patients/services users/ Visitors etc)*	This policy applies to all employees employed within the Trust, individuals registered with the Bank, locums, individuals on honorary contracts, work experience and Hospital Volunteers.
How have the groups above been involved in the development of this policy/function?	The Procedure will be circulated to the Management Board and Joint Negotiating Committee prior to the final ratification process by the Board of Directors.
How does the policy/function fit with the Trust's Corporate aims?	The procedure is intended to support the Trust's Corporate aims and specifically in relation to being an Employer of Choice.
What are the intended outcomes of the policy/function?	The procedure is designed to encourage staff to report and resolve incidents of workplace harassment and bullying.
What are the resources linked to the policy/function?	There are no specific resources linked to the procedure.

Assessing the Impacts

What is the likely impact (whether intended or unintended/ positive or negative) of the policy/function on the public at large?

The over-riding purpose of the Dignity at Work Policy – Dealing with Harassment and Bullying in the Workplace, is to protect our staff from bullying, harassment, aggression and discrimination. The policy is intended to enable effective action to be taken to tackle the harassment/bullying and to prevent further incidents in the workplace.

The Trust has in place a Violence and Aggression Policy that is intended to support staff in dealing with harassment/bullying from patients, service users and the public.

Is there likely to be a differential impact on any group? If yes, please state the impact (positive or negative) and provide additional details (i.e. affected groups, reasons for the differential impact).

a. Grounds of Race, Ethnicity, Colour, Nationally or National Origin (i.e. people of differing ethnic backgrounds including minority groups such as Romany Travellers, Refugees, Asylum Seekers)	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: The policy is intended to prevent harassment/bullying on the grounds of Race, Ethnicity, Colour, Nationally or National Origin

b. Grounds of Gender or Marital Status Women or Men	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: The policy is intended to prevent harassment/bullying on the grounds of gender or marital status (women and men).
c. Grounds of Gender or Marital Status Transgender or Transsexual people	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: The policy is intended to prevent harassment/bullying on the grounds of gender or marital status (Transgender and Transsexual people).
d. Grounds of Religion or Belief (Religious/Faith or other groups with a recognised belief system)	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: The policy is intended to prevent harassment/bullying on the grounds of Religion or Belief.
e. Grounds of Physical or Sensory Impairment or Mental Disability	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: The policy is intended to prevent harassment/bullying on the grounds of Physical/Sensory Impairment/Mental Disability.
f. Grounds of Age (Older People, Young People and Children)	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: The policy is intended to prevent harassment/bullying on the grounds of Age.
g. Grounds of Sexual Orientation (Lesbian, Gay, Bisexual)	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: The policy is intended to prevent harassment/bullying on the grounds of sexual orientation.
h. Grounds of Offending Past	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: The policy is intended to prevent

<table>
<tr><td></td><td></td><td colspan="2">harassment/bullying on the grounds of offending history.</td></tr>
<tr><td>i. Other Grounds (i.e. poverty, homelessness, immigration status, language, social origin)</td><td>Differential Impact?
Yes ☒
No ☐</td><td colspan="2">Positive Impact ☒
Negative Impact ☐
Please provide further details:
The policy is intended to prevent harassment/bullying of any type regardless of individual circumstances</td></tr>
<tr><td colspan="2">Is the Policy/Function directly discriminatory?
Yes ☐ No ☒
(under the Sex Discrimination Act, Race Relations Act, Disability Discrimination Act, Religion or Belief Regulations, Sexual Orientation Regulations, Age Discrimination Regulations or relevant policy)</td><td colspan="2">Is the Policy/Function indirectly discriminatory?
Yes ☐ No ☒</td><td rowspan="2">Is the Policy/Function intended to support equality of opportunity through positive action or action to remove any disadvantage?
Yes ☒ No ☐
Please provide details:
The policy is designed to reduce workplace harassment and bullying.</td></tr>
<tr><td colspan="3">If the Policy/Function is not directly or indirectly discriminatory, does it still have an adverse impact?
Yes ☐ No ☒ Please provide details:</td></tr>
</table>

Taking Action

What changes or practical measures would help reduce or overcome the adverse impact or potential for unlawful discrimination on particular equality groups?
Please consider measures such as changes in communication methods, language support, disability measures, changes in eligibility criteria, different methods of delivery, outreach, shared targets with other departments, etc.

- Staff, whose first language is not English, will have access to interpreters, should they require the service, when reporting harassment or bullying within the Trust.
- Staff with visual impairments, may request that written responses are recorded on to audio tape or CD.
- Staff with hearing impairments, may request the attendance of a sign language interpreter and/or a loop system. Alternatively, they may submit their concern in writing.
- Staff with mobility impairments will be able to request to meet in a ground floor, or other mutually agreed accessible room.
- Staff who require any adjustments not indicated in the above list should ensure that the person they are reporting the harassment or bullying incident(s) to is aware of the adjustments that they require.
- Requesting an adjustment within the guidelines of the Equal Opportunity legislation and/or good practice, should not preclude an individual from reporting harassment or bullying within the Trust.

What do you think are the main issues that could hinder the effective implementation of equality within your policy (service, plan or function)? *In your response please consider* ▪ *Whether the policy complements other key Trust policies including unwritten 'policies in action'* ▪ *Resources (staff competencies, knowledge, time), finances and whether service delivery models reflect differentiated needs*
There are no significant issues that would impair equality of opportunity in the use and operation of the policy.
What are your conclusions on the impact of the proposed policy/function on different equalities groups? *In your response please consider:* ▪ *How will the policy impact upon people?* ▪ *Available data and research to assess whether the proposed policy will or will not have a differential or adverse impact on different equalities groups* ▪ *If there is an adverse or potential adverse impact, what are the reasons?* ▪ *Are there any issues relating to unlawful direct or indirect discrimination?*
Managers and Staff who use the policy to manage reports of harassment and bullying in the workplace will be acting fairly for all equalities groups.

Challenge and Consultation

How have you consulted with stakeholders and equalities groups likely to be affected by the policy? *How you have consulted with key stakeholders groups in the process of developing the policy to obtain their views on how robust the policy is and how well it will meet the needs of all equalities groups. Please liaise with your departmental colleagues or with Research and Intelligence to see if there are opportunities for joint consultation about other Equality Impact Assessments being carried out.*
The Procedure will be circulated to the Management Board and Joint Negotiating Committee prior to the final ratification process by the Board of Directors.
What do stakeholders you have consulted with think about the policy that you have developed? *The views of key stakeholders about the policy and any proposed measures to reduce or overcome adverse impact on equalities groups or potential unlawful discrimination*
No comments related to the EIA received.

ENCLOSURE

Agenda Item :

Month : May 2009

Birmingham Women's NHS
NHS Foundation Trust

Subject:	Retirement Policy
Report by:	Neil Savage, Director of Workforce and Organisational Development
Author:	Steve Stanier, Senior Human Resources Manager

Context and background for report

The Trust Retirement Policy has been written in response to the Employment Equality (Age) Regulations 2006.

- The Policy sets out the Trust's approach to retirement
- Addresses the issue of those staff who wish to work beyond the age of 65

Key issues for trust board consideration and decision:

The Policy sets out the retirement process and gives some examples of the flexible retirement options that are available to staff through the NHS Pension Scheme.

The Policy makes clear the responsibilities of both staff and management and provides managers with a clear process and associated documentation.

The Policy has been discussed and approved by the Trust's Joint Negotiating Committee, the Trust Employment Policy Review Group and Management Board prior to presentation to the Board of Directors.

Recommendations:

The Board of Directors are asked to **ratify** the retirement policy for implementation from 1st June 2009.

Birmingham Women's NHS
NHS Foundation Trust

RETIREMENT POLICY

Draft

VERSION:	Version 3 - May 2009
IMPLEMENTATION DATE:	1st June 2009
REVIEW DATE:	May 2012

Type:	Retirement Policy	Version: Ref:	Version 3 May 2009	Directorate:	Workforce and OD

Aim:	This policy sets out the Trust's approach to retirement and details a number of flexible approaches to retirement that may be of interest to staff
Scope (who it applies to) :	Applies to all Staff working for the Trust.

CONTENT

References:	Terms and Conditions of Service Employment Equality (Age) Regulations 2006 NHS Employers
Appendices:	A. Flowchart B. Retirement letter C. Retirement letter (individual working beyond retirement age) D. Guidance for managers E. Letter inviting individual to discuss their application F. Letter detailing the outcome of meeting G. Appeal procedure H. Letter detailing outcome of the appeal
Ratified by: **Date:**	JNC, Management Board
Final Approval by: **Date:**	Board of Directors
Approval Signatories	Chief Executive Staff Side Chair
Implementation Date:	1st June 2009

Review and consultation process (when review required & by whom):	JNC Management Board Board of Directors
Responsibility for Implementation:	Human Resources Team Directorate and Department Managers

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

HISTORY

Review date:	May 2012	**Effective from:**	June 2009
Effective to:	31 May 2012		
Action Required by Trust/Dept	Regular review to ensure the policy continues to provide for the needs of the Trust and the workforce.		

Distribution methods:	Global email and Global U Drive

Birmingham Women's NHS
NHS Foundation Trust

RETIREMENT POLICY

1. INTRODUCTION

This policy sets out the procedures to be followed when staff are approaching retirement age and in circumstances where staff make the decision to retire. It also defines the process and criteria that will be applied if a member of staff wishes to make a request to work beyond their normal retirement date.

2. BACKGROUND

2.1 Further to the Employment Equality (Age) Regulations 2006 the Trust acknowledges that employees will have the right to request to work beyond 65 or any other retirement age set by the Trust. For the Trust and the NHS this is 65. The Trust recognises that it makes good business sense to provide employment opportunites for its staff beyond retirement age as it enables the Trust to retain skilled staff and reduce recruitment costs.

3. AIMS

3.1 The Retirement Policy sets out the Trust's approach to retirement.

3.2 The Trust will positively consider requests from staff to work beyond 65. However, the final decision will be based on service delivery requirements.

3.4 There are a number of options available within the NHS Pension Scheme for flexible retirement and staff wishing to discuss this should contact the Pensions Administrator in the Payroll Department.

4. SCOPE

4.1 The Retirement Policy applies to all staff working for the Trust.

4.2 Hospital Chaplains who, in line with the churches' regulations for retirement, will be allowed to continue working until the age of 70, on the basis that all Hospital Chaplains have to be licensed or given permission to perform duties by their respective churches.

5. RESPONSIBILITIES

5.1 Responsibilities of Employees

Employees have a responsibility to discuss their intentions about retirement with their line manager.

They also have a responsibility to contact the Pensions Department to discuss matters relating to their Pension.

5.2 Responsibilities of Line Managers

Line Managers have a responsibility to write to their employees at least 6 months before their 65th birthday to clarify further employees continued employment or retirement plans.

Line Managers are also responsible for ensuring that the appropriate paperwork and records are completed and maintained.

5.3 Responsibilities of Human Resources

The Human Resources Department will notify line managers of staff approaching 65 years of age.

The Human Resources Department will support the line manager in the correct process detailed in this policy.

The Human Resources Deparment will review the Policy as per legislative or NHS Pension changes.

6. POLICY IN PRACTICE

This Policy will be used to assist staff and managers in the correct administrative and procedural processes required for Retirement.

7. NHS PENSION BENEFITS

7.1 Separate NHS Pension Scheme provisions are provided for early retirement on the grounds of ill health (see Management of Sickness and Ill Health Policy).

Voluntary Early Retirement (VER) may also be available under the NHS Pension Scheme to members between 50 and 60. However, retirement benefits would be reduced to take account of early payment and anyone considering this option should contact the Pensions Administrator for an estimate.

7.2 Since the 6th March 1995 the NHS Pension Scheme only allows a return to work with the same employer after taking a pension at 60 or over. Employees retiring after the after the age of 60 could return to work after a break of 24 hours, to the same post or another post, provided they did not work more than 16 hours per week for the first month. This is not the case for staff who are interested in taking early retirement before the age of 60. This is due to the restriction in place that current income should not exceed the new income until the ago of 60 or over. A retirement is a legally fair dismissal. Therefore any re-employment, following retirement must go through the proper recruitment and selection process.

7.3 **Flexible Retirement – the options**

Some employees wish to consider alternatives to simply stopping work as they begin to prepare for retirement. There are 4 alternatives to retirement:-

- Wind Down

  As an employee approaches their retirement they may have a desire to gradually reduce the number of hours they work leading up to their actual date of retirement.

  The employee would need to put their request in writing to their line manager, clearly outlining their proposed pattern of work.

  This type of request should be considered as any request for flexible working and judged on the basis of needs of the service.

- Step Down (less demanding role)

  As an employee approaches retirement they may request to continue in a less demanding role. This change would normally take place during t he period between the date the employee gives notice of their intention to retire until the actual date that the employee leaves the Trust.

  If the employee and Trust agree to a change in role, the employee would be paid the appropriate rate for that post in accordance with Agenda for Change Terms and Conditions. The Trust should confirm that this is a Step Down option and the employee's pension before this date will be frozen.

  The employee would then commence a second pension based on the stepped down pay. When the employee finally retires they will receive both pensions added together. The frozen pension will also be kept up to date with cost of living increases during this period.

  To retire and start receiving a NHS Pension but to return to part-time or full-time work. This could include working during a specified period (e.g. winter or during annual leave periods) or being available for temporary assignments to help cover staff shortages.

- To retire and start receiving a NHS Pension but to be available for occasional work if required.

It is recommended that an employee takes advice from the Pensions Agency and or Financial Adviser about the options available to them before making a decision to retire, particularly in terms of return to work after retirement.

For further details please contact the Pensions Administrator/your manager/ or Human Resources.

7.4 Leaving the Pension Scheme

Managers and staff should be aware that a minimum of 12 weeks' notice is required to process pension benefits and to ensure that an employee's monies are available at the time of leaving the Trust. If you have more than one NHS job, at the time of your retirement, you would need to resign from all posts before you could claim your retirement benefits. In order to avoid delays, all staff are advised to give their manager a minimum of 12 weeks' notice of their intention to retire.

8. PRE-RETIREMENT

8.1 The Trust currently runs a pre-retirement course at regular intervals for staff who are looking to retire in the next 5 years. These courses will be publicised by the Human Resources Department in advance.

8.2 All NHS Pension Scheme members are able to request a pension forecast from the NHS Pensions Agency either by telephoning 01253 774774 quoting their national insurance number or, alternatively, going on line to www.nhsbsa.nhs.uk/pensions.

9. EXTENSION OF SERVICE BEYOND RETIREMENT AGE

9.1 The Trust is legally required under the Employment Equality (Age) Regulations 2006 to write to employees who are approaching retirement age to notifying them of their right to continue to work beyond the age of 65.

9.2 It is the line managers responsibility to write to the employee at least 6 months prior to the employee's 65th birthday.

9.3 The employee should inform the manager in writing of their request to continue their employment and confirm the duration. Either:

a. Indefinitely
b. For a stated period OR
c. Until a stated date

The employee needs to be aware of the notice period they are required to give to their manager in order to ensure the pension can be paid on time (a minimum of 12 weeks).

9.4 An employee may only make one request in relation to any one intended date of retirement.

10. KEEP IN TOUCH

Retired employees are a valuable resource of experience and skill who may be willing to work for limited periods to "help out". Managers should retain a register of specialist retirees and should ask employees who are to retire whether they wish to join the register. Employees who are required to be registered with a professional body must ensure that their registration is kept up to date.

11. PROCESS

11.1 All notices shall be in writing and be dated.

11.2 On receipt of the request the line manager shall hold a meeting within 28 days to discuss the request with the employee. The employee can be supported by a staff side representative, or work colleague at the meeting.

11.3 The duty to hold a meeting does not apply if, the manager and employee agree that the employee's employment will continue indefinitely and the manager gives notice to the employee to that effect, OR the manager and employee agree that the employee's employment will continue for an agreed period with an end date.

11.4 When the decision is made, the line manager needs to confirm in writing within 14 days either of the following outcomes:

a) The decision is that the employee's employment will continue indefinitely.

b) The decision is that the employee's employment will continue for a further period. There is a need to specifiy the length of the period or the date on which it will end.

c) Where the decision is to refuse the request, the manager needs to confirm that the Trust wishes to retire the employee and the date on which the retirement is to take effect.

d) **N.B.** It should be noted that there is no longer an upper age limit for unfair dismissal claims.

12. APPEAL PROCEDURE

12.1 An employee is entitled to appeal against the decision of the Trust not to allow them to continue their employment after the age of 65.

12.2 Appeals must be made in writing to the Director of Workforce and Organisational Development and received within 21 days of the letter notifying them of the managers decision. The letter must state the basis of their appeal.

12.3 An appeal hearing will be held within a reasonable period after the notice of appeal.

12.4 The employee and their representative will be informed in writing of the date, venue and time of the appeal hearing at least 7 days before the appeal unless otherwise agreed by all parties. They will also be advised of the names of those who will hear the appeal.

12.5 The appealent will be given an opportunitry to discuss their reasons for wanting to continue their employement beyond their 65th birthday.

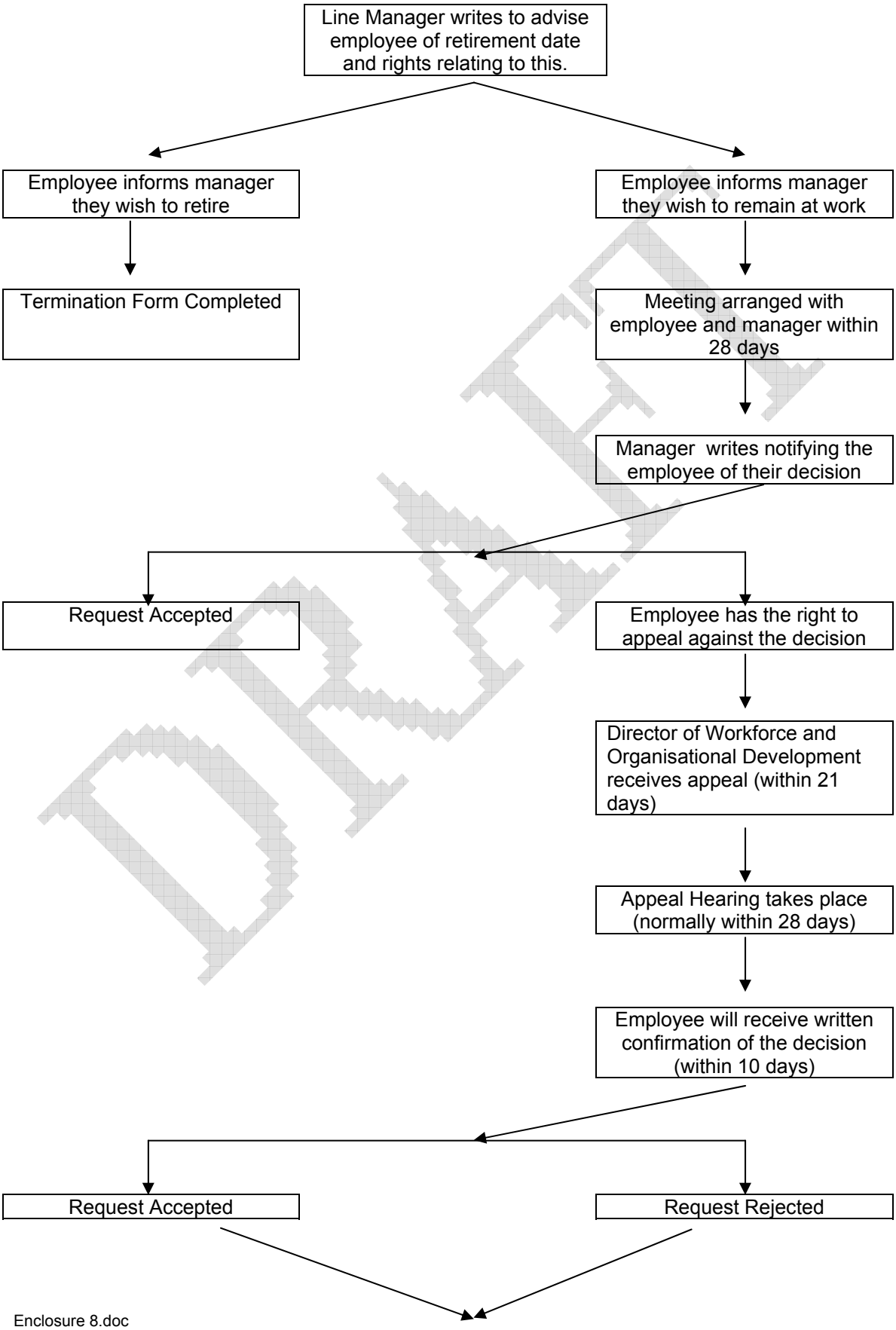
12.6 The outcome of the appeal will be communicated to the employee in writing within 10 working days. The Trust's decision following this appeal hearing will be final.

13. MONITORING THE POLICY

This policy is subject to joint monitoring and shall be reviewed by the Human Resources Department and the JNC,no later than three years post adoption.

APPENDIX A

RETIREMENT PROCESS



End of Internal Process

APPENDIX B

Retirement Letter

Date
Address

Dear

The Employment Equality (Age) Regulations 2006 came into force on the 1st October 2006. The regulations cover all aspects of the employment cycle from recruitment and terms and conditions of employment through to retirement. The regulations make it unlawful to discriminate either directly or indirectly against anyone, on the grounds of age.

As part of these regulations all employees now have the right to make a request to work beyond the age of 65 and we, as the employer have a duty to consider such requests.

I am therefore writing to inform you that your current retirement date will be **<<Date of Retirement>>**. However, under the regulations you have the right to request to continue working beyond this date.

As your employer we will carefully consider any request you make to work beyond this date and **<<Manager>>** will inform you in writing if this is not possible.

Your request to work beyond your current date of retirement must be made in writing to, **<<manager>>** not later than **<<date=3 months prior to retirement date>>**. Failure to submit your request to work beyond the age of 65 by the above mentioned date will mean you lose your statutory right to have your request considered and you will be retired on **<<date>>**.

Should you have any questions related to the content of this letter, please do not hesitate to contact me.

Yours sincerely

<<Line Manager Name>>
<<Title>>

cc HR

APPENDIX C

Retirement Letter
(To individual who is working beyond retirement)

Date
Address

Dear

The Employment Equality (Age) Regulations 2006 came into force on the 1st October 2006. The regulations cover all aspects of the employment cycle from recruitment and terms and conditions of employment through to retirement. The regulations make it unlawful to discriminate either directly or indirectly against anyone, on the grounds of age.

As part of these regulations all employees now have the right to make a request to work beyond the age of 65 and we, as the employer have a duty to consider such requests.

I am therefore writing to inform you that your current retirement date will be **<<Date of Retirement>>**. However, under the regulations you have the right to request to continue working beyond this date.

As your employer we will carefully consider any request you make to work beyond this date and **<<Manager>>** will inform you in writing if this is not possible.

As you are already working beyond your statutory retirement date, we will make the assumption that you intend to **>>>>>>>>>>>>>>>>>>>>>**.

Should you have any questions related to the content of this letter, please do not hesitate to contact me.

Yours sincerely

<<Line Manager Name>>
<<Title>>

cc HR

APPENDIX D

Guidance for Managers

1. Employees wishing to retire before 65 years of age

Employees wishing to retire before 65 should discuss this with their Manager and the Trust's Pensions department before giving formal notice to the Trust.

Upon receipt of their formal notice, managers should send a copy of the resignation letter to the Human Resources Department and complete the appropriate termination form.

2. Employees Approaching 65 Years of Age

It is most important that managers adhere to the timescales set out below as not to do so would be a breach of the Employment Equality (Age) Regulations 2006.

Managers should:

- Write to the employee between 6 and 12 months before the employee's 65th birthday notifying them of their automatic date of retirement (i.e. their 65th birthday) and of their right to request to continue working beyond this date (see letter at Appendix B).

- Such written requests should be received by the manager 3-6 months before the employee's 65th birthday.

- Upon receipt of a written request to continue working beyond 65, arrange to hold a meeting with the employee within 28 days. Employees may be accompanied at this meeting by a work colleague employed by the Trust or a representative of a trade union recognised by the Trust.

  At the meeting:

  - Allow the employee to explain fully why he/she wishes to continue working.

  - Not make a decision about whether or not to agree to the employee's request until you have considered the employee's case fully.

  - Give full and fair consideration to whether or not the employee's request can be accommodated, taking into account the relevant business needs of the organisation.

- Consider the individual employee's skills, abilities and performance when considering whether or not to agree to the request.

- Write to the employee within 14 days outlining your decision using the letter in Appendix F.

- If the request is refused, inform the employee of their right of appeal.

- If the request is approved, the appointment will be on a fixed term contract not exceeding 12 months.

- This procedure must be repeated each time an employee nears the agreed extended point for retirement, unless the agreed extended period is less than six months.

APPENDIX E

Letter inviting an individual to discuss their application.

Date
Address

Dear

I would like to acknowledge receipt of your application to work beyond retirement received on **<<date>>.**

In order for your request to be considered I would like to invite you to attend a meeting to discuss your application in more detail following which I will be able to make a fully informed decision.

The meeting has been arranged as follows;

Date: **<<insert date>>**
Time: **<<insert time>>**
Venue: **<<insert venue>>**

You also have the right to be accompanied to the meeting by a Trade Union Representative or a friend/colleague employed by the trust.

If the above arrangements are not convenient please do not hesitiate to contact me in order that an alternative time and date can be arranged.

Yours sincerely

<<Line Manager Name>>
<<Job Title>>

APPENDIX F

Letter to the employee detailing the outcome of their request

Date
Address

Dear

Following our recent meeting on **<<insert date, time and venue>>** to discuss your request to continue working beyond your retirement I would like to confirm the outcome.

At our meeting you clearly outlined your reasons for wishing to continue working beyond retirement and based on this I am **<<approving/not approving>>** your request.

The reasons for not approving your request are as follows;

<<detail the reasoning for your decision>>

I am aware my decision may come as a disappointment to you, however, taking in to account all factors my decision is as outlined above.

You do have the right to one level of appeal against this decision which must be made in writing, within 21 days of the date of this letter to**; <<insert details>>**

Yours sincerely

<<Line Manager Name>>
<<Job Title>>

APPENDIX G

PROCEDURE FOR APPEAL

In order to ensure consistency throughout the Trust, the following arrangements have been agreed with the Trade Unions through the JNC and must be followed for every appeal against a decision made for the employee to retire.

It should be noted that, in exceptional circumstances, an appeal hearing, which has been arranged, and a date agreed, may be re-arranged at the request of either side on one occasion. However, in the case of a requested second postponement, the hearing will proceed.

1. PRE-HEARING

1.1 The panel will consist of:

- a Senior Manager of the Trust
- HR Representative

1.2 Before any appeal commences, all the Panel members and Presenting Officer MUST have copies of:

- the written request not to retire
- the written record of the meeting held to discuss the request or a copy of the decision made in writing
- the appeal letter to the Director of Workforce and OD outlining the reasons for appeal

Neither party may submit new evidence to the appeal hearing that was not available at the time of the meeting or decision made.

The HR Department will forward the above documents to the Panel at least 10 working days before the Appeal.

2. ARRANGEMENTS ON THE DAY

2.1 It is essential that each party is allocated a separate room.

2.2 The designated Chairperson for the hearing will introduce all parties and briefly outline the issue under discussion.

2.3 The staff representative will then be invited to present the staff side case.

2.4 The management representative and the panel will then have the opportunity to ask any questions relating to the staff side case.

2.5 The management representative will then state the management case.

2.6 The staff representative and panel will then have the opportunity to ask any questions relating to the management case.

2.7 The panel will then ask any final questions ensuring they have elicited all relevant information.

2.8 No **new** information should be introduced at this stage of the hearing.

2.9 The panel will then adjourn to make a decision and, when ready, the Chairperson will reconvene the hearing and give the decision to the parties involved. A decision will be given on the same day, except in exceptional circumstances.

NOTE

Nothing in the Procedure prevents the Panel from adjourning at any stage to clarify or amplify any statement. The length of any adjournment must be agreed with both parties. Adjournments can be requested by either side or by Panel Members.

APPENDIX H

Appeal Outcome Letter

Date
Address

Dear

An appeal hearing to consider your appeal against the decision not to allow you to continue working after retirement was held on **<<date>>** and heard by **<<names and titles>>**. The panel considered the case put forward by you and management and would like to confirm that the decision made by **<<name>> <<job title>>** will **<<be upheld/not be upheld (delete as applicable)>>**. The reasons for the decision are as follows;

<<detail the reasons>>

In accordance with trust policy you had the right to one level of appeal against the original decision and therefore the decision of the panel on this occasion is final.

Yours sincerely

<<Name of hearing manager>>
<<Job Title>>

Birmingham Women's NHS
NHS Foundation Trust

Equality Impact Assessment

Assessment Summary

Directorate:	Workforce and Organisational Development
Department / Team:	Human Resources
Assessor Name and Job Title:	Steve Stanier, Senior Human Resources Manager
Name of Policy/Function[1], Service, Plan, SLA, Function, Contract or Framework:	Retirement Policy
Is this a new policy or function?	New ☒ Existing ☐
Date Started: February 2009	**Date Completed:** May 2009
Associated Policies/Functions?	Flexible Working Policy Recruitment and Selection Policy Payroll and Pensions Department Human Resources
Summary of Impact Assessment Outcome	**Adverse Affects: Found** ☐ **Not Found** ☒
Who is responsible for implementing actions?	Human Resources Team
Review Date:	April 2012
Signed:	**Date:**

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

Policy/Function Description

What is the aim of purpose of the Policy/Function?	The Policy sets out the Trust's approach to retirement and details a number of flexible approaches to retirement that may be of interest to staff.
Who is intended to benefit from this policy/function? And in what way? *(incl. Staff/Patients/services users/ Visitors etc)*	Those who are approaching retirement age. Line Managers and Human Resources Team. This Policy provides consistent guidance and information to staff and managers.
How have the groups above been involved in the development of this policy/function?	Human Resources Team have worked together to produce the Retirement Policy. The Policy has been consulted with JNC, Management Board and Board of Directors.
How does the policy/function fit with the Trust's Corporate aims?	To ensure that staff and managers are aware of corporate and individual responsibility and to ensure there is guidance for Trust HR Team.
What are the intended outcomes of the policy/function?	Corporate objective 8 and Legal requirements.
What are the resources linked to the policy/function?	Payroll, Pensions and HR Team.

Assessing the Impacts

What is the likely impact (whether intended or unintended/ positive or negative) of the policy/function on the public at large? There is no negative impact on the public at large as this Policy relates to staff at or approaching retirement age. The Policy sets out guidance for staff and managers and is intended to be positive.

Is there likely to be a differential impact on any group? If yes, please state the impact (positive or negative) and provide additional details (i.e. affected groups, reasons for the differential impact).		
a. Grounds of Race, Ethnicity, Colour, Nationality or National Origin (i.e. people of differing ethnic backgrounds including minority groups such as Romany Travellers, Refugees, Asylum Seekers)	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
b. Grounds of Gender or Marital Status Women or Men	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
c. Grounds of Gender or Marital Status Transgender or Transsexual people	Differential Impact? Yes ☒ No ☐	Positive Impact ☐ Negative Impact ☒ Please provide further details: *Relating to different statutory retirement ages for men and women.*
d. Grounds of Religion or Belief (Religious/Faith or other groups with a recognised belief system)	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
e. Grounds of Physical or Sensory Impairment or Mental Disability	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: *Consider alternative communication methods for staff with sensory impairment.*
f. Grounds of Age (Older People, Young People and Children)	Differential Impact? Yes ☒ No ☐	Positive Impact ☒ Negative Impact ☐ Please provide further details: *Clarifies normal state retirement age and those who wish to work beyond normal retirement age.*

g. Grounds of Sexual Orientation (Lesbian, Gay, Bisexual)	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
h. Grounds of Offending Past	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
i. Other Grounds (i.e. poverty, homelessness, immigration status, language, social origin)	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:

Is the Policy/Function directly discriminatory? Yes ☐ No ☒ *(under the Sex Discrimination Act, Race Relations Act, Disability Discrimination Act, Religion or Belief Regulations, Sexual Orientation Regulations, Age Discrimination Regulations or relevant policy)*	Is the Policy/Function indirectly discriminatory? Yes ☐ No ☒ If yes, is this objectively justifiable in proportion to meeting a legitimate aim? Yes ☐ No ☐	Is the Policy/Function intended to support equality of opportunity through positive action or action to remove any disadvantage? Yes ☒ No ☐ Please provide details: *In line with Employment Equality (Age) Regulations 2006*
If the Policy/Function is not directly or indirectly discriminatory, does it still have an adverse impact? Yes ☐ No ☒ Please provide details:		

Taking Action

What changes or practical measures would help reduce or overcome the adverse impact or potential for unlawful discrimination on particular equality groups? *Please consider measures such as changes in communication methods, language support, disability measures, changes in eligibility criteria, different methods of delivery, outreach, shared targets with other departments, etc.*
The Policy makes reference to the Employment Equality (Age) Regulations 2006 which has been referred to in this Policy. The Trust needs to be mindful of the impact for men on the differing statutory retirement age. Need to consider how we communicate this policy to staff with sensory impairments.

What do you think are the main issues that could hinder the effective implementation of equality within your policy (service, plan or function)? *In your response please consider* ▪ *Whether the policy complements other key Trust policies including unwritten 'policies in action'* ▪ *Resources (staff competencies, knowledge, time), finances and whether service delivery models reflect differentiated needs*
Differing retirement ages.
What are your conclusions on the impact of the proposed policy/function on different equalities groups? *In your response please consider:* ▪ *How will the policy impact upon people?* ▪ *Available data and research to assess whether the proposed policy will or will not have a differential or adverse impact on different equalities groups* ▪ *If there is an adverse or potential adverse impact, what are the reasons?* ▪ *Are there any issues relating to unlawful direct or indirect discrimination?*
This policy does not have an impact on other equality groups. Should an employee be ill, there maybe a need to consider ill health retirement with the NHS Pensions Agency and via the Trusts Sickness Absence Policy.

Challenge and Consultation

How have you consulted with stakeholders and equalities groups likely to be affected by the policy? *How you have consulted with key stakeholders groups in the process of developing the policy to obtain their views on how robust the policy is and how well it will meet the needs of all equalities groups. Please liaise with your departmental colleagues or with Research and Intelligence to see if there are opportunities for joint consultation about other Equality Impact Assessments being carried out.*
Joint Negotiating Committee *Management Board* *Board of Directors*
What do stakeholders you have consulted with think about the policy that you have developed? *The views of key stakeholders about the policy and any proposed measures to reduce or overcome adverse impact on equalities groups or potential unlawful discrimination*
To be confirmed

Impact Assessment Summary

Policy/Function:	
Positive Impacts ***(Note the groups affected)*** *Guidance and consistency of approach* *Satisfies legal requirements*	Negative Impacts ***(Note the groups affected)*** *Potential for staff with sensory impairments not to receive the same message as the workforce at large*
Additional Information and Evidence: *None*	
Recommendations: *1. Regularly review the Policy in line with Trust Policy Guidelines* *2. Consider contingency communication methods for staff who have sensory impairments.*	
Benefits and Costs Associated with Recommendations and Actions: *Consistent application of policy to the whole workforce at no cost.*	
Assessor Name:	Steve Stanier
Assessor Job Title:	Senior HR Manager
Date Completed:	27th April 2009

ENCLOSURE

Birmingham Women's NHS
NHS Foundation Trust

SUBJECT :	Infection Control Policy for reducing the risks associated with Intravenous devices	
REPORT BY :	Jane Owen	
AUTHOR :	Julie Suviste	

CONTEXT AND BACKGROUND FOR REPORT

This policy outlines the procedures that should be adopted at all times during the insertion and on-going care and maintenance of intravenous devices including peripheral and central venous devices. Where appropriate the described procedures reflect national evidenced based guidance or best practice recommendations.

This policy has been approved by the Infection Control Committee on April 16th 2009

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

The purpose of this policy is to:

- To ensure all aspects of intravenous practice are consistent throughout the Trust.
- To standardise the care of peripheral and central venous devices using evidence based guidance or accepted best practice.
- To inform Trust staff of their responsibilities regarding the insertion, maintenance, access and removal of intravenous devices.
- To ensure that rates of infections associated with intravenous devices are kept to a minimum.

RECOMMENDATIONS

To approve the policy

ENCLOSURE

Birmingham Women's NHS Foundation Trust

POLICY FOR REDUCING THE RISKS ASSOCIATED WITH INTRAVENOUS DEVICES

Date of Policy: April 2009

Author: Julie Suviste, Charlotte King

Next Review Date: January 2012

Type:	Infection Control Policy for reducing the risks associated with Intravenous devices	**Version: Ref:**	1	**Directorate:**	N/A

Aim:	To outline the procedures that must be adopted during the insertion, care and maintenance of intravenous devices at **BWNFt** to prevent or minimise the risks of infection.
Scope (who it applies to):	All grades and disciplines of staff who are involved in the insertion and on-going care and maintenance of intravenous devices, including peripheral venous cannulae (PVC's) and central venous catheters (CVC's).

Ratified by: **Date:**	Infection Control Committee Board of Directors
Final Approval by: **Date:**	
Approval Signatories	
Implementation Date:	

Review and consultation process (when review required & by whom):	Wide consultation with key clinical staff was undertaken during the production of the policy. The same process will be undertaken during any review process.
Responsibility for Implementation:	Infection Control Team. Director of Nursing/Midwifery/DIPC

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

HISTORY

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

Distribution methods:	Copy on Global U Drive Any printed copies may not necessarily contain latest updates and should be compared to the version on the U Drive.

1. INTRODUCTION

Intravenous devices are commonly inserted during a patient's clinical management to provide a means of direct access to the vascular system. As such devices by pass the body's normal defence mechanisms i.e. the skin, they also provide a potential route for micro-organisms to enter the vascular system either at the time of insertion or whilst the device is in place. Infections related to intravenous devices can range from localised infection at the insertion site to blood stream infections (bacteraemia) and are often associated with increased morbidity, prolonged hospitalisation and increased financial costs.

Evidence based guidance and best practice recommendations for care of intravenous devices including peripheral and central venous devices are available within the National Evidence-based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (Pratt et al 2007). Evidenced based compliance tools (High Impact Interventions) have also been published by the Department of Health (DOH 2007) and are contained in the document, Saving Lives: reducing infection, delivering clean and safe care. Specific High Impact Interventions are available for the insertion and on-going care of peripheral and central venous devices.

This policy outlines the procedures that should be adopted at all times during the insertion and on-going care and maintenance of intravenous devices including peripheral and central venous devices. Where appropriate the described procedures reflect national evidenced based guidance or best practice recommendations.

2. PURPOSE

The purpose of this policy is to:

- To ensure all aspects of intravenous practice are consistent throughout the Trust.
- To standardise the care of peripheral and central venous devices using evidence based guidance or accepted best practice.
- To inform Trust staff of their responsibilities regarding the insertion, maintenance, access and removal of intravenous devices.
- To ensure that rates of infections associated with intravenous devices are kept to a minimum.

3. SCOPE

This policy applies to all BWFT employees who are involved in the insertion and care of intravenous devices including peripheral intravenous devices and central venous catheters (CVC). The policy must be used in conjunction with the following documents:

- Aseptic Technique Policy
- Policy for Effective and Appropriate Hand Hygiene
- Policy for the Management of risks associated with Needlestick injuries and mucous membrane exposures to Blood & Body Fluids
- Neonatal Protocols
    - Insertion of a percutaneous central venous line.

- Insertion of an Umbilical Venous Catheter.
- Insertion of an Umbilical Arterial Catheter.

- Obstetric Protocols
  - Guidelines for the care of women with invasive monitoring

4. DUTIES

4.1 Duties within the Organisation

- The Trust Board of Directors has a responsibility to ensure that patients, staff and others are protected against the risks of acquiring healthcare associated infections, through the provision of appropriate care which is consistent with evidence based clinical practice. Ensuring that appropriate policies and procedures and relevant training is provided by the Trust.

- The Director of Infection Prevention and Control is responsible for ensuring that policies and procedures are made available and that relevant training is accessed by all staff who are involved in the insertion and care of intravenous devices. Training records should be centrally held, with mechanisms in place to identify deficiencies in training and follow-up of staff who fail to attend relevant training sessions.

- Professional Heads of Nursing/ Midwifery and Ward/ Department Managers are responsible for ensuring that all relevant staff are aware of and comply with this policy on a day- to-day basis.

- Ward and Department Managers must ensure that all relevant staff have access to and complete the agreed training sessions. Ensuring that all staff involved in the care and maintenance of intravenous devices have been appropriately trained and deemed as competent to do so.

- It is the duty of all healthcare workers who are involved in the care of intravenous devices to understand the risks associated with such devices and be responsible for updating their knowledge and maintaining the highest standards of practice. No member of staff should handle an intravenous device unless they have been trained and deemed as competent to do so. Attendance at relevant training will be identified and monitored through the individual's Personal Development Review process.

- The Infection Prevention and Control team are responsible for ensuring that this policy reflects national guidance and is available electronically on the Trust intranet. (accessed via the Global 'U' Drive). In conjunction with the Professional Heads of Nursing/Midwifery they are responsible for co-ordinating the compliance monitoring of this policy and ensuring that appropriate actions are taken if compliance to this policy is inadequate

4.2 Identification of Stakeholders

This policy applies to all staff working at Birmingham Women's NHS Foundation Trust who are involved in the insertion and care of intravenous devices. Key stakeholders include the following:

- Director of Infection Prevention and Control
- Professional Heads of Nursing/Midwifery (Matrons)
- Key Clinicians
- Professional Development Facilitators
- Key Clinical Leads in all Directorates i.e. NNU, Obstetrics/Maternity Gynaecology

4.3 Consultation with Stakeholders

Input and comments were sought from the key stakeholders listed above and amendments made to the policy as necessary.

5. PROCEDURES FOR REDUCING RISKS OF INFECTION

Evidenced based recommendations relating to the insertion and on-going care of intravenous devices are incorporated in the High Impact Interventions (DOH 2007). Individual compliance tools 'care bundles' are available for both peripheral and central venous devices. Key elements include:

- Assessment of need
- Catheter type
- Insertion site
- Skin preparation
- Personal protective equipment
- Hand hygiene
- Aseptic technique
- Dressings
- Safe disposal of sharps
- Documentation

5.1 Asepsis

Asepsis is a general term that refers to the prevention of contamination of tissues or equipment during invasive procedures or care procedures that involve breaches of the skin or mucous membranes. It is a key to reducing the risks of infection during insertion and care of intravenous devices. Poor asepsis during insertion or management of devices can lead to the risk of cross transmission of microorganisms from the hands of healthcare workers and/or the equipment to susceptible patient sites and may result in serious life threatening infections (Pratt et al 2007).

5.12 Aseptic Technique

An aseptic technique is the "method undertaken to prevent contamination of susceptible sites, by ensuring only sterile objects and fluids make contact with these sites, at the same time the risk of air borne contamination is minimized (ICNA, 2003).

An aseptic technique consists of the following key principles;

- Good hand hygiene.

- Recognition and non-touch of key parts of medical devices and equipment.
- Use of sterile gloves for surgical invasive procedures including the insertion of central venous devices, and during care and management of devices where non-touch of key parts cannot be guaranteed.
- The use of non-sterile gloves for less invasive procedures e.g. setting up an intravenous infusion, or administration of medication via an intravenous or epidural catheter, provided that the requirements for hand hygiene and non-touch of key parts are complied with.
- Minimisation of the risk of airborne contamination.

An aseptic technique should be adopted during the insertion and management of all intravenous access devices. Maximum aseptic precautions should be adopted for the insertion of central venous access devices, which includes the use of a sterile gown, sterile gloves and sterile drapes, eye/face protection should also be worn where there is a risk of splashing with blood or body fluids. It is desirable to undertake insertion of central venous access devices in an operating theatre or dedicated clean area. However, it is recognised that in this Trust that the majority of such devices are used in neonates receiving intensive or high dependency care, and placement in the operating theatre is impractical.

5.13 Aseptic Non Touch Technique – (ANTT)

An Aseptic Non-Touch Technique (ANTT) technique should be adopted during the care of the insertion site and access or manipulation of intravenous devices. The main principles are the same as an aseptic technique but some components may vary according to the complexity of the procedure, and whether the avoidance of touching key parts can be achieved. ANTT aims to prevent contamination of susceptible sites by micro organisms that could cause infection, by ensuring that only sterile equipment and fluids are used and the parts of components that should remain sterile, e.g. the tip of intravenous connectors, are not touched or allowed to come into contact with non sterile surfaces (http://www.antt.co.uk).

It is important to recognise that the aim is for asepsis not sterility. The individual healthcare worker needs to decide between sterile or non sterile field/gloves and ask themselves 'can I do this procedure without touching key-parts?'

If the answer is **NO** – they use a sterile dressing pack and sterile gloves.
If **YES** – then non-sterile gloves can be worn.

When clean, non sterile gloves are worn rather than sterile gloves a 'non touch aseptic technique' is essential to maintain asepsis. This means avoiding touching **key parts** of the equipment (and the patient) used during the procedure. In general, this means avoiding touching:

- Sterile equipment that will be used invasively e.g. the tip of a needle or hub of cannula.
- Sterile products used for preparing solutions for injection e.g. the hub of the syringe or tip of a needle.
- Seals of IV connectors that have been disinfected prior to administration of medication.

- Skin after it has been disinfected prior to phlebotomy or cannulation.
- Intravenous device sites.

Four Key Stages to ANTT

- Thorough hand washing using an effective technique (Refer to trust '6' step technique).
- Selection of an appropriate aseptic field.
- Identification and non-contamination of **key parts.** Protecting the key components at all times by using a non-touch technique.
- Protection of self and the patient by wearing disposable gloves & apron (and other PPE as appropriate).

The main principle is that you cannot infect a key part if it is not touched. Any key part must only come into contact with other key parts (i.e. syringe tip and needle hub).

5.2 Assessment of Need

Before an intravenous device is inserted an assessment of need should always be undertaken.

- Once inserted this should be reviewed daily, or if the patient's clinical condition changes.
- It should include questioning the need for the device and available alternatives e.g. oral medication.
- All interventions with the intravenous device should be documented in the clinical notes.
- The insertion site should be assessed at least daily for signs of infection.
- The Visual Infusion Phlebitis (VIP) score should be documented for all peripheral venous devices at least once per shift.

5.3 Choice of Device

The choice of device is dependant on the type and duration of therapy required. Examples of intravenous devices that may be used in the trust include:

- Peripheral venous catheters (PVC) – recommended up to 96 hours
- Peripherally Inserted Central Catheters (PICC)
- Umbilical catheters – use in Paediatrics/Neonates
- Central Venous Catheters (CVC)

Single lumen catheters should be always be used unless multiple ports are essential. Tunnelled catheters or implantable ports should be used for long term devices (1-3 weeks). Antimicrobial impregnated CVC's are also commercially available and are recommended to be considered for high risk adult patients who require short-term treatment (less than 10 days).

5.4 Insertion Site

The risks for infection should be assessed against the risk of mechanical complications when choosing the insertion site:

- In adult patients subclavian sites are recommended in preference to the jugular or femoral sites for non-tunnelled central venous devices, unless medically contraindicated.
- In neonatal patients access sites may differ depending upon available venous access. Femoral, umbilical and antecubital veins are frequently used.
- Peripheral venous devices should ideally be inserted where there is likely to be least mechanical irritation. In neonatal patients choice may be limited to peripheral access points.

5.5 Hand Hygiene

Effective hand hygiene is a key element of an aseptic procedure. Hands must therefore be decontaminated:

- Before and after insertion, or any manipulation / intervention associated with the intravenous device.
- Prior to administering drugs, changing infusions or change of dressings.
- Between dirty and clean procedures (e.g. CVC dressing removal and site disinfection).
- Following removal protective clothing i.e. gloves, aprons.

5.6 Intravenous Therapy Working Field and Equipment

The healthcare worker will need to decide on the most appropriate working field, in relation to the task to be undertaken.

- Assess if a clean tray or dressing trolley with a sterile dressing towel is required as the 'working field'. This will be determined by the number of medications and infusions to be administered. Where there is exposure of key parts in direct contact with the working field then a sterile towel should be used, be that in a tray or on the dressing trolley.
- Clean and used items must be clearly distinguished i.e. once a line is cleaned the used alcohol/chlorhexidine wipe **must not** be replaced back into the clean working field.
- Gather equipment, check all sterile equipment is in date and packaging is intact, avoid opening packaging until a few minutes before use.

5.7 Preparation of the insertion site

Effective skin cleansing of the insertion site will reduce the number of micro-organisms that may be present and is considered to be key to reducing risks of infection.

- In adult patients and infants over 12 months of age products/solutions containing 2% chlorhexidine gluconate in 70% isopropyl alcohol are recommended (if device tolerant).
- A solution of alcoholic povidine iodine should be used for patients with a previous history of chlorhexidine sensitivity.
- In neonates or pre-term infants lower concentrations of aqueous chlorhexidine solutions may be used to reduce the risk of potential skin sensitivities or

complications that they may occur with the use of higher concentrations of chlorhexidine and alcohol based products.
- All preparations should be designated as single patient use and should be allowed to dry prior to insertion of the intravenous device.

5.8 Dressings

Following insertion of the intravenous device a suitable dressing should be used to protect the insertion site.

- Sterile, transparent, semi-permeable polyurethane dressings are recommended .for all intravenous insertion sites, to allow for easy inspection.
- Evidence suggests that transparent dressings should be changed every 7 days or sooner if they are no longer intact or moisture collects under the dressing.
- If a transparent dressing is not suitable due to the patient's clinical or physical factors i.e. oozing/bleeding of the insertion site, a sterile gauze dressing may be used.
- The gauze dressing should be assessed daily and replaced with a transparent dressing as soon as possible.
- A solution of alcoholic chlorhexidine/aqueous chlorhexidine where appropriate should be used to clean the insertion site during dressing changes.

5.9 Line Removal

All intravascular devices should be removed when:

- They are no longer clinically indicated.
- When there are signs of infection or other complications associated with the device, following consultation with medical staff.
- Devices should not be replaced as a matter of routine; an assessment of need should always be undertaken prior to replacement of any intravascular device.

The removal of all intravenous devices must be undertaken aseptically and should only be undertaken by appropriately trained healthcare workers. For some devices, removal may need to be carried out in an operating theatre. The practitioner should identify the best place for removal depending upon the device.

5.91 Peripheral Venous Catheters

- In adults, evidence suggests that peripheral catheters should be replaced after 72-96 hours (depending on type of therapy) or sooner if complications are suspected.
- In neonates peripheral devices may be left in place for longer if there are no complications (phlebitis, extravasation or line-related infection) suspected and they are still clinically indicated.

6. GENERAL PRINCIPLES IN MANAGEMENT OF INTRAVENOUS DEVICES

- Insertion details should be documented in the patient's clinical notes or on the correct individual documentation records i.e. Trust peripheral venous documentation form.
- The insertion site should be inspected for signs of infection at least daily.

- The insertion site should be inspected for signs of infection, phlebitis or extravasation at least once per shift or more frequently if clinically indicated.
- All interventions and observations should be documented in the patients clinical notes or where provided on the intravenous device documentation form.
- The catheter hub or ports of intravenous devices should be cleaned with individual wipes impregnated with 2% chlorhexidine in 70% alcohol , which is allowed to dry , prior to access.
- Where used device sterile caps should be replaced each time the device is accessed.
- Administration sets should be changed:
    - Immediately following the administration of blood or blood products.
    - Following administration of Total Parental Nutrition.
    - After 72 hours if used for administration of other intravenous fluids.
- All sharps should be handled safely and should be disposed of directly into a sharps container at the point of use.

7. EDUCATION OF PATIENTS, CARERS AND HEALTHCARE WORKERS

- Only staff who have undertaken the necessary training and have been deemed competent should undertake insertion and care of intravenous devices.
- Where applicable patients /parents/ carers should be trained on how to look after the device before discharge from hospital or by community staff where peripheral venous devices are inserted in the community. This training should include:
    - Practices to reduce the risks of infection, including hand washing technique and aseptic non-touch technique.
    - Identifying signs and symptoms of infection.
    - How to report concerns.

8. MONITORING OF COMPLIANCE WITH THIS POLICY

The Health and Social Care Act 2008 places a statutory duty on trusts to audit key clinical policies. High Impact Interventions (DOH 2007) will be used by individual Ward and Department areas to monitor compliance, identifying any areas of non-compliance and taking local action as necessary.

9. ASSOCIATED DOCUMENTS & REFERENCES

Department of Health (2008) The Health and Social Care Act 2008 Code of practice for the NHS on the prevention and control of healthcare associated infections and related guidance. London DH

Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care. London DH.

Pratt RJ, Pellowe CM, Wilson JA, Loveday HP et al (2007) epic2: National Evidence-Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals in England. Journal of Hospital Infection Vol 65 (Supplement)

Department of Health (2006) The Health Act – Code of Practice for the Prevention and Control of Health Care Associated Infections. London. DH Updated January 2008.

Preventing Infections in Vascular Access (PIVA) toolkit (2005) Infection Control Nurses Association in conjunction with 3M Health Care

Department of Health (2003) Winning Ways: working together to reduce healthcare associated infection in England. London: The Stationary Office.

Infection Control Nurse Association (2001) Guidelines For Preventing Intravascular Catheter-related Infection. Fitwise Publications Bathgate.

Rowley S (2001) Aseptic Non-Touch Technique. Nursing Times. Vol 96 Issue 7. Page 6

Website – (http://www.antt.co.uk).

Appendix 1

INSERTION AND MANAGEMENT OF A PERIPHERAL VENOUS DEVICE

- Always assess risks for infection against mechanical complications.
- Insertion site should be ideally where there is least mechanical irritation.
- Hands must be decontaminated with soap and water or alcohol hand gel as per Trust Hand Hygiene policy prior to insertion.
- Non-sterile gloves should be worn when inserting peripheral venous devices.
- The insertion site must be thoroughly cleansed with a product containing chlorhexidine/alcohol which should be allowed to dry. Do not re-palpate the vein or touch insertion site.
    - Adults - swab impregnated with 2% chlorhexidine in 70% alcohol.
    - Neonates - 0.5% aqueous chlorhexidine.

Devices must be inserted using an aseptic non –touch technique.

- Insertion sites must be covered with sterile, transparent, semi-permeable polyurethane dressing to allow easy inspection.
- Insertion details should be documented on the peripheral venous documentation form.
- If clean and intact dressings may remain in situ for the life of the device. Replace the dressing if it becomes wet, loose or soiled.
- The insertion site should be checked at least once each shift (minimum 8 hourly) for visual signs of inflammation, swelling and discharge, the Visual Infusion Phlebitis (VIP) Score and any interventions with the device should be documented on the peripheral venous documentation form .
- If the VIP score is 2 and above the line must be removed. If there is a clinical indication not to do this, it must be clearly documented in the patients clinical notes.
    - Adult patients - it is recommended that peripheral venous devices are routinely removed 72-96 hrs after insertion and only re-sited if clinically indicated. If the device has not been removed the reasons why must be clearly documented in the patients notes.
- Prior to accessing the device, i.e. for administration of drugs etc, the device hub/port should be disinfected with a single use swab impregnated with 2% chlorhexidine in 70% alcohol, which is allowed to dry.
- Following removal of the device a sterile dressing must be used to cover the puncture site.

Appendix 2

INSERTION AND MANAGEMENT OF A CENTRAL VENOUS DEVICE

- Unless medically contraindicated, in adults the subclavian site must always be considered as the optimum site for insertion of a non-tunnelled CVC, rather than jugular or femoral sites.
- For neonatal patients umbilical or antecubital access site should be used depending on proposed use or therapy required.
- Maximum aseptic precautions should be adopted during the insertion of all central venous devices.
- A sterile gown and sterile gloves should be worn by the operator during insertion procedure. Face and eye protection should also be worn, if there is a potential risk of exposure to blood/body fluids in line with Standard precautions.
- Hands must be decontaminated with an antiseptic solution i.e. 4% Chlorhexidine as per Trust Hand Hygiene policy prior to the procedure.
- The insertion site should be cleaned using a solution containing chlorhexidine gluconate this will vary dependant upon patient group.
- **In Adult**s
    - 2 % chlorhexidine gluconate solution in 70% isopropyl alcohol e.g. "Chloraprep" (if line tolerant) or povidone-iodine in cases of alcohol incompatibility or patient chlorhexidine sensitivity are recommended. This should always be allowed to air-dry.

  In Neonates

    - 0.5% acqueous chlorhexidine should be used to prepare the insertion site. This should be allowed to air dry
- Insertion sites must be covered with a sterile, transparent, semi-permeable polyurethane dressing, to allow for easy inspection. The dressing must be changed every 7 days or sooner if the dressing becomes wet, loose or soiled.
- Insertion details should be clearly documented in the medical/nursing notes. This is the responsibility of the person inserting the device.
- During dressing changes:
    - Decontaminate hands as per Trusts Hand Hygiene Policy
    - Wear sterile gloves
    - Use an aseptic technique
    - Clean the insertion site
        - In neonates use 0.5 % aqueous chlorhexidine solution
        - In adults use 2% chlorhexidine in 70% isopropyl alcohol e.g. "Chloraprep". 10% povidone-iodine can be used in where there is a risk of chlorhexidine sensitivity.

    - Re-apply sterile dressing when site is dry
- The insertion site should be checked daily for visual signs of inflammation, swelling and discharge and documented.
- The line should be removed when no longer required or clinically indicated.
- A sterile dressing should be applied to the puncture site on the removal of the device.

Birmingham Women's NHS
NHS Foundation Trust

Equality Impact Assessment Toolkit

Stage 1 – Defining the Scope of the Equality Impact Assessment

The initial stage of the Equality Impact Assessment involves

- Deciding who will carry out the impact assessment,
- Identifying the main equality issues and defining the scope of the impact assessment, and
- Assessing the relevance of the policy, service, plan or function to the different equalities groups.

This section focuses on the initial planning and risk assessment to make sure that the basic requirements are in place to carry out an effective Equality Impact Assessment that can improve the way a particular policy, service, plan, function, contract, SLA or Framework is delivered.

Assessment Details

Directorate:	Trust Wide - All Clinical areas within Directorates
Department / Team:	Infection Control Team
Assessor Name and Job Title:	Julie Suviste Infection Control Nurse Specialist
Name of Policy/Function[1], Service, Plan, SLA, Function, Contract or Framework:	Policy for reducing the risks associated with Intravenous Devices
Is this a new policy or function?	New ☒ Existing ☐
Date Started: _16__/__04__/__2009_	**Date Completed: _21__/_04___/__2009_**
Associated Policies/Functions?	Infection Control Policies including: 1. Policy for effective and appropriate Hand Hygiene 2. Aseptic Technique Policy 3. Policy for the management of risks associated with needlestick injuries and mucous membrane exposures to blood and body fluids. Local protocols for insertion of intravenous devices in all Directorates
Summary of Impact Assessment Outcome	**Adverse Affects: Found** ☐ **Not Found** ☒
Who is responsible for implementing actions?	**N/A**

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

Review Date:	**January 2012**
Signed:	**Date: 21st April 2009**

Policy/Function Description

What is the aim of purpose of the Policy/Function?	To ensure safe, consistent and evidence based practice by all relevant healthcare professionals during the insertion and management of intravenous devices in the Trust.
Who is intended to benefit from this policy/function? And in what way? *(incl. Staff/Patients/services users/ Visitors etc)*	Patients and Staff. Patients receive evidenced based, consistent care. Staff undertake care in line with evidence based and best practice recommendations which is consistent throughout the Trust.
How have the groups above been involved in the development of this policy/function?	Key clinical staff have been involved in the consultation process during development of the policy.
How does the policy/function fit with the Trust's Corporate aims?	The policy aims to ensure all patients with intravenous devices receive consistent evidenced based care in line with Department of Health recommendations. Also ensuring that any risks of healthcare associated infections related to intravenous devices are prevented or minimised.
What are the intended outcomes of the policy/function?	Safe and consistent evidenced based practice for all patients with intravenous devices.
What are the resources linked to the policy/function?	Introduction of different products for skin preparation and during management of intravenous devices in line with Department of Health recommendations. There will be an increased financial cost associated with their introduction. Production of posters detailing use of appropriate products during insertion and management of devices which will support training and education requirements.

Assessing the Impacts

What is the likely impact (whether intended or unintended/ positive or negative) of the policy/function on the public at large?

Positive – Standardised care for all patients with intravenous devices which is line with Department of Health recommendations, ensuring compliance with the High Impact Interventions (Saving Lives – reducing infection, delivering clean and safe care Department of Health 2007).

Negative – Introduction of change in practice could produce negative reaction. Recommended products for skin preparation are more expensive than current products, there may be some reluctance to introduce them in some clinical areas due to increased costs.

Is there likely to be a differential impact on any group? If yes, please state the impact (positive or negative) and provide additional details (i.e. affected groups, reasons for the differential impact).		
a. Grounds of Race, Ethnicity, Colour, Nationally or National Origin (i.e. people of differing ethnic backgrounds including minority groups such as Romany Travellers, Refugees, Asylum Seekers)	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
b. Grounds of Gender or Marital Status Women or Men	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
c. Grounds of Gender or Marital Status Transgender or Transsexual people	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
d. Grounds of Religion or Belief (Religious/Faith or other groups with a recognised belief system)	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
e. Grounds of Physical or Sensory Impairment or Mental Disability	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:

f. Grounds of Age (Older People, Young People and Children)	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
g. Grounds of Sexual Orientation (Lesbian, Gay, Bisexual)	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
h. Grounds of Offending Past	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:
i. Other Grounds (i.e. poverty, homelessness, immigration status, language, social origin)	Differential Impact? Yes ☐ No ☒	Positive Impact ☐ Negative Impact ☐ Please provide further details:

Is the Policy/Function directly discriminatory? Yes ☐ No ☒ *(under the Sex Discrimination Act, Race Relations Act, Disability Discrimination Act, Religion or Belief Regulations, Sexual Orientation Regulations, Age Discrimination Regulations or relevant policy)*	Is the Policy/Function indirectly discriminatory? Yes ☐ No ☒ If yes, is this objectively justifiable in proportion to meeting a legitimate aim? Yes ☐ No ☐	Is the Policy/Function intended to support equality of opportunity through positive action or action to remove any disadvantage? Yes ☒ No ☐ Please provide details:
If the Policy/Function is not directly or indirectly discriminatory, does it still have an adverse impact? Yes ☐ No ☒ Please provide details:		

Taking Action

What changes or practical measures would help reduce or overcome the adverse impact or potential for unlawful discrimination on particular equality groups? *Please consider measures such as changes in communication methods, language support, disability measures, changes in eligibility criteria, different methods of delivery, outreach, shared targets with other departments, etc.*
N/A
What do you think are the main issues that could hinder the effective implementation of equality within your policy (service, plan or function)? *In your response please consider* ▪ *Whether the policy complements other key Trust policies including unwritten 'policies in action'* ▪ *Resources (staff competencies, knowledge, time), finances and whether service delivery models reflect differentiated needs*
N/A
What are your conclusions on the impact of the proposed policy/function on different equalities groups? *In your response please consider:* ▪ *How will the policy impact upon people?* ▪ *Available data and research to assess whether the proposed policy will or will not have a differential or adverse impact on different equalities groups* ▪ *If there is an adverse or potential adverse impact, what are the reasons?* ▪ *Are there any issues relating to unlawful direct or indirect discrimination?*
N/A

Challenge and Consultation

How have you consulted with stakeholders and equalities groups likely to be affected by the policy?
How you have consulted with key stakeholders groups in the process of developing the policy to obtain their views on how robust the policy is and how well it will meet the needs of all equalities groups. Please liaise with your departmental colleagues or with Research and Intelligence to see if there are opportunities for joint consultation about other Equality Impact Assessments being carried out.

During development of the policy there has been wide multidisciplinary consultation with key clinical staff in all Directorates. This consisted of key senior Medical and Nursing and Midwifery staff, including key clinicians who are involved in insertion of intravenous devices, Matrons (Heads of Nursing and Midwifery) and Staff in Professional and Practice Development who are involved in education and training of clinical practice.

All comments made were reviewed and where necessary the policy was amended accordingly.

What do stakeholders you have consulted with think about the policy that you have developed? *The views of key stakeholders about the policy and any proposed measures to reduce or overcome adverse impact on equalities groups or potential unlawful discrimination*

N/A

Impact Assessment Summary

Policy/Function: Policy for Reducing the risks of Infections associated with Intravenous Devices	
Positive Impacts *(Note the groups affected)* All patients with intravenous devices will receive safe, consistent and evidenced based care during insertion and management. Healthcare associated infections related to intravenous devices will be prevented or minimised as much as possible.	**Negative Impacts** *(Note the groups affected)*
Additional Information and Evidence: The policy has been based on national evidenced based guidance and best practice recommendations including: Saving Lives; reducing infection, delivering clean and safe care. Department of Health 2007 Epic 2: National Evidenced-Based Guidelines for preventing Healthcare Associated Infection in NHS Hospitals in England. Pratt et al 2007	
Recommendations: The policy is approved.	
Benefits and Costs Associated with Recommendations and Actions: Patients receive safe and consistent care in line with national evidence- based and best practice recommendations.	

Assessor Name:	**Julie Suviste**
Assessor Job Title:	**Infection Control Nurse Specialist**
Date Completed:	**21.04.09**

ENCLOSURE

Birmingham Women's NHS
NHS Foundation Trust

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

KEY ISSUES FOR TRUST BOARD CONSIDERATION AND DECISION:

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

Seal No.	Date	Description of Document Sealed	Value	Signed By	Attested By
33	27th April 2009	Landlord's consent for assignment of lease-telecoms equipment (4 copies)	Nil	Julie Burgess	Jason Burn
35	27th April 2009	Contract to install CHP plant- Cofathec Heatsave Ltd (2 copies) Plus agreement for appointment of engineers, architects and surveyors (3 copies)	£1,405,499	Julie Burgess	Jason Burn

RECOMMENDATION:

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