The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 6th November, 2014 at 9.30am
Clinical Education Centre

Meeting in Public Session
All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – R Miner**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 2nd October 2014	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 2nd October 2014	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	E Rees	To Note & Discuss	10.00
	7.2 Nurse Staffing Report	Enclosure 5	D Mcmahon	To Note & Discuss	10.10
	7.3 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 6	D Bland	To Note	10.20
	7.4 Moving Patients Out of Hours	Enclosure 7	J Scott	To Note	10.30
	7.5 Safeguarding Quarterly Report	Enclosure 8	D Mcmahon	To Note	10.40
	7.6 Keogh Report	Enclosure 9	J Cotterill	To Note	10.50
	7.7 Francis Report	Enclosure 10	J Cotterill	To Note	11.00
	7.8 Organ Donation Annual Report	Enclosure 11	D Badger	To Note	11.10
	7.9 Food and Nutrition Report	Enclosure 12	R Graves	To Note	11.20
	7.10 Audit Committee Exception Report	Enclosure 13	J Fellows	To Note	11.30
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 14	D Badger	To Note & Discuss	11.40

9.	**Date of Next Board of Directors Meeting** 9.30am 4th December, 2014, Clinical Education Centre		J Edwards		11.50
10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards		11.50

Enclosure 1

The Dudley Group NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 2nd October, 2014 at 9:30am in the Clinical Education Centre.

Present:

John Edwards, Chairman
Ann Becke, Non Executive Director
David Badger, Non Executive Director
David Bland, Non Executive Director
Jonathan Fellows, Non Executive Director
Paul Assinder, Director of Finance and Information
Richard Miner, Non Executive Director
Paul Harrison, Medical Director
Jon Scott, Interim Director of Operations
Denise McMahon, Nursing Director
Paul Taylor, Interim Director of Finance

In Attendance:

Helen Forrester, PA
Elena Peris-Cross, Administrative Assistant
Liz Abbiss, Head of Communications and Patient Experience
Julie Cotterill, Associate Director of Governance/Board Secretary
Anne Baines, Director of Strategy and Performance
Elizabeth Rees, Director of Infection Prevention and Control (Item 7.1)

14/077 Note of Apologies and Welcome

Apologies were received from Paula Clark.

The Chairman welcomed Anne Baines to her first formal Board meeting and welcomed Paul Taylor as Interim Director of Finance, replacing Paul Assinder.

14/078 Declarations of Interest

There were no declarations of interest.

14/079 Announcements

There were no announcements to be made.

14/080 Minutes of the previous Board meeting held on 4th September, 2014 (Enclosure 1)

The minutes of the previous meeting were approved by the Board as a true and correct record of the meetings discussion and signed by the Chairman.

14/081 Action Sheet, 4th September 2014 (Enclosure 2)

All of the actions were either complete or appear on this or future meeting agendas.

14/082 Patient Story

Liz Abbiss presented the patient story, she explained that the video was of a younger adult who had attended in an emergency situation.

The Nursing Director commented that the patient had felt very vulnerable but had received a good experience in every stage of her care.

The Interim Director of Operations asked if feedback is shared with the Ambulance Trust. Liz Abbiss confirmed that feedback is not currently shared but this would be possible. The Chairman agreed that it would be useful to present the feedback to Sir Graham Meldrum to share with the West Midlands Ambulance Service Board members.

Liz Abbiss to share the positive patient story feedback with the West Midlands Ambulance Service.

14/083 Chief Executive's Overview Report (Enclosure 3)

The Director of Finance and Information/Deputy Chief Executive presented the Chief Executive's Report including the following highlights:

Friends and Family: The Board noted performance for September. The wards had achieved a compliance rate of 78.2% and ED had achieved 69%, which represented a drop in performance for both of these areas, however Maternity had achieved a compliance rate of 91.3% which was a marked improvement. The Trust remains amongst the top performing organisations for its friends and family results in the West Midlands. The Board noted that there will be some changes to the test in the next financial year, including:

- Mandatory free text
- Change to scoring method
- Collection of demographic data
- Children and young people included
- No response rate targets

The Interim Director of Finance suggested the use of postcode for collecting the demographic data.

The Director of Finance and Information/Deputy Chief Executive confirmed that we are consulting Commissioners around what they would like to see included.

The Board noted that there had been a favourable response rate to the staff friends and family survey and the score was well above the national average against the criteria.

Senior Information Risk Owner: The Board formally approved the appointment of the Associate Director of Governance/Board Secretary into the role of Senior Information Risk Owner until the appointment of a substantive Director of Finance.

Appointment of Interim Director of Finance: The Board approved the appointment of Paul Taylor as Interim Director of Finance with full voting rights.

Assignment of Director for Dudley Clinical Services Board: The Board approved the recommendation for Anne Baines, Director of Strategy and Performance to be appointed as Director of the Dudley Clinical Services Ltd Board.

Update on Datix Refresh: The Datix risk reporting system had now moved onto a new IT server that will give the system operational security. Trust IT will provide support in transferring data. The Associated Director of Governance/Board Secretary confirmed that the migration will be complete by mid-October.

Patient Survey on Cancer Services: Macmillan Cancer Support confirmed the previous day that The Dudley Group of Hospitals NHS Foundation Trust had been rated as the most improved Trust in the country for Cancer Services. The Chairman noted the Board's delight at the news and asked that all staff concerned were congratulated on the achievement.

Cancer Services staff to be congratulated for the achievement of best improved Trust in the country.

14/084 Patient Safety and Quality

14/084.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Director of Infection, Prevention and Control presented her exception report given as Enclosure 4, including the following points to note:

MRSA: There were no post 48 hour cases to date this year. The Board noted that there had recently been one pre 48 hour case recently. An update on MRSA screening guidance will be included in the November Board report.

C.Diff: No post 48 hour cases to note in September. The Board noted that the Trust has commenced the process of identifying lapses in care (unavoidable and avoidable cases) and the first meeting had taken place with the CCG the previous Friday. There was a further meeting scheduled for tomorrow to review cases from earlier in the year. The Director of Infection Prevention and Control confirmed that there had been some issues at the meeting relating to documentation. The Chairman confirmed that the Trust reports all 48 hour cases but the contract with the CCG only looks at avoidable cases. The Nursing Director commented that as we move to an electronic system we need to decide what exactly documented means. The Chairman agreed that the Trust needs to agree with the CCG that they will accept an electronic record.

Norovirus: There were no cases to report.

Ebola: A full update on Ebola had been presented at the last Board meeting and following international concern, the Trust had in place its own local plan. The Board noted that face fit testing was now complete.

The Chairman noted the positive performance, noted the comments around lapses in care and noted as a Board the Trust wishes to move towards electronic documentation.

MRSA screening guidance to be included in the November Infection Control report. Discussion to take place with the CCG around the acceptance of electronic documentation.

14/084.2 Workforce and Staff Engagement Committee Exception Report (Enclosure 5).

Mrs Becke, Non Executive Director and Committee Chair, presented the Workforce and Staff Engagement Committee exception report given at Enclosure 5, including the following issues:

- "Deep-dive" review being undertaken in Human Resources.

KPI's

- Turnover: No concerns.
- Mandatory Training: The Board noted that performance had dropped and Directorates were requested to attend the Committee to present a recovery plan.
- Appraisals: Concern had been raised at the Committee and the Nursing Division had given assurance that the position would be resolved.
- Vacancies: 270 WTE vacancies which was within the normal range.
- National Staff Survey: The Committee had received an update report on actions. The 2014 survey went live on 22nd September, 2014.

The Board noted the report.

14/084.3 Nurse Staffing Report (Enclosure 6)

The Nursing Director presented the Nurse Staffing report given as Enclosure 6.

The Board noted that a paragraph had been included in the report relating to the risk assessment of shifts.

The August report shows an improvement against the previous month.

Board members noted that unregistered nurses are shown in blue and registered nurses displayed in amber. There is a reduction in the number of shifts reported this month.

The Nursing Director confirmed that there is an additional pressure experienced as a result of having a junior workforce.

There were no red flag areas to note in the report.

The Chairman noted the report and noted the continuing downward trend and that there were no red flags in the report this month.

Mr Bland, Non Executive Director, commented on the 270 WTE equivalent vacancies and whether this implies that there are this many bank and agency staff each month.

The Nursing Director stated that there is a discrepancy between the Electronic Staff Record (ESR) and real time.

14/083.4 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 7)

Mr Bland, Non Executive Director and Committee Chair, presented the Clinical Quality, Safety and Patient Experience Committee Exception report given as Enclosure 7. Key items to note included:

- **Serious Incident Monitoring Report:** The Board noted the changes to the reporting of pressure ulcers.
- **Quality Dashboard:** The Board noted that in relation to TAL the exception report should read "36% of appointments booked" and this was not such a positive picture as described in the report. Mr Badger, Non Executive Director, confirmed that the Finance and Performance Committee are monitoring the TAL action plan.
- **Quality Accounts:** Performance is on track.

The Chairman noted the exception report.

14/084.5 Board Assurance Framework (Enclosure 8)

The Associate Director of Governance/Board Secretary, presented the Board Assurance Framework as at September 2014, given as Enclosure 8.

The Board noted that the Framework focuses on corporate risks. There are twelve corporate risks and five with a score of twenty or above. The Board Assurance Framework focuses on these five risks. New updates are highlighted in yellow and there have been three new risks included since the previous report.

The Associate Director of Governance/Board Secretary confirmed that the risks on the Corporate Risk Register will required a review and update following changes to the Executive Director team.

Mr Badger, Non Executive Director, stated that the layout and highlighting in the report is extremely helpful. He also raised the absence of timescales in the mitigating actions column. The Associate Director of Governance/Board Secretary confirmed that these timescales are included in the Corporate Risk Register, which is the next report on the agenda.

The Chairman commented that the work around the JAC medicines management system came onto the Risk Register recently. He asked at what point will the risk be managed down?

The Medical Director confirmed that this would not happen in the near future. The Interim Director of Operations confirmed that this was an item for discussion at the next Executive Directors meeting.

The Chairman asked about winter care and whether work is progressing with colleagues to produce a plan.

The Interim Director of Operations confirmed that actions taken by partners in the past have not delivered as they had been forecast. The Trust had written to Monitor with a request for funding for additional winter pressures.

The Interim Director of Operations also confirmed that the Trust had written to the Local Authority in relation to fining for failure to manage delayed transfers of care.

The Chairman noted the report.

14/084.6 Corporate Risk Register (Enclosure 9)

The Associate Director of Governance/Board Secretary, presented the Corporate Risk Register, given as Enclosure 9.

The Board noted that the Corporate Risk Register drives the Board Assurance Framework. It is a live document and is updated on a regular basis.

The Risk and Assurance Group have identified that there is work to do around new risks.

The Board noted that six new risks have been included on the register and twenty risks have been removed. The document will change significantly over the next few months.

Mr Miner, Non Executive Director, asked if there is a risk around the changes at Board level, the Turnround Plan and ownership and also around the new IT implementation, he suggested that these should be brought back as a matter of urgency.

The Chairman noted that there are a number of issues that relate to changes in the Executive Team and confirmed that the Executive Team should be given time to consider these and bring back the Board Assurance Framework to the December Board.

Executive Team to consider risks around changes at Board level, Turnround Plan and ownership and IT implementation and bring back the updated Board Assurance Framework to the December Board meeting.

14/084.7 Revalidation Report (Enclosure 10)

The Medical Director presented the Revalidation report, given as Enclosure 10.

The report outlines progress made in quarter one and highlights any issues.

The Trust is performing well and making good progress. The Board noted that an extract of the governance arrangements are included in the report. The Trust has an appraisal rate of 98.4% and 6% deferral rate on revalidations due to insufficient evidence.

Board members noted that the Trust is performing well against its peers.

The Interim Director of Finance asked about the three doctors not taking part in revalidation. The Medical Director confirmed that action has now been taken in relation to these members of staff.

The Chairman stated that there was a suggestion to separate out the Medical Director from Responsible Officer role. The Medical Director confirmed that the Trust is looking to do this and this will be covered in the Private Board report.

The Chairman noted the report and the positive performance and passed on his and the Board's congratulations to the Medical Director and his team on progress.

14/085 Finance

14/085.1Finance and Performance Report (Enclosure 11)

Mr Badger, Non Executive Director and Committee Chair presented the Finance and Performance Committee report, given as Enclosure 11. The report given an overview from April to August. Key issues noted at the last Committee meeting included:

There is a deficit on income and expenditure and a shortfall on turnround and CIP. Current trajectory has moved to just over £10m.

The Board noted a month on month deterioration and also the ever increasing risk around liquidity.

Key actions from the last meeting included the need to bring greater control to income and expenditure. The Committee had commenced a schedule of meetings with the new Divisional Directors. There was an urgent need to look at how the Trust could increase its elective work.

The Trust was also examining what could be removed from its capital programme.

There was concern over turnround and the take being taken to seen any movement. All major turnround schemes are now in escalation.

The Board noted with concern that finance is the greatest challenge the Trust has ever faced.

The Director of Finance and Information stated that there are two main issues, the sub-optimum mix of activity which means the Trust is not hitting its income targets and turnround. In relation to turnround the main problem is not around the plan but the difficulty in its implementation at ground level. He stated that if tariff drops by 4% next year there will be an even bigger challenge for the Trust.

Mr Badger stated that the Committee received its first presentation from one of the new Divisional Directors and this was very encouraging.

Mr Miner, Non Executive Director, asked if it was the Director of Finance and Information's views that it is still within our own power to improve the situation. The Director of Finance and Information agreed that it was but it was an extremely difficult challenge. The Trust has to deliver changes that have an impact on the cash situation.

The Chairman agreed that the Trust is busy but not busy in the right areas.

The Interim Director of Operations confirmed that outliers have been driven down in September and every opportunity has been given to Surgery to deliver the required activity. Going forward during winter the Trust needs to increase its capacity that does not require an inpatient bed.

The Chairman asked if there is demand to fill additional capacity.

The Interim Director of Operations confirmed that the Trust has an order book to run down and it could also pick up work that is currently going to the private sector. It can also offer to help other CCGs.

The Chairman stated that the Trust must resolve these issues this year to give itself a chance for next year.

Mrs Becke, Non Executive Director, commented that our Community Services element can assist us. We may need a plan to invest to see a benefit elsewhere.

The Interim Director of Operations commented that we do not have community beds like Walsall. The biggest challenge is the rise in the number of patients coming into ED that could be dealt with elsewhere. There needs to be a rapid response service up and running.

Performance

The Board noted the good news and strong performance.

ED 4 Hour Target: The Trust had met the quarter two target with a performance of 96.1%. The Board noted that it will be a challenge to hold the target in quarter three.

RTT: The Finance and Performance Committee were assured around the RTT plan.

The Board noted that there had been breaches in diagnostic waits and ultrasound and the route cause for this is around staffing issues. The Committee are looking at short, medium and long term actions.

Mrs Becke, Non Executive Director, asked based on the run rate in ED, is it likely that the Trust will achieve the year's target.

The Interim Director of Operations stated that meeting the target for the year will be extremely difficult as the Trust had significantly failed its quarter one target.

Mr Badger, Non Executive Director, stated that the Trust must focus on achieving the quarterly target.

The Interim Director of Operations confirmed that the Trust had achieve 98 and 99% against the ED target in the last 9 days. He confirmed that the Trust will aspire to deliver the annual target but the quarter one performance means that this is a real challenge.

The Interim Director of Operations highlighted the recent teleconference with the Emergency Care Intensive Support Team (ECIST) who had confirmed that they were content that the Trust is meeting all of its requirements and had therefore signed off the Trust from its support. The Chairman asked for his congratulations to be passed on to the team on this news.

The Chairman stated that the Trust's governance risk rating remains a narrative one and the Trust remains on monthly monitoring.

The Board noted the report and the financial challenges and noted the positive performance.

14/086 Any Other Business

The Chairman confirmed that this was the last public Board meeting for Paul Assinder, Director of Finance and Information and Deputy Chief Executive. On behalf of the Board the Chairman thanked Paul for all the work he has done for the Trust during the last nine years.

There were no other items of business to report and the meeting was closed.

14/087 Date of Next Meeting

The next Board meeting will be held on Thursday, 6th November, 2014, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 2nd October 2014

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
14/063.3	Moving Patients Out of Hours	Update report including audit results and agreed metrics to be presented to the Board in the Autumn.	JS	6/11/14	On Agenda
14/063.4	Safeguarding Quarterly Report	Board to revisit DNAR and the work being undertaken with the CCG later in the year.	PH/DM	6/11/14	On Agenda
14/082	Patient Story	Liz Abbiss to share the positive patient story feedback with the West Midlands Ambulance Service.	LA	6/11/14	Done
14/083	Chief Executive's Report	Cancer Services staff to be congratulated for the achievement of best improved Trust in the country.	PC	6/11/14	Done
14/084	Infection Prevention and Control Exception Report	MRSA screening guidance to be included in the November Infection Control Report. Discussion to take place with the CCG around the acceptance of electronic documentation.	DM DM	6/11/14 6/11/14	On Agenda
14/073.4	Complaints Report	Director of Governance to ensure that personal liability and clinical negligence claims reported year by year is included in the next complaints report.	JC	4/12/14	
14/084.6	Corporate Risk Register	Executive Team to consider risks around changes at Board level, Turnround Plan and ownership and IT implementation and bring back the updated Board Assurance Framework to the December Board meeting.	JC	4/12/14	

Enclosure 3

The Dudley Gr
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 6th November 2014

TITLE:	**Chief Executive's Report**		
AUTHOR:	**Paula Clark**	**PRESENTER**	**Paula Clark**

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Test Performance
- NHSE – Five Year Forward View

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Equality Assured	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To note contents of the paper and discuss issues of importance to the Board

The Dudley Group NHS
NHS Foundation Trust

Chief Executive Update – November 2014

Friends and Family Test Performance:

During October 2014 the roll out of FFT across the community, outpatients and day case surgery areas of the Trust was achieved in line with early implementation guidance. Patients utilising those services now have the opportunity to give us feedback via FFT about their experiences.

The FFT inpatient response rates have dipped again in October 2014 and work is under way to address this to ensure we meet the CQUIN target. This has included meeting with all matrons and lead nurses to look at what can be learned from those wards that are achieving/over achieving the required response rate and developing actions specific to those inpatient areas that are falling well below the target. The response rates will be monitored weekly.

FFT Inpatient and A&E provisional October 2014 results 01.10.14 – 28.10.14

	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14	Sep-14	Q2	October
	01.04.14	01.05.14	01.06.14	01.04.14	01.07.14	01.08.14	01.09.14	01.07.14	01.10.14
Date range	30.04.14	31.05.14	30.06.14	30.06.14	31.07.14	31.08.14	30.9.14	30.09.14	28.10.14
Number of eligible inpatients	1886	**2023**	1951	5860	2073	2004	1912	5987	*1843*
Number of respondents	644	**519**	483	1646	577	548	447	1577	*340*
Ward FFT score	82	**86**	85	84	81	82	79	80.8	81
Ward footfall	34%	**26%**	25%	28%	28%	27%	23%	26%	18%
Number of eligible A&E patients	4258	***4605***	4679	13542	4843	4551	4552	13970	*3862*
Number of respondents	686	***614***	1159	2459	1712	847	581	3141	*863*
A&E FFT Score	64	**53**	57	57	70	71	56	67.7	56
A&E footfall	16%	**13%**	25%	18%	35%	19%	13%	22%	22%
TRUST FFT Score (A&E/Inpatient)	73	68	66	68	73	75	69.9	72	63
TRUST footfall	22%	17%	25%	21%	33%	21%	15%	24%	21%

Inpatient FFT Score	82+	A&E FFT Score	68+	FFT Scores key	Top 20% of Trusts (based on March 14 score
	79-81		65-67		Top 30% of Trusts (based on March 14 score
	<79		<65		Below top 30% of Trusts (based on March 14
Response rate:					
Response rate A&E	<15%	15-20%	20%+		
Response rate Inpatients	<25%	25-30%	30-40% +	40%+ ✸	

FFT results for the four maternity areas is a more mixed picture in October with good performance from all areas except the postnatal ward and community areas that has contributed to the combined rate dipping into the red for the first time this year.

The Dudley Group NHS
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FFT Maternity provisional Oct 14 results 01.10.14 – 28.10.14

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q2	Oct prelim data up to 28th
Maternity - Antenatal	Score	64	80	78	79	66	71	72	76
	Response rate	14%	18%	13%	21%	19%	26%	22%	16%
Maternity - Birth	Score	62	85	83	90	94	98	93	90
	Response rate	44%	33%	34%	30%	23%	24%	25%	15%
Maternity - Postnatal ward	Score	57	85	79	87	94	96	92	87
	Response rate	43%	31%	32%	29%	23%	24%	25%	14%
Maternity - Postnatal community	Score	86	90	85	85	85	76	82	83
	Response rate	16%	9%	15%	13%	12%	11%	11%	5%
Combined	Score	63	85	81	86	88	88	87	84
	Response rate	32%	24%	25%	24%	20%	21%	21%	13%

% of footfall (response rate)	<15%	15%+

Antenatal	80+	76-79	<76	FFT Scores key	Top 20% of Trusts (based on March 14 score
Birth	89+	86-88	<86		Top 30% of Trusts (based on March 14 score
Postnatal ward	81+	75-81	<75		Below top 30% of Trusts (based on March 14
Postnatal community	90+	84-89	<84		

NHSE Five Year Forward View:

NHS England published the Five Year Forward View which aims to provide a strategic framework within which the NHS will operate and develop in future years, and therefore forms key reading for all of our members. The document has been led by Simon Stevens, chief executive, NHS England and has shared branding with the statutory bodies, including Monitor, Trust Development Authority (TDA), the Care Quality Commission (CQC), Health Education England (HEE) and Public Health England (PHE).

The attached briefing summarises the content of the Five Year Forward View (the 'Forward View'), providing the FTN's initial analysis on each chapter, as well as thematic summary of the key implications for our membership.

(see attachment for FTN On the Day Briefing)

Foundation Trust Network
on the day briefing

NHS England Five Year Forward View

On The Day Briefing by the Foundation Trust Network
23 October 2014

INTRODUCTION

Today NHS England published the Five Year Forward View which aims to provide a strategic framework within which the NHS will operate and develop in future years, and therefore forms key reading for all of our members. The document has been led by Simon Stevens, chief executive, NHS England and has shared branding with the statutory bodies, including Monitor, Trust Development Authority (TDA), the Care Quality Commission (CQC), Health Education England (HEE) and Public Health England (PHE).

This briefing summarises the content of the Five Year Forward View (the 'Forward View'), providing FTN's initial analysis on each chapter, as well as thematic summary of the key implications for our membership. As always, we would welcome your comments and feedback on the proposals. Please contact: Cassandra.cameron@foundationtrustnetwork.org

KEY MESSAGES

- **FTN welcomes the overall tone of the publication which seeks to act as an 'enabling framework'** and clearly articulates the improvements and achievements the NHS has delivered over the last ten years
- **We welcome the principle of new partnerships between local health economies and the central bodies** which we hope will champion local accountability and provider autonomy and help to align the national policy and regulatory approach across the statutory bodies
- **We look forward to hearing more detail about the potential for local flexibilities to national rules and regulations** where there is a clear case for differential treatment in order to transform and sustain high quality care for patients
- **NHS providers will wish to look closely at the models of care proposed within the Five Year Forward View to inform local discussions with their partners about what best serves the interests of their populations.** We welcome the alignment with the Dalton Review and the acknowledgement that change will build on the progress many trusts are already progressing with their locality partners.

However,

- **While we accept that the proportion of public spending available to the NHS remains a political decision, there is a clear and pressing need for additional funding to meet growth in demand if NHS providers are to remain sustainable and protect quality of care in the immediate term, as well as a need to invest in new ways of working.** The lack of detail within the funding options proposed will not alleviate concerns across our membership. Additional investment in primary care can only be made with some provision for 'double running' to protect patient safety in the secondary care sector during the

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transition to new models. We note with considerable caution assumptions about the potential use of 'FT surpluses' as one source of funding to drive local transformation and note the autonomy of provider boards to take those decisions based on the needs of their local populations

- **While greater alignment of the national bodies is welcome, greater clarity about the role NHS England, and the regulators, intend to play in supporting the transition to new models of care in localities would be helpful**, and we look forward to working with members and the national bodies to shape this process. It is important that proposals relating to improved performance information (with regard to pathways or supporting a 'healthy workforce') honour the spirit of a new central/local partnership and do not evolve into top heavy performance frameworks
- **In the current financial environment, it remains essential that NHS provider boards have the autonomy to make informed decisions in the interests of their local populations,** working in partnership across their local health economies
- **There is an urgent need for a higher quality of debate between a representative cross section of providers, and NHS England with regard to their intentions for specialised commissioning, which remain unclear within this report**
- **We would welcome further clarity on how the new models of care proposed interact with, and enable, those trusts in the FT pipeline to develop sustainable solutions**
- **Ensuring commissioner capacity to take on additional responsibilities and a larger proportion of the budget in commissioning primary care, will be fundamental.** We would urge an incremental approach in order to test the approach and manage risk at local levels.

CHAPTER 1: Why does the NHS need to change?

The opening chapter sets out the rationale for NHS England's strategy by acknowledging the significant progress in care quality, patient satisfaction and clinical outcomes, as well as delivery efficiencies the NHS has made in fifteen years despite sustained growth in budgetary and population pressures. Common challenges facing all industrialised countries' health systems reflect the broader context for strategic change in the NHS: changes in patient health needs and personal preferences about how care is delivered and received; changes in treatments, technologies and care delivery that require and enable more patient-centred approaches to organising care services; and sustained constraint on central funding for health services.

This broader context frames the more specific imperatives that NHS England identifies as driving the rationale for a strategy to drive change across the NHS:

- *The health and wellbeing gap*: prevention strategies are needed to reduce health inequalities and prevent further increasing proportions of funds and services allocated to treating avoidable illness.
- *The care and quality gap:* reshaping care delivery and harnessing technology to reduce variation in quality, safety and outcomes.
- *The funding and efficiency gap:* matching 'reasonable' funding levels with system efficiencies.

The subsequent chapters set out the three elements of the strategy – prevention, service delivery reform, and implementation – to achieve the Forward View's future vision of the NHS.

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FTN View:

We welcome the report's acknowledgement of the NHS's achievements. We look forward to contributing to a new central-local partnership which champions provider autonomy and local accountability.

CHAPTER 2: What will the future look like? A new relationship with patients and communities

The centrality of **prevention** to future sustainability underpins the approaches outlined in this chapter, which are designed to target lifestyle behaviours specifically and to help counter the deprivation and social and economic influences contributing to rising avoidable illness. These approaches position the NHS as a social movement - an 'activist agent of health-related social change' - by facilitating healthier lifestyles and incentivising earlier intervention:

- *Incentivising and supporting healthier behaviour* - focusing specifically on strategies to reduce and prevent smoking, obesity, and harmful drinking.
- *Local democratic leadership on public health* – giving local authorities and Health and Wellbeing Boards stronger powers to more rapidly implement localised public health improvement strategies.
- *Targeted prevention* – emphasising the NHS's role in secondary prevention, through proactive primary care, more systematic use of evidence-based interventions and strategic investment decisions. NHS England will develop a preventative services programme with Public Health England.
- *NHS Support to help people get in and stay in employment* – implementing the new Fit For Work scheme and improving access to NHS services for at-risk individuals.
- *Workplace health* - incentivising employment-based access to NICE-approved mental and physical health programmes, and the NHS specifically to 'set a national example' on healthy lifestyles with a range of health improvement strategies for NHS staff, who will also act as local 'health ambassadors'.

In addition, NHE England will focus on strategies that aim to **personalise care by empowering patients** – improving patient access to their records; giving patients a greater say and control over their healthcare; and facilitating improved personal health monitoring and management. Voluntary access to Integrated personal Commissioning (IPC) will provide personal 'year of care' budgets that enable blended health and social care services, managed by either the patient, their local council, the NHE or a voluntary organisation.

NHS England will seek to more directly **engage communities** through programmes and strategies that provide better support for professional and voluntary carers, including flexible working for NHS staff with major unpaid caring responsibilities, and encouraging community volunteering (citing Yorkshire Ambulance Services' "community first responders" program as an example). NHS England will also encourage stronger local charitable and voluntary sector partnerships by accelerating and easing access to local NSH funding through a shorter local alternative to the standard NHS contract, and encouraging funders to commit where possible to multiyear funding.

FTN View:

NHS England's emphasis on local democratic leadership and flexible, locally tailored public health strategies is welcome. However, while Health and Wellbeing Boards remain the primary vehicle for NHS input into localised decision-making, the essential contribution from NHS providers will remain as variable as their inclusion by

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HWBs across the country. This proposal will need to be backed by a framework for engagement that clearly specifies the involvement of local NHS providers in developing locally tailored public health strategies.

We also welcome NHS England's vision of the NHS as a social movement – Foundation Trusts collectively enjoy the active involvement of over two million members. As the big 'experiment' in public involvement in health is now coming to fruition, the challenge for the future is to involve them effectively to help drive the necessary prevention and engagement strategies in the English population. Fortunately, many NHS foundation trusts have strong public engagement mechanisms and are well placed to build on their current arrangements to enhance public engagement and deliver strong local accountability. Central support for local NHS leadership will be essential is this is to be achieved. Similarly, accountability for performance can only be meaningful if it involves the recipients of the service and their representatives and therefore to be effective must be led at a local level.

The ambitions to empower patients through strategies such as integrated personal commissioning suggest a very complicated blend of health and social care provision to meet complex and interdependent healthcare needs. To be realisable, NHS England and Monitor will need to significantly consider the current approach to tariff to ensure that funding will follow the patient through the system and compensate providers appropriately for costs.

However, we are concerned that the Forward View's main strategy for coping with increased demand rests on greater investment in prevention. In the short term at least, NHS providers will require an injection of funds to sustain quality of care and rising operational pressures. Investment is also required to move to the new models of care proposed.

CHAPTER 3: What will the future look like? New models of care

NHS England positions the need for new models of care in the context of existing approaches to NHS service provision that are an increasingly costly impediment to improvements in patient-centred and coordinated care. New approaches to care delivery in the NHS will be guided by key imperatives including:

- A need to manage networks of care, not just organisations;
- Necessary growth in out-of-hospital care;
- Integration of mental and physical health services around the patient or service user;
- Faster learning from local and international best practice; and
- Evaluation of the beneficial impacts on cost and patient benefit.

NHS England considers the strengthening of primary and out-of hospital care as critical to effective service delivery transformation across the NHS. The Forward View sets out several immediate measures to stabilise general practice that include:

- Stabilised core funding for the next two years while an independent review examines resource distribution for primary care;
- Giving CCGs greater influence over the wider NHS budget to facilitate a shift in investment from acute to primary and community services;
- New funding through schemes such as the Challenge Fund to improve GP infrastructure and services availability, and GP training and recruitment and retention schemes.

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Innovations in primary and secondary care delivery in Kent, Airedale, Cornwall, Rotherham, and London are cited as good examples of early transformations underway in care models that have led to improved care quality, patient experience and value for money. The following **seven new care delivery models** will be prioritised and promoted by NHE England:

Multispeciality Community Providers (MCPs) – extended group practices of GPs, nurses, therapists and other community-based professionals will be allowed to form as federations, networks or single organisations to provide an expanded range of care services and shift more outpatient and ambulatory care out of hospital settings. These organisations could eventually take over running local community hospitals, facilitate more immediate referral and coordination between GP and hospital care, and hold responsibility for management of patients' personal health budgets. NHS England will work with emerging practice groups to address barriers to change, service models, access to funding, and optimal use of technology, workforce and infrastructure.

Primary and Acute Care Systems (PACs) will form a new variant of single organisation, providing vertically integrated GP and hospital care together with mental health and community services. These models will be pilot-tested by NHS England with the aim of developing prototypes; they could be achieved by:

- Permitting hospitals to open their own GP surgeries with registered lists, allowing FTs with surpluses and strong investment positions to expand primary care in areas of high health inequalities;
- Positioning PACs as the next stage in development of MCPs who are in a position to take over running their local DGH; or
- An Accountable Care Organisation-type approach where the organisation is responsible for holistic healthcare services for a population of registered patients under a delegated capitation budget.

Urgent and emergency care (UEC) networks – a reorganisation and simplification of existing NHS UEC pathways by developing networks of linked hospitals to facilitate more rapid access to: specialist emergency and major trauma centres; seven day services; proper funding and integration of mental health crisis services including liaison psychiatry; strengthening clinical triage and advice services; and new ways of measuring the quality of UEC services.

Viable smaller hospitals – where smaller hospitals provide the best option clinically, financially and with local support, their sustainability will be bolstered by reviewing:

- the NHS payments regime to account for impacts of scale (as evidenced by lower EBITDA margins for smaller FTs);
- models of medical staffing to build sustainable cost structures; and
- as will be recommended in the Dalton Review, three new organisational models of small hospital provision that gain the benefits of scale without having to centralise services:
    - 'hospital chains';
    - outsourced specialist services provision (ie; Moorfields Eye Hospital); and
    - a mini-PACs approach incorporating local acute, primary and community care.

Specialised care - where there's a strong evidence base for a greater concentration of a particular care service (as has been demonstrated for orthopaedic care in South West London), NHS England will work with local partners to drive consolidation through a programme of three-year rolling reviews. Specialised providers will be incentivised through prime contracting and delegated capitated budgets to develop geographic networks of services, integrating organisations and services around patients.

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Modern maternity services - NSH England will commission a review of future models of maternity units to report by summer 2015; seek better alignment of tariff-based funding with patient choice; and facilitate midwifery services.

Enhanced health in care homes – utilising the Better Care Fund, NHS England will work with local authority social services and care homes to develop new shared models of in-reach support to reduce avoidable admissions to hospital.

NHS England will lead the development of new local and national partnerships to facilitate the introduction and development of these new approaches, to enable the necessary local discretion in the application of payment rules, regulatory approaches, staffing models and workforce policies, alongside technical and transitional support. They will support these processes by developing:

- detailed prototypes of the seven new care models outlined above;
- a shared method of assessing the characteristics of local heath economies to help inform local choice of preferred models;
- national and regional expertise and support for implementation through greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks;
- national flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models; and
- design of a pump-priming model to fast-track care model transition in areas where it is likely to most rapidly deliver improvement, including through support for FTs that are willing to use accrued savings to help local service transformation.

FTN View:

FTN welcomes the Forward View's emphasis on driving towards more integrated models of care. We particularly welcome the potential for smaller providers to thrive including within networks in their local health economy. We also welcome alignment with the Dalton Review and with existing work underway to review the urgent and emergency care, and the proposals for variants of integrated and accountable care organisations.

We particularly welcome the potential for local flexibilities with regards to pricing and regulation. We also look forward to much greater clarity on how the central bodies will support and enable change at local levels working closely with providers.

However, there is an immediate need for greater clarity about NHS England's intentions with regards to specialised commissioning. Fundamentally, it is not clear where the investment to allow providers to move to new models will come from given current pressures on the service.

We are pleased that NHS England is seeking to strike a balance between the need for locally tailored models of service delivery and commonalities across health communities. However FTN will of course be looking in much greater detail at each of the proposed models on members' behalf and will provide you with a more comprehensive analysis of the implications in due course.

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CHAPTER 4: How we will get there?

To implement the prevention strategies and care delivery models outlined in chapters 2 and 3, NHS England will focus on the following approaches:

Aligned national leadership – strategies to develop shared work across the key national health bodies to reduce burden on frontline service provision will include:

- cooperation with national statutory bodies and patient and voluntary sector organisations to develop a combined work programme that supports the development of new local care models;
- greater alignment between NHE England, Monitor and TDA across their respective local assessment, reporting and intervention regimes for FTs, NHS trusts and CCGS to develop a develop a whole-system, geographically based intervention regime where appropriate, and a new risk-based assurance regime for CCGs including 'special measures';
- deploy national regulatory, pricing and funding regimes under existing flexibilities and discretion to incentivise local change where in the interest of patients; and
- re-energise the National Quality Board as a forum where key NHS oversight organisations can share intelligence, agree action and monitor overall assurance on quality.

Support a modern workforce – working with Health Education England, NHS England will:

- Develop improved recruitment and retention strategies for NHS organisations that include professional skill development, flexibility in deployment across organisational and sector boundaries, and improved education and training;
- Improve existing workforce flexibility through commissioning and expansion of new health and care roles for clinicians and nurses;
- Support NHS organisations to evolve their existing work and pay systems, and terms and conditions to reward high performance, support job and service redesign and encourage recruitment and retention.

Exploit the information revolution – a National Information Board for NHS information technology will publish before April 2015 a set of 'road maps' setting out how to transform digital care in the NHS, including:

- Comprehensive transparency of performance data to drive choice and improvement;
- NHS-accredited health apps to assist patients to organise and manage their health and care;
- Fully interoperable electronic health records to which patients will have full access, with the NHS number being used in all care settings;
- Widespread availability of on-line family doctor appointments and electronic and repeat prescribing;
- Joining up of hospital, GP, administrative and audit data (with patients given the choice of 'opting out');
- Approaches that also support non-technology users to access to information or their medical records.

Accelerate useful health innovation – a range of strategies will be explored to speed development of new treatments and diagnostics, and to combine different healthcare technologies to transform care through 'combinatorial innovation'. NHS England will test three new mechanisms to support innovation in healthcare delivery:

- A small number of real world 'test bed' sites alongside Academic Health Science Networks and Centres;
- Expanding NHS operational research to address pressing and high-impact healthcare service redesign challenges and behavioural 'nudge' policies in healthcare;

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- Explore development of health and care 'new towns' where modern healthcare services are designed and implemented free of legacy constraints, and integrate health and social care and other social services including welfare, housing and education (for example, as currently planned for Watford).

Drive efficiency and productive reinvestment – to address the predicted £30 billion funding gap by 2020/21, NHS England will focus strategies on the three drivers of cost pressure:

- **Demand** – as outlined in the FYFW, NHS England's commissioning will promote a more activist prevention and public health agenda; greater support for patients, carer and community organisations, and new models of care.
- **Efficiency** – Accelerating current NHE efficiency programmes and supporting the FYFP strategies to drive up the annual NHS net efficiency gain from 0.8% to 2.0% from now until 2020.
- **Funding** – three possible approaches to address the funding gap are discussed. Depending on the combined efficiency and funding option pursued, £30 billion gap could be reduced by one third, one half, or all the way.
    - **Scenario one:** the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The predicted combined effect would cut the £30 billion gap by about a third, to £21 billion by 2020/21.
    - **Scenario two:** the NHS budget remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. NHS England estimates the combined effect would halve the £30 billion gap in 2020/21 to £16 billion.
    - **Scenario three**: the NHS receives the infrastructure and operating investment to rapidly adopt the new care models and ways of working described in the Forward View, which NHS England estimates will deliver demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' NHS England predicts the £30 billion gap would be closed by 2020/21.

FTN View:

Strong local leadership is critical to achieving the radical change described. The Forward View's recognition of this is important, as a set of assumptions flow from it. This includes an expectation of underlying capability and capacity within the individual and collective participants in a local health economy. In particular, organisational boards – of providers and commissioners – must take responsibility for agreeing local health priorities and be held accountable for the results. To date, emphasis has been on provider accountability, with little attention paid to commissioners.

CCGs remain under-developed and do not exercise the full breadth of their rights and responsibilities, in particular, towards demand management and unmet need. The Forward View's places a great deal of weight on the ability of CCGs to lead transformational change, but they are unproven. The Better Care Fund is promoted as a model for closer working between the NHS and local government, but the FTN would urge a review of the Fund to date, including the performance of CCGs in developing its strategic intent, planning and implementation.

The FTN welcomes the growing consensus across the sector that there should not be wholesale structural reorganisation of the NHS, and the Forward View's acknowledgement that the only "wrong answer" is "to keep changing your mind". However, such commitments are often accompanied by an expectation of other far-reaching changes. This is true of the Forward View, and it is important that the implications of such changes do not force fundamental reorganisation by stealth.

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In particular, the Forward View champions greater collaboration between Monitor, the TDA and NHS England in regional working and whole system geographical intervention. This raises serious questions about the autonomy and accountability of individual organisations within a health economy, as well as that of the statutory bodies themselves. The role of good governance in delivering results and successful change cannot be understated. Without corporate governance there is no direction, no accountable leadership and no systematic control. That good boards lead good organisations is proven day in, day out across the public and private sectors. Any solution to healthcare challenges over the coming period must include locally accountable boards of directors leading strong, responsive institutions. Careful consideration of this proposal is critical.

We welcome the clear recognition that more money is needed for the NHS to support patient care and transition to new models of care. Doing so will deliver benefits for both patients and taxpayers. The Forward View puts forward a tangible assessment of the NHS's funding needs. Part and parcel of closing any funding gap is a realistic expectation of achievable productivity gains. The Forward View recognises whole system efficiencies, and – with providers the key determinants in driving such savings – a clearer parallel statement that provider efficiency requirements must be set at a credible level is necessary.

We also welcome recognition that investment is needed in new models of care, but there also needs to be a firmer commitment to longer term planning and funding cycles, and to reform of payment mechanisms in order to ensure adequate funding for services delivered. This would make bests use of funding, enabling investment in savings and improvements, as well as help to better share risk and reward through local health economies.

ADDITIONAL THEMATIC ANALYSIS

There are a number of issues and themes running through the Forward View that it is worth highlighting. As more information emerges around implementation and how the Forward View will fit with other parts of the system infrastructure and established processes the FTN will ensure that members are fully informed.

PROVIDER FINANCES

Alongside the funding section the Forward View makes a number of proposals on provider finances in terms of payment systems, control and accountability for expenditure. These sit alongside the core proposals on funding (set out above in the summary of section 4):

- Use of FT surpluses and investment powers – it is suggested that FT surpluses and investment power could be used to kick start the expansion of new style primary care. It is also suggested that FT surpluses could be used to pump prime a cross section of the new care models.
- Tariff adjustments/tariff issues - the Forward View commits NHS England and Monitor to working together to consider adjustments to the payments to reflect the costs that smaller providers face. It will also ensure that tariff funding supports choices for maternity rather than constraining them.
- Payment rules – throughout the document it is made clear that to implement new care models and new approaches discretion will be needed nationally and locally in applying payment rules. Our view is that these will need to be over and above the current scale of local variations and modifications to be meaningful.
- Split between national and local funding – the Forward View suggests that incrementally local CCGs will gain more influence over the total NHS budget for their local populations across the piece from primary through to specialised care.

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- Prevention - The introduction of integrated personal commissioning, a voluntary approach to blending health and social care funding for those with complex needs, which will mean an integrated "year of care budget" managed by individuals or their behalf by councils, NHS or voluntary organisations.
- New models of care – over time GP led multispecialty community providers could take delegated responsibility for managing the health service budget for registered patients, or the pooled health and social care budget where relevant.
- There is a clear shift in investment from acute to primary and community services. Where this is clinically appropriate and patient benefit then it is sensible to move care closer to home, but this will need funding to run in parallel run

Although the Forward View sets out options for sustainable funding, it is unclear how the different approaches to tariff and investment will be reflected in them.

COMPETITION AND REGULATION

Although regulation and competition do not have a separate focus in the report, they are clearly underpinning elements of any new structures and system.

More integrated organisational models, such as the Multispecialty Community Providers and Primary and Acute Care Systems, could potentially reduce patient choice and would require a shift in approach from the regulators and competition authorities when reviewing and approving significant transactions.

In terms of regulation:

- It is clear a more flexible and nuanced regulatory approach would be needed to support the development of new organisational models and new models of care, with a focus on health economies and/or pathways, rather than institutions.
- The vision sets out a proposal for a geographical – either regional or local health economy approach to regulation and intervention regime, using flexibilities and discretion.
- The future impact of being in special measures is unclear – it is suggested that new organisational models may be imposed as a result of local failure "and the resulting implementation of special measures".

In terms of competition:

- The future role of competition in the NHS is unclear. A different approach than currently exists would be required to deliver this vision. The future role of the Competition and Mergers Authority (CMA) also seems unclear. They are currently restricted in the way they analyse 'substantial lessening of competition', which is based on economic principles and a refined economic formula. Reviewing proposed models that incorporate elements of vertical integration may well present challenges.
- The vision seems to support the AQP agenda, by calling for a shift in focus around the role of the voluntary sector in providing NHS services, committing to reducing the time and complexity associated with these organisations securing contracts to provide services.

These proposals do suggest a substantial shift away from both the institutional focus and accountability of the current regulatory regime, to a geographical, whole system, local health economy approach to accountability and regulation.

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FOCUS ON MENTAL HEALTH

The document sets out five year ambitions for mental health, driving towards both an equal response to mental and physical health and treating the two together. It references current and planned initiatives including the introduction of waiting standards for mental health from next April. It also references the importance of tackling mental health problems as part of NHS support to help people get and stay in employment.

Importantly it states a wider ambition of genuine parity of esteem between physical and mental health by 2020 improving waiting time standards and expanding mental health services to include children's services, eating disorder and those with bipolar conditions. This will need:

- New commissioning approaches;
- Additional staff to coordinate care
- Further investment

The need to properly fund and integrate mental health crisis services, specifically including liaison psychiatry, is highlighted as part of the proposals to develop urgent and emergency care networks.

Alongside this it highlights support for people with dementia, and the proposes a five year approach to offer consistent standards of support for patients newly diagnosed – including named clinicians or advisors to develop proper care plans developed in partnership in partnership with carers and families. It proposes a broader coalition of support pulling together statutory services, communities and business.

One of the key areas of concern in mental health over the past year has been around the shape of commissioning of specialised services, and the provision of children's and adolescent mental health services in particular. It is a shame that the forward view does not focus more heavily on commissioning and address the importance of these 'life stage' services in mental health.

FTN MEDIA AND BLOGS:

PRESS STATEMENT

Five Year Forward View is a statement of great confidence in the NHS

"The Five Year Forward View (5YFV) published today by NHS England is a statement of great confidence in the NHS", said Chris Hopson, chief executive of the Foundation Trust Network.

"It both recognises the strengths and unique place of the NHS in our nation to improve its peoples' health and the changes it will need to make to achieve them. At a time when everyone is worried about coping with this winter's huge demand and the tough tariff expected for next year, it is important to be able to look further forward with vision and ambition for the future. While noting the careful implementation it will require, the FTN strongly welcomes this tone and also the realism that recognises much of the vision can only be fulfilled with significant additional funding, including for mental health services.

"The 5YFV rightly recognises that the NHS is admired world wide, and has a history of progress and of improving the nation's health. It also clearly states the country's rising health needs and the increasing demand that will continue to be placed on the NHS. Its emphasis on parallel endeavours to avoid ill health, minimise the need for dependence on health and social care services and to develop a health care service fit for the 21st

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century is very welcome. Simon Stevens is also quite right to highlight the role we must all play as individuals and employers to promote healthy lifestyles to minimise ill health and dependency.

"NHS England's broad view under Simon Stevens helps us to step back and see what we can achieve and what we should want for ourselves and our country's health. His talk of both patients and citizens is a meaningful affirmation that healthcare is not simple and only about treatment and transactions, but about lifestyle, social cohesion and community collaboration. While true, our members across the ambulance, community, mental health and acute sectors are already pioneering elements of the plan and collaborating with primary care, voluntary sector and local authorities to create new models of care.

"We are also encouraged that it has been developed in partnership with other NHS regulators and national bodies and seeks a new partnership for local and national bodies with a clear emphasis on enabling and emancipating providers across all sectors to innovate and collaborate by removing barriers and stimulating progress where necessary which we hope will reduce regulatory burden and barriers to rapid progress.

"With the general election looming the 5YFV presents a perfect opportunity for political unity on the way forward and a welcome first step would be for the political parties to commit to its vision. We have a tough winter and painful funding round to get through, and significant detail to work out to make a reality of the view. However, having a view and a route to it, beyond the short-term targets, quarterly figures and small pots of patching funding, provides hope and opportunity for the NHS' sustainability and the improving health of this country."

In an exclusive blog for the HSJ, FTN chief executive Chris Hopson provides his analysis: www.hsj.co.uk/comment/the-entire-nhs-can-back-the-forward-views-vision/5076088.article

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Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors November 2014 - PUBLIC

TITLE:	Infection Prevention and Control Exception Report		
AUTHOR:	Denise McMahon – Director of Nursing Dr Elizabeth Rees - Consultant Microbiologist/ Infection Control Doctor/ Director of Infection Prevention and Control	**PRESENTER:**	Dr Elizabeth Rees - Consultant Microbiologist/ Infection Control Doctor/ Director of Infection Prevention and Control

CORPORATE OBJECTIVE:

SG01: Quality, Safety & Service Transformation Reputation – To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.

SUMMARY OF KEY ISSUES:

The Board of Directors are asked to note Trust Performance against C. Difficile and MRSA targets and the other notable infections.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Infection Prevention and Control	
	Risk Register: Y		**Risk Score:** IC010 – Score: 16	
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:**	Outcome 8 – Cleanliness and Infection Control
	NHSLA	**N**	**Details:**	
	Monitor	**Y**	**Details:**	Compliance Framework
	Equality Assured	**N**	**Details:**	
	Other	**N**	**Details:**	

ACTION REQUIRED OF BOARD:

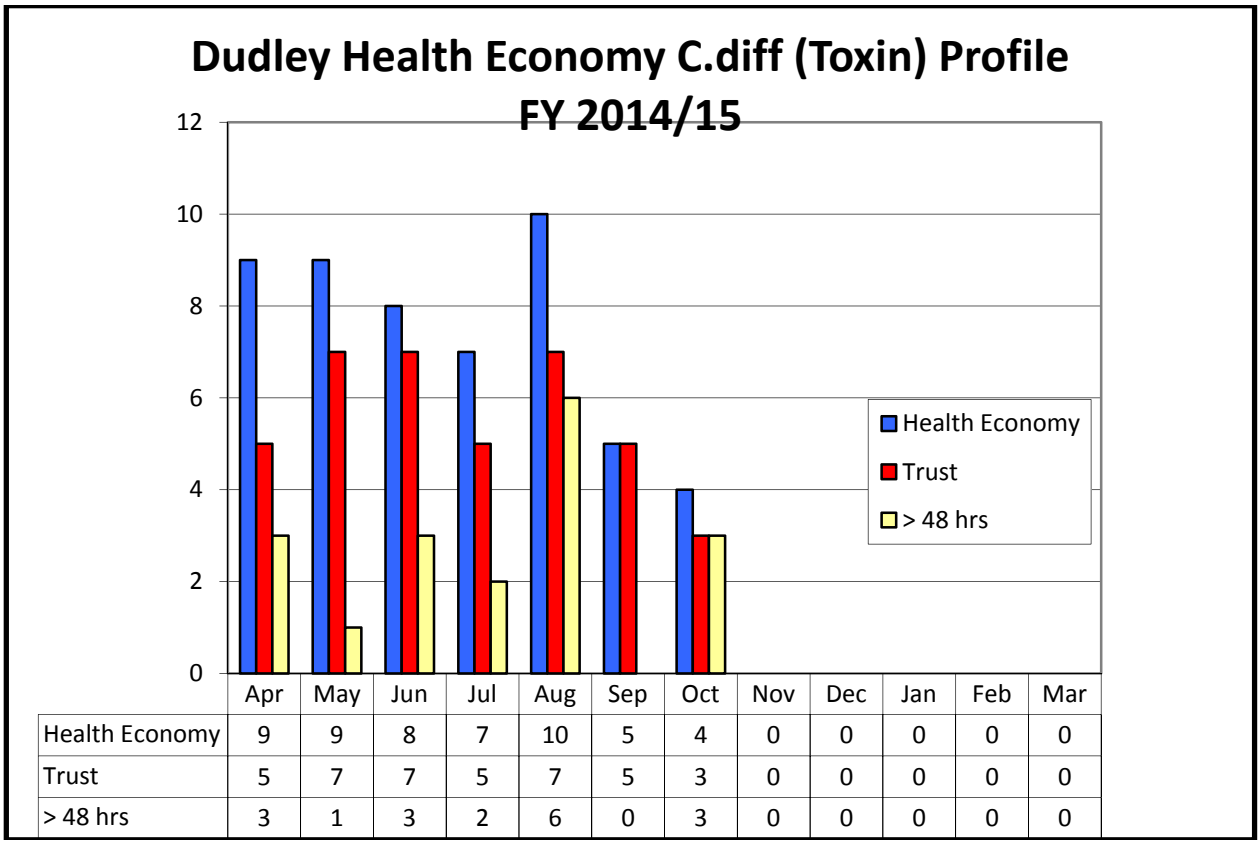
Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

Summary:

Clostridium Difficile – The target for 2014/15 is 48 cases, equivalent to 20.5 CDI cases per 100,000 bed days. At the time of writing (29/10/2014) we have 3 post 48 hour cases recorded in October 2014 against a trajectory for the month of 3 cases.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	9	9	8	7	10	5	4	0	0	0	0	0
Trust	5	7	7	5	7	5	3	0	0	0	0	0
> 48 hrs	3	1	3	2	6	0	3	0	0	0	0	0

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], has commenced. The process is now running smoothly and we are working with the CCG to catch up with cases from April 2014.

MRSA bacteraemia (Post 48 hrs) – There have been no post 48 hour MRSA bacteraemia cases identified so far this year.

Norovirus – There are no wards currently affected.

Ebola – Public Health England (PHE) have issued further advice, which the Trust is adopting, including displaying public information at entry points into the Acute Trust. A walk through of local plans was undertaken and further work to add detail to the plans is being completed.

Reference

1. *Clostridium difficile* infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation, Public Health England.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 6th November 2014

TITLE:	**Monthly Nurse/Midwife Staffing Position – September 2014**		
AUTHOR:	Denise McMahon Director of Nursing	**PRESENTER:**	Denise McMahon Director of Nursing

CORPORATE OBJECTIVE:

SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation

SGO2: Patient Experience - To provide the best possible patient experience

SGO5: Staff Commitment - To create a high commitment culture from our staff with positive morale and a "can do" attitude

SUMMARY OF KEY ISSUES:

Attached is the monthly information on nurse/midwife staffing.

As previously stated, there is no set template for this information and so the intention behind the format of the attached has been to make potentially complex information as clear and easily understandable as possible. As this is a recent requirement, the format will evolve as time progresses but no changes have been made to the format since last month.

The paper indicates for the month of September 2014 when day and night shifts on all wards were (green) and were not staffed to the planned levels for both registered (amber) and unregistered staff (blue), with the day shift registered figures also taking into consideration the 1:8 nurse to patient ratio for general wards. Unsafe staffing will also be charted (red). The planned levels for each ward vary dependent on the types of patients and their medical specialities and national ratios apply to specialist areas such as intensive care, midwifery and paediatric areas.

When shortfalls occurred the reasons for gaps and the actions being taken to address these are outlined and an assessment of any impact on key quality indicators has been undertaken.

IMPLICATIONS OF PAPER:

RISK	**Y** **Risk Register: Y**		**Risk Score and Description:** Nurse staffing levels are sub-optimal (20) Loss of experienced midwives (15)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** 13: Staffing
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance with the Risk Assessment Framework
	Equality Assured	**Y**	**Details:** Better Health Outcomes for all Improved patients access and experience
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

To discuss and review the staffing situation and actions being taken and agree to the publication of the paper.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Monthly Nurse/Midwife Staffing Position

September 2014

One of the requirements set out in the National Quality Board Report 'How to ensure the right people, with the right skills, are in the right place at the right time' and the Government's commitments set out in 'Hard Truths', is the need for the Board to receive monthly updates on staffing information.

The attached chart follows the same format as the updated one last month. It indicates for the month of August 2014 when day and night shifts on all wards were and were not staffed to the planned levels for both registered and unregistered staff, with the day shift registered figures also taking into consideration the 1:8 nurse to patient ratio for general wards.

In line with the recently published NICE (2014) guideline on safe staffing:
1) An establishment (an allocated number of registered and care support workers) is calculated for each ward based on a combination of the results of the six monthly Safer Nursing Care Tool exercise and senior nurse professional judgement both based on the number and types of patients on that ward (with the Board receiving a six monthly paper on this). The establishment forms a planned number of registered and care support workers each shift.
2) Each six weeks the Lead Nurse draws up a duty rota aimed at achieving those planned numbers.
3) Each shift the nurse in charge assesses if the staff available meet the patients' nursing needs.
Following the shift, the nurse in charge completes a monthly form indicating the planned and actual numbers and, if the actual doesn't meet the planned, what actions have been taken, if any is needed for the patients on that day. Each month the completed form for every ward is sent to the Nursing Directorate where they are analysed and the attached chart compiled.

It can be seen from the chart (green) that the staffing available met the patients' nursing needs in the majority of cases. In a number of instances, despite attempts through the use of deployment of staff or the use of bank/agency staff, the number of planned staff for the patients on that shift were not reached.

When there is an unregistered staff shortfall the shift is marked in blue and when there is a registered staff shortfall this is marked in amber. If the shift is reported as unsafe, this will be marked as red. In all instances of shortfalls, the planned and actual numbers are indicated.

When shortfalls have occurred the reasons for the gaps and the actions being taken to address these in the future are outlined below.

With regards to qualified staff vacancies, on the 22nd September 26 local and 5 international nurses finished their induction and have commenced a supernumerary period on the wards. In addition, recruitment continues in Scotland, Ireland, Spain and Portugal.

An assessment of any impact on key quality indicators has been undertaken. From as far as possible as it is to ascertain, these shortfalls have not affected the results of any of the nursing care indicator measures or other quality measures such as the number of infections. In addition, there is no evidence that they have affected patient feedback in terms of the answers to the real time surveys or in the number of concerns or complaints received.

Nice (2014) Safe Staffing for nursing in adult in-patient wards in acute hospitals (London: July 2014)

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS SEPTEMBER 2014

WARD	No.	RN/ Unreg	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A1	1	RN	Vacancy	Bank unable to fill. Dependency of patients meant safety maintained.
A3	2	RN	Staff Sickness	Bank unable to fill. On both occasions lead nurse worked clinically leaving one nurse short on each shift.
A4	1	RN	Vacancy	Both bank and stroke sister cancelled availability at last minute. Liaised with other areas contacted for support and Site Coordinator/Matron contacted.
B1	2	RN	Vacancy/Staff sickness	On one night, eight patients in total on ward so one station closed. On other occasion, ratio was acceptable but workload not predicted due to post surgical requirements. Liaised with other areas contacted for support and Site Coordinator/Matron contacted.
B6	2	RN	Vacancy/Staff sickness	On one night, bank unable to fill. Support sought from other surgical wards. Three empty beds and ward closed to admissions. On other night, bank nurse had to be sent home due to sickness. Again, three empty beds and ward closed to admissions. Liaised with other areas contacted for support and Site Coordinator/Matron contacted.
C1	7	RN	Vacancy/Sickness	Bank and agency unable to fill. Of the six night occasions, extra care workers employed. Dependency of patients meant safety maintained.
C3A	2	RN	Vacancy	One occasion bank unable to fill and on the other bank nurse did not turn up. Untrained staff reallocated to provide patient support required. Dependency of patients meant safety maintained.
C4	1 4	RN Unreg	Staff sickness Patients requiring 1:1 care	Bank and agency unable to fill. All required care undertaken. Safety maintained. Lead nurse, shift lead and Unreg from other ward assisted.
C6	2	RN	Staff sickness	One one occasion, bank unable to fill while on the other bank staff cancelled. Further admissions to ward stopped. On one occasion, day staff assisted to midnight.
C7	4	RN	Vacancy	Bank and agency unable to fill. Following assessment of nurse in change patient dependency such that safety maintained and all care needs attended to.
C8	1	RN	Staff sickness	Bank and agency unable to fill. Liaised with other areas contacted for support and Site Coordinator/Matron contacted.
MHDU	1	RN	Vacancy	Liaised with other areas contacted for support and Matron contacted.
Neonatal Unit	3	RN	Staff sickness	On one occasion, advanced nurse practitioner assisted, on another two babies transferred to post natal ward and on the third occasion transitional care nurse assisted with babies on the unit.

Sep-14

SHIFT

		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16	
WARD	**STAFF**	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	Reg																																
	Unreg																																
WARD A2	Reg																																
	Unreg																																
WARD A3	Reg																																
	Unreg																																
WARD A4	Reg																						3/1										
	Unreg																																
WARD B1	Reg																																2/1
	Unreg																																
WARD B2 HIP	Reg																																
	Unreg																																
WARD B2 TRAUMA	Reg																																
	Unreg																																
WARD B3	Reg																																
	Unreg																																
WARD B4	Reg																																
	Unreg																																
WARD B5	Reg																																
	Unreg																																
WARD B6	Reg																2/1																
	Unreg																																
WARD C1	Reg		4/3																				4/3		4/3		4/3						4/3
	Unreg																																
WARD C2* **	Reg																																
	Unreg																																
WARD C3A	Reg	3/2		3/2																													
	Unreg																																
WARD C3B	Reg																																
	Unreg																																
WARD C4	Reg																																
	Unreg																									4/3						4/3	
WARD C5	Reg																																
	Unreg																																
WARD C6	Reg																																
	Unreg																																
WARD C7	Reg																							5/4				5/4		5/4			
	Unreg																																
WARD C8	Reg																																
	Unreg																																
CCU	Reg																																
	Unreg																																
PCCU	Reg																																
	Unreg																																
EAU	Reg																																
	Unreg																																
MHDU	Reg																																
	Unreg																																
CRITICAL CARE*	Reg																																
	Unreg																																
NEONATAL**	Reg																																
MATERNITY ******	Reg																																
	Unreg																																

		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
WARD	**STAFF**	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	Reg												2/1																		
	Unreg																														
WARD A2	Reg																														
	Unreg																														
WARD A3	Reg	4/3		4/3																											
	Unreg																														
WARD A4	Reg																														
	Unreg																														
WARD B1	Reg				3/2																										
	Unreg																														
WARD B2 HIP	Reg																														
	Unreg																														
WARD B2 TRAUMA	Reg																														
	Unreg																														
WARD B3	Reg																														
	Unreg																														
WARD B4	Reg																														
	Unreg																														
WARD B5	Reg																														
	Unreg																														
WARD B6	Reg																				2/1										
	Unreg																														
WARD C1	Reg											4/3				6/5															
	Unreg																														
WARD C2* **	Reg																														
	Unreg																														
WARD C3A	Reg																														
	Unreg																														
WARD C3B	Reg																														
	Unreg																														
WARD C4	Reg															3/2															
	Unreg							4/3																		4/3					
WARD C5	Reg																														
	Unreg																														
WARD C6	Reg						2/1			3/1																					
	Unreg																														
WARD C7	Reg	5/4																													
	Unreg																														
WARD C8	Reg																						4/3								
	Unreg																														
CCU	Reg																														
	Unreg																														
PCCU	Reg																														
	Unreg																														
EAU	Reg																														
	Unreg																														
MHDU	Reg																											4/3			
	Unreg																														
CRITICAL CARE*	Reg																														
	Unreg																														
NEONATAL**	Reg																	9/7				9/6						9/7			
MATERNITY ******	Reg																														
	Unreg																														

Key: Unsafe staffing (red) | Registered nurse shortfall (amber) | Care Support Worker shortfall (blue)

* Critical Care has 6 ITU beds and 8 HDU beds

** Neonatal Unit has 3 ITU cots, 2 HDU cots and 18 Special care cots. Ratios reflect BAPM guidance and include a single figure for registered and non registered staff

*** Children's ward accommodates children needing direct supervision care, HDU care 2 beds, under 2 years of age care and general paediatric care. There are no designated beds for these categories, other than HDU and the beds are utilised for whatever category of patient requires care.

**** Midwifery registered staffing levels are assessed as the midwife: birth ratio and is compliant with the 'Birthrate +' staffing assessment

Enclosure 6

Paper for submission to the Board on 6th November 2014

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 11th September 2014		
AUTHOR:	Julie Cotterill Associate Director of Governance / Board Secretary	**PRESENTER:**	David Bland (NED) CQSPE Committee Chair
CORPORATE OBJECTIVES: SGO1: Quality, Safety & Service Transformation, Reputation, SGO2: Patient Experience SGO5: Staff Commitment			

SUMMARY OF KEY ISSUES

Serious Incident (SI) Monitoring Report (August 2014) - 8 new incidents were reported in the month (5 Patient Falls resulting in Fracture, 2 Confidentiality Breaches and 1 Stillbirth Pre-delivery). There were 55 open general SI's in total (24 RCA/investigations in progress, 30 awaiting assurance that all actions had been completed and 1 recommended for closure). The Committee supported the closure of 1 Serious Incident which was an unexpected admission to neonatal unit.

The Committee considered incident trends and noted that falls resulting in fractures over the last 2 months had shown an upward trend, with 5 incidents reported in August 2014. Of these, 2 incidents occurred in Ward B2, 1 in Ward B4 and 2 incidents occurred in Ward C3.

The Trust now reports all Grade 3 and 4 pressure ulcers. High numbers were reported on three wards and for a 12 month rolling period it was shown that C3 had 11, B2 had 10 and C5 had 7. The Committee discussed the actions taken to improve patient care in these areas.

There were three breaches in the 2 days from identification of an incident and reporting to STEIS which all related to patient falls on B2 and B4. No Never Events were reported in this period.

Quality Dashboard for Month 4 (July) 2014/2015 - Key issues arising included:

- TAL – Appointment booking within 4 days was below target and had been referred to the Finance and Performance Committee. The main concern was ophthalmology where a lot of work was in progress.
- Maternity: Increase in breast feeding initiation rates and Maternity: Smoking in Pregnancy were both showing as red. The breast feeding target had been green for the previous 4 months.
- The Nursing Care Indicator (NCI) for Think Glucose was amber for July. The Committee was advised that this subject was being removed from future NCIs. The Committee was advised that the content of NCI's was under review as many checks had been added to the tool over a period of time and it had moved away from the original audit of the care the patients were receiving.
- NHS Choices information was released the day before the meeting and the number of Dupuytren's Contracture day case procedures was higher than the acceptable range.

The Committee **noted** the quality dashboard for July 2014.

Policy Group Recommendations - 16 guidelines had been revised and five documents had been taken back to the Policy Group with minor amendments and had been collectively agreed. The Committee **ratified** the 21 guidelines/policies.

Mortality Report - The Committee received an update on mortality indices, the Trust Mortality Tracking System and actions taken to date. The action log showed that 1 action had not been completed, 4 were in progress and 1 was complete.

Referring to a "12 week audit compliance" for the period March 2013 to February 2014 the Committee was assured that with the exception of renal the specialties were doing well. The Committee requested assurance in terms of actions in progress and requested an update for next month.

The Committee considered the SHMI figures and the Trusts position when benchmarked against others and discussed the progress to date. The Committee **received** the Mortality Report and **noted** the progress on the agreed actions.

Patient Experience Group (10th July 2014) – the Committee was advised that the minutes were for information only as the group had met again the day before. The CCG was driving for transparency and the Patient Experience Group would be amending their Terms of Reference and would now invite the CCG to join the meeting.

Patient Safety Leadership Walk rounds on B2 had identified an issue regarding trailing wires. The Committee confirmed that action had been taken. Future quarterly Board reports presented by Mr Graves and Mr Scott would include Patient Safety Leadership Walk rounds and concerns raised.

Mrs Becke referred to a culture issue that had been highlighted at the Safeguarding Board with regard to "Out of Hours Medical Photography". The Committee was advised that guidance had been put on the Hub about staff taking photographs and this would be shared with the Safeguarding Board. The Committee **noted** the key issues arising from the Patient Experience Group held on 10th July 2014.

Internal Safeguarding Board (31st July 2014 and 21st August 2014) – the following issues were highlighted:

- **PAN Board Review meeting -** two case conferences regarding restraint issues were now closed. A report would be published by the Safeguarding Board in the near future and made available in the public domain.
- **Safeguarding Training compliance –**there was a slight decrease in safeguarding training which related mainly to nursing staff and a mandatory training plan was in place to address this.

The Committee **noted** the key issues arising from the Internal Safeguarding Board held on 31st July and 21st August 2014.

The Committee was advised that the Local Supervising Authority Midwifery Officers report had been released and would be presented next month

IMPLICATIONS OF PAPER:

RISK	Y		**Risk Description:** Committee reports ref to the risk register
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:** Outcome 1 - Respecting & Involving people, 4 – Care & welfare of people, 7 – Safeguarding, 16 – Assessing & monitoring quality of service
	NHSLA	Y	**Details:** Risk management arrangements e.g. safeguarding
	Monitor	Y	**Details:** Ability to meet national targets and priorities
	Equality Assured	Y	**Details:** Better health outcomes for all Improved patient access and experience
	Other	Y	**Details:** Quality Report/Accounts

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 11th September 2014 and refer to the full minutes for further details.

The Clinical Quality, Safety & Patient Experience Committee was established to provide assurance to the Board on Clinical Quality and Safety standards, (including Clinical Effectiveness, Patient Safety and Patient Experience). It sets clear quality performance expectations and ensures the development and delivery of high quality care and continuous improvements through innovation and the use of levers such as CQUINS. It identifies and advises on quality improvement priorities and the organisational learning from these and monitors compliance with Health Standards ensuring the Trust fulfils its obligations with regard to the Health Act (2009) and Monitor in the production of an Annual Quality Account and Report.

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors Meeting on Thursday 6th November 2014

TITLE:	Moving Patients Out of Hours		
AUTHOR:	Karen Hanson Divisional Manager – Patient Flow	**PRESENTER**	Jon Scott Interim Director of Operations

CORPORATE OBJECTIVE: SG01, SG02, SG06

SUMMARY OF KEY ISSUES:

This is a briefing paper providing information and subsequently assurance as to the progress made around patient flow and the management of patient moves out of hours.

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details:**
	NHSLA	**Y/N**	**Details:**
	Monitor	**Y/N**	**Details:**
	Equality Assured	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE COMMITTEE:

This a briefing paper to provide assurance that processes are being adhered too and that there is a performance management structure in place.

STRATEGIC OBJECTIVES : *(Please select for inclusion on front sheet)*		
SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
SGO2.	Patient experience	To provide the best possible patient experience
SGO3.	Diversification	To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio
SGO4.	Clinical Partnerships	To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO5.	Staff Commitment	To create a high commitment culture from our staff with positive morale and a “can do” attitude
SGO6.	Enabling Objectives	To deliver an infrastructure that supports delivery

The Dudley Group NHS
NHS Foundation Trust

Report to: - Board of Directors – November 2014

Report Title: - Moving Patients Out of Hours

Report Author: - Jon Scott – Director of Operations

Date:- 28th October 2014

Introduction

This briefing report provides information on the movement of patients out of hours and provides assurance that the Trust has taken steps to minimise unnecessary/avoidable moves as part of improving patient experience.

The following information is provided:

- The areas you would expect to see movement
- Steps being taken to reduce unnecessary moves from 21.00

Background

The original request for the briefing paper came from Board following the Sir Bruce Keogh letter earlier this year. It was noted at the time that there are instances where it is clinically or operationally appropriate to transfer patients between clinical areas out of hours. However the Board of Directors requested assurance that the hospital processes employed are appropriate. It requested that an audit be undertaken to review the processes and provide assurance.

Exclusions to the Moves

There are a number of areas which are excluded from recorded as 'out of hours' moves. The Trust operates assessment units within medicine and surgery as well as the Ambulatory Emergency Care unit. In these areas patients attend throughout the 24 hour period and are, therefore, not included in the transfer numbers. In addition the Maternity Unit is also excluded.

Improvement to Patient Flow

A number of key actions have been undertaken since June 2014, as follows;

There has been a daily increase in the use of the Discharge Lounge. The Discharge Lounge policy has been revised and re-launched to the nursing teams to ensure that the reasons for non compliance with use are very specific. Any wards that discharge patients directly from the wards are identified to the Heads of Nursing to ensure that the reasons fit with the policy. The increased use of the lounge supports patients moving earlier in the day to the right place first time and thus reducing the need to move overnight.

Use of the Discharge Lounge is also promoted by the Clinical Site Coordinator who goes to each ward to ensure that patients are moving appropriately. Use of the discharge lounge is reported daily via the Capacity meetings to the Divisional Directors, Deputy Directors of Operations and Heads of Nursing.

The "Home for Lunch" philosophy was reinvigorated in July and is currently being piloted on C5. Overall in the Trust there is a slow but definite increase in the percentage of patients discharged by midday. In June 2014 the number discharged before noon was 16% of all discharges and, at the time of writing the report, in October it was 18%.

In September the Emergency Assessment Unit started twice daily board meetings at 09:00 and 14:30 to ensure that the unit is aware of bed availability within the hospital and that there are actions to ensure that the moves take place before 21:00.

The 16:30 daily capacity meeting ensure that an evening action plan to support patient flow is agreed. Any patients that are for discharge home the following day are planned to move to A1 or C8 flexi area. This avoids the need to outlie patients into surgery which, historically, is an action that occurs late in the day.

Since these actions have been implemented the Trust has seen a decline in outlying patients into surgery.

The Audit

The outlying policy states that if patients are moved after 23:00 a Datix should be raised. This audit of moves is taken from this and from out of hours moves data provided by the Information department.

Table 1, shows the individual Datix's that have been reported and it demonstrates a reduction in incidents since June.

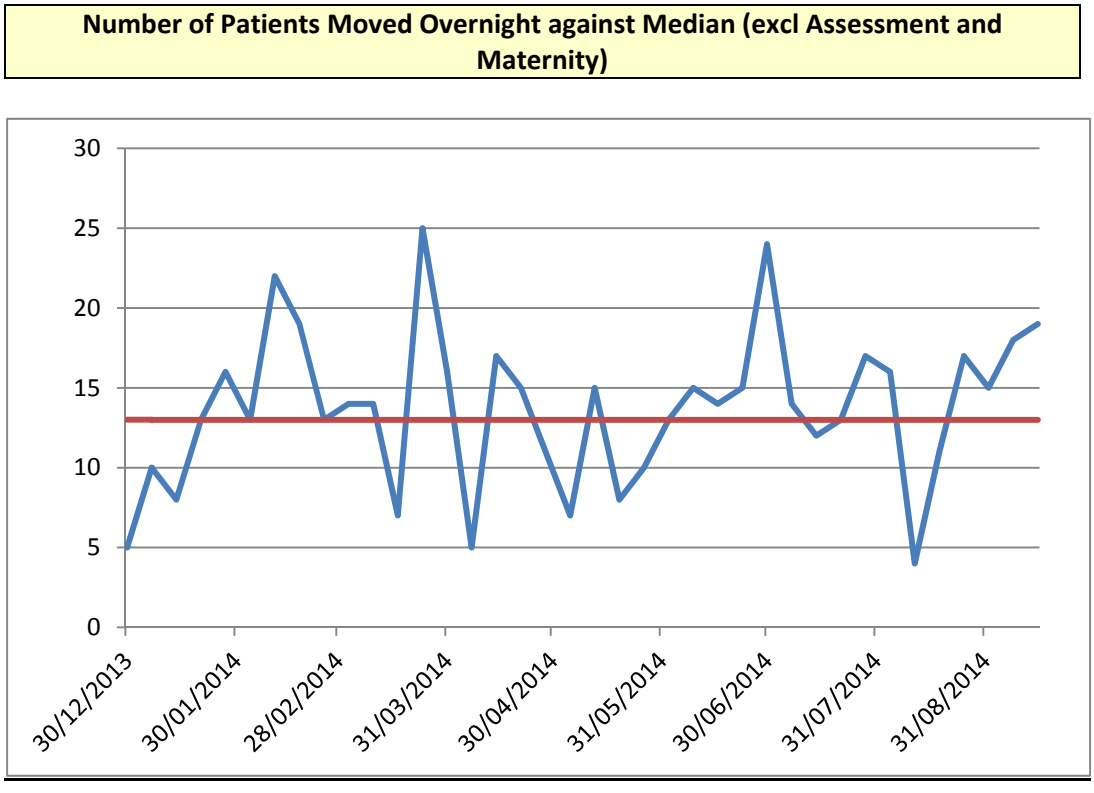
Graph 1, shows the overall number of patient moved (excluding assessment areas and Maternity) which, at this time, does not show an improvement.

The Dudley Group NHS
NHS Foundation Trust

Table 1:

	2014 01	2014 02	2014 03	2014 04	2014 05	2014 06	2014 07	2014 08	2014 09	Total
Ward A1 (Rheumatology/Pain)	0	0	1	1	0	0	0	0	0	2
Ward A2 (Geriatric Care)	0	0	0	0	1	0	0	0	0	1
Ward A3 (Stroke)	0	0	0	0	0	0	1	2	1	4
Ward C1 (Renal)	1	0	0	0	0	0	0	0	0	1
Site Coordinators	2	0	0	0	0	0	0	0	0	2
Emergency Department	0	0	0	0	0	2	1	0	0	3
Emergency Assessment Unit	1	1	1	1	0	0	0	0	0	4
Endoscopy	0	0	0	1	0	0	0	0	0	1
MHDU	0	0	0	1	0	0	0	0	0	1
Ward C8 (AMU)	1	2	3	2	2	0	0	0	0	10
INAPPROPRIATE Transfer (Including Out of Hours)	**5**	**3**	**5**	**6**	**3**	**2**	**2**	**2**	**1**	**29**

Graph 1: Ward Moves During the Night



Performance Management

As a result of the Datix audit and the performance graph a performance dashboard will be tabled at the weekly operations meeting chaired by the Interim Director of Operations and attended by the Divisional Directors and Deputy Directors of Operations. This will be used to discuss out of hours patient move reasons and actions that are to be taken to reduce them.

In addition a clinical audit request has been submitted to undertake a case by case review of those moves highlighted by Datix and the Information report. The Clinical Audit team have received a request for this audit and will be providing information on completion timescales.

Conclusion

This report has highlighted the improvements made in attempt to reduce the transfer of patients out of hours. While there has been an improvement in the number of patients being discharged in the day time and a reduction in the number of outliers there is further work that needs to be done to reduce the overall number of patient moves out of hours.

The clinical site coordinator and divisional management teams provide daily challenge to wards and other areas to ensure that this important patient experience issue is further minimised.

The Board of Directors is asked to note the content of this report and the continuing improvement in the number of discharges before midday.

A further report following the clinical audit will be provided to the Board of Directors at the earliest opportunity.

The Dudley Group NHS Foundation Trust

Enclosure 8

Paper for submission to the Board of Directors on 6th November 2014

TITLE:	Safeguarding Report to Trust Board – October 2014		
AUTHOR:	Pam Smith Deputy Director of Nursing	**PRESENTER:**	Denise McMahon Director of Nursing

CORPORATE OBJECTIVE:

SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation

SGO2: Patient experience - To provide the best possible patient experience

SGO6: Enabling Objectives - To deliver an infrastructure that supports delivery

SUMMARY OF KEY ISSUES:

1. **ALLEGATIONS OF UNLAWFUL RESTRAINT - CONCERNS RAISED BY INDEPENDENT CHAIR OF SAFEGUARDING BOARDS**
   A report on the outcome of the cases has been approved at Dudley Children's Safeguarding Board and Dudley Adults Safeguarding Board. A copy of the report is due to be published on the Safeguarding Boards' websites. Details of the allegations raised and the actions taken to hold the Trust to account are detailed in the Trust's Annual Safeguarding Report 2013/14 (page 13-14).

2. **CQC/OFSTED ASSESSMENT**
   This unannounced inspection is still awaited; the inspection is expected imminently. The local Authority has requested that all agencies are prepared for this. The Internal Safeguarding Board members are aware of the unannounced inspection and staff in key areas have been briefed as required.

3. **LEARNING DISABILITY STRATEGY**
   The Learning Disability Strategy was launched on 28th March 2014 and received positive feedback from Trust staff and partner agencies. An action plan has been developed to ensure that the strategy is embedded throughout the Trust. A progress updated as at the end of September 2014 has been provided to the Clinical Quality, Safety and Patient Experience Committee. All actions are on track.

4. **TRAINING**

   4.1 Safeguarding Children compliance
   Safeguarding Children Foundation training compliance is now at 85.4%. This is a slight decrease from July 2014. Intermediate training compliance is now at 66.4%. This is a 2% increase from July 2014.

   4.2 Safeguarding Adults compliance
   Safeguarding Adults training compliance is now at 83.3%. This is a slight decrease from July 2014.

   4.3 Mental Health compliance
   Mental Health training compliance is now at 73%. This needs to reach 100% compliance by March 2015 to meet the CQUIN target.

   4.4 Learning Disabilities CQUIN
   The numbers of staff to be trained in Learning Disability to meet the CQUI target for 2014/15 has been identified. 50% of staff identified to undertake training have completed this. This is within the CQUIN target identified for Quarter 2.

   4.5 Safeguarding Maternity Compliance
   Safeguarding Adults 83% - increased from 80% in August 2014.
   Safeguarding Children Foundation (level 1) 94% - increased from 92% in August 2014.
   Safeguarding Children Intermediate (level 2) 85% - maintained from August 2014.

5. Annual Safeguarding Report 2013/14

The annual Safeguarding Report for 2013/14 has been developed by the Internal Safeguarding Board. The report provides information on the safeguarding activities from 1st April 2014 to 31st March 2014 including summaries on national and local issues; policies and procedures; details on safeguarding referrals and incidents; Audit; and Training and Education. A section on new developments/new initiatives and future developments for 2014/15.

Overall there has been an increase in the numbers of staff who have completed Safeguarding training in 2013/14. This is identified in the report by Directorate.

There has also been an increase in the number of referrals and incidents for both Maternity and Adults.

6. Safeguarding CQUIN 2014/15

The safeguarding CQUIN target for 2014/15 is to present one adult and one child case to the Board in each quarter.

For quarter 1 a case regarding a child who had several admissions to the children's ward with faltering growth was reviewed. The child; the youngest of 4 was under the care of the Paediatrician. The frequent admissions to the ward and past medical history of the siblings to support an organic cause for faltering growth. However, during an admission when the child was 10% dehydrated. Within 24 hours of admission the child gained 10% of their body weight. Blood tests identified re-feeding syndrome one of the causes of which can be starvation. Safeguarding concerns were raised. Observations of the parent child interaction identified some unusual behaviour including a lack of response from the mother to her child.

6.1 Quarter 1 – Service User Stories

Child Service User Story

Child A was referred to the local authority and a strategy meeting held; this was well attended by agencies. There were no barriers to sharing communication and a plan to protect the children was agreed. A detailed medical report was written. A child protection plan was implemented and an alert was attached to the child's records.

Parents were fully engaged in the safeguarding process. The child was too young to express wishes or feelings.

The following actions were identified as learning from the case:

- Professionals to be alert to the possibility of fabricated or induced illness.
- Faltering growth pathway to include observation of child and normal feeding routines.
- Professionals to be aware of guidelines regarding not informing parents when fabricated or induced illness is suspected.

The learning points from the case have been shared with staff involved with the case at Ward Huddle board meetings and at Trust's Safeguarding Forum to ensure that the learning is shared Trust wide.

Adult Service User Story

Adult 1 was referred to social services by the patient's son. The patient had end stage Dementia and challenging behaviour. The son felt that she was unnecessarily sedated and kept in bed. Patient had developed a stage 3 pressure ulcer to the sacrum which was identified and reported by the ward.

The case notes were reviewed; statements from therapy staff regarding the advice for patient. To be nursed in bed at time period of relatives concerns. A Root Cause Analysis investigation of the Pressure Ulcer development was completed.

The patient's son was updated on progress with the investigation via the social worker and at case conferences by the safeguarding lead. The patient lacked capacity to understand the

concerns that had been raised by her sons.

A referral was made to the local authority and proceeded to a safeguarding investigation. The Named Nurse for Safeguarding shared appropriate information in relation to concerns raised and the internal investigation.

It was difficult for the patient to express to staff her wishes and feelings. The findings were that the family had not been informed that the patient had been assessed as having poor balance and sitting position and were not aware of the risk of falls. There was no evidence of over sedation. The patient was generally chatty but not always so at visiting times. This may have been due to tiredness at the beginning of her stay in hospital; this was not relayed to her sons. Following the acute episode of care the patient was able to weight bear and support herself; requiring supervision from a 1:1 nurse.

The family were happy with the outcome of the investigation and felt reassured by the findings.

The following actions were identified as learning from the case:

- To review ward documentation regarding patient's behaviour.
- Accurate waterlow assessment to be completed.
- Datix incident to be reported timely.
- Round table meeting for Adult Safeguarding Nurse, C8 and C3.
- All patients to be placed on a seat cushion when sat out.
- Monitor completion of level 2 and level 4 observations by bank staff.

The learning points from the case have been shared with staff involved with the case at Ward Huddle board meetings and at the Pressure Ulcer Group meetings to ensure that the Learning is shared Trust wide.

Following presentation to the Trust board both cases will be discussed at the Clinical Commissioning Group's Clinical Quality Review Meeting to ensure that all aspects of the CQUIN target are met.

6.2 Quarter 2 – Service User Story
Child Service User Story
Child J is a teenager who is an insulin dependent Diabetic since 3 years old. He lives with his family. There have been ongoing concerns about compliance and has considerable input from the Paediatric Diabetes Specialist Nurses. He has missed a lot of time from school.

Using Right Services Right Time threshold document, it was assessed that the child had complex needs which could be met using a Common Assessment Framework (CAF) with a multi agency approach. The lead Nurse for the CAF was the Diabetes Specialist Nurse. J was aware of the CAF and was seen by members of the team at school.

Concerns escalated as despite the CAF and Team Around the Child (TAC) approach J missed appointments and his mother did not attend his outpatients appointments with him. He was often accompanied by his older sibling. Mother frequently refused to engage, despite telephone calls, texts, visits. The CAF had been in place for 6 months, however, his blood sugar readings and he was missing school. Mother still refused to engage with professionals.

The following actions were identified as learning from the case:

- Professionals to have a greater understanding of disguised compliance and working with highly resistant families.
- Safeguarding training to highlight awareness of compliance with their child's care.
- Where appropriate professionals to partake in multi agency training for working with highly resistant families.
- Early help and CAF to be initiated when there are concerns around compliance.
- Trust Lead for CAF to monitor numbers of CAF updated to emphasise the importance of

Early help.

The learning from this case will be shared at the Safeguarding Forum.

Adult Service User Story
A safeguarding alert was raised when a patient made an allegation of an inappropriate examination by a doctor whilst she was in the Emergency Department (ED). There was a female present with the patient at the time of the examination but her identity was not known. The patient and her partner gave conflicting identities of the accompanying person.

A Datix incident form was completed and an online referral completed to Social Services. The local police were also informed. The Doctor who was working as an agency person at the time of the allegation was suspended from working at Dudley Group (DG) pending investigation. DGs Human resources were informed of this action. The Named Nurse for Safeguarding Adults liaised with the Safeguarding Lead for the CCG who found out the Doctors place of work (GP rotation programme) and informed them of the concerns raised. The Trust's Medical Director continued to liaise with the Doctor, GP Practice, Deanery, local GMC representative throughout the investigation.

An investigation was commenced for the concerns regarding the doctor who was a Person In a Position of Trust (PIPOT). During the investigation concerns were also raised regarding the welfare of the patient. Patient's partner was very domineering and did not allow the patient to speak unless he was present. He was reluctant to leave the wards/departments and could be verbally aggressive toward staff.

A referral was made to the local authority and it progressed to a safeguarding investigation and a PIPOT investigation. The outcome of the investigation was that there was no case to answer against the doctor whom the allegations had been made against.

The following actions were identified as learning from the case:

- Recommendations for professional chaperones to be used where possible for intimate examinations even when people have their own chaperone to be included in safeguarding training.
- Scenario to be used in safeguarding training and reference made to use of chaperones.

Learning from the investigation to be shared with ED staff and to be cascaded in their department meetings and training sessions.

IMPLICATIONS OF PAPER:			
Risk Management	**Risk Register:** N		
	Risk Register: CSO11 Score 6		Lack of Safeguarding Children Intermediate Training
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Compliance with Care Quality Standards Outcome 7
	NHSLA	**Y**	**Details:** CNST Maternity standards
	Monitor	**Y**	**Details:** Ability to maintain at least level 1 NHSLA
	Equality Assured	**Y**	**Details:** Better Health outcomes Improved Patient access and Experience
	Other	**N**	**Details:** Safeguarding

ACTION REQUIRED OF THE BOARD:			
Decision	**Approval**	**Discussion**	**Other**
		Y	

RECOMMENDATIONS FOR THE BOARD: To note the key issues arising from the Safeguarding Report to Trust Board and identify any actions for follow up.

1. ALLEGATIONS OF UNLAWFUL RESTRAINT - CONCERNS RAISED BY INDEPENDENT CHAIR OF SAFEGUARDING BOARDS

A report on the outcome of the cases has been approved at Dudley Children's Safeguarding Board and Dudley Adults Safeguarding Board. A copy of the report is due to be published on the Safeguarding Boards' websites. Details of the allegations raised and the actions taken to hold the Trust to account are detailed in the Trust's Annual Safeguarding Report 2013/14 (page 13-14).

2. CQC/OFSTED ASSESSMENT

This unannounced inspection is still awaited; the inspection is expected imminently. The local Authority has requested that all agencies are prepared for this. The Internal Safeguarding Board members are aware of the unannounced inspection and staff in key areas have been briefed as required.

3. LEARNING DISABILITY STRATEGY

The Learning Disability Strategy was launched on 28th March 2014 and received positive feedback from Trust staff and partner agencies. An action plan has been developed to ensure that the strategy is embedded throughout the Trust. A progress updated as at the end of September 2014 has been provided to the Clinical Quality, Safety and Patient Experience Committee. All actions are on track.

4. TRAINING

4.1 Safeguarding Children compliance

Safeguarding Children Foundation training compliance is now at 85.4%. This is a slight decrease from July 2014. Intermediate training compliance is now at 66.4%. This is a 2% increase from July 2014.

4.2 Safeguarding Adults compliance

Safeguarding Adults training compliance is now at 83.3%. This is a slight decrease from July 2014.

4.3 Mental Health compliance

Mental Health training compliance is now at 73%. This needs to reach 100% compliance by March 2015 to meet the CQUIN target.

4.4 Learning Disabilities CQUIN

The numbers of staff to be trained in Learning Disability to meet the CQUI target for 2014/15 has been identified. 50% of staff identified to undertake training have completed this. This is within the CQUIN target identified for Quarter 2.

4.5 Safeguarding Maternity Compliance

Safeguarding Adults 83% - increased from 80% in August 2014.

Safeguarding Children Foundation (level 1) 94% - increased from 92% in August 2014.

Safeguarding Children Intermediate (level 2) 85% - maintained from August 2014.

5. Annual Safeguarding Report 2013/14

The annual Safeguarding Report for 2013/14 has been developed by the Internal Safeguarding Board. The report provides information on the safeguarding activities from 1st April 2014 to 31st March 2014 including summaries on national and local issues; policies and procedures; details on safeguarding referrals and incidents; Audit; and Training and Education. A section on new developments/new initiatives and future developments for 2014/15.

Overall there has been an increase in the numbers of staff who have completed Safeguarding training in 2013/14. This is identified in the report by Directorate.

There has also been an increase in the number of referrals and incidents for both Maternity and Adults.

6. Safeguarding CQUIN 2014/15
The safeguarding CQUIN target for 2014/15 is to present one adult and one child case to the Board in each quarter.

For quarter 1 a case regarding a child who had several admissions to the children's ward with faltering growth was reviewed. The child; the youngest of 4 was under the care of the Paediatrician. The frequent admissions to the ward and past medical history of the siblings to support an organic cause for faltering growth. However, during an admission when the child was 10% dehydrated. Within 24 hours of admission the child gained 10% of their body weight. Blood tests identified re-feeding syndrome one of the causes of which can be starvation. Safeguarding concerns were raised. Observations of the parent child interaction identified some unusual behaviour including a lack of response from the mother to her child.

6.1 Quarter 1 – Service User Stories

Child Service User Story
Child A was referred to the local authority and a strategy meeting held; this was well attended by agencies. There were no barriers to sharing communication and a plan to protect the children was agreed. A detailed medical report was written. A child protection plan was implemented and an alert was attached to the child's records.

Parents were fully engaged in the safeguarding process. The child was too young to express wishes or feelings.

The following actions were identified as learning from the case:

- Professionals to be alert to the possibility of fabricated or induced illness.
- Faltering growth pathway to include observation of child and normal feeding routines.
- Professionals to be aware of guidelines regarding not informing parents when fabricated or induced illness is suspected.

The learning points from the case have been shared with staff involved with the case at Ward Huddle board meetings and at Trust's Safeguarding Forum to ensure that the learning is shared Trust wide.

Adult Service User Story
Adult 1 was referred to social services by the patient's son. The patient had end stage Dementia and challenging behaviour. The son felt that she was unnecessarily sedated and kept in bed. Patient had developed a stage 3 pressure ulcer to the sacrum which was identified and reported by the ward.

The case notes were reviewed; statements from therapy staff regarding the advice for patient. To be nursed in bed at time period of relatives concerns. A Root Cause Analysis investigation of the Pressure Ulcer development was completed.

The patient's son was updated on progress with the investigation via the social worker and at case conferences by the safeguarding lead. The patient lacked capacity to understand the concerns that had been raised by her sons.

A referral was made to the local authority and proceeded to a safeguarding investigation. The Named Nurse for Safeguarding shared appropriate information in relation to concerns raised and the internal investigation.

It was difficult for the patient to express to staff her wishes and feelings. The findings were that the family had not been informed that the patient had been assessed as having poor balance and sitting position and were not aware of the risk of falls. There was no evidence of over sedation. The patient was generally chatty but not always so at visiting times. This may have been due to tiredness at the beginning of her stay in hospital; this was not relayed to her sons. Following the acute episode of care the patient was able to weight bear and support herself; requiring supervision from a 1:1 nurse.

The family were happy with the outcome of the investigation and felt reassured by the findings:

The following actions were identified as learning from the case:

- To review ward documentation regarding patient's behaviour.
- Accurate waterlow assessment to be completed.
- Datix incident to be reported timely.
- Round table meeting for Adult Safeguarding Nurse, C8 and C3.
- All patients to be placed on a seat cushion when sat out.
- Monitor completion of level 2 and level 4 observations by bank staff.

The learning points from the case have been shared with staff involved with the case at Ward Huddle board meetings and at the Pressure Ulcer Group meetings to ensure that the learning is shared Trust wide.

Following presentation to the Trust board both cases will be discussed at the Clinical Commissioning Group's Clinical Quality Review Meeting to ensure that all aspects of the CQUIN target are met.

6.2 Quarter 2 Service User Stories

Child Service User Story
Child J is a teenager who is an insulin dependent Diabetic since 3 years old. He lives with his family. There have been ongoing concerns about compliance and has considerable input from the Paediatric Diabetes Specialist Nurses. He has missed a lot of time from school.

Using Right Services Right Time threshold document, it was assessed that the child had complex needs which could be met using a Common Assessment Framework (CAF) with a multi agency approach. The lead Nurse for the CAF was the Diabetes Specialist Nurse. J was aware of the CAF and was seen by members of the team at school.

Concerns escalated as despite the CAF and Team Around the Child (TAC) approach J missed appointments and his mother did not attend his outpatients appointments with him. He was often accompanied by his older sibling. Mother frequently refused to engage, despite telephone calls, texts, visits. The CAF had been in place for 6 months, however, his blood sugar readings and he was missing school. Mother still refused to engage with professionals.

The Named Nurse arranged to attend a CAF meeting at the school, the mother did not attend the appointment. At this stage child J's school attendance was less than 50%, there had been a referral to Education Inclusion Services. It was identified that J was making poor progress as regards educational achievement. J's food and drink were monitored at school, as were his blood sugar readings at lunch time, there had been few occasions when they were in the appropriate range. J's HbA1c was not in the recommended range. His injection sites continued to be lumpy.

An inter agency referral was made as the concerns were escalating, the situation was not improving but deteriorating and the concerns were that J would suffer significant harm if this continued.

The referral was allocated as Child In Need by Children's Services and there have been two weekly meetings attended by health and social care primarily. The outcome of safeguarding actions has been that the child's mother has appeared to adhere more to the guidance she is being given by practitioners. There is close communication between the social worker and Diabetes Nurses. The school member of staff who supervises J's routine at lunchtime has received training and also liaises regularly with the Diabetes Nurses if there are problems. The school health Adviser has been involved in the Child In Need meetings and will invite J to attend drop-in sessions when at school. Mother has expressed dissatisfaction with the process but vacillates between defensiveness and hopelessness.

There have been longstanding issues with this family and there is potential for multi agency work to have had a greater impact if employed earlier. Introducing Early Help/CAF where there are compliance issues with a clear focus on the child needs to be encouraged. It is important to recognise disguised compliance, a tactic which can be employed by resistant families and to follow guidance appropriately when this occurs. Practitioners may have benefited from training on working with resistant families and disguised compliance.
The effects of disguised compliance are emphasized in training. There is a Trust Lead for CAF and Early Help, CAF is promoted in training and numbers of CAF initiated are monitored by the Internal safeguarding Board. The trust lead should emphasise the benefits of Early Help in training and monitor levels of CAF initiated.

All staff were aware of the safeguarding concerns when there is limited compliance with health care requirements. Advice was sought appropriately and all staff are aware that they may need to apply the escalation policy if there is not sustained improvement. There is a level of tension between the social care and diabetes professionals as the level of risk is hard to evidence whilst the child remains well. It is of paramount importance that all professionals keep the child at the focus of their work and make every attempt to encourage J to express his views. Staff are aware of the" What to do if you are concerned that a child is being abused guidance" and have sought help and made a referral appropriately.

The following actions were identified as learning from the case:

- Professionals to have a greater understanding of disguised compliance and working with highly resistant families.
- Safeguarding training to highlight awareness of compliance with their child's care.
- Where appropriate professionals to partake in multi agency training for working with highly resistant families.
- Early help and CAF to be initiated when there are concerns around compliance.
- Trust Lead for CAF to monitor numbers of CAF updated to emphasise the importance of early help.

The learning from this case will be shared at the Safeguarding Forum.

Adult Service User Story
A safeguarding alert was raised when a patient made an allegation of an inappropriate examination by a doctor whilst she was in the Emergency Department (ED). There was a female present with the patient at the time of the examination but her identity was not known. The patient and her partner gave conflicting identities of the accompanying person.

A Datix incident form was completed and an online referral completed to Social Services. The local police were also informed. The Doctor who was working as an agency person at the time of the allegation was suspended from working at Dudley Group (DG) pending investigation. DGs Human resources were informed of this action. The Named Nurse for Safeguarding Adults liaised with the Safeguarding Lead for the CCG who found out the Doctors place of work (GP rotation programme) and informed them of the concerns raised. DGs Medical Director continued to liaise with the Doctor, GP Practice, Deanery, local GMC representative throughout the investigation.

The patient and her partner were made aware of the referrals to partner agencies and also of actions taken by DG.

The doctor came up to hospital whilst on annual leave to speak to Human Resources and saw the patient and her partner in the main hospital corridor where an alleged fracas took place between the Dr and the woman's partner which was caught on CCTV.

The police interviewed the patient but decided no criminal act had occurred.

An investigation was commenced for the concerns regarding the doctor who was a Person In a Position of Trust (PIPOT). During the investigation concerns were also raised regarding the welfare of the patient. Patient's partner was very domineering and did not allow the patient to speak unless he was present. He was reluctant to leave the wards/departments and could be verbally aggressive toward staff. Staff concerns were raised to the Police who advised caution in the partner's presence as he was known to them and could be violent. Concerns that the patient may be a victim of domestic abuse or possibly being trafficked or exploited was shared with the police who stated they could not give us any information but confirmed there were reasons to be concerned for her safety. Police interviewed the patient on the ward and she did agree to move to live with her mother down south. There was a restraining order against her partner to go near her mother. Ward staff and police liaised with each other to provide a safe means of transporting patient to be with her mother, however, she discharged herself before this happened. Police were informed of the discharge.

Investigation tools used: Discussions with the patient and her partner. Statements taken by the Police from the patient and her partner. A review of the case notes and electronic records.

Policies: Safeguarding Adults Policy, Incident Investigation Policy, PIPOT Policy, Human Resources Policy.

A referral was made to the local authority and it progressed to a safeguarding investigation and a PIPOT investigation. The outcome of the investigation was that there was no case to answer against the doctor whom the allegations had been made against.

Best practice was achieved through good multi-agency working and sharing of appropriate information to safeguard the patient and also the doctor involved. Other agencies and professionals involved outside of DG were:- CCG Safeguarding Lead, Dudley Safeguarding/social services, GP Practice, Police, Deanery and local GMC representative. Professionals involved internally were the Named Nurse for Safeguarding Adults, Deputy Director of Nursing, Medical Director, Human Resources, Clinical Governance, Security Advisor, Emergency Department and C8 staff. Communication about the progression of the investigation were maintained at all times with the patient. Professional challenges for staff included the difficult relationship between the patient and her partner and also the partner's attitude toward staff at DG. The police shared that there may be some domestic abuse or exploitation in their relationship but were unable to give any further details of this.

At the time the original PIPOT allegation was made DG staff liaised with our partners in the CCG to ensure the GP Practice that the Doctor worked for were aware of the concerns raised. A 72 hour meeting was held to discuss the PIPOT incident and CCG and Social Services colleagues attended. A PIPOT/Safeguarding meeting was also held with Social Services to discuss the safeguarding concerns raised.

Concerns were discussed with the patient and documented in the case notes on several occasions. Discussions were had with the patient by Trust staff and also the police.

The patient was made aware of the investigation outcome in relation to the alleged inappropriate behaviour. The patient made the decision to discharge herself and went back to live with her partner even though a plan for safe discharge to her mother in the South of England had been arranged in liaison with the police.

The following actions were identified as learning from the case:

- Recommendations for professional chaperones to be used where possible for intimate examinations even when people have their own chaperone to be included in safeguarding training.
- Scenario to be used in safeguarding training and reference made to use of chaperones.

Learning from the investigation to be shared with ED staff and to be cascaded in their department meetings and training sessions.

Pam Smith
Deputy Director of Nursing
13TH October 2014

The Dudley Group NHS
NHS Foundation Trust

ANNUAL REPORT

SAFEGUARDING CHILDREN AND ADULTS

APRIL 2013 – MARCH 2014

CONTENTS:

1. Introduction

All health care organisations have a responsibility for safeguarding children and adults. Safeguarding is broader than protection as it also includes prevention. Safeguarding is defined as: all agencies working with Vulnerable Adults, Children, including the unborn child and their families taking all reasonable measures to ensure that the risks of harm to their welfare are minimised and that where there are concerns about their welfare, agencies take appropriate action to address those concerns working to agreed local policies and procedures in full partnership with other agencies.

The Care Quality Commission has a range of statutory independent enforcement actions to use where care does not meet the essential levels of safety and quality that users are entitled to expect. NHS Foundation Trusts are regulated by Monitor which has the authority to hold them to account for meeting their safeguarding responsibilities.

It is the Trust board's responsibility to ensure that the organisation acts in accordance with its legislative requirements.

This annual report demonstrates to the Trust Board how the organisation is discharging its statutory duties in relation to safeguarding children under section 11 of the Children Act (2004).

2. National & Local Issues

National

Although some of the guidance was published before 2013/14 it has been included as it still has an effect on how the Trust organises and delivers services.

CQC Declaration

The Care Quality Commission (CQC) is the independent regulator of safety and quality for all health services. From April 2010 NHS Foundation Trusts needed be registered with the CQC, which requires Trusts to review safeguarding arrangements and declare whether they are compliant with CQC regulations. CQC licence NHS organisations to provide treatment care and support if they meet the essential standards but can give the level of enforcement action, required to the infringement, if they are found to be non-compliant. This could include warning notices, imposition or variation of conditions, suspension of registration to provide certain services, fines, prosecution or cancellation of registration.

The Trust was reviewed by the CQC in March 2014. The Trust received positive verbal feedback from the reviewing team. The final report and rating for the Trust is due to be published in June 2014.

Francis Report (2013)

The Francis Report was published in February 2013. It reviewed the conditions of appalling care at Mid Staffordshire NHS Foundation Trust between 2005 and 2008 identified in the Public Inquiry.

The report made 290 recommendations; these were grouped according to themes identified by the inquiry. The recommendations identify the organisation it is suggested should take them forward.

The themes identified in the table of recommendations were:

- Accountability for implementation of the recommendations
- Putting the patient first
- Fundamental standards of behaviour
- A common culture made real throughout the system – an integrated hierarchy of standards of service
- Responsibility for, and effectiveness of, healthcare standards
- Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions
- Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings
- Enhancement of the role of supportive agencies
- Effective complaints handling
- Performance management and strategic oversight
- Patient, public and local scrutiny
- Medical training and education
- Openness, transparency and candour
- Nursing (focus of culture of caring; strong nursing voice)

- Leadership
- Professional regulation of fitness to practise
- Caring for the elderly
- Information
- Coroners and inquests
- Department of Health leadership

Keogh Mortality Review (2013)

The Keogh Mortality review was commissioned in February 2013 by the Prime Minister to review the quality of care and treatment provided by those NHS Trusts and NHS Foundation Trusts that were persistent outliers on mortality indicators. A total of fourteen hospital Trusts were investigated as part of this review.

Although the fourteen hospital Trusts covered by the review were selected using national measures as a 'warning sign' or 'smoke alarm' for potential quality problems, the investigation looked more broadly at the quality of care and treatment provided within these organisations.

The review considered the performance of the hospitals across six key areas:

- Mortality
- Patient Experience
- Safety
- Workforce
- Clinical and Operational effectiveness
- Leadership and Governance

The Mortality data reviewed was from the NHS Information Centre, the CQC, Dr Foster, the Imperial College and Healthcare Evaluation Data (HED). The Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) were contained within the evidence packs for each of the fourteen Trusts.

Key findings at both a national and local level have been collated, examined and recommendations have been made.

The Trust was one of the fourteen hospitals reviewed. Key findings and recommendations identified were:

- A review of quality governance arrangements and better communication of them to staff
- Embed a culture of learning from when things go wrong and improve its processes to capture themes from: Incidents and Root Cause Analysis investigations; Feedback and complaints; Mortality reviews
- Review Mortality data more systematically and use this alongside its learning from directorate reviews to target improvement actions more effectively
- Review system for bed management, patient flows and discharges to address operational effectiveness and improve patient experience
- Embed a patient experience strategy and demonstrate effective monitoring of performance
- Review nurse staffing levels and skill mix to meet nationally accepted good practice
- Improve consistency of safety and equipment checks
- Improve consistency of pressure ulcer care including prioritisation of patients and access to equipment
- Review Theatre staff engagement

The Trust was one of two out of the fourteen Trusts that were not put into special measures.

An action plan to address the recommendations was implemented in collaboration with the Clinical Commissioning Group.

CHILDREN

Working Together (2013)

The new Working together to safeguard children (2013) streamlines previous guidance documents to clarify the responsibilities of professionals towards safeguarding children and strengthen the focus away from processes and onto the needs of the child.

It replaces:

- Working together to safeguard children (2010)
- Framework for the assessment of children in need and their families (2000)
- Statutory guidance on making arrangements to safeguarding and promote the welfare of children under section 11 of the Children Act 2004 (2007)

Most of the responsibilities and procedures in the new 2013 Working together remain the same as the 2010 guidance, but the guidance is presented in a much more succinct and less detailed way.

There are 5 chapters in the new guidance. It seeks to emphasise that effective safeguarding systems are those where:

- The child's needs are paramount, and the needs and wishes of each child, should be put first, so that every child receives the support they need before a problem escalates
- All professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children
- All professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care
- High quality professionals are able to use their expert judgement to put the child's needs at the heart of the safeguarding system so that the right solution can be found for each individual child
- Local areas innovate and changes are informed by evidence and examination of the data.

Effective safeguarding arrangements in every local area should be underpinned by two key principles:

- Safeguarding is everyone's responsibility; for services to be effective each professional and organisation should play their full part
- A child centred approach; for services to be effective they should be based on a clear understanding of the needs and views of children.

Safeguarding children and young people roles and competencies for health care staff: Intercollegiate Document (2014)

In 2006 the Royal Colleges and professional bodies jointly published *Safeguarding children and young people: roles and competences for health care staff*. The document described six levels of competences and provided model role descriptions for named and designated professionals. The framework was subsequently revised in 2010 in response to policy developments, including the Laming review. Since that time, further reviews across the UK have reinforced the need to further improve the safeguarding skills and understanding of health staff, and to improve access to safeguarding training. An expert working group was commissioned by the Chief Nursing Officer which recommended that the intercollegiate framework would be the basis for future training.

The updated document should continue to be used in conjunction with key statutory and non-statutory guidance, and with competency frameworks and curricula relating to specific professional groups. The revised version of Working Together signposts health care organisations to the intercollegiate safeguarding framework and states that 'All staff working in healthcare settings –including those who predominantly treat adults - should receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance'.

This Guidance sets out minimum training requirements and is not intended to replace contractual arrangements between commissioners and providers or NHS organisations and their employees. It is acknowledged that some employers may require certain staff groups to be trained to a higher level than described here to better fulfil their organisational intent and purpose.

ADULTS

NICE Guidance Domestic Violence (2014)

The term 'domestic violence and abuse' is used to mean: any incident or pattern of incidents of controlling coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or are family members. This includes: psychological, physical, sexual, financial and emotional abuse.
It also includes 'honour' based violence and forced Marriage.

Confidential enquiry into the premature deaths of people with a learning disability (2013)

The Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD) was tasked with investigating the avoidable or premature deaths of people with learning disabilities through a series of retrospective reviews of deaths. The aim was to review the patterns of care that people received in the period leading up to their deaths, to identify errors or omissions contributing to these deaths, to illustrate evidence of good

practice, and to provide improved evidence on avoiding premature death.

The Inquiry's research team found that 37% of the deaths of people with a learning disability were considered avoidable and compared with the general population, men with a learning disability died on average thirteen years earlier, while women with a learning disability died 20 years earlier.

Overall, 22% of people with a learning disability looked at by the inquiry had died under the age of 50 compared to just 9% of the general population.

The key recommendations from the inquiry team are for the establishment and funding of a National Learning Disability Mortality Review Body in England. This would allow for the continued collection of mortality data for people with a learning disability and investigation of the most serious cases.

Autism NICE guidance (2012)

The pathway/guidance covers the recognition, referral, diagnosis and management of autism in children, young people and adults.

The term autism describes qualitative differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and rigid and repetitive behaviours. Here 'autism' refers to 'autism spectrum disorders' encompassing autism, Asperger's syndrome and atypical autism (or pervasive developmental disorder not otherwise specified).

Autism is a lifelong condition that has a great impact on children, young people and adults and their family or carers. Diagnosis and needs assessment can offer an understanding of why a person is different from their peers and can open doors to support and services in education, health services, social care and a route into voluntary organisations and contact with other people and families with similar experiences. All this can improve the lives of people with autism and their families.

Winterbourne view-Transforming Care (2012)

The Department of Health review published a national response to Winterbourne View in 2012. The executive summary identified that the abuse revealed at Winterbourne View hospital was criminal. Staff whose job was to care for and help people instead routinely mistreated and abused them. Its management allowed a culture of abuse to flourish. Warning signs were not picked up or acted on by health services or local authorities, and concerns raised by a whistleblower went unheeded. The fact that it took a television documentary to raise the alarm was itself a mark of failings in the system.

Steps to respond to those failings, including tightening up the accountability of management and corporate boards for what goes on in their organisations are also identified. Though individual members of staff at Winterbourne View have been convicted, this case has revealed weaknesses in the system's ability to hold the leaders

of care organisations to account. This is a gap in the care regulatory framework which the Government is committed to address.

The abuse in Winterbourne View is only part of the story. Many of the actions in the report cover the wider issue of how children, young people and adults with learning disabilities or autism are cared for who also have mental health conditions or behaviours described as challenging.

The review highlighted a widespread failure to design, commission and provide services which give people the support they need close to home and which are in line with well established best practice. Equally, there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals.

Children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging can be, and have a right to be, given the support and care they need in a community-based setting, near to family and friends. Closed institutions, with people far from home and family, deny people the right care and present the risk of poor care and abuse.

Prevent **Strategy (2011)**

The *Prevent* strategy was launched in 2011. *Prevent* is part of the Government's counter-terrorist strategy known as CONTEST.

Prevent aims to reduce the risk faced from terrorism by stopping people becoming terrorists or supporting terrorism.

Healthcare professionals have a key role in *Prevent*. The strategy promotes collaboration and co-operation among public service organisations in order to provide support to vulnerable individuals. The strategy focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist-related activity.

Prevent does not require staff to do anything in addition to their normal duties. What is important is that if staff are concerned that a vulnerable individual is being exploited, they can raise the concern in accordance with the organisation's policies.

The Prevent Strategy is included in all foundation safeguarding training. There are also information leaflets and referral forms on the Trust's intranet. Training on Prevent was commenced in April 2013 and information regarding the Prevent strategy made available on the Hub; the Trust's intranet.

6 Lives -The provision of public services to people with a learning disability (2009) and Healthcare for All (2008)

Following the appointment of the Acute Liaison Nurse for Learning Disabilities the Trust re-reviewed both documents to ensure that the recommendations had been implemented.

In March 2009 Mencap published a report, Death by Indifference, which set out case studies relating to six people with learning disabilities. Mencap believe that they died unnecessarily as a result of receiving worse healthcare than people without learning disabilities. On behalf of the families involved, Mencap asked the Health Service and Local Government Ombudsmen to investigate complaints about all six cases, three of which span both health and social care. The investigation reports illustrate some significant and distressing failures in service across both health and social care. They show the devastating impact of organisational behaviour which does not adapt to individual needs, or even consistently follow procedures designed to maintain a basic quality of service for everyone. They identify a lack of leadership and a failure to understand the law in relation to disability discrimination and human rights. This led to situations in which people with learning disabilities were treated less favourably than others, resulting in prolonged suffering and inappropriate care.

The Independent Inquiry, led by Sir Jonathan Michael 'sought to identify the action needed to ensure adults and children with learning disabilities receive appropriate treatment in acute and primary healthcare in England'. The outcome of the report, which was published in July 2008, found that there was evidence of good practice but also 'appalling examples of discrimination, abuse and neglect across the range of health services'. The Inquiry found convincing evidence that people with learning disabilities have higher levels of unmet need and receive less effective treatment, despite the fact that the Disability Discrimination Act and Mental Capacity Act set out a clear legal framework for the delivery of equal treatment. The report makes it clear that: "…People with learning disabilities are not visible or identifiable to health services, and hence the quality of their care is impossible to assess."

LOCAL

New Independent Chair appointed to Dudley Safeguarding Children Board and Safeguarding Adults Board

Dudley Safeguarding Children Board and Dudley Safeguarding Adults Board announced that they were commissioning Roger Clayton as their Independent Chair. Roger is a retired senior Police officer; having previously served in the West Midlands and chaired both the Children's and Adults boards in Gloucestershire.

Safeguarding adults: multi-agency policy and procedures for the West Midlands

This policy was launched in January 2013 and reflects the commitment of health organisations in the West Midlands and allied local authorities to work together to safeguard adults at risk.

The procedures outlined aim to make sure that:

- The needs and interests of adults at risk are always respected and upheld
- The human rights of adults at risk are respected and upheld
- A proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse

The procedures also aim to ensure that each adult at risk maintains:

- Choice and control
- Safety
- Health
- Quality of life
- Dignity and respect

Winterbourne action plan

An action plan has been developed to ensure that the Trust meets the key principles and desired outcomes identified in the model of care to promote high quality services for people with learning disabilities and behaviour which challenges.

Autism NICE guidance action plan

An action plan has been developed to ensure that the Trust meets the key principles and desired outcomes identified in the model of care to promote high quality services for people with Autism.

Appointment of acute Liaison Nurse for Learning Disabilities

An acute Liaison Nurse for Learning Disabilities was appointed to the Trust is July 2013. The role was created to ensure that patients with a Learning Disability who access the Dudley Group NHS Foundation Trust receive appropriate care and treatment from hospital staff.

Allegations of Unlawful restraint raised in the media

In January 2014, the Trust was facing allegations of unlawful restraint of patients at Russells Hall Hospital. An article appeared in the Sunday Telegraph reporting this and the CQC received an anonymous referral regarding an alleged unlawful restraint in December 2013.

The Safeguarding Board proposed that a panel be convened to examine policy and practice in respect of these issues. The panel was established and comprised of board members from children and adults, council services, West Midlands Police, Healthwatch, Age UK, lay representatives along with Trust staff themselves. This group met on four separate occasions between February and May 2014.

The Chief Executive Officer authorised an independent review to clarify the facts of these allegations and the Trust's position against national safeguard standards. The police also reviewed the paperwork on the alleged restraint issue to determine if crimes had been committed.

The council's Adult Social Care Team conducted two separate safeguard processes in conjunction with the police investigating the two restraint issues. The CQC conducted a two day inspection at Russells Hall with a particular focus on the issue of unlawful restraint.

In addition, the Clinical Commissioning Group conducted a review of incident recording at Russells Hall Hospital.

Alongside these reviews and investigations, the Trust was advised by the Safeguarding boards to report on concerns raised at a Children's Act Section 11 Audit and the Safeguard Peer Challenge, which raised concerns about:

- Evidence of hearing the voice of a child
- Safe recruitment practices
- Attendance at child protection case conferences
- Attendance at Safeguarding Board meetings
- Quality of hospital discharge
- Care of people with challenging behaviour
- Do not resuscitate (DNAR) policy

It needs to be highlighted however that areas for consideration recommended by the review panel were not limited to the Trust.

The Trust was asked to provide information to all of the agencies looking at these concerns and throughout the process there was openness and transparency in the information provided.

The Trust provided an action plan on the changes made to policy and protocol to address these issues and the partnership commitments required to ensure people with challenging behaviour as well as those requiring support to move safely out of the hospital. This was recognised as a multiple agency responsibility.

The Independent review identified that there has been no evidence of unlawful restraint found in the hospital. However there have been learning opportunities identified in respect of training for both medical and security staff and policies and procedures have been strengthened to address these learning points. The breadth of the investigation, the number of agencies involved in the process together with the Safeguard investigations has identified key issues regarding communication, training and information sharing with relatives of patients, the Trust have acknowledged these issues and instigated action plans to promote the learning from these investigations.

A report on the conclusions of these investigations has been presented to both Children and Adults Safeguarding Boards.

Learning Disability Strategy

The Learning Disability strategy was launched in March 2014. This represents the Trust's commitment to improving the care and treatment of people with learning disabilities when accessing the Trust. It is designed to support all hospital staff in delivering high quality, person-centred, and safe acute hospital services for people with learning disabilities. It sets out what we want to achieve and what patients can expect both now and over the next 3 years, taking into consideration both professional and national standards. It also describes a number of underpining aims and actions that will take place from 2013-16.

The strategy is an important part of our overall Trust strategic objectives and links with the Trust Forward Plan, its Vision and Values and other strategies including the Nursing and Midwifery Strategy and the Clinical, Quality and Patient Experience strategies.

The primary purpose of the Trust is to deliver high quality care to our patients and service users, and this strategy describes how we intend to develop our nursing, midwifery and support services to improve the care and treatment to patients with Learning Disabilities.

MATERNITY

The Common Assessment Framework (CAF) has also been introduced to encourage early intervention for vulnerable families; particularly by Community Midwives. The referral trends to the Named Lead Midwife Safeguarding and Specialist Midwife – Vulnerable Women's maternity service has shown a constant increase on the Safeguarding Maternity Report which is discussed and shared at the Trust's Internal Safeguarding Board meeting.

The Safeguarding in Maternity Services (Child protection) policy has been updated and ratified. This is accessible to all Trust staff via the 'Hub', the Trust's intranet.

During the past year there has been guidance from Central Office regarding awareness raising, prevalence and training for Female Genital Mutilation (FGM). The Named Lead Midwife and Specialist Midwife offer multi-agency training via the Dudley Safeguarding Children's Board. All pregnant women 'booked' to deliver at the Trust are screened for

FGM and if identified at any time during pregnancy, a care pathway is implemented to offer appropriate care to this group of women.

At monthly intervals, referrals for FGM are collated and sent to the Trust's Information Department to forward to the Department of Health. It has been identified that other areas in the Trust require awareness raising/training to help identify this form of abuse. Support is being offered by the Maternity Service.

The Specialist Midwife has been successful in providing the National Society for the Prevention of Cruelty to Children (NSPCC) FGM helpline number on the reverse of the pregnant women's hand held notes. The Trust has requested free leaflets, in a variety of languages, posters and DVD's from the Home Office to help Health Care Professionals to develop awareness of FGM.

Serious Case Reviews

CHILDREN

Dudley Safeguarding Children Board published the full report from its serious case review in respect of an 18 month old child who died whilst in the care of her parents and subject to a child protection plan. The cause of death remains unknown, however, hypothermia and the child's weight were considered to be important factors. The review into the death of Child C identifies four key learning themes: thresholds for intervention including cross-border working and the management of children with faltering growth. The review makes 7 recommendations for Dudley and Sandwell Local Safeguarding

Children Boards and 1 recommendation for the Trust. This was for the Trust to undertake a thematic audit on the impact of safeguarding children training upon the day to day practice of clinicians and that staff are making appropriate contributions to the formal child protection processes. This audit demonstrated that staff do make appropriate contributions to formal child protection processes.

ADULTS

There have been no serious case reviews in 2013/14. There has been one Independent Management Review (August 2013).

Independent Management Review (IMR) - August 2013

Following a review of the management of care of a patient with a learning disability, specific safeguarding concerns were highlighted around the hospital staff response to managing patients with Learning Disabilities (LD) and the management of patients who lack capacity to make decisions about their care.

Dudley Safeguarding Adults Board requested an IMR to identify the issues and concerns and to identify any learning to minimise the risk of any shortcomings in the management of patients with Learning Disabilities being repeated. As part of the IMR the Trust was asked to include input from the organisation "Changing our Lives" who have close working links with agencies working with people who serve adults with learning disabilities including advocacy.

The IMR supported the findings of the Trust Root Cause Analysis (RCA) that found evidence of poor compliance with the Trust Policy that outlined the referral process to Dudley Advocacy and significant others when making decisions about the patient's medical care. Furthermore the Trust did not follow appropriate procedures in relation to mental capacity.

The review found:

- There was no specific ongoing training for senior medical staff and consultants on MCA, LD or DoLs.
- Training specifically relating to the management of patients with LD was insufficient.
- Staff understanding of the need to involve other people in decision making when patients do not have capacity to make decisions was inconsistent and needed improvement.
- The role of Independent Mental Capacity Advocate (IMCA) and the need to ensure individuals have their best interests represented other than in an emergency situation was suboptimal.
- The initial decisions relating to care and treatment should have included the care home staff who have a wealth of knowledge in regards to the patients in their

own care. There was an indentified lack of staff knowledge in relation to the Mental Capacity Act and IMCA policies.

- Staff did not always escalate concerns appropriately; this was a reflection of the training and education provided.

Recommendations

To develop a strategy that is endorsed by the Chief Executive Office (CEO) and Executive Directors and aimed to:

- improve training in relation to LD, MCA, DoLS
- deliver a top to bottom approach throughout the organisation
- place the needs of patients with learning disabilities at a high priority
- Ensure that MCA training is delivered as a mandatory component for all clinical staff
- Develop a Learning Disability strategy to provide specific Learning Disability training for all clinical staff
- Utilise the skills and experiences of people with Learning Disability to deliver training that is relevant and meaningful for clinical staff
- Strengthen relationships and links with Community Learning Disabilities teams, Advocacy services and mental health services
- Improve the knowledge of all clinical staff in respect of Learning Disability, MCA 'Best interest' principles and IMCA.
- As part of the improved training ensure staff are aware of the policy and procedures and where to find them and how to access support and guidance.
- Review, adopt and implement the 'Quality of Health 'principles (Changing Our Lives) and incorporate into hospital care and treatment.
- Ensure the process for managing patients with a Learning Disability includes appropriate assessment of risk and mitigation in respect of individual patient need.
- Re-launch the Learning Disabilities checklist for staff to refer to.
- Implement learning from care review sessions for medical/nursing staff.
- Implement the use of patient hospital passport.
- Review and monitor the risk assessment in relation to the care and management of patients with LD and/or who lack capacity.

In response to the observations of the Independent Reviewers Dudley Safeguarding Adults Board were advised to request other agencies known to the patient to conduct a review regarding implementation and monitoring of Annual Health checks and end of life plans.

The Trust has taken a number of actions to address the recommendations. These have been achieved following the successful appointment of an acute Liaison Nurse for Learning Disabilities.

Dudley Safeguarding Children Board

The Boards key priorities for 2013-2015 are:

1. Improve the **protection of children from abuse and neglect,** through more effective inter-agency working, with specific reference to:

- Strengthening the analysis of risk and protective factors in families
- Improving the consistency and timeliness of information sharing
- Evidencing the 'voice of children, young people and their families'

2. Improving the **effectiveness of early help and intervention** for children and young people who are vulnerable, with specific reference to:

- Embedding common assessment across key partner agencies, with a particular focus on neglect and transition
- Enabling children and young people to receive the right services at the right time in the right place
- Ensuring that key strategic approaches are joined-up and communicated effectively

3. Strengthen the effectiveness of support and challenge provided by partners of the Board to improve **safeguarding outcomes** for children, young people and their families through:

- Embedding quality assurance across partner agencies
- Developing an outcomes-based approach to improvement
- Engaging children, young people and their families in learning

4. Improve inter-agency responses to young people who are at risk of, or who have suffered, **sexual abuse and exploitation** through:

- Strengthening **prevention** and earlier intervention across partner agencies and raising awareness and recognition of sexual exploitation
- Improving the **protection** of young people who are involved in sexually exploitative relationships
- Maximising opportunities to disrupt the activities of perpetrators and **prosecute** them wherever possible

5. Improve the safeguarding and protection of children and young people who are living in households where there is **domestic abuse, parental mental health and parental alcohol and substance misuse** through:

- Embedding a 'Think Family' approach
- Developing and implementing evidence-based strategies to minimise risks for children & young people

Dudley Safeguarding Children Board undertook a multi agency audit of compliance against child protection standards in September 2013.

The Trust is represented at the Safeguarding Children's board meetings by the Deputy Director of Nursing, the Named Nurse for safeguarding children and the Designated Doctor.

During 2013/14 the Safeguarding Children Team continued to be involved in a number of activities. These ranged from child protection conferences, child death reviews, strategy meetings with police and social services, training, external and internal safeguarding meetings and supervision alongside daily management of child protection and safeguarding cases throughout the hospital. The Named Nurse for Safeguarding Children has also provided support to the Named nurse for safeguarding Adults.

Dudley Safeguarding Adults Board

The Boards key priorities for 2013-15 are:

1. Safeguarding Adults Board members to assure themselves that their agencies are partners in Safeguarding and understand the safeguard process and the issues it raises for its workforce and Dudley residents:

- Board members to accept and take responsibility for the governance arrangements of the board.

- Partners to ensure that information regarding the West Midlands Safeguard procedure is disseminated throughout their agency.

- Partner presentations to the Board regarding agency safeguarding initiatives.

- The sub-group remits to be reviewed to ensure multi-agency input to the work of the board

- Partner agencies to recognise the training requirements of their staff and ensure that staff receives appropriate training.

2. The experience of Victims of Abuse influences the work of the Board

- Practice learning events and case studies to demonstrate the victim's story to board members and partner agencies

- The board receives information on serious case reviews at Board meeting throughout 2013

- Outcomes of interventions of those who have gone through a safeguard incident to be relayed to Board members to ensure that victims are central to the safeguard process

- Board members demonstrate engagement of their agencies with people who use services as part of their safeguard role

3. Promotion of the Adult Safeguard Agenda through partnership working.

- Demonstrate that links are in place with Children's services through safer recruitment Initiatives and Forced Marriage Training. To learn from inspection outcomes from both services

- To continue to link with the Community Safety Partnerships with regard to Hate Crime, Substance Misuse and Domestic Abuse

- Adult Safeguard messages are actively promoted to the public. The Partnerships use their information and publicity strategy to communicate its work

- Plans and targets for Safeguarding adults are included in other strategies for Older People who use Mental Health and Learning Disability services

4. To improve consistency and Quality of Inter-Agency Adult Safeguard Practice.

- The Board members to assure themselves that robust quality assurance arrangements and performance management strategies are in place for safeguarding

- Data is collected on the number/quality of referrals/investigations/protection plans and outcomes with interpretation of trends

- All agencies of the Board to audit recording against current individual agency practice standards to ensure the totality of the work with any individual is recorded

- Procedures for the management and collection of repeat referrals/contacts relating to individual vulnerable adults should be developed and implemented

5. Local response to the Winterbourne View Reports.

- Action plan for the response to Winterbourne View reports in the Dudley Area to include assessment/treatment; commissioning/safeguarding; restraints and controls

ADULTS

Pressure Ulcers

In April 2013 the Trust changed the tool used to stage the depth of pressure ulcers. The new tool was adapted from the agreed national tool so that it is clearer and easier to use. Several education sessions took place across the Trust and the Tissue Viability team undertook a trolley dash across all wards. During the trolley dash the team gave out information about the new staging tool and took the opportunity to raise awareness about all aspects considered important to prevent pressure ulcers.

The '50 day dash' continued with some wards achieving over 500 days free from avoidable stage 2, 3 and 4 pressure ulcers. The initial campaign was launched with the aim of wards reaching 50 days free from pressure sores. The information remained visible on the Trust intranet and a number of wards were recently rewarded for all their hard work with a visit from the chief executive and a well done speech.

Increased awareness of pressure ulcer prevention, lead to an increased demand in specialist pressure relieving equipment. This type of equipment was not available on every bed, so the Trust had to ensure that when needed the equipment was available as soon as possible. To ensure there are no delays the Tissue Viability team looked into

alternative equipment and following work to evaluate several different options new static air mattresses have been introduced. These are in-situ on all inpatient beds (excluding Maternity and Paediatrics). These mattresses have air cells inside them and are suitable for patients who are at high risk of developing pressure ulcers. There will still be instances when plug in mattresses are required but for the majority of patients high risk equipment will already be in place with no delays. Where plug in mattresses are required they can be issued within an acceptable time frame because overall demand for this type of equipment has reduced significantly.

Pressure ulcer prevention and management documents are now being used across the hospital and community. The prevention document includes a SKIN bundle, which carers complete to ensure every aspect of pressure ulcer prevention is addressed at each patient care episode. There are weekly audits of the document in the hospital to ensure compliance and to assist with identifying where improvements are needed.

The Trust has recognised the importance of continually updating community carers in pressure sore prevention and completion of the SKIN bundle documents. This includes carers in the home and residential home settings. SKIN bundle sessions continue for this group of staff across the year on a rolling programme and all sessions are well attended. The Trust has supported the continued hospital link nurse sessions in which nurses off all wards are kept updated every 2 weeks.

Recently the Trust has employed 2 new nurses to support community services. They will support community nurses through development of guidance and education to continue the work to improve pressure sore prevention.

An Innovative video campaign was launched during the festive period; this was a fun video reminding staff of the ways to reduce the risk of pressure ulcers. The video is available on the hub for staff to see.

A draft business case has been developed to increase the Tissue Viability nursing team to meet the requirements set in the CQUIN target for 2014/15. There is a requirement that all stage 3 and 4 pressure ulcers that develop in the acute trust or on the district nurse case load must be reviewed by a tissue viability nurse.

All root cause analysis investigations for stage 3 and 4 pressure ulcers that develop in the acute trust or on the district nurse case load continue to be reviewed at the Acute Trust and Community Pressure Ulcer meetings.

3. Staffing and Administration Arrangements

The Safeguarding Team are detailed below:

Ann Becke	Non Executive Director Non Executive Lead Safeguarding
Denise McMahon	Director of Nursing Executive Lead Safeguarding
Pam Smith	Deputy Director of Nursing

	Deputy Executive Lead Safeguarding
Yvonne O'Connor	Deputy Director of Nursing
Dr Zala Ibrahim	Designated Paediatrician for Safeguarding Children
Dr Anshu Sharma Dr Deepak Parasuraman	Named Consultants for Safeguarding Children
Carol Weston	Named Nurse for Safeguarding Children
Dr Nicholas Stockdale	Safeguarding Adults Lead Doctor
Judith Page	Named Nurse for Safeguarding Adults
Sally Burns	Named Lead Midwife Safeguarding
Bev Tinsley	Specialist Midwife Vulnerable Women
Jacqueline Howells	Acute Liaison Nurse Learning Disability
Julie Lavender	Safeguarding Administrator to Designated Consultant Safeguarding Administrator to Named Nurse for Safeguarding Children

The Safeguarding Named Nurses/Midwives and Deputy Directors of Nursing are available Monday to Friday 8am-5pm providing advice and guidance to all wards/departments where there are safeguarding concerns.

The Designated Consultant and Named Consultant are available alternate weeks on call for Safeguarding children cases**.**

The Safeguarding Adults Lead Doctor has one session for safeguarding concerns.

There is no provision for on call guidance regarding safeguarding adults' cases.

The Safeguarding Administrator is available Monday to Wednesday 8am-4pm to provide medical secretarial support and is a point of contact for outside agencies. The Safeguarding Administrator to the Named Nurse for Safeguarding Children is available for 15 hours per week.

Members of the safeguarding team participate in board and committee meetings of the Dudley Safeguarding Children's Board and Dudley Safeguarding Adults Board.

4. Internal Safeguarding Board

The Trust Internal Safeguarding Board met monthly during 2013-14 to discuss all aspects of Safeguarding. The Board membership involves all individuals who have safeguarding as a key priority of their role and who have direct line of accountability for safeguarding to the Board Level Lead (Director of Nursing).

Reporting Arrangements

The Internal Safeguarding Board will report, via the Safeguarding Board Lead, to the Clinical, Quality Safety and Patient Experience committee and to the Board of Directors quarterly and, via the Deputy Director of Nursing, quarterly to the Trust Children's Service Group, and monthly to the Maternity and Children's Risk Management Team. In addition to the Internal Safeguarding Board a retrospective annual report will be for review by the Board of Directors.

The Internal Safeguarding Board also links to the following external groups:

- Child Death Review Panel
- Health Safeguarding Forum for Children
- Dudley Safeguarding Children's Board
- Health Safeguarding Board for Adults
- Dudley Safeguarding Board for Adults

Membership

Deputy Director of Nursing – Safeguarding Lead
Matron for Paediatrics and Neonates
Head of Midwifery
Designated Paediatrician for Safeguarding Children
Named Consultant for Safeguarding Children
Safeguarding Adults Lead Doctor
Named Lead Nurse for Safeguarding Children
Named Lead Nurse for Safeguarding Adults
Named Lead Midwife Safeguarding
Specialist Midwife for Vulnerable Women
Acute Liaison Nurse Learning Disability
Deputy Matron Mental Health

The board has the power to co-opt any person necessary to assist in its deliberations.

Role of the Internal Safeguarding Board

To provide a robust internal reporting mechanism to address and monitor issues relating to the safeguarding of children and adults.

Main Task of the Internal Safeguarding Board

- To review all safeguarding issues
- To review, approve and monitor agreed actions in relation to all:
    - Child Death Reviews
    - Serious Case Reviews
    - Internal Management Reviews
    - Serious Untoward Incidents
    - Root Cause Analysis.
- To ensure that all external reviews are signed off by the Safeguarding Board Lead before being shared with other parties.
- To ensure the Safeguarding Board Lead has identified a 'key worker' to lead any investigation.
- To ensure any investigation is completed using an agreed template
- To ensure that the Trust is positioned to meet all national policy and statutory regulations relating to safeguarding children and adults and promoting their welfare.
- To receive and record responses and 'position statements' to external reviews
- To monitor compliance with Standards for Better Health, Standard C2.
- To ensure the Trust has in place a coordinated training programme that ensures that identified staff are trained appropriately in all aspect of safeguarding
- To monitor all levels of adult and children safeguarding training
- To agree the safeguarding audit programme to ensure that agreed objectives are met
- To agree any necessary immediate actions to mitigate risks arising from audits, investigations and/or training compliance

5. Policies and Procedures

Safeguarding Children's policy

The Safeguarding Children's policy has been reviewed and was ratified by the Dudley Safeguarding Children Board in October 2013.

Safeguarding Children Training policy

The safeguarding children and young people Roles and Competencies for healthcare staff intercollegiate document has been updated in March 2014.

Staff are able to access safeguarding training by elearning, face to face in-house, and some training is provided free of charge by the safeguarding childrens board.

There are a number of courses available for staff and the named nurse participates in the delivery of some of these. The named nurse continues to be an accredited board trainer.

Competence is reviewed as part of appraisal in conjunction with individual learning and development plan. Annual appraisal is crucial to determine an individual's attainment and maintenance of the required knowledge, skills and competence. The Trust should assure themselves that appraisers have the necessary knowledge, skills and competence to undertake appraisals and in the case of medical or nursing staff to oversee revalidation.

There are five levels of training for different groups of staff and the document includes a separate recommendation for those at Board level, Chief Executive Officers, Trust and Health care Board Executive and Non Executive Directors/Members which should comprise training at Level 1 but also specific training as required.

Safeguarding Adults policy

The Safeguarding Adults policy was reviewed and updated in January 2014. Changes to the policy include advice and guidance on 'Self neglect', 'Social networking' and the discharge of 'Vulnerable adults'.

The policy includes links to the 'multi agency policy and procedures for the West Midlands' and contains guidance on issues such as domestic abuse, honour based violence, female genital mutilation, forced marriage, human trafficking, prisoners and abuse by children.

Reference is now made to the Department Health guidance 'Safeguarding Adults: The Role of the Health Service Practitioner', 2011. The guidance states '*Health services have a duty to safeguard all patients but provide additional measures for patients who are less able to protect themselves from harm and abuse.'* The six principles are outlined in the policy.

Safeguarding Adults Training policy

The Safeguarding Adults Training policy was reviewed in March 2014. The policy outlines the mandatory 'Basic Awareness Training' provided for induction and refresher

training. It also identifies staff who need to attend the multi agency training which includes 'Practice Issues'. E learning has also been made available for refresher training or for staff not working in clinical areas.

Managers are provided with a monthly update of their staffs training requirements and achievements. Updates on training figures are provided at the Internal Safeguarding Board monthly. Staff who are employed by the Private Finance Initiative partners are now engaged in safeguarding training following recommendations of a Serious Case Review in 2010.

Guidelines

All guidelines are reviewed three yearly unless National guidance changes. Action Plans are developed in response to new guidance.

The following policies/guidelines were updated in 2013/14:

Maternal Mental Health Guideline with the addition of CAMHS information

Pregnant Drug/Alcohol User

Pregnant Drug Dependent woman, not known to service
Safeguarding in maternity Services (Child Protection) Policy which incorporates; safeguarding processes, Midwifery Alerts, Extra Process Steps

Asylum Seekers/recent migrants/refuges/English not first language

Baby being discharged into Foster care

Concealed Pregnancy

Domestic Abuse

Fabricated Illness

Female Genital Mutilation

Late Booking

Learning Disability/Difficulty/Assessing Mental Capacity

Persistant Defaulter

Previous Children's Services Involvement

Substance Misuse

Surrogate Pregnancy

Teenage Pregnancy/Sexual Exploitation

Unexpected Death of a Neonate

Any Other Vulnerability

6. Referrals

The Named Nurses for Safeguarding monitor the number of safeguarding referrals made each month from 1st April to 31st March. The referral figures are reported these to the Internal Safeguarding Board each month and the year to date total is reviewed.

Referrals made to Named Nurse for Safeguarding Children 1st April 2013 to March 2014:

Number of Concerns	280
Number relating directly to NHS Care	0
Number relating to Inpatient care RHH	0
Inter agency referrals	138
Pressure Ulcers	0
Medical Examinations requested by other agencies	110
Failure to Follow Procedure	3
CAF initiated including Midwifery as reported by CAF team.	0

The number of concerns identified each month ranged between 17-20. New developments in 2013/14 included the monitoring of the numbers of invitation and

attendance at case conferences (Nov 2013) and the numbers of Common Assessment Framework assessments completed (Feb 2014). There were no failures to follow procedure identified in 2013/14.

Referrals made to Named Nurse for Safeguarding Adults:

Number of Concerns Identified by hospital staff	660
Number of Concerns Identified by Community staff	108
Number relating directly to NHS Care	58
Number relating to Inpatient care RHH	55
Number relating to care by Community staff	2
Inter agency referrals	324
Pressure Ulcers developed in Hospital and Communuty (reported by other agencies)	11
Medical Examinations requested by other agencies	N/A

The number of concerns identified each month ranged between 40-79. The number of Pressure ulcers identified on admission to the Trust for 2013/14 was 225. There were no failures to follow procedures identified for 2013/14.

Referrals made to Named Lead Midwife 1st April 2013 to 31st March 2014:

Number of Concerns Identified	819
Number relating directly to NHS Care	1
Number relating to Inpatient care RHH	6
Inter agency referrals	46
Young Mother referrals	140
Pregnant Substance Mis users	25

Domestic Violence	82
Maternal Mental Health	199
Safeguarding and Child Protection	89
Number of Common Assessment Frameworks commenced	19
Failure to Follow Procedure	0

The number of concerns identified increased in 2013/14 to 843 compared to 595 in 2012/13. The complexity of women also increased.

Referrals made to Acute Liaison Nurse Learning Disability 1st February 2014 to 31st March 2014:

Number of flagged attendances in Outpatients	118
Number of flagged attendances in Emergency Department	52
Number of flagged admissions	42
Number of flagged admissions made directly to the Acute Learning Disability Liaison Nurse	22

Monitoring of the number of flagged attendances in Outpatients/Emergency Department and admissions to the Trust commenced in February 2014.

7. Audits

Safeguarding Children Annual Audit

Dudley Safeguarding Children's Board published new inter-agency Child Protection Standards in September 2012, in response to the Ofsted and Care Quality Commission Inspection of Safeguarding and Looked After Children, published in January 2011. The audit forms part of DSCB's commitment to '*improve the protection of children from abuse and neglect, through more effective inter-agency working.'* It involved auditing 12 cases across police, social care, health and education in respect of children who have been subject to child protection investigations (Section 47), which were initiated since 1st September 2012 and practice observations of child protection conferences and core groups. The key focus was to determine compliance and assess quality of practice with reference to the Inter-Agency Child Protection Standards, published by DSCB in September 2013.

Learning themes included:

- Improvements to information sharing and police checks
- Lack of health involvement in strategy discussions
- Timeliness and completion of agency reports for child protection conferences

A summary of the audit findings can be downloaded from
http://safeguardingchildren.dudley.gov.uk

The Trust participated in this multi Agency case note Child protection standards Audit, the specific learning points for the Trust were to implement a system to include:

- Recording of invitations to, attendance at, and outcomes of, child protection conferences
- Produce a standardised report template for reports to case conferences.
- To promote engagement in core groups (when appropriate)
- Initiation of specialist health assessments

Section 11 Audit

The Section 11 audit resulted in a detailed action plan. The primary focus of this is to increase the engagement of children in service development and to ensure that at each encounter within the hospital the child's voice is heard and evidenced. Hearing the child's voice is a theme to be developed and there are initiatives underway within specific areas to achieve this.

Medical Audit of Did Not Attends (DNA's)

The medical audit of DNA's identified the following recommendations:

- To ensure updated laminated flow diagram is available in all clinic rooms in children's out patients so consultants are aware of the required process
- Consultants to make it clear to whom letters have been sent (specify if sent to Health Visitor, School nurse etc)
- Clinic Nurses to document in notes when notification sent

- To alert surgeons and dermatology to process
- Template letters for 1st, 2nd, 3rd, low risk or high risk DNAs to be available to paediatric secretaries to allow standardised letters to be sent/created on Big Hand
- Copy letters to family if applicable

Safeguarding Adults Annual Audit

An annual Safeguarding Adults audit was not undertaken in 2013/14. The Named Nurse for Safeguarding Adults has been working collaboratively with the Dudley Safeguarding Adults Board Quality and Performance Sub group to develop an audit proforma. The first audit is being planned for 2014/15.

8. CQUIN Schemes

Learning Disability CQUIN

The Learning Disability CQUIN for 2013/14 identified a requirement to recruit an acute liaison nurse for learning disability to provide learning disability awareness training to staff in admission areas: Emergency Department, Emergency Assessment Unit and Preoperative Assessment. 98% of staff needed to be trained for 2013/14. Learning disability awareness training is available via organised and bespoke sessions as requested by ward/department areas. This is provided by the Learning Disability Liaison Nurse and includes:

- Introduction to the Learning Disabilities Liaison Nurse role
- Communication issues and strategies
- Top tips when working with people with a learning disability
- Guidance on implementing reasonable adjustments
- Advice on the Mental Capacity Act 2005
- Specific health issues for people with learning disabilities

A process to gain feedback from patients with a learning disability also needed to be implemented. The acute Liaison Nurse for Learning Disabilities held patient summits with the support of Dudley Advocacy service to gain feedback. The CQUIN scheme for 2013/14 was achieved.

Pressure Ulcer CQUIN

The pressure ulcer CQUIN for 2013/14 identified a requirement to reduce the number of grade 3 and grade 4 pressure ulcers reported in the Trust.

The CQUIN target for pressure ulcers for 2013/14 was to:

- Reduce avoidable stage 4 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 50% in 2013/14
- Reduce avoidable stage 3 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 25% in 2013/14
- Reduce avoidable stage 3 and 4 community acquired pressure ulcers that occur on the district nurse caseload so that the number for 2012/13 has been reduced by 25% in 2013/14

In order to ensure compliance with the CQUIN the Trust identified Pressure Ulcers as one of its quality priorities for 2013/14. The Trust met the CQUIN target for Pressure Ulcers in 2013/14.

Achievement of quality priority 2013/14

The total number of avoidable stage 3 and 4 pressure ulcers that developed in hospital in 2013/14 was 36. This is a marked decreased from 2011/12 and 2012/13 when the number of avoidable stage 3 and 4 pressure ulcers was 110 and 51 respectively.

The target set for avoidable stage 3 pressure ulcers that developed in hospital was a 25 per cent reduction from 2012/13. In 2012/13 there were 23 stage 3 ulcers and so the target should have been fewer than 16 stage 3 pressure ulcers. The Trust had 36 stage 3 pressure ulcers in 2013/14; hence the target was not met. This non-achievement should be seen in context of the introduction of a new staging tool and the overall yearly reduction of stage 3 and 4 pressure ulcers from 51 to 36. Also, it is likely that the numbers of stage 3 ulcers have risen as some of these would previously have developed into stage 4.

A reduction in the number of avoidable stage 4 hospital acquired pressure ulcers by 50 per cent was set in 2013/14. In 2012/13 there were 28 stage 4 ulcers; this has reduced to no stage 4 pressure ulcers in 2013/14.

The target for a 25 per cent reduction of avoidable stage 3 and 4 pressure ulcers in 2013/14 from 2012/13 was achieved with an actual reduction of more than 80 per cent; 3 in 2013/14 compared with 18 in 2012/13.

9. Safeguarding Forum

Safeguarding Forum

The Safeguarding Forum has met on six occasions. The membership of medical and nursing staff from areas where children are seen or admitted to has been extended to include a representative from an adult surgical ward. The meeting focuses on information sharing from the named nurse for Safeguarding Children including updates on policies and procedures, local and nationally.

Topics discussed have included:

- The Common Assessment framework and its use
- Information sharing and the role of Paediatric Liaison.
- The Family Nurse Partnership
- Results of audits
- NICE guidance
- Safe Sleeping guidelines
- Review of Incidents

There is an opportunity for staff to share concerns and receive supervision from the named nurse regarding specific cases. The meetings have been well attended by the small group of staff identified as able to take a lead and promote good safeguarding practice in their areas however this has not been recognised formally.

Supervision

The designated doctor accesses supervision via the regional network of Designated Doctors.

The named Nurse for safeguarding children is clinically supervised by the designated nurse for safeguarding children.

The designated doctor and named nurse provide clinical supervision on request.

The named nurse for safeguarding provides clinical supervision to the diabetes nurses with specific focus on non compliant diabetic patients.

The Named nurse provides advice across all areas, of the trust including where there are concerns about adult issues which impact their ability to care for their children eg domestic abuse, substance misuse, mental health and learning disability.

10. Training and Education

Training for Safeguarding children is available as part of the Induction and Mandatory programmes. There are also safeguarding training courses as part of the in house learning programme and via e learning. The Named Nurses/Midwives for Safeguarding provide training on the Trust Induction and the Mandatory Refresher Training programme. Feedback to trainers is provided by Learning and Development and there has been a recent change to electronic feedback from staff regarding the training they have undertaken.

Staff are also able to access courses provided by the Dudley Safeguarding Children's Board at no cost.

Managers are provided with a monthly update of their staffs training requirements and achievements and percentage compliance figures Trust wide are monitored by the Internal Safeguarding Board monthly.

The overall % figures for Safeguarding training by Directorate are displayed below:

Directorate	Safeguarding Adults	Safeguarding Children Level 1	Safeguarding Children Level 2
Ambulatory Medicine	91.2%	92.5%	67.4%
Business Services	n/a	90%	n/a
Chief Executive	83.3%	97.4%	100%
Clinical & Spec Support Services	91.1%	89.3%	64.5%
Diagnostics	88.6%	86.7%	77.4%
Emergency Medicine	76.4%	70.6%	48.9%
Finance & Information	72.7%	98.7%	n/a
Head of Estates & FM	n/a	100%	n/a

Human resources	100%	100%	n/a
Medical Director	90%	82.4%	100%
Nursing	100%	87.8%	90.9%
Research and Development	100%	96.4%	n/a
Specialist Medicine	86.4%	84.4%	70.3%
Surgery & Anaesthetics	85.3%	83.2%	53%
Trauma, Orthopaedics & Orthogeriatric Rehab	79%	76.4%	54.9%
Women & Children	83.4%	92.6%	76.4%
Grand Total	**86%**	**86.5%**	**62.9%**

The percentage compliance for safeguarding adults and children training increased during 2013/14. Further work is needed in 2014/15 to ensure that the Trust's target of 95% compliance is met.

11. Incidents

CHILDREN

Date	Dept	Concern	Actions taken
Dec 11		Child on child protection plan found deceased at home.	Action plan monitored by SCR committee and Health joint forum. Training audit commenced using NSPCC tool. Agreed actions with L&D to follow up at three months stage audit in place.
Jan 13	Paediatrics	Baby on child protection plan 'shaken baby' injury.	Report from SILP author presented to DSCB. Mother now pregnant attending ANC midwives aware of previous concerns.

Sept 13	Paediatrics	Non compliant Diabetic	Continuing issues re: fabricating test results. PLO commenced. Continues to be non compliant with care, social worker aware. Recent inpatient stay section 20 in place, disruptive on ward with damage to surroundings. Foster placement found, parents refused consent for placement; mother discharged against medical advice. Social care advised safe and well check. Missed psychiatric appointment.
Sept 13	Paediatrics	Non compliant Diabetic	LAC review highlighted increasing concerns. New placement in area. Staff trained for diabetes care.
Sept 13	Paediatrics	Non compliant Diabetic	CAF in place.

MATERNITY

Date	Dept	Concern	Actions taken
Sept 13	Maternity	Para 3, on methadone programme. Partner has mental health issues and uses substances. Incidences of domestic abuse	Referred to SPMW by drugs worker. All children on child protection plans, social worker aware of pregnancy. Attending antenatal appointments and engaging with professionals.**Children and unborn on Child in Need Plan**
Nov 13	Maternity	Mother stating she is pregnant. 4 children in local authority care. Hep C positive on a Methadone prescription.	Not engaging with drug team when asked to attend to confirm pregnancy. Social worker informed. Attended A&E dept but left department before full assessment completed. Message left for community midwife. Has appointed at Atlantic House with SPMW. Nuchal scan, attended plans to continue with pregnancy, for initial assessment by Social Worker**.** Unsure whether to continue pregnancy but failed to attend for TOP in London, ANC appt sent. Social worker to complete core assessment**.** Attending for antenatal care. Engaging with all professionals**. Disengaged with services, further appointments arranged. For ICPCC**
Jan 14	Maternity	Presented in ED with abdominal pain. Pregnancy confirmed.	Dating scan performed in EPAC – Community midwife and social worker

		Previous history of concealed pregnancies and children placed in local authority care.	notified. Antenatal care initiated. Initial case conference held, but maternity services were not invited. Core group attended to compile child protection plan**. Child protection plan in place. Parents aware plan is to accommodate baby in a place of safety with supervised contact for parents. Aim to obtain a care order following delivery and place baby in local authority care.**
Jan 14	Maternity	Presented in antenatal clinic. Un-booked, Pregnant ? 16 weeks History of current drug use. On Subutex. NFA. Known to drug treatment team.	Scan performed 8 weeks gestation. Antenatal booking commenced. See at 12 weeks with dating scan and clinic. Community midwife and drug worker notified. 14+ social worker notified of pregnancy. FNP assigned to work with mother. Compliant with medication. **Has stopped her drug treatment against advice, disengaging with specialist services. Considering a termination of pregnancy.**
Jan 14	Maternity	?fabricated illness- disclosed diabetic and epileptic, not substantiated. Social care involved with first baby who lives with maternal grandmother	Incident in community related to being prescribed Epilim by GP has been discussed at the professionals meeting. Initial antenatal care and screening being undertaken. **Initial case conference held, unborn subject of a child protection plan. 'Alert flag' to be initiated on OASIS to alert professionals Not to prescribe any epileptic/diabetic medication until a formal diagnosis justifies the action.**
Jan 14	Maternity	Mild learning difficulties, housing issues, 'risky behaviour'	Unborn on a child protection plan, for mother and baby residential placement. **Baby delivered and mother and baby discharged to supported housing in 'Living Springs' to commence a residential assessment. SW not informed of delivery or discharge, DATIX submitted**
Jan 14	Maternity	Illegal immigrant bought into the UK. 17yrs old, pregnancy due to rape.	Brought into A&E after being found on a pavement in Dudley. Children's services accommodated mother in a hostel. Booked

		No English, no antenatal care.FGM.	by CMW, accessing antenatal services. Seen in ANC, interpreter used to converse. Type 2 FGM identified. **Child in Need plan in place for the unborn. Engaging with all professionals and agencies. Birth partner identified, re housed and immigration application in process.**
Jan 14	Maternity	3rd pregnancy. On street Subutex, history of CVA in 2011. Partner in custody for armed robbery. No fixed abode.	ICPCC planned for 19/02. Written report submitted. Accessing antenatal care. **Unborn subject of a child protection plan. Core group attended to formulate the plan. NS engaging with antenatal services.**
Jan 14	Maternity	1st baby, suffering with depression in antenatal period	Admitted in labour, developed psychotic behavior. Seen by psychiatric team and transferred two days postnatal to the Barberry Unit – perinatal psychiatric services. **Remains at the Barberry unit after being sectioned under the mental health act, making progress.**
Jan 14	Maternity	2 siblings on child protection plans. SPMW informed social worker 07/02 of positive urine toxicology to street heroin. Care proceedings initiated.	14/02/14 SPMW notified by biochemistry that the toxicology test result was an incorrect result. The result had been manually entered in the biochemistry lab. The street heroin result was – negative. Datix completed, social worker notified, SPMW attempted to contact NJW x2 occasions. Discussed with Carol Barley (clinical governance). **RCA to be held 12/03/14. Letter of apology sent by the Trust to the parents.**
Feb 14	Maternity	Partner has ADHD and woman lives with his mother, who has real issues with Children's Services	Woman presents to HCP's as extremely submissive and withdrawn. **Referral to Children's services, pre-birth assessment to be undertaken by allocated SW.**
Feb 14	Maternity	Late booker; not informed CMW/GP of pregnancy. Disengaging with Drug Team, was on methadone, stopped collecting script 12.02 Breached 'bail'	Attended ED 01.03.14. USS performed = 15/40. **Advised to seek GP/CMW referral and to see Drug Worker asap to recommence her script.**

Feb 14	Maternity	Attended ANC with PV bleeding, scan, viable pregnancy, unsure whether to proceed with pregnancy. Using street heroin. Previous baby not with parents.	**Attended x 3 times in ANC, still undecided, now 16/40, asked CMW to 'book' pregnancy and has numerous appts at drug team but has not attended. Will refer to Children Services at 20/40.**

ADULTS

Date	Dept	Concern	Actions taken
Dec 12	A2	Poor understanding/implementation of the Mental capacity Act	Feb 14 – Final Medical report from Medical Director shared with Safeguarding Manager. X3 Sessions on MCA act held with medical staff. Mar 14 - Concerns remain over compliancy of medical staff attending MCA act training. Trainers and IMCA report low attendances at training. MCA training is not mandatory at present. This is under review. X3 Sessions on MCA act held with medical staff.
Jan 13	ED/C8	Allegation by care home and CLDT that the legal framework of the Mental Capacity Act were not followed when making serious decisions about medical treatment.	July 13 - Individual Management review process commenced. Meeting held with Manager from 'Changing Our Lives' organisation. Aug 13 – IMR complete. To be presented to DSAB Sept. October 13 – IMR presented 27th September to DSAB. Training and awareness re MCA to be addressed by Medical Director with Consultants. X3 Sessions on MCA act held with medical staff. Mar 14 - Concerns remain over compliancy of medical staff attending MCAct training. Trainers and IMCA report low attendances

			at training. MCA training is not mandatory at present. This is under review.
Aug 13	OPD	Patient was in early pregnancy and claimed to have diabetes which could not be substantiated. She attended the diabetes antenatal clinic having obtained a prescription for insulin under false pretences. Previous evidence of tampering with prescriptions, obtaining an NHS insulin pump illegally, and impersonating a letter from a doctor to obtain treatments. Concerns also raised as patient has 5 children at home.	Referred to Adult and Children's services. Information also shared with Police, Mental Health and CCG. Patient has chosen to go to New Cross to access maternity care so information shared. October 13 – Case note medical review requested by Designated Nurse for Children's Safeguarding, CCG and Head of Safeguarding for Children's Services. Review to be completed by Endocrinology consultant. Awaiting Case Conference. Informed by PPU, Black Country Hub, West Midlands Police that they will be taking no further action. Dec 13 – Strategy meeting held. No further action to be taken by children's services. CAF may be offered to family. Alert completed by Midwifery Safeguarding lead to health economy. March 14 – Safeguarding Midwife has discussed alert with information Governance for this case and other similar cases.
Sept 13	C6	Alleged transfer of patient to care home without having wife's permission and not dressed appropriately	Strategy meeting held. Concerns upheld by safeguarding manager. RCA in progress. Feb 14 – staff confirmed that patient had been discharged in a theatre gown with a pad on but nothing to secure it in place. Shift Lead on day of discharge confirmed they had been unable to confirm with wife that patient was being discharged but had made numerous calls and left a message for his wife. NIC states they had discussed this with discharge team and been told patient must be discharged as it was a spot purchase bed. For discussion at ISB.

Oct 13	C3	Allegation of unsafe discharge	Strategy meeting held. Allegations substantiated. Round table discussion held with MDT. Action plan under development. Feb 14 – Action plan completed. Awaiting further case conference with safeguarding manager and family to share outcome of investigation.
Oct 13	District Nurses	Unclassified stage 3 pressure ulcer	RCA completed. Action plan devised. Concerns to be addressed re documentation that are not on the action plan. (raised by CCG) Awaiting a meeting with C. Coley to discuss.
Dec 13	EAU/Xray	Allegation of inappropriate restraint	RCA in progress. Dudley Safeguarding, CCG and CQC aware. Mar 14 - Draft received and reviewed by Acting Deputy Director of Nursing.CCG and SSW from Dudley Safeguarding have requested to review medical records.
Jan 14	C3	Allegation of unsafe discharge by care home who state patient was immobile.	Case notes reviewed. Documented that patient was independently mobile with supervision whilst on C3. ADL assessment confirms this as does discharge letter. Case conference cancelled. Awaiting new date.
Jan 14	District Nurses Stepping stones	Allegations of poor documentation and delivery of care by DNs at this practice. Concerns raised by CCG Quality and Safety Lead.	CCG state there are other areas of concern at this practice. Meeting to be arranged to discuss concerns with Colleen Coley, Jane Atkinson and Safeguarding Named Nurse. Datix to be completed once all areas of concern known. Mar 14 – Meeting arranged for 25/03/14.
Jan 14	C3	Allegation by Hollybush House of a pressure ulcer developing on C3.	No RCA completed during the patients admission. Case notes to be requested and reviewed re pressure care. Mar 14 – No update received.
Feb 14	A1	SW raised concerns re discharge planning,	Concerns investigated and were unsubstantiated. Findings discussed with

		pressure ulcers and follow up care for pressure ulcers.	allocated safeguarding social worker. Case closed.
Feb 14	B2	Concerns raised by manager of Hollybush House re discharge planning.	RCA commenced.
Feb 14	C7	Concerns raised by daughter re discharge planning.	RCA commenced.
Feb 14	C4	Concerns raised by patient's family re discharge planning.	RCA commenced.
Feb 14	C5	Concerns raised by patient's neighbor and Social Services re discharge planning.	Investigation commenced.
	C3	Concerns raised by social worker and care home re bruising to abdomen.	Case notes requested for review.
Feb 14	A2	Person In Position of Trust concern.	Investigation ongoing.
Feb 14	Community /C1	Patient found on floor at home by DNs not responding. It was identified left leg and foot had full depth burns from open fire. Patient is well known to social services and concerns have been previously raised by DNs re risks at home and patient's vulnerability.	72 hour meeting held to ascertain facts of the incident and to decide if it should be an SI in view of multi agency involvement. Safeguarding manager informed of concerns and will arrange a strategy meeting.
Feb 14	B2	Pressure ulcer developed in trust	RCA requested by TVN.
Mar 14	C3	Security staff intervened following a patient's behaviour becoming aggressive. Staff present felt undue force was used.	72hr meeting held. RCA commenced. Safeguarding Manager aware and arranging a strategy meeting. Family have met with the Chief Executive and Assistant Nursing Director. Police and CQC informed by Safeguarding

			Manager.

LEARNING DISABILITY

Date	Dept	Concern	Actions taken
Feb 14		Poor understanding of MCA.	Advised to complete capacity assessment and document, and to call Best Interest meeting-re treatment options. Patient now at Palliative stage. Advised 2nd capacity assessment re care environment, chaired BI meeting to decide on appropriate future care environment.
Mar 14		Consultant has decided NOT to undertake surgery and has gone against the original Best Interest meeting decision.	Suggested to GB social worker that another best interest meeting needs to be held, with the 'new' surgeon. Secretary emailed to suggest this is arranged. IMCA involved with original decision and has advised he will attend this meeting, but he is very unhappy about the situation for GB.
Mar 14		Complaint made by patient's sister re hospital care relating to care from 2010 this has been investigated-however social care reinvestigating same complaint.	Complaint was dealt with and Best Interest meeting held in December 2013, with agreed actions. Sister received a letter from Paula Clarke in January 2014, outlining the measures taken to address the complaint. Sister has taken our letter to Social Service complaints dept and they are now investigating this. Email contact from CTLD re- actions on the Best Interest minutes – assured them actions are complete. PALS alerted to make them aware.

12. Developments/New Initiatives in 2013/14

CHILDREN

Following the completion of the section 11 audit in 2013 opportunities to evidence the voice of the child have been implemented.

These include:

- Section on the child's wishes to be included in the ward Admission documentation, ED Electronic record and Child Protection medical form
- Review of admission documentation and Emergency Department Electronic record to be included in the monthly Nursing Care Indicators audits
- Monthly audit of Child Protection medical form
- Implementation of a 'Feedback board' on Children's ward/children's outpatients/Children's Area in the Emergency Department

MATERNITY

The referral pathway for maternal mental health is being reviewed by the Clinical Commissioning Group and Mental Health services providers for Dudley. This will promote agreement for future service provision and training provision. Referrals continue to be made to the Perinatal mental health service at the Barbary Centre when required.

The risk assessment tool and documentation for women with learning disabilities are being implemented. This process will be added to the current safeguarding guideline and, when agreed, the process will be launched with any required training implemented and included in the vulnerable women's updates. Monthly meetings with the Trust acute liaison nurse for learning disabilities continue.

ADULTS

Health Care Home Practitioners Forum – First meeting was held 18th March 2013. The aim of the group is to provide an arena for all healthcare professionals who visit homes on a regular basis or come into contact with patients from care homes to share information and to collect the "Soft Intelligence" about issues that may not meet the safeguarding threshold. The information shared comes from various sources, such as safeguarding, CCG, CQC Liaison meetings, Mental Health, Commissioning (Health and Social Care) and Dudley Group (acute and community). It is chaired by the CCG Safeguarding and Quality Lead Nurse and is held monthly. The Trust's Named Nurse for Safeguarding Adults and the Emergency Departments Welfare Nurse attend regularly.

Safeguarding Alert/referral form –This was launched in June 2013 by Dudley Safeguarding Adults Board. The Emergency Department continue to make telephone referrals as agreed by Dudley Safeguarding Adults Board but the Trust has firmly embedded the alert form in its safeguarding practice.

13. Future Developments planned for 2014/15

CHILDREN

To continue to implement and embed the recommendations of the Section 11 audit to evidence hearing the voice of the child; improve attendance at child protection case conferences and improve attendance at Safeguarding Board meetings and seniority of membership.

MATERNITY

The Named Lead Midwife and Specialist Midwife for Vulnerable Women plan to develop an unborn baby Network in collaboration with other agencies.

ADULTS

Safeguarding Adults Forum

The Named Nurse for Safeguarding Adults is developing a Safeguarding Adults Forum. Each ward/department will be asked to nominate a member of staff and a deputy to attend the forum. This will be held every third month and will discuss current themes, changes in safeguarding locally and nationally, recent investigations and also give staff an opportunity to discuss any concerns they have around safeguarding. The first forum is scheduled to take place in 2014/15.

Challenging Behaviour training and Dementia Awareness for Security officers

The Deputy Matron Mental Health and the acute Liaison Nurse for Learning Disabilities are developing training for Security officers on how to respond to patients who have challenging behaviour or Dementia.

LEARNING DISABILITY

Patient summits

There will be facilitated Patient Summits held quarterly at a neutral venue with invited participants who have used the hospital within the preceding three months.

People with learning disabilities and their carers will be invited to attend the summits, which will be called 'Our Hospital-Our Voice' meetings. This will be an opportunity for the patient voice to heard, for input into the friends and family test to be made by people

with learning disabilities and their carers and also enable views to be included in the future planning of hospital services.

A detailed action plan is available which includes timescales and the names of persons responsible for the actions. The delivery of the actions will be monitored via quarterly reports to the Internal Safeguarding Board, and the learning disability liaison group. There will be regularly reports to the Learning Disability Partnership Board via the Health sub group. There will be an annual report to the Board of directors and a regular report made available to CCG commissioners.

Case note audit

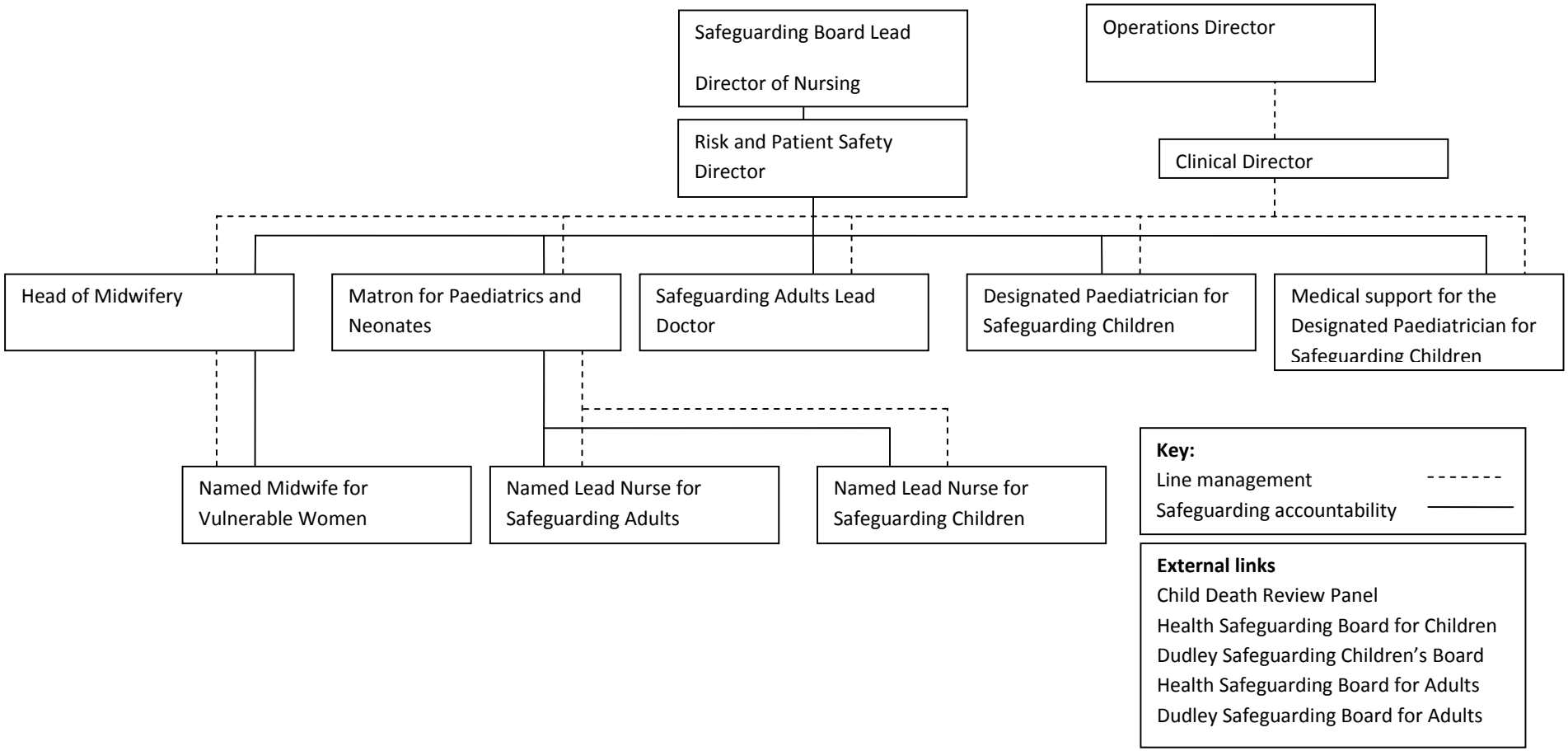
There will be a case file audit of the case notes of 12 patients with a learning disability who have been an inpatient within the Trust. This audit will measure the use of the recommended tools highlighted within the learning disability awareness training, and the use of the Mental Capacity Act 2005 within patient care.

This audit will review the use of the learning disability check list and care plan. It will also review the recording of any reasonable adjustments made and the use of the mental capacity act 2005.

Using a simple matrix the results will be recorded, and a regular report made available to CCG commissioners, and the internal safeguarding board meetings.

14. Appendices

Appendix One - SAFEGUARDING ADULTS AND CHILDREN ACCOUNTABILITY ORGANISATIONAL CHART



The Dudley Gro
NHS Foundation Trust

Enclosure 9

Paper for submission to the Board on 6th November 2014

TITLE:	**Keogh Final Action Plan – October 2014**		
AUTHOR:	**All Directors**	**PRESENTER**	**Paula Clark** **Chief Executive**

CORPORATE OBJECTIVE: SGO1: Quality, safety & service transformation, reputation,

SGO2: Patient Experience, SGO5: Staff commitment

SUMMARY OF KEY ISSUES:

Following the inquiry into Mid Staffordshire NHS Foundation Trust, the Medical Director for NHS England identified 14 Trusts for formal review. The Keogh Review published in July 2013 resulted in the Trust receiving 39 recommendations; nine of which were deemed urgent. The Trust's response to the Keogh report was led by the Chief Executive and Chairman.

Regular reports on the Trusts progress against the recommendations have been received at the Board. The attached action plan confirms that the outstanding actions have now all been closed or moved to alternative work streams.

The Trust has received independent assurance from the Internal Auditors that recommendations have been progressed and are supported by a clear and transparent audit trail.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 1 - Respecting & Involving people Outcome 4 – Care & welfare of people Outcome 7 - Safeguarding Outcome 12 – Requirements relating to workers Outcome 16 – Assessing & monitoring quality of service provision
	NHSLA	**N**	**Details: N/A**
	Monitor	**Y**	**Details:** Compliance requirements
	Equality Assured	**Y**	**Details:** Better health outcomes for all Improved patient access and experience
	Other	**Y**	Details: Confirmation of action to DoH

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
Y			

RECOMMENDATIONS FOR THE BOARD

The Board is requested to:

- Receive the report and note the actions identified by Lead Directors in response to this.
- Note the independent assurance received from the Trusts auditors (reported to Audit Committee on 21st October 2014) on the Trusts progress and
- Formally close the Keogh Action Plan

The Dudley Group NHS
NHS Foundation Trust

KEOGH INVESTIGATION ACTION PLAN – OCTOBER 2014

GOVERNANCE AND LEADERSHIP											
Keogh Concerns / Key Issues (Rapid Response Review Report (RRR) & Risk Summit (RS))		Recommended Action	Priority	Improvement Action			Lead	Action Date	Outcome Measure	Board Assurance/	RAG
				Planned	Progress	Completed					
i. Quality Governance Structure											
RRR	Management information presented to the Board does not appear to identify common themes and issues and the information presented does not enable the Board to effectively challenge on all aspects of quality	2. The Board should consider how it reviews management information provided to it to demonstrate adequate challenge on the progress being made on the Trust's quality priorities	**High**	2.1 This will be covered by the terms of the Deloitte Review at 1.1 above and the Board's response to it.	**Report to February Board on the development of the balanced scorecard and use of this as an overview of all quality, HR, finance and performance standards.** **Work continues on the development of the balanced score card.**	**Balanced score card now in use at Directorate performance meetings**	PA	**November 2013** **Revised Date January 2014**	**Monthly Integrated Performance Report (balanced score card)**	1.1 Deloitte Terms of Reference 1.1 Deloitte Draft Report **2.1 Report to Feb Board on Development of the balanced scorecard**	
RRR	A number of senior staff interviewed could not articulate how the governance processes were working in practice in the Trust and in their own directorate, for example the escalation procedures and clinical supervision policy. A number of the clinical directors could not describe how their directorate governance processes operated in practice and how issues fed into the overall Trust governance arrangements.	3. Following the HAY Group training the Trust should ensure that all senior clinical staff are aware of their responsibility for governance in their directorate and are held accountable for this. If this is still not embedded, further training may be required.	**High**	3.1 The Trust will address clinical understanding as part of a wider development programme following its organisational restructure. It will be given support by NHS England to develop its education programme.	3.1 The Trust has been working with the HAY Group under the NHS Leadership Academy for six months to up-skill Clinical Directors and senior consultants to fulfil their roles more effectively in relation to leadership and governance. This programme is nearing completion. ***This work will be progressed further following re-reorganisation.***	3.1 Directorate Performance meetings now established. Consistent Meeting agendas at Directorate level **Restructure complete , Governance structure in Divisions in place**	RC/JC RC/PC	Sept 2013 **Revised end date April 2014**	**All directorate governance meetings chaired by CD, with agendas including the Trusts mandatory agenda items**	**3.1 HAY workshops** **3.2 Divisional Governance Structure**	

CLINICAL AND OPERATIONAL EFFECTIVENESS												
	Keogh Concerns / Key Issues (Rapid Response Review Report (RRR) & Risk Summit (RS))	**Recommended Action**	**Priority**	**Improvement Action**			**Lead**	**Action Date**	**Outcome Measure**	**Board Assurance**	**RAG**
				Planned	**In progress**	**Completed**					
v. Managing capacity including bed management and patient flows											
RS	*The Trust has capacity challenges which its operational management procedures are not addressing fully*	*RS 4. The Trust's system for bed management, patient flows and discharge need to be urgently reviewed and improved to address operational effectiveness issues and improve patient experience*		*The Trust is working through the recommendations of the Emergency Care Intensive Support Team review following their visit to the Trust in November 12. This focuses on bed management and patient flows. The Trust has a business case for implementation of electronic white boards on each ward and enhancing its electronic ADT system (Admissions, Discharges and Transfers).*	*Emergency Care Intensive Support Team (ECIST) has been invited in to review processes and their recommendations will be implemented by Oct 2013.* *ECIST will attend the Trust on 9th October to review progress.* ***Following ECIST return visit in Oct 13 and LOS review in Feb 14, focussed action plan devised to identify the most impactful interventions for completion by May 14*** ***Evaluation of winter schemes including AEC and frail elderly unit in collaboration with Commissioners (May 2014)***	*ECIST follow up review team response agreed. Action plan being delivered* *AEC unit saw 451 patients in first month Weekly planning meeting identifies upcoming high risk (capacity) days* *Directorate management teams operating manager and nurse of the day for capacity management Improved weekend medical (GP and hospital doctor cover* *Transfer nurses routinely booked for high trigger* days. ***AEC and frail elderly unit trials complete Action plan complete and shared with Monitor*** ECIST Action plan now delivered and monitored via the Urgent Care Group Capacity concerns as BAF	RC	Oct 2013 **Continuing against revised action plan.** **May 2014**	**Improvements in short and long stay LOS measure in AMU, AEC and frail elderly assessment unit** **Completion of the Morning Board Round audit process as monitored by Transformation LOS working group** **Reduction in 4 hour beaches** **Improvement in F&F results**	RS4. ECIT action plan **Urgent Care Group minutes /notes**	

CLINICAL AND OPERATIONAL EFFECTIVENESS											
	Keogh Concerns / Key Issues (Rapid Response Review Report (RRR) & Risk Summit (RS))	**Recommended Action**	**Priority**	**Improvement Action**			**Lead**	**Action Date**	**Outcome Measure**	**Board Assurance**	**RAG**
				Planned	**In progress**	**Completed**					
RRR	The Trust has had consistently high activity levels in recent months and has challenges in meeting A&E wait targets and with increasing average length of stay. Staff and patients consistently spoke of how busy the hospital was. Evidence of poor bed management and flows was noted including: • Use of escalation areas over extended periods. • EAU was being used for extended stays which was not the intended use of the unit, due to infection control procedures. • A number of patients were identified as outliers. Inconsistent explanations about how their care was being managed. • A number of patients were found to be waiting on trolleys in EAU They could not be admitted due to bed shortages. • Observations in A&E noted ambulances stacked outside waiting to deliver patients to the Trust	15. The Trust should discuss more sustainable solutions to the high capacity levels and bed management challenges with its key stakeholders such as the CCG and social care colleagues.	**Urgent**	15.1 Play a constructive part in the Dudley Urgent Care Board, Black Country Urgent Care Board Area Team Urgent Care Board to:	15.1 Urgent care plan completion - work linked to bed management is part of a wider externally supported programme that is looking at urgent care planning and management. **Following ECIST return visit in Oct 13 and LOS review in Feb 14, focussed action plan devised to identify the most impactful interventions for completion by May 14**	ECIST follow up review team response agreed. Action plan being delivered **Better Care Fund support for complex discharges identified** **ECIST Action plan now delivered and monitored via the Urgent Care Group**	RC	Nov 13 **Revised - In accordance with ECIST Action Plan**	**Memorandum of agreement between the LA, CCG and Trust regarding delayed transfer of care** **Consensus agreement re utilisation of Better Care Fund**	15.1 ECIST action plan **Urgent Care Group minutes /notes**	
				a)Identify an innovative solution to ambulance diversion to appropriate solutions **Community rapid response team commissioned to support ambulance service to care for frail elderly in their normal place of residence (June 14)**	a)The Trust is working with the CCG and LA to identify the best options for ambulance conveyance Working through Dudley CCG to manage inappropriate ambulance conveyance	Continuing to progressing single point of access **ECIST Action plan now delivered and monitored via the Urgent Care Group**		Nov 13 **June 2014**	**Reduction in ambulance conveyances (%)** **Increased uptake via GPs of Frail Elderly rapid response team**		

PATIENT EXPERIENCE											
	Keogh Concerns / Key Issues (Rapid Response Review Report (RRR) & Risk Summit (RS))	**Recommended Action**	**Priority**	**Improvement Action**			**Lead**	**Action Date**	**Outcome Measure**	**Board Assurance**	**RAG**
				Planned	**In progress**	**Completed**					
ii. Complaints process											
RRR	The management of complaints process reflects that the Trust is not always using information sources available to effectively review and identify learning to improve how care is delivered in the organisation. As noted in the governance section, the Trust is also not using complaints information alongside other information, such as ward level data on patient feedback and incidents, to target areas of the organisation which need more support to improve overall patient experience.	20. Implement a more effective process to capture learning for the Trust from complaints and ensure these are shared at ward level	**Urgent**	20.1 Development of a complaints liaison role to support patients and capture learning from complaints.	***20.1 This has been delayed due to the wider organisational restructure and consultation***	**Restructure completed and liaison role not now required Patient Experience element now in the Communications Department and has now been recruited to**	PC	**Apr 2014**	**20 Trends and themes from complaints captured and learning shared across the organisation at monthly complaint meeting to review trends and complaint responses**	20.1 Complaints quarterly reports	
				20.2 Review the arrangements for capturing and learning from both complaints and incidents and develop and share ward level information, report quarterly to the CQSPE Committee on complaint outcomes, learning and implementation	20.2 refer to 19.1 above A number of recommendations were made to generally improve the complaints handling process, including • The recording and monitoring of responses • Monitoring of delays • Chief Executive involvement in complaints meetings • Learning opportunities Integration of PALS and Complaints	Complaints review meeting established	PC	Oct 2013		20.2 Minutes of Complaints review meeting and actions arising	

CLINICAL AND OPERATIONAL EFFECTIVENESS											
	Keogh Concerns / Key Issues (Rapid Response Review Report (RRR) & Risk Summit (RS))	**Recommended Action**	**Priority**	**Improvement Action**			**Lead**	**Action Date**	**Outcome Measure**	**Board Assurance**	**RAG**
				Planned	**In progress**	**Completed**					
iv. Management of outpatient appointments											
RRR	The management of the OP appointments was considered as not efficient or well organised by some patients at the listening events. The panel did not observe outpatients directly.	22. The Trust should review its outpatient appointments process to consider how it can address the frequent complaints.	**Med**	22.1 The Trust is conducting a phased demand and capacity review across all outpatient specialties, starting with areas that have issues with meeting the current demand levels for appointments and have frequent complaints about the service.	22.1 Cross operational directorate process now in place to reduce cancellation and re bookings and improve patient experience. Shared with CCG **Service Improvement programme OPD steering group meets regularly to review progress against detailed implementation plan**	**Capacity and demand plan, completed as part of 2 year IBP submission process. Action plans for Ophthalmology and Dermatology now complete and being worked through (includes, for example, daily planning huddles in dermatology, new consultant capacity and follow up reprioritisation procedure in Ophthalmology)** **"ROAR" health record retrieval process in place and has improved OPD case note availability significantly, since inception.** **Residual issues about transformation now moved to the Transformation Work stream under Anne Baines (Director of Strategy and Performance)**	RB/RC	**Implementations clear following capacity/ demand planning by Q1 2014/15**	**Reduction in level of complaints in OP appointments** **Improvement in Choose & Book and TAL performance**	22.1 Ophthalmology Summary Implementation Plan **Transformation Reports**	

WORKFORCE AND SAFETY											
	Keogh Concerns / Key Issues (Rapid Response Review Report (RRR) & Risk Summit (RS))	**Recommended Action**	**Priority**	**Improvement Action**			**Lead**	**Action Date**	**Outcome Measure**	**Board Assurance**	**RAG**
				Planned	**In progress**	**Completed**					
Workforce planning											
i. Nurse staffing levels and skill mix											
RRR	The Board has not reviewed overall Trust staff levels since 2011 but has reviewed staffing and invested in some high risk areas via business cases including maternity, EAU and stroke. There does not appear to be a detailed regular review by management of ward staffing levels including triangulation of available data to ensure that staffing levels are safe. The following issues were noted: • E-rostering is not consistently used on wards and therefore rota planning did not appear effective. • The rationale behind the different staffing levels and mix was not always clear • A number of wards, including the Trusts two largest wards (A2 and C1) had registered nursing ratios that were below nationally recognised good practice • A reliance on bank and agency staff on many of the general wards noted by staff as a risk to quality in many of the ward observations and focus groups.	29. The Trust should review its nursing staffing rotas and embed the consistent use of the Allocate e-rostering that it is implementing.	**High**	29.1 Implementation of new e rostering system with Allocate in accordance with the approved project plan and timeline.	29.1 This is progressing. A rolling programme of implementation commenced in September 2013. The anticipated date of completion is March 2014. Implementation has been completed for A4 and the next phase of roll out is on wards C3, B4, C8 and EAU. The electronic rostering website on the HUB has been updated with relevant documentation and system links. A monthly newsletter has been developed to inform staff of progress A central roster team will take over the day to day management of rosters with input from lead nurses for approval of request changes, annual leave etc	Allocate now rolled out to every ward. Implementing full functionality. Will require embedding. Extra training for all roster leads, lead nurses and Matrons being provided to maximise the wider roster management benefits and reduce the reliance on bank and agency staff **Implemented and in place**	PA/ DMc	Revised end date Mar 2014	Achievement of RCN best practise qualified staffing ratios All wards achieve staffing ratios Decrease in Bank and agency staff expenditure	29.1 **Board Paper June 2014 re staffing levels and agency usage to F&P** **Board and F&P papers Sept 2014**	

PRESSURE ULCERS											
	Keogh Concerns / Key Issues (Rapid Response Review Report (RRR) & Risk Summit (RS))	Recommended Action	Priority	Improvement Action			Lead	Action Date	Outcome Measure	Board Assurance	RAG
				Planned	In progress	Completed					
iii. Divergence from guidelines and inaccurate documentation											
RRR	Patient notes were reviewed for several patients with existing pressure ulcers. Examples were identified where the Waterlow score had been recorded inaccurately or the protocol had not been adhered to, based on the specific circumstances for that patient. This has resulted in patients not receiving the level of care which is stipulated in their flowchart.	45. TVNs to support link nurses to educate re Waterlow assessments. Consider use of flash cards or other quick grab educational tools which can be displayed (posters etc)	High	45.2 E- Learning package to be created to test knowledge and to offer guidance on the assessment and completion of the waterlow.	45.2 Preliminary meeting has taken place and work commenced on contents. Work has now commenced on the development of this package. Initial delays resulted from lack of knowledge and training on the software package in use. E learning Package for Waterlow assessment to be launched 1st July 2014. Skin Bundles amended to include a daily review by a trained nurse from June 2014. Pilot of memory foam pillows to off load heels in medical ward, surgical ward and critical care agreed.	**E-learning package completed and in place** **Skin bundles have been amended and audited by Safety Express to Quality and Safety Group up to CQSPE and audited quarterly by Quality Accounts**	DMC	Sept 2013 **(Revised end date Jan 2014)** **Revised end Date Feb 2014** **Revised to July 2014**	**45 Tissue Viability Link nurses will have attended update sessions and will be in possession of educational Tools.** **Compliance – 100%**	45.1 Waterlow guidance PU Prevention document **45.2 Skin bundle audit results** **Quality and Safety Group and CQSPE papers and minutes**	

Enclosure 10

The Dudley G
NHS Foundation Trust

Paper for submission to the Board on 6th November 2014

TITLE:	**Francis Inquiry Table of Recommendations requiring Local Action (*exception report*)**		
AUTHOR:	**All Directors**	**PRESENTER**	**Paula Clark Chief Executive**

CORPORATE OBJECTIVE: SGO1: Quality, safety & service transformation, reputation, SGO2: Patient Experience, SGO5: Staff commitment

SUMMARY OF KEY ISSUES:

The Board has received regular progress reports against the Francis recommendations requiring local actions. The attached action plan confirms that the outstanding actions have now all been closed or moved to alternative work streams.

The Trust has received independent assurance from the Internal Auditors that recommendations have been progressed and are supported by a clear and transparent audit trail.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 1 - Respecting & Involving people Outcome 4 – Care & welfare of people Outcome 7 - Safeguarding Outcome 12 – Requirements relating to workers Outcome 16 – Assessing & monitoring quality of service provision
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance requirements
	Equality Assured	**Y**	**Details:** Better health outcomes for all Improved patient access and experience
	Other	**Y**	Details: Confirmation of action to DoH

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
Y			

RECOMMENDATIONS FOR THE BOARD

The Board is requested to:

- Receive the report and note the actions identified by Lead Directors in response to this.
- Note the independent assurance received from the Trusts auditors (reported to Audit Committee on 21st October 2014) on the Trusts progress and
- Formally close the Francis Action Plan

Report to Board November 2014 - Francis Inquiry Table of Recommendations requiring Local Action

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.					
	Nursing					
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the:	23	Director of Nursing and Human Resources		
		– Regular, comprehensive feedback on performance and concerns;	23		Nurses referred to NMC report to be taken to the Board.	**CLOSED** **Paper received at Private Board September 2014**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Caring for the elderly - Approaches applicable to all patients but requiring special attention for the elderly					
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations	i) MDTs currently form a vital part of care at DGNHSFT. ii) A review, initially in care of the elderly, will be undertaken to ensure that the contribution of all staff involved in the care of patients is included (particularly linking different teams, PFI partners etc), and the lessons of Francis applied where appropriate	**CLOSED** **ECIST Recommendations delivered. Wellbeing workers implemented. Food Management on Board Agenda**
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • The NHS should develop a greater willingness to communicate by email with relatives • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered	25	Director of Ops/Medical Director /Director of Finance & Information	All e-mails from patients relatives and nurses are responded to by the Executive team. Ward level will require more process. The trust plans to move to an Electronic Patient Record system in the future and will include this requirement in the system specification. In Oct 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved discharge letter functionality specified by Francis in Autumn 2014.	**CLOSED Intentional rounding in place Skin, fluid and falls bundles audited by NCI's**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25	Director of Operations	i) Late night discharge reports are provided to clinical teams routinely to enable peer review and challenge ii) Review of the criteria for and protocol supporting patient moves at night as a requirement of managing bed capacity during periods of high escalation levels Discharge lounge is now appropriately staffed and furnished to provide care for patients awaiting discharge. This is now used daily and patient attendance numbers audited	**CLOSED** **Report about night time moves to the November 2014 Board** **Enhanced Staffing for C8 and the Discharge Lounge in the establishment paper that went to Board in June 2014**
242 243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25	Director of Nursing & Medical Director/ Director of Finance & Information	Not currently possible to record electronically. This functionality is specified in a replacement EPR solution being procured by the Trust In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved functionality specified by Francis in Autumn 2014. Paper charts are at each bedside.	**CLOSED** **We have a functional EPR system and SOARIAN this will be enhanced in the IT Strategy – refer to IT Strategy Board** **CLOSED**
					Compliance with charts is audited via Nursing Care Indicators.	**CLOSED**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Information					
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.	26	Director of Finance & Information	The requirements outlined here will be considered when reviewing the electronic Patient Information Systems. In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved functionality specified by Francis in Autumn 2014. Information is currently shared and available via the manual systems in place across the Trust.	**CLOSED** **CCIO appointed and progressing these issues as objectives – refer to IT Strategy Board**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		• Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. • Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.				

Enclosure 11

The Dudley Gro
NHS Foundation Trust

Paper for submission to the Board on 6th November 2014

TITLE:	**Organ Donation Committee Report**		
AUTHOR:	Rebecca Timmins, Specialist Nurse-Organ Donation Dr Julian Sonksen, Clinical Lead Organ Donation	**PRESENTER**	Mr David Badger Rebecca Timmins, Specialist Nurse-Organ Donation
CORPORATE OBJECTIVE: SGO2. Patient experience.			

SUMMARY OF KEY ISSUES:

- Report Trust performance in comparison to nation key performance indicators monitored by NHS Blood and Transplant, and Organ Donation Plan 2014-17
- Summary of grand unveiling of "The Gift of Life" sculpture 8th October 2014
- Report progress with Organ Donation Plan 2014-17

IMPLICATIONS OF PAPER: ***(Please complete risk and compliance details below)***

RISK			**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	√	**Details: Outcomes 1,4,6.**
	NHSLA		**Details:**
	Monitor		**Details:**
	Equality Assured		**Details:**
	Other		**Details: Organ Donation Taskforce Recommendation**

ACTION REQUIRED OF COMMITTEE: .

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD

- ***To support and advocate the Specialist Nurse-Organ Donation to be involved in all approaches to the family for organ donation where this is possible, in line with best practice and national guidance(NICE CG135).***

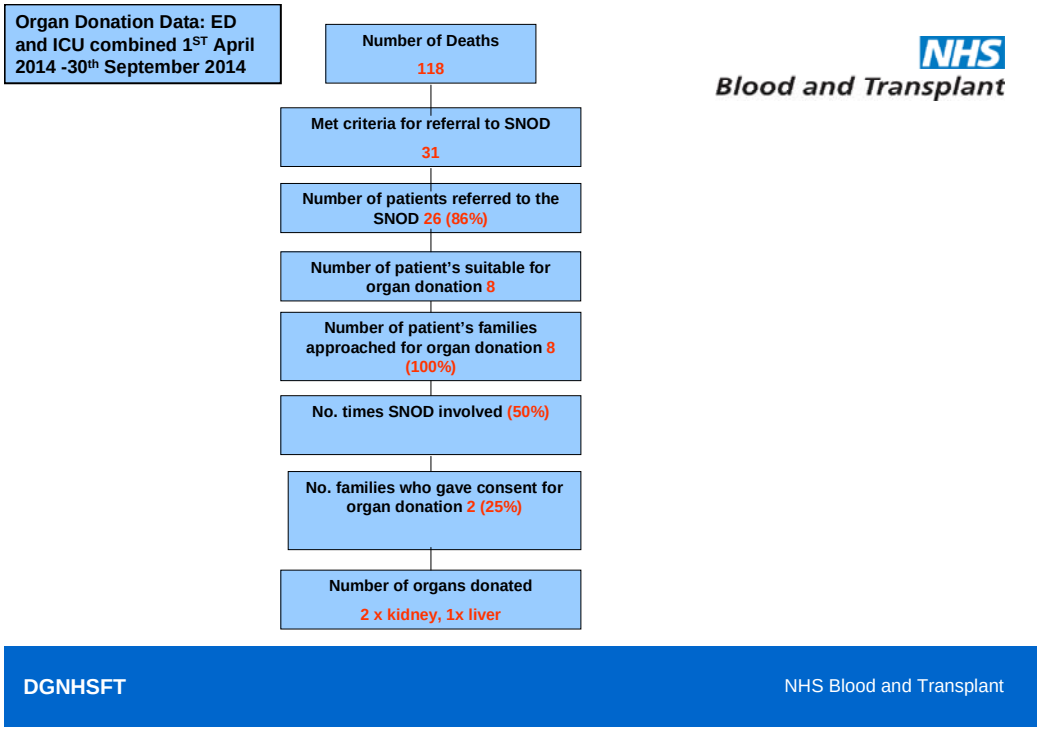
STRATEGIC OBJECTIVES : ***(Please select for inclusion on front sheet)***		
SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
SGO2.	Patient experience	To provide the best possible patient experience
SGO3.	Diversification	To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio
SGO4.	Clinical Partnerships	To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO5.	Staff Commitment	To create a high commitment culture from our staff with positive morale and a “can do” attitude
SGO6.	Enabling Objectives	To deliver an infrastructure that supports delivery

The Dudley Group NHS
NHS Foundation Trust

PAPER FOR SUBMISSION TO TRUST BOARD

Title:	**Organ Donation Committee Report**
Summary:	This report from the Organ Donation Committee to the Trust Board will outline the Trust's Organ Donation Data, and progress with Dudley Group NHS Foundation Trust Organ Donation Plan 2014-17. Section 1 – Organ Donation Data Section 2- Standards approved by DGNHSFT ODC data Section 3 - Issues arising from Organ Donation Data and actions planned Section 4 - Donor Recognition Project Appendix 1- DGNHSFT 6 months Organ Donation Data Appendix 2- Progress with 2014-17 Organ Donation Plan
Action required of Trust Board	The Trust Board is asked to: (a) Support action plans to address Organ Donation Data (b) Support actions planned as part of 2014-17 Organ Donation Plan
Corporate objective ref:	Quality strategy
CQC Essential Standards	Outcome 1, 4, 6.
Author:	Miss Rebecca Timmins: Specialist Nurse Organ Donation Dr Julian Sonksen
Lead Director:	Mr David Badger
Date of Paper:	20th October 2014
For Trust Board meeting on:	6th November 2014

Section 1: Organ Donation Data



Our performance is benchmarked below against the national average key milestones of the donation process.

- **Neurological Death Testing (NDT);** The trust is currently achieving a 100% NDT rate (3 out of 3 patients had NDT undertaken). The national average is currently 80%. There was 1 patient who did not meet all of the criteria for Neurological Death Testing, and could therefore not be tested. The NHSBT Potential Donor Audit is highlighting this 1 case as a "Not Tested" case, therefore altering the NDT rate.

- **Referral to the Specialist Nurse- Organ Donation (SN-OD) for consideration for Donation after Brain Death (DBD) donation**; The trust is currently achieving 100% referral to the SN-OD for DBD donation, all 3 patients that had Neurological Death Tests performed were referred to the SNOD. The national average is 95%.

  Approach to the family for consent for DBD donation; The trust has achieved 100% approach rate to the family for DBD Donation, 2 out of the 3 patients that had Neurological Death Tests performed had absolute contraindications to organ donation, therefore 1 patients family was approached for organ donation. The national average is 93%.

- **Obtaining consent for DBD donation;** Consent was not obtained for organ donation on the 1 occasion. The consent rate for DBD Donation is therefore 0%. The national average is 67%.

- **SNOD involvement in the approach for DBD Donation:** 100% SNOD involvement.

- **Number of Organ's donated from DBD donors;** 0 organs were donated from 0 DBD Donor at the Trust.
- **Referral to the SN-OD for consideration for Donation after Cardiac Death (DCD) donation**; The referral rate to the SN-OD for DCD donation is 86%. The national average is 76%.
- **Approach to the family for DCD donation;** There were 7 out of 7 approaches to the family for DCD donation. The approach rate in the trust is therefore 100%. The national average is 46%.
- **SNOD involvement in the approach to the family for DCD:** The SNOD was involved in 3 out of 7 (42%) of approaches for DCD Donation. The national average is 73%.
- **Consent for DCD donation;** Out of the 7 approaches to the family for DCD donation, consent was given on 2 occasions. The consent rate in the trust for DCD donation is 28%. The national average is 51%.
- **Number of Organs donated from DCD donors;** There have been 3 organs donated from 2 DCD Donor at the Trust so far this year. This resulted in 1 x kidney transplant and 1 liver transplant.
- **Number of people in Dudley on the Organ Donor Register:** There are currently103,214 people in Dudley on the Organ Donor Register which consists of an additional 4591 registrations in a year. This is a 4.7% annual increase, the national average increase for the same timeframe is 4%.

o Section 2 – Standards approved by Dudley Group NHS Foundation Trust Organ Donation Committee Data

The standards approved by DGNHSFT Organ Donation Committee were previously CQUIN's adopted by the Trust and other West Midlands Hospitals during 2011/12. The Organ Donation Committee continues to monitor this best practice criteria and data.

NHS Blood and Transplant

DGNHSFT Standards approved by ODC Trust data, from 1st April 2014 to date

N1; No of deaths where the diagnosis of ND was suspected and patient met criteria for ND Testing and had ND tests performed	Target set 80%	100% (3/3) 1 case where patient was unable to be tested
N2; Number of cases where ND testing was planned and the SNOD was informed	Target set 90%	100%
N3; Number of cases where there was a decision to WOT in a patient with a catastrophic Neuro Injury and the SNOD was informed before WOT	Target set 50%	81%
N4; Number of cases where ND was confirmed or a decision to WOT as per N3, and an approach was made to the family for organ donation	Target set 65%	40% (last quarter this did not occur on 2/2 occasions)
N5; Number of times that donation activity if formally considered by committee and progress with annual plan	At least quarterly	achieving

DGNHSFT NHS Blood and Transplant

Section 3: Issues arising from Organ Donation data and actions planned

Organ Donation Data

- **SNOD involvement in the approach to the family for DCD:**

The SNOD was involved in 3 out of 7 (42%) of approaches for DCD Donation overall.

As per Organ Donation Plan 2014-17: The SNOD was involved in 50% of approaches to family for organ donation when the patient had a neurological injury. Target 100%.

As per Organ Donation Plan 2014-17: The SNOD was involved in 66% of approaches t the family for organ donation in patients who did not have a neurological injury. Target 100%.

N4: Number of cases where the patient had either Neurological Death confirmed or a decision was made to withdraw treatment (and the patient had a catastrophic Neurological Injury), an approach to the family for organ donation occurred. The SNOD was involved in 40% (2 out of 5) approaches to the family for organ donation. The families were approached by either a SNOD or Health Care Professional about organ donation in this group of patients in 60% of occasions.

- **Actions taken:**

Datix reporting to continue to look further in to why the SNOD is not involved in the approach to the family for organ donation. The data identifies that this occurs only when the embedded SNOD is not on site (i.e. Annual Leave, Weekends) and reliance upon the on call SNOD Team to attend is required.

SNOD involvement in approaches to the family for organ donation is written in Trust Policy.

Staff actively encouraged to utilize on call SNOD and consider timeframes of at least 2 hours notification in order for the on call SNOD to arrive on site for approach.

Section 4: Donor recognition project

The grand unveiling of the “Gift of Life” sculpture occurred at Russells Hall Hospital on the 8th October 2014 by HRH Duke of Gloucester. Over 30 family members of patients who had donated their organs at the hospital attended. Patient’s families commented that they were delighted that their loved one had been remembered, even when they had died some decades previously. The Duke of Gloucester had lunch at the hospital and met with staff, donor families, and then unveiled the sculpture. A spiritual service was then held within the prayer centre, remembering the patients who had donated and the gift of life given to others.

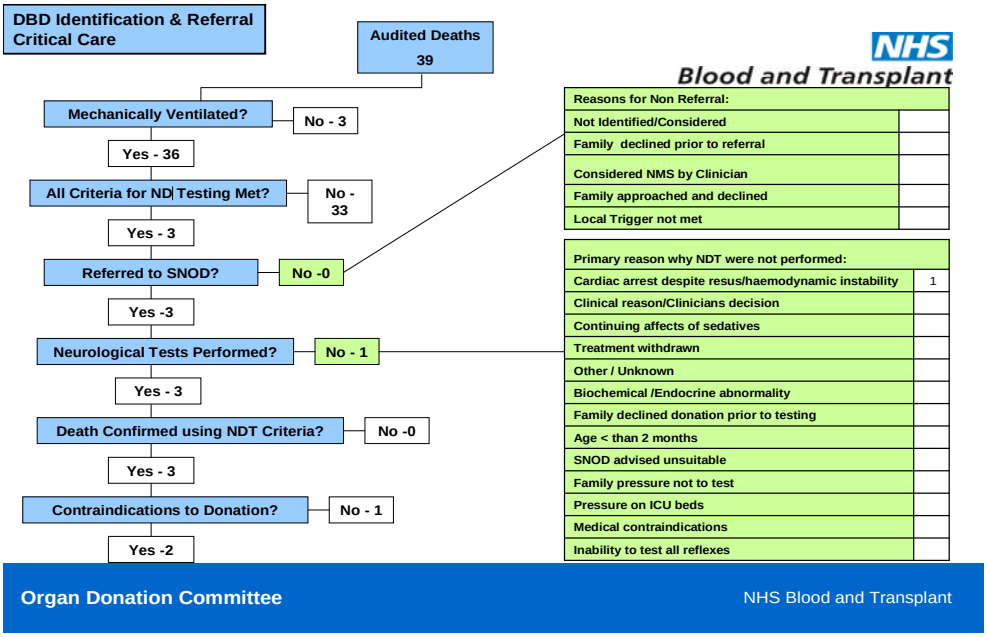
The event was covered by Radio WM, Express and Star Newspaper and Dudley News, raising the profile of organ donation and the gift given by patients at the hospital.

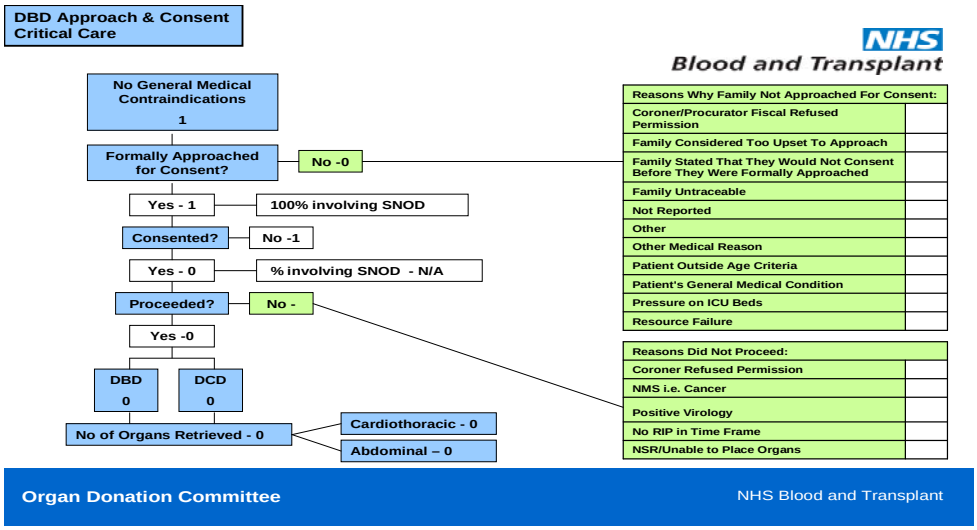
Organ Donation Chairman Steve Waltho, HRH Duke of Gloucester, Trust Chairman John Edwards at the unveiling of “The Gift of Life” sculpture.

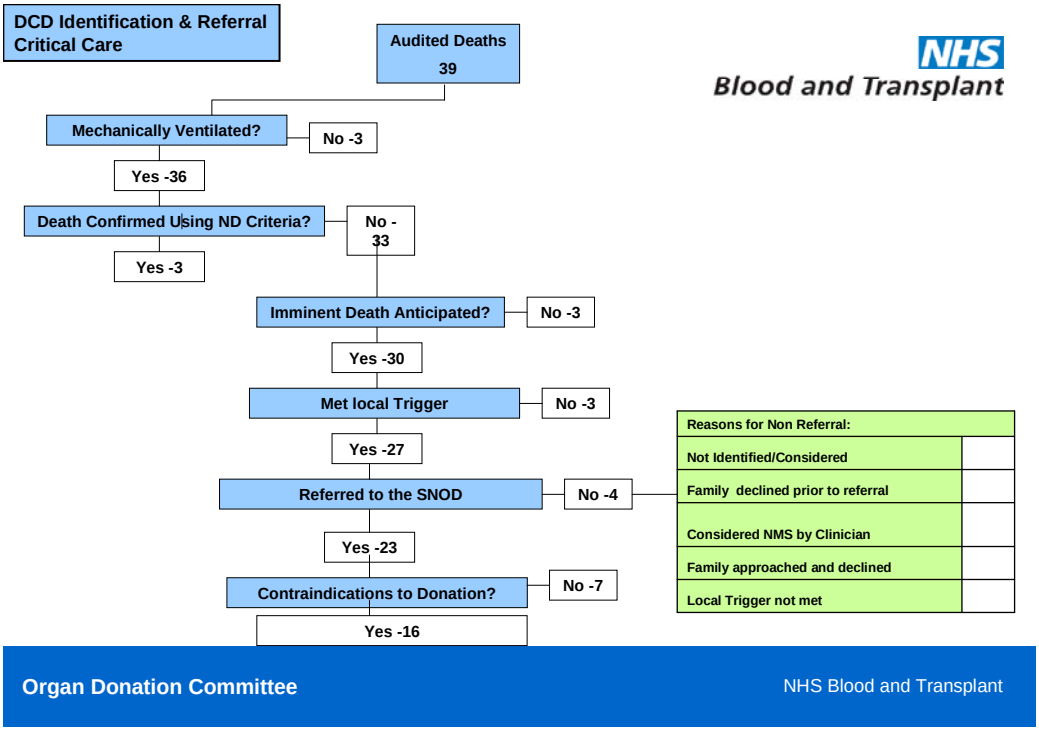
HRH Duke of Gloucester spent time talking with the families of patients who had donated at the hospital, staff, the artist who made “The Gift of Life Sculpture” and the artist who undertook the groundwork to the sculpture.

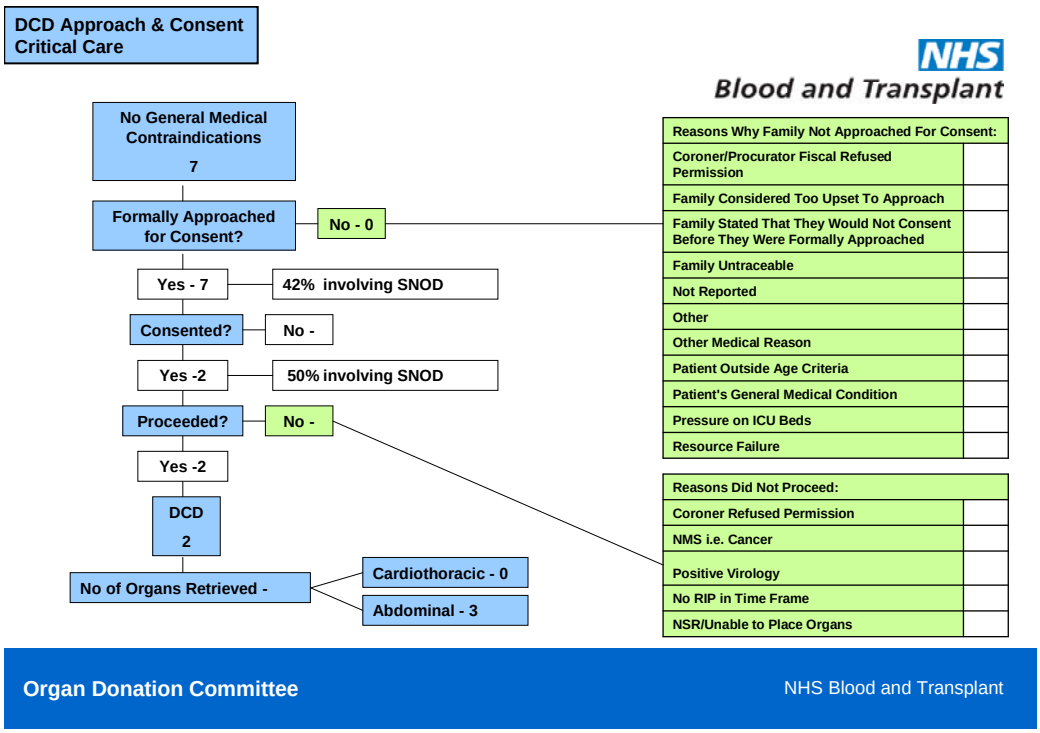
Appendix 1: Trust Organ Donation Data 1st April-30TH September 2014

The Potential Donor Audit (PDA) is an audit of all deaths in Emergency Department's and Intensive Care Unit's where the patient was under the age of 80. The current upper age limit for organ donation is 85 years of age and therefore we would like to report to the Trust Board all donation data in the trust, at which the PDA does not capture. This Appendix demonstrates Critical Care performance, however out of 79 deaths in the Emergency Department; there were 2 patients that were not referred to the SNOD in addition to this data displayed.






DCD Identification & Referral
Critical Care
Audited Deaths
39
Mechanically Ventilated?
No -3
Yes -36
Death Confirmed Using ND Criteria?
No -
33
Yes -3
Imminent Death Anticipated?
No -3
Yes -30
Met local Trigger
No -3
Yes -27
Referred to the SNOD
No -4
Yes -23
Contraindications to Donation?
No -7
Yes -16
Reasons for Non Referral:
Not Identified/Considered
Family declined prior to referral
Considered NMS by Clinician
Family approached and declined
Local Trigger not met
NHS
Blood and Transplant
Organ Donation Committee
NHS Blood and Transplant


DCD Approach & Consent
Critical Care
No General Medical
Contraindications
7
Formally Approached
for Consent?
No - 0
Yes - 7
42% involving SNOD
Consented?
No -
Yes -2
50% involving SNOD
Proceeded?
No -
Yes -2
DCD
2
No of Organs Retrieved -
Cardiothoracic - 0
Abdominal - 3
Reasons Why Family Not Approached For Consent:
Coroner/Procurator Fiscal Refused Permission
Family Considered Too Upset To Approach
Family Stated That They Would Not Consent Before They Were Formally Approached
Family Untraceable
Not Reported
Other
Other Medical Reason
Patient Outside Age Criteria
Patient's General Medical Condition
Pressure on ICU Beds
Resource Failure
Reasons Did Not Proceed:
Coroner Refused Permission
NMS i.e. Cancer
Positive Virology
No RIP in Time Frame
NSR/Unable to Place Organs
NHS
Blood and Transplant
Organ Donation Committee
NHS Blood and Transplant

Appendix 2: Progress with 2014-17 Organ Donation Plan

Action Plan	Progress	Outstanding actions
To monitor DGNHSFT organ donation performance indicators: • To achieve 100% Neurological Death Testing rate in ED/ICU Combined when Neurological Death is suspected. • To achieve 100% referral to the SNOD of patients where Neurological Death is suspected • To achieve 100% SNOD involvement in the approach to the family for DBD donation (once ND confirmed). • To achieve 100% referral to the SNOD of patients who meet the MNC for DCD donation and have a neurological injury. • To achieve at least 70% referral to the SNOD of patients who meet the MNC for DCD donation and do not have a neurological injury. • To achieve 100% SNOD involvement in the approach for DCD donation and the patient has a neurological injury	• 100% NDT rate is achieved • 100% referral to the SNOD when ND had been confirmed by NDT. 1 patient who could not be NDT was not referred to the SNOD. • 100% SNOD involvement in the approach for DBD is achieved. • 90% referral achieved of this patient group. • 94% referral achieved of this patient group. • SNOD was involved in **50%** (2 out of 4) of approaches to this patient group.	• Staff Training to be rolled out on DCD/DBD policy and updates • Nursing and Medical Staff to undertake E Learning mandatory training on Organ Donation which incorporates approaching the family for donation with the SNOD present.

• To achieve at least 100% SNOD involvement in the approach for DCD donation and the patient does not have a neurological injury	• There were 3 approaches to patient's families, the SNOD was involved in **66%** of approaches.	
Dudley Group NHS Foundation Trust (DGNHFT) will deliver a Donor recognition project in line with recommendation 12 of the Organ Donation Taskforce Recommendations 2008, and NHSBT 2020 strategy to increase societies support for organ donation.	• Wonderful day had by all on the 8th October 2014 when the "Gift of Life" sculpture was unveiled by HRH Duke of Gloucester • Action Plan achieved	
Annual E Learning package will be developed and implemented for DGNHSFT staff working on ICU and on organ donation	• Funding secured for project Charitable Funds • Supplier of package identified	• E Learning content being developed with supplier. ICU Sister Kate Kemp to develop package if given some non clinical time whilst Rebecca Timmins (SNOD) on Maternity Leave. • E Learning pack to be delivered to staff

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 6th November 2014

TITLE:	**Patient Catering – Update to Board paper of 3rd July 2014**		
AUTHOR:	**Robert Grave. Deputy Director (Facilities & Estates)**	**PRESENTER**	**Robert Graves. Deputy Director (Facilities & Estates)**
CORPORATE OBJECTIVE: SG02 Patient Experience			
SUMMARY OF KEY ISSUES: The report covers: • General update. • Actions taken by Interserve as an update from the last report. • What needs to happen to effect change and improvement and updated from the last report. • Patient survey information.			
IMPLICATIONS OF PAPER: (*Please complete risk and compliance details below)*			
RISK	**Y**		**Risk Description: Poor perception of food quality, choice and serving interface can affect the patients experience and in turn local and national patient experience survey scores can be adversely affected.**
	Risk Register:		**Risk Score: 4 x 4 =16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**		**Details: Risk is assessed by CQC via PLACE assessment scores and inpatient survey scores on food.**
	NHSLA		**Details:**
	Monitor		**Details:**

	Equality Assured		**Details:**
	Other		**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
	X	**X**	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS
The Board of Directors is asked to note the contents of the report and:

1. That Interserve remain actively engaged in improving the patient catering. There is a risk to limited improvement without full staff engagement in both ward staff to patient at protected meal times in serving and in developing and maintaining a clear and safe environment where patient's views and concerns on patient catering are sought recorded and where necessary placed on the Help Desk.
2. That even with improvements in the standard of patient catering a significant increase in patient scores may not be maintained until both staff and patients perceptions of the service are aligned with the actual improvement through a staff and patient communication campaign linked with the menus review.

STRATEGIC OBJECTIVES : ***(Please select for inclusion on front sheet)***		
SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
SGO2.	Patient experience	To provide the best possible patient experience
SGO3.	Diversification	To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio
SGO4.	Clinical Partnerships	To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO5.	Staff Commitment	To create a high commitment culture from our staff with positive morale and a "can do" attitude
SGO6.	Enabling Objectives	To deliver an infrastructure that supports delivery

The Dudley Group NHS
NHS Foundation Trust

Background
The purpose of this report is to highlight the progress made to date and to identify further work that needs undertaking to continue to improve Patient Catering as a dynamic process.

General update
The average inpatient stay (excluding inpatient stays over 18 days) is 4.1 days and for children it is 1.5 days. It is reasonable that the nutrition element of dietary impact is less of a priority than the overall quality of the patient experience. Patient catering is one of the indicators on how our Trust is perceived by our public both within PLACE and National Survey for Adult Inpatients.

For longer term inpatients, patient catering is far more important, both nutritionally and emotionally, as an anchor for their daily routine and for their health and well being.

Increasingly Trusts are linking better patient catering with patients getting better faster and reducing their stay in hospital. Patient catering needs to be appealing and well presented for the patient experience to be truly excellent. Good, well-presented food with choices that patients want will give the Trust the outcomes it wants; happier, shorter staying patients that praise the Trust on its commitment to them. This can only be achieved by a true partnership between Summit/Interserve and Trust staff who actively embrace each other's role in delivering patient catering.

Since the beginning of the Project Agreement very little was been done to improve patient catering and our national score has been increasingly worsening. The menus had not been updated since the start of the contract. Over the last two years; the first year was spent in discussions with Interserve on alternative patient catering solutions, which did not yield any improvement. The last twelve months has been a rigorous assessment of the contract terms (an output specification) engaging with both Summit and Interseve and a detailed action plan of incremental improvement.

The Way Forward
There are 3 elements to developing and improving the patient catering experience:-

- The supply chain of food which is controlled by Interserve.
- The preparation and delivery of food to wards, which is undertaken by Interserve.
- The delivery of food to patients (and where necessary feeding) by ward staff.

To date the main focus has been on lunch and dinners (supplied by Interserve).
Ward staff prepare and deliver breakfasts and hot drinks. To further improve scores after the roll out of the new menus for lunch and dinner, breakfast will be assessed and recommendations made where improvements can be made in service delivery and where the patient experience scores can be increased.

1. **The supply chain**
   New menus have been designed and a four week trial, with two repeat cycles, completed. This included vegetarian, pureed and soft chew options. Tillery Valley has heavily engaged with Interserve and the Trust and is working closely with us. Poor performing products have been dropped and the supply chain is increasingly more reliable and consistent. It is worth noting that some of the poor products were not Tillery Valley supplied, but alternative and possibly cheaper products. Speciality suppliers have been engaged for soft chew and dietary challenging products. Fruit has been added to the daily menu, as have chips, with positive feedback from the wards and patients. Bread has been changed and margarine has been replaced with butter. Sandwich fillings have been changed and new nourishing soups have been introduced.

2. **Preparation and delivery**
   Interserve has undertaken additional training for their staff, and have produced a manual for each ward covering laying out the food trolleys, standard dress, plug in points for the trolley, standardised ward kitchen layouts etc.

   Interserve has senior management agreement to replace the existing trolleys with new trolleys that will include plate warming. This should help improve patient perception of food temperature, which has consistently been the largest number of patient complaints about the patient catering service. The final choice is dependent on new models currently reaching the market place.

3. **Ward staff**
   The nursing directorate is increasingly focused on patient catering within its new structure and there are examples of excellence. There is a greater emphasis on staffing at meal times in conjunction with Interserve to ensure a smooth and efficient delivery of the meals to patients. This is good for ward staff as it reduces the time that Interserve are on wards plating up meals and good for patients as the quality and temperature of food deteriorates with time.

   Breakfasts and hot drinks are both prepared and served by Trust ward staff. The terms of the PFI Project Agreement allows for materials for seven hot drinks per day, so it is assumed that is the target for ward staff to achieve.

   Breakfasts have not been audited to date and will be the next section of patient meals to be assessed.

Food Assessments / Surveys

Annually there are two national indicators which include patient catering. These are the Patient Led Assessment of the Care Environment (PLACE) and the National Survey for Adult Inpatients (which is published by the CQC and is often referred to as the Picker survey).

PLACE is a moderately complex assessment and the food element looks at our processes and environment as well as the food itself. The 2014 results recorded a 6% increase on the 2013 results. This is a good improvement though the Trust is still below the median. PLACE is made up of two parts. The first part is a yes or no response by the Trust on achieving set criteria against the weighting measures. The second part is the assessors' scores which is part privacy and dignity and part quality of patient food.

The National Survey for Adult Inpatients asks three questions on patient catering:

- How would you rate the hospital food?
- Were you offered a choice of food?
- Did you get help from staff to eat your meals?

These are weighted questions and the scoring is moderately complex. The Trusts 2013 'rating' score was 4.3 out of 10 taken during July 2013 and this was the third worst score recorded nationally. The current real-time scores are better and are shown in Appendix 1. Last year our actual score for July mirrored our recorded score which is unusual as looking at the last three years' scores recorded at the bed head there is a variation of 0.8 better than inpatients in the follow up survey – which we would expect.

The current overall score for the existing menu, with improvements, is 5.9 and is showing a consistent pattern of results on a representational sample

Our patient experience scores are shown in Appendix 1.

Records are kept on the impact that the introduction of various changes to food menus has made, showing scores for each initiative. This table is shown in Appendix 1.

In addition the score for the new menu has shown a significant increase to 7.4 for the final week of the trial menu, which is exceptionally high, but does not include the variation experienced in the follow up survey, however, it is directly comparable to the scores in Appendix 1.

The PFI Catering Contract

The Project Agreement covers:

- The supply chain of food which is controlled by Interserve.
- The preparation and delivery of food to wards, which is undertaken by Interserve.

Ward staff cover:

- The delivery of food to patients from the trolley after having been plated up by Interserve (and where necessary feeding) by ward staff.

All three elements are mutually interrelated and must be dealt with in a holistic action plan to deliver improvement.

Interserve Actions

Interserve continues to make incremental improvements and is continuing to work with both Trust dieticians and their principle food supplier Tillery Valley. New menus have been designed (by Trust Dieticians) and a four week trial on C2 (Children's) C5 and B4 has been completed. This included the active encouragement to include housekeepers and all ward staff in the tasting. Amendments to the menus are being made following assessment and removing the lowest scoring dishes. The next stage will be a patient panel, which will include Governors. The final part of the exercise will be a direct comparison of food 'ideally produced' by Tillery Valley, with our onsite ward food, to identify any deficiencies in the 'on site' production.

Interserve have been asked to produce a roll out programme of the new menus including any resources and training required.

Additional improvements already made are sandwiches with better bread and specialist fillings, nourishing soup and additional training on food preparation and customer service.

Induction and ongoing training covering the Interserve catering service is being built into the individual ward manuals that the Trust has instructed Interserve to produce. This seeks standardised and processed methodology to increase the control and quality systems, as to date catering services is not consistent in delivery. This is seen as a dynamic manual that will be regularly reviewed and updated (at least annually).

Patient meal times are not always being protected and actions are being taken by Interserve to ensure all of their services respect protected mealtimes. Currently only lunch is a protected mealtime, however Interserve will look to showing similar respect for other mealtimes.

As food temperature has been a consistent complaint, Interserve will be investing £0.5M in new trolleys, which will also include plate heating. Temperature is a contractual requirement, however Interserve will successfully be able to argue mitigation until the ward staff and Interserve serving relationship is fully embedded.

Interserve are costing directly delivered patient meals to the patient, this will require ward staff to verify patient choices as suitable for their care and any restrictions for medical reasons. Interserve are proposing the use of an electronic tablet (IT) to choose, report to the central kitchen on each choice and then build up a profile of preferences over a period of time to accurately target

quantities on wards. Patient ordering would happen the day of the meal, and as there are constant admissions and discharges a limited number of additional portions would be included on the patient catering trolley for variations in choices.

This variation in procedure removes the waiting for patients to choose their food at meal times and may be a cost effective alternative to ward staff delivering this service. This process will be quicker and a better patient experience. It is quite possible that alternative models may have to be trialled to find out what is both most contractually efficient and gives the best possible patient experience. Trust IT has been approached about using the Trust Wi-Fi to operate the tablet.

The use of electronic ordering and recording will also help to reduce food wastage, which will shortly become a national environmental target.

Contractually this will deliver the Project Agreement output of self monitoring as long as there is real time recording of first choices of patient meals being delivered. To date there is evidence that patients are not getting first choices and this is not being recorded and no deductions are being taken. Under the current system this will only improve if ward staff actively audit and report failings on the Help Desk or an audit function is added.

Trust Actions

It is equally as important that our own Trust staff engage in ensuring the best possible patient experience in serving, protecting the protected meal times and giving very robust feedback on the quality, timeliness, temperature and accuracy of requested menu choices via the Help Desk as fed back by patients, to lever the service improvements. Our own staff must also believe that our patient meals are a quality product and that means a carefully constructed communication exercise, including staff in regular taste testing so they know and endorse the patient meals.

To apply contractual pressure would require significant Trust commitment to record each and every contractual failure on the Help Desk. To date this does not happen and though we are aware of contractual deficiencies, through patient questionnaires, the actual failures are not being recorded by ward staff. Whilst the evident commitment from Summit and Interserve to invest and work at improving patient catering remains, it is not the intention to apply NCI's and Deficiency Points for other than serious breaches.

Interserve record the numbers of Trust staff assisting with the meal service, plus get the ward staff to sign off the service at the end of the meal service. It is proposed that ward staff also sign off that Interserve have provided a service in accordance with the contract. Currently Interserve mitigate their liability on temperature by claiming lack of ward staff support at meal times.

The Huddle Boards on wards will also be utilised to increase the focus on Patient Catering and display the patient experience scores.

Recommendations

That the existing focus on patient catering is maintained and that the process of development of new menus and the role out is completed.

This requires Trust staff tasting of the new food menus, followed by a patient tasting panel with input from Governors.

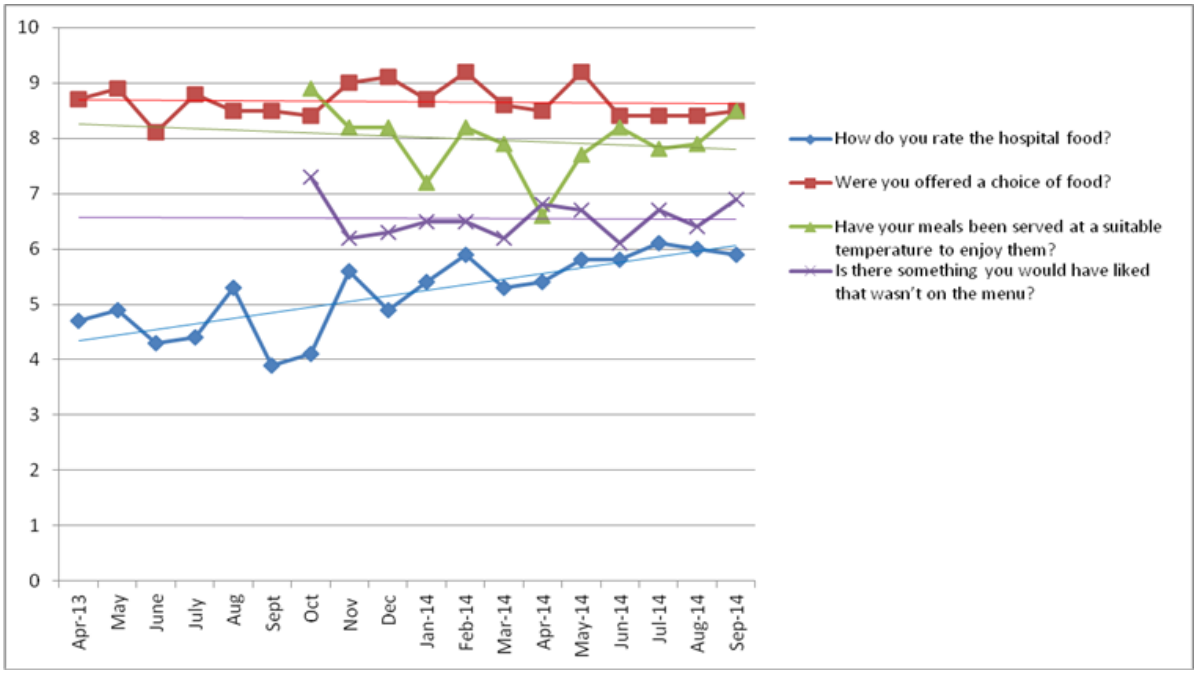
That patient catering is treated as a dynamic and consistent continual improvement programme and regular reports continue to be received by the Board no less than annually, even when the Trust achieve significantly higher scores.

Appendix 1

Patient Experience Data Report – Board June 2014

The first two questions in the chart below track national survey questions, the following two questions have been added by the Trust to track issues highlighted by patients.

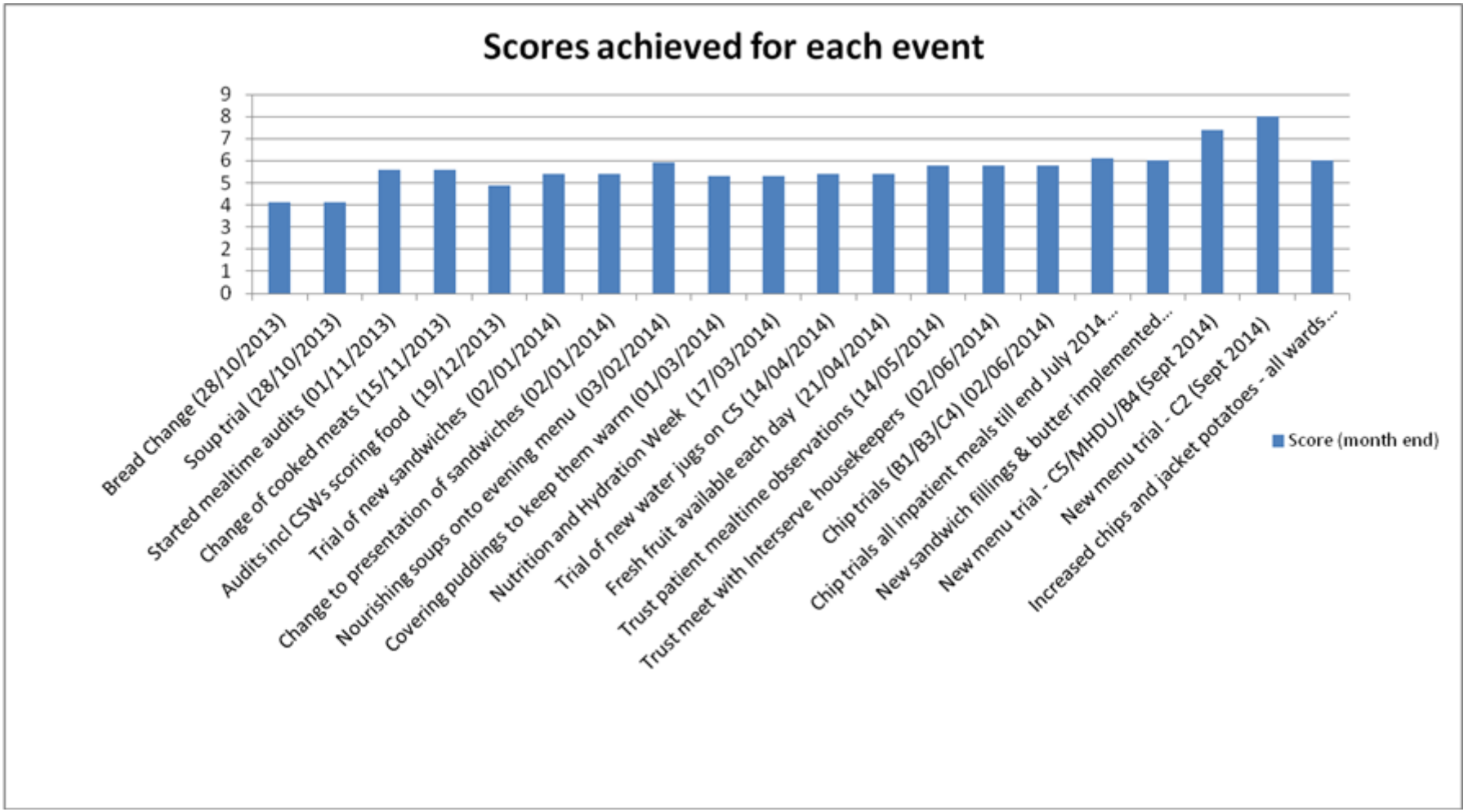
	Apr -13	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-14	Feb -14	Mar -14	Apr -14	May -14	Jun -14	Jul-14	Aug -14	Sep-14
How do you rate the hospital food?	4.7	4.9	4.3	4.4	5.3	3.9	4.1	5.6	4.9	5.4	5.9	5.3	5.4	5.8	5.8	6.1	6	5.9
Were you offered a choice of food?	8.7	8.9	8.1	8.8	8.5	8.5	8.4	9	9.1	8.7	9.2	8.6	8.5	9.2	8.4	8.4	8.4	8.5
Have your meals been served at a suitable temperature to enjoy them?							8.9	8.2	8.2	7.2	8.2	7.9	6.6	7.7	8.2	7.8	7.9	8.5
Is there something you would have liked that wasn't on the menu?							7.3	6.2	6.3	6.5	6.5	6.2	6.8	6.7	6.1	6.7	6.4	6.9
Number of Responses	109	90	127	142	165	122	117	181	291	207	203	247	260	271	250	311	214	191



The chart opposite shows the following trends:

- The rating of hospital food is showing a sustained upwards trend.
- Were you offered a choice of food is showing a slight upward trend
- Have your meals been served at a suitable temperature – this is showing a downward trend (Interserve are doing a Business Case to provide new trolleys to try and improve this facility)
- Is there something you would have liked that wasn't on the menu – this is showing a slight downward trend (this is being addressed by asking patients what they would have liked and including popular items on the new proposed menus)

The table below shows the score from the Patient Experience Data collected from July 2013, along with the actual scores following the introduction of the various initiatives.



Enclosure 13

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 6th November 2014

TITLE:	**Audit Committee Exception Report**		
AUTHOR:	**Jonathan Fellows**	**PRESENTER**	**Jonathan Fellows**
CORPORATE OBJECTIVE: Quality			

SUMMARY OF KEY ISSUES:

The Trust Audit Committee met on 21st October 2014 and considered progress reports from:

- Internal Audit
- Local Counter Fraud Specialist (LCFS)
- Clinical Audit
- Risk and Assurance Committee
- Caldicott and Information Governance Group
- Research and Development Directorate

In addition, the Committee reviewed the External Audit plans and fees for the audits of the Trust and Charitable Funds for 2014/15.

A summary of key issues discussed and items referred to the Trust Board is shown below.

Progress Report from Internal Audit

Since the last Committee meeting 9 final Internal Audit reports have been issued, with a further 14 reviews in progress or scheduled to be completed by January. The 9 final reports were rated as follows:

IT Business Continuity	**AMBER**
Capital Programme – Development of Business Cases	**AMBER**
Emergency Planning & Continuity of Electricity and Water Supplies	**RED**
Francis and Keogh Reports – Implementation of Recommendations	**GREEN**
Deprivation of Liberty Safeguards	**GREEN**
Mortality Tracking System	**AMBER**
Board Governance Review	Good Progress
Development of 2 and 5 year Integrated Business Plans	Compliant
Follow up of Deloitte Quality Governance review recommendations	Reasonable Progress

RED opinion	The Board CANNOT take assurance that controls are suitably designed, consistently applied or effective
AMBER/RED opinion	The Board can take SOME assurance that controls are suitably designed, consistently applied or effective
AMBER/GREEN opinion	The Board can take REASONABLE assurance that controls are suitably designed, consistently applied or effective
GREEN opinion	The Board can take SUBSTANTIAL assurance that controls are suitably designed, consistently applied or effective

The **GREEN** rated report on Deprivation of Liberty Safeguards (DOLS) found soundly established controls, however made 5 low priority recommendations to improve the detail of documentation and to introduce a formal reporting mechanism to the Trust Board. All recommendations have been accepted and actioned.

There were 3 reports rated **AMBER**. The report on Capital Programme – Development of Business Cases found the business case tracker was not being regularly updated, also that not all business cases had a post implementation review undertaken following completion to determine whether or not the planned benefits were achieved. The report made 4 medium priority and 2 low priority recommendations, all of which have been actioned and the updated business case tracker will be presented to F&P Committee.

The report on the Mortality Tracking System found that most of the processes were operating well; however there were improvements that could be made to coding validation and to the peer review process. The report made 2 high priority, 3 medium priority and 4 low priority recommendations, with the high priority ones relating to the need for consultants to audit in patient deaths as soon as possible, plus to the introduction of an escalation process to highlight cases where peer review had not been undertaken within a 12 week period. All recommendations have been accepted and are targeted to be actioned by January 2015, with exception reports planned to be reported to the CQSPE Committee on a quarterly basis.

The report on IT Business Continuity made 1 high priority and 4 medium priority recommendations. The high priority recommendation was that a Trust-wide Business Impact Analysis should be carried out to rank all the IT services, infrastructure and applications by their respective criticality to the Trust.

Work to identify key business critical systems is targeted to be completed by December, although ensuring full business continuity is dependent on the new systems installation project, which will take up to two years to complete, although the hardware should be in place by March 2015.

The **RED** rated report is a concern. The review found not all departments/wards have documented continuity plans and that even for those that do, plans were out of date and had not been reviewed and updated annually, as they are required to be.

In addition to the lack of monitoring of business continuity plans for wards and departments, there has not been any work undertaken to ensure the continuity of either electricity or water supplies.

There is a schedule for testing back up generators by Interserve on behalf of the Trust, however the Emergency Planning Officer does not receive any notification that tests have taken place, nor any details of their outcomes.

The Trust is also required to have reserve water tanks to sustain normal water consumption for up to four hours at each of its three acute sites (Russells Hall, Guest and Corbett), however there are currently no checks conducted to ensure that the back up water tanks will function correctly, nor that the water levels would be sufficient to meet demand in the event of disruption to the normal water supply.

Internal Audit made 3 high priority, 1 medium priority and 2 low priority recommendations in relation to emergency planning. All have been accepted by management, with implementation due before the end of the calendar year. Internal Audit will be undertaking a follow up review in the early part of 2015 to ensure all recommendations have been properly actioned.

The Audit Committee noted the GREEN rating for DOLS. On the RED rated report relating to Emergency Planning and Continuity of Electricity and Water Supplies, the Committee requested that the issues relating to the lack of emergency planning and in particular the failure to ensure continuity of electricity and water supplies be discussed by the Directors Risk and Assurance Group and an explanation given to the Audit Committee in January of why the essential checks required have not been carried out.

The timing of some internal audit reviews has been rescheduled, in order to allow actions already being taken by Trust management to bed in prior to audits and hence make recommendations more beneficial. The reviews affected are:

- Electronic Health Records Governance Arrangements
- Ward Staffing Ratios
- Data Quality – Clostridium Difficile
- Lessons Learnt – Claims, Complaints and Incidents

All these reviews will however still be completed in the financial year.

The internal audit recommendation tracker currently shows 10 high priority and 23 medium priority recommendations as remaining open. Of these, 4 high priority and 9 medium priority recommendations are shown as having passed their implementation dates. However, the Trust is in the process of moving from the 4Action recommendation tracking system to a spreadsheet based alternative that will improve the management of recommendations, in addition to which recommendations are being reassigned in order to reflect the new structure and any changes to the responsibilities of the senior management team. After this work is completed all open recommendations will be reviewed and it is likely that more will be able to be closed as having been fully actioned.

Other Progress Reports

Progress on proactive LCFS work remains in line with plan. There had not been any new investigations undertaken since the last Audit Committee meeting. However, a report back to the Audit Committee has concluded that there is insufficient evidence to proceed with a police investigation into possible suspect business practices within and between companies supplying services to the Trust via the PFI contractor. As a result, it has been agreed that no further work will be undertaken by the LCFS, although Internal Audit will be carrying out work in this area to mitigate any systems weaknesses.

The LCFS had undertaken a pro-active exercise and assessment of staff awareness of whistleblowing. This concluded that the current policy is well written and includes all key aspects that would be expected to be covered, while the staff survey results showed 98% of respondents know what whistleblowing is, 925% are aware the Trust has a policy and 85% know where to find it, although only 52% have actually read it. Despite this, 69% said they know what would constitute a whistleblowing claim and 74% said they knew how to report a whistleblowing concern. The LCFS report makes 3 recommendations, all accepted by management:

1) To include whistleblowing awareness within the corporate and local induction policy;

2) To remind all managers of their duty under the policy to inform HR of all reported allegations;

3) To ensure that the whistleblowing effectiveness monitoring arrangements reflect current practice.

Clinical Audit proposed a further 33 audits to be included in the 2014/15 annual plan and these were agreed, taking the total number to 172. Of 19 audits brought forward from 2013/14, 7 have now been completed. Following notification from the Healthcare Quality Improvement Partnership (HQIP), 1 further national clinical audit has been removed from the plan – National Audit of Seizures in Hospital (NASH) as this audit will no longer be collecting data in 2014/15. Encouragingly, of the 85 recommendations arising from completed clinical audits, only 6 had passed their due date for action and these were being followed up.

The Risk and Assurance Group had met on 9th September and had reviewed the risk registers for each directorate. In addition, a review of procedural documents held on the central document site had identified 156 that had passed their review dates and actions had been put in place to manage these. One central alert from the National Patient Safety Association (NPSA), had been identified as not being actioned by its due date: Safer Spinal (Intrathecal), Epidural and Regional Devices. The delay had been caused by a shortage of companies producing suitable products and implementation was now targeted for January 2015, with product trials underway.

Terms of reference for the Caldicott and Information Governance (IG) were reviewed and approved by the Audit Committee. The progress report showed that at 30th September, overall compliance with mandatory IG training was 76.8%. Corporate (84.0%) and Surgery (85.6%) were above the 80% target, while Nursing (66.7%) and Medicine & Community (77.9%) were below. There were 2 information governance incidents identified for the period from August to October and the outcomes of investigations into these will be reported at the next Audit Committee meeting. It was also noted that since January, there had been a total of 383 Freedom of Information requests received in the Trust.

The Research & Development progress update is intended to report to the Audit Committee the number of research studies undertaken and also advise the Committee of any serious adverse events that occurred to patients enrolled in research studies. Between July and October, 16 site specific assessments have taken place (i.e. where Dudley Group is the host organisation). There have been 14 serious adverse effects reported that could potentially be linked to the research trials and these have been reported to the chief clinician overseeing the trial for review and escalation as necessary. Over the past year there have been 1,743 patients recruited to take part across around 100 studies, helping the Trust to secure Collaborative Research Network funding.

External Audit Plans and Fees 2014/15

Deloitte presented the audit plans and fees for the audits of the Trust and Charitable Funds for the 2014/15 financial year.

For the Trust, the plan takes account of new Monitor governance requirements. The audit approach will focus on key areas of risk, including financial standing and efficiency requirements, recognition of NHS revenue, accruals and provisions and the capital programme. Planning meetings are scheduled to take place between September and January, interim audit in February and the year end work in April and May, to meet the accounts sign off deadline in May. The audit fee for the Trust will be £79,100, subject to two areas where further clarification is awaited:

a) For the Quality Accounts, the fee of £17,500 included in the overall cost might have to be reviewed depending on the guidance yet to be issued by Monitor and on confirmation of the mandatory and local indicators to be included in audit testing; and

b) Should Monitor require Foundation Trusts Accounts to include an enhanced audit report, this is likely to increase the overall audit fee by £2,500. Enhanced audit reports, which are already in place for listed companies, provide an overview of the scope of the audit, describe the risks that had the greatest impact on the audit and explain how materiality has been applied in the planning and performance of audits.

For Charitable Funds, the key risks include recognition of revenue and correct treatment of restricted and unrestricted funds. The audit timetable targets presentation of findings to the Audit Committee and sign off of the Accounts in July 2015, although in practice much of the Charitable Funds audit work will be completed alongside that for the Trust, as the Charitable Funds results have to be consolidated into the Trust Accounts. The fee for the Charitable Funds audit remains at £5,000.

The Audit Committee accepted both audit plans and agreed to recommend them to the Board for acceptance.

Finally, the Audit Committee approved amended its Terms of Reference to make explicit the requirement to formally consider its effectiveness on an annual basis. The recommendation that regular reviews of effectiveness be undertaken was made in the Deloitte review of Board Governance and most if not all sub Committees have already been undertaking such reviews; however Terms of Reference for some committees need to be amended in order to formalise this. In addition, Monitor has now published guidance requiring Trusts to commission governance reviews at least every three years.

The Audit Committee recommends that the Board considers and agrees the appropriate timing for the next governance review and the form this might take, so that it can be appropriately planned as part of the future Board calendar.

IMPLICATIONS OF PAPER:			
RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**No**	**Details:**
	NHSLA	**No**	**Details:**
	Monitor	**Yes**	**Details: Licence Compliance**
	Equality Assured	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

a) **Note the RED rated internal audit report on Emergency Planning at the Trust Acute Sites and Continuity of Electricity and Water Supplies and the actions taken by the Audit Committee**

b) **Note the GREEN rating received for the audit undertaken into the Deprivation of Liberty Safeguards**

c) **Note the changes to the Clinical Audit plan with 33 additional audits added**

d) **Accept the proposed audit plans for the Trust and Charitable Funds for 2014/15, noting the potential requirement for an enhanced audit report in the Trust Annual Accounts and the consequent additional work and cost this may involve**

e) **Note the change to the Audit Committee ToR to formalise the annual effectiveness review process**

f) **Note the requirement from Monitor for governance reviews to be undertaken at least every 3 years and the recommendation from the Audit Committee that the Board consider and agree the timing and form for the next governance review**

STRATEGIC OBJECTIVES : *(Please select for inclusion on front sheet)*		
SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
SGO2.	Patient experience	To provide the best possible patient experience
SGO3.	Diversification	To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio
SGO4.	Clinical Partnerships	To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO5.	Staff Commitment	To create a high commitment culture from our staff with positive morale and a “can do” attitude
SGO6.	Enabling Objectives	To deliver an infrastructure that supports delivery

The Audit Committee was established to provide assurance to the Board that there is an effective system of integrated governance, risk management and internal control across the whole of the organisation’s activities (both clinical and non clinical), that supports the achievement of the organisation’s objectives and that this system is established and maintained In particular the Committee reviews the adequacy and effectiveness of all risk and control related disclosure statements including the Annual Report, Quality Report and Annual Governance Statement, underlying assurance processes and policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification. In addition the Committee reviews the findings, implications and management responses to the work of the External Auditors, ensures there is an effective Internal Audit function and that the organisation has adequate arrangements in place for countering fraud

Enclosure 14

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On 6 November 2014

TITLE	**Performance Report April – September 2014**		
AUTHOR	**Paul Taylor Director of Finance and Information**	**PRESENTER**	**David Badger F & P Committee Chairman**

CORPORATE OBJECTIVE: SG06 Enabling Objective

SUMMARY OF KEY ISSUES:

- **Deficit of £0.6m in September (£0.3m worse than plan)**
- **Deficit of £5.5m for year to date, (£1.2m worse than plan)**
- **Deficit budget for 2014-15 of £6.7m likely to be exceeded, with a forecast of £9.8m deficit now declared**
- **A&E 4 Hours waiting time met in August and for Quarter 2 to date**
- **Some RTT waiting time pressures, but targets being met**

RISKS	**Risk Register**	**Risk Score Y**	**Details: Risk to achievement of the overall financial target for the year Financial deficit above Monitor plan now forecast**
COMPLIANCE	**CQC**	**Y**	**Details: The Trust is awaiting a report from the Chief Inspector of Hospitals following an inspection in the Spring. This is subject to appeal.**
	NHSLA	**N**	

	Monitor	**Y**	**Details:** **The Trust has rated itself 'Amber' for Governance & '3' (good) for Finance (CoS) at Q2, but 2 for Finance for the forthcoming 12 months. The Trust remains on monthly monitoring by Monitor.** **Monitor has notified the Trust that it is investigating A&E performance in the Trust and its long term business viability.**
	Other	**Y**	**Details:** **Significant exposure to performance fines by commissioners**

ACTION REQUIRED OF COUNCIL

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the report

The Dudley Group NHS
NHS Foundation Trust

Report of the Director of Finance and Information to the Board of Directors

Report on Finance and Performance for April to September 2014

1. Background

The Finance & Performance Committee of the Board met on 30th October 2014. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered forecast year end performance reports.

Highlights of the discussion at the meeting are as follows:

2. Financial Performance for the 6 months period April to September 2014 (Appendix 1)

The Trust has had a difficult start to the year following the Board of Directors agreement to a 24 months balanced budget, with a planned deficit of £6.7m in 2014-15. The first half year showed a trading deficit of £5.5m which was £1.2m worse than plan. Whilst the position has improved since the first quarter, it has not improved sufficiently to bring forecasts back in line with the original planned position.

For September 2014 the Trust posted a monthly deficit of £0.6m, £0.3m worse than plan.

For the 6 months period to September 2014 a cumulative deficit of £5.5m is recorded. Key variances include income at +£2.1m (+1.3%); Non Pay -£1.9m (-3.4%); CIP not achieved -£1.6m.

These adverse trading trends are largely the result of the following factors:

- **Our inability to meet elective in-patient activity targets, resulting in significant loss of income from commissioners**.
- **Significant increases in emergency activity levels above plan**
- **Continued spending above budget on agency & locum front line medical & nursing staff**

- **Higher than anticipated spending on drugs and devices, which are recharged to commissioners under the terms of our healthcare contracts with them**
- **A slower than anticipated start to turnaround savings.**

The Trust is now forecasting a deficit of £9.8m for 2014-15.

At 30th September 2014 the Trust had cash reserves of £19.5m (£21.8m in August) and 11.0 days liquidity (11.8 previously).

Capital spending for the period was £2.6m (£0.8m Medical Equipment, £0.3m IT, £1.0m PFI Lifecycle), some £0.5m below plan.

3. Performance Targets and Standards (Appendix 2)

The Trust's non financial performance for the period remains relatively strong. Performance against the Monitor Governance KPI set is given at Appendix 2.

Highlights include:

a) A&E 4 Hour Waits

Quarter 2 performance was 96.1% compared to the constitution target of 95%. This is a considerable improvement from the 92.1% recorded in Q1, which gives a combined year to date performance of 94.1%. Despite unprecedented levels of emergency and A&E activity levels in October 2014, significant effort is being put into the achievement of the target in the reminder of the year

b) Never Events

The Trust had no 'never events' in September 2014 or for the period to date.

c) Referral to Treatment Waiting Times

The RTT admitted waiting time standard of 90% of patients was just met again in Q2 with 90.6% of patients being seen in time. There is confidence that this will continue to be achieved for the rest of the year.RTT non-admitted and incomplete pathways KPIs are both well within their thresholds, with performances of 99.1% and 95.9% respectively

d) Diagnostic Waits

The committee considered rectification plans for diagnostic waits (mostly for ultrasound) and endoscopy 6 week waits.

4. **Divisional performance Review**

The Committee considered the first performance presentation from the Division of Medicine and Community Services. Discussion of Turnaround activities, I&E performance, activity and target performance, workforce were discussed, as well as their forward plans.

5. **Turnaround Progress Report**

The Committee considered the extent of the progress being made to date on the Turnaround Programme, and in particular on the large scale cross-organisational schemes. It was agreed that a change of emphasis to concentrate of cost reduction schemes was required; together with a change of accountability to more fully involve budget holders. The workforce scheme, in particular was in need of being refreshed and it was agreed that more active vacancy controls would be implemented immediately to minimise the potential workforce reduction impact on existing staff

6. **Overview of Financial Position and Next Steps.**

There was unanimous support to the approach recommended of augmenting the existing Turnaround programme with more active cost reduction schemes, including workforce reductions. A more radical “workforce re-profiling” approach will be required to take advantage of the 40 or so posts that become vacant each month, in order to reduce the pay costs of the Trust to previous affordable levels. It was recognised that certain posts would need to be filled (ward based band 2,5 and 6 nursing posts for example), but that a greater emphasis for other posts would be placed on restructuring departments to reduce costs and maintain activity and quality.

P Taylor
Director of Finance & Information

APPENDIX 1

THE DUDLEY GROUP NHS FOUNDATION TRUST

INCOME & EXPENDITURE SUMMARY 2014/15 as at SEPTEMBER 2014

Current Month Plan £000	Current Month Actual £000		Annual Plan £000	Plan to Date £000	Actual to Date £000	Variance to Date £000
		Income				
24,222	24,687	NHS Clinical Revenue	289,124	144,629	145,335	706
5	3	Private Patient	57	28	27	(1)
841	535	Other Non Mandatory	7,053	3,931	4,584	653
51	132	Research & Development	704	397	721	324
755	750	Education & Training	8,948	4,466	4,508	41
41	47	Car Parking	489	245	288	43
12	4	Accommodation	96	69	62	(7)
295	286	Non Patient Services to Other Bodies	3,599	1,790	1,848	57
316	473	Miscellaneous Other	3,343	1,632	1,936	304
26,536	**26,916**	**Total Income**	**313,412**	**157,188**	**159,308**	**2,120**
		Expenditure				
(2,283)	(2,640)	Drug Costs	(26,892)	(13,672)	(15,298)	(1,626)
(2,517)	(2,707)	Clinical Supplies	(27,773)	(13,892)	(14,379)	(487)
(348)	(353)	Non-Clinical Supplies	(3,933)	(2,123)	(2,401)	(279)
0	0	Secondary Commissioning	0	0	0	0
(15,515)	(15,105)	Employee Benefits (Permanent)	(190,481)	(94,042)	(90,946)	3,096
(186)	(487)	Employee Benefits (Agency/Locum)	(1,464)	(748)	(3,698)	(2,950)
(76)	(94)	Research & Development	(961)	(503)	(571)	(68)
(52)	2	Education & Training	(635)	(293)	(198)	95
(86)	(66)	Consultancy Expense	(662)	(484)	(715)	(230)
(1,991)	(1,870)	Miscellaneous Other	(21,967)	(11,502)	(11,185)	317
(2,930)	(2,930)	PFI Unitary Payment	(39,267)	(19,634)	(19,634)	0
1,311	1,311	IFRIC12 PFI Adjustment	17,571	8,786	8,786	0
(780)	(674)	Other PFI Expenses	(7,110)	(3,558)	(3,235)	323
539	0	CIP Requirement	6,299	1,632	0	(1,632)
(24,915)	**(25,612)**	**Total Expenditure**	**(297,275)**	**(150,033)**	**(153,474)**	**(3,441)**
1,621	**1,304**	**Surplus/(Deficit) EBITDA**	**16,137**	**7,155**	**5,833**	**(1,321)**
		Other				
0	0	Profit/(Loss) on Disposal	20	20	20	0
0	0	Impairment	0	0	0	0
(749)	(759)	Depreciation	(9,137)	(4,504)	(4,553)	(49)
0	13	Donated Assets	0	0	131	131
12	9	Interest Receivable	140	70	64	(6)
(1,151)	(1,152)	Interest Payable	(13,888)	(6,977)	(6,976)	1
(1,888)	**(1,888)**	**Total Other**	**(22,865)**	**(11,391)**	**(11,314)**	**77**
(268)	**(584)**	**Net Surplus/(Deficit)**	**(6,728)**	**(4,236)**	**(5,480)**	**(1,244)**

Note 1: Adverse variances are shown in brackets and red; Income/Surplus = positive; Expenditure/Deficit = negative;

Note 2: R&D Expenditure includes both pay and non-pay

APPENDIX 2

Dudley Group FT

Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

	Threshold & Weighting		Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements							N/A
INFECTION CONTROL (SAFETY)							
HCAI - Clostridium Difficile - meeting the C Diff objective	48	1.0	7	8			**15**
HCAI - Clostridium Difficile - Avoidable Cases			5				**5**
CANCER WAIT TARGETS (QUALITY)							
Max waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	1.0	96.9	96.5			**96.8**
Max waiting time of 2 weeks from urgent GP referral to date first seen for symptomatic breast patients.	93%		97.3	934.2			**96.3**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	1.0	99.7	99.6			**99.7**
Maximum waiting time of 31 days for second of subsequent treatments – Anti Cancer Drug Treatments	98%	1.0	100	100			**100**
Maximum waiting time of 31 days for second of subsequent treatments – Surgery	94%		98.2	100			**99.1**
Maximum waiting time of 31 days for second of subsequent treatments – Radiotherapy	94%		N/A	N/A	N/A	N/A	N/A
Maximum two month (62 days) wait from referral to treatment for all cancers – Urgent GP Referral to Treatment	85%	1.0	88.1	87.0			**88**
Maximum two month (62 days) wait from referral to treatment for all cancers – From National Screening Service Referral	90%		100	100			**100**
A&E (QUALITY)							
% Patients Waiting Less than 4 hours in A&E	95%	1.0	92.1	96.1			**94.1**
REFERRAL TO TREATMENT – RTT (PATIENT EXPERIENCE)							
RTT – Admitted % Treated within 18 weeks	90%	1.0	90.1	90.6			N/A
RTT – Non-Admitted % Treated within 18 weeks	95%	1.0	99.2	99.1			N/A
RTT – Incomplete pathways % waiting within 18 weeks	92%	1.0	94.7	95.9			N/A
Community Services (Effectiveness)							
Referral to treatment information	50%	1.0	98.0	99.0			N/A
Referral information	50%		64.9	65.4			N/A
Treatment activity information	50%		99.5	100			N/A

Dudley Group FT

Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

	Threshold & Weighting	Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements						N/A
PATIENT EXPERIENCE						
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Yes/No 0.5	Yes	Yes			N/A
Risk of, or actual, failure to deliver mandatory services	Yes/No 4.0	No	No			N/A
CQC Compliance action outstanding	Yes/No 2.0	No	No			N/A
CQC enforcement notice currently in effect	Yes/No 4.0	No	No			N/A
Moderate CQC concerns regarding the safety of healthcare provision	Yes/No 1.0	No	No			N/A
Major CQC concerns regarding the safety of healthcare provision	Yes/No 2.0	No	No			N/A
Unable to maintain a minimum published CNST level 1.0 or have in place appropriate alternative arrangements	Yes/No 2.0	No	No			N/A