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**Strategy and Strategic Planning**

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**Assurance Framework**
| 1015 | 433/18 | Board Assurance Framework | Enc. | 101 | For approval | Anna Milanec, Director of Corporate Affairs |
| 434/18 | Risk Management Report, including the Risk Register (with risks scoring 15 and above) | Enc. | 104 | For noting | Angela Wood, Interim Chief Nurse |
| 435/18 | Governance Report | Enc. | 113 | For noting | Anna Milanec, Director of Corporate Affairs |
| 436/18 | Mortality Review work | Enc. | 127 | For noting | Dr Callum Gardner, Interim Medical Director |
| 437/18 | CQC Monthly Report | Enc. | 321 | For noting | Angela Wood, Interim Chief Nurse |
| 438/18 | Patient Led Assessment of the Care Environment, Report | Enc. | 345 | For information | Angela Wood, Interim Chief Nurse |
| 439/18 | The National Staff Flu Campaign Executive Summary Report | Enc. | 351 | For noting | Angela Wood, Interim Chief Nurse |

**Board Governance**

| 1055 | 440/10 | Review: Audit Committee Terms of Reference | Enc. | 360 | For approval | Anna Milanec, Director of Corporate Affairs |
| 441/18 | Any other business | - | - | For approval | Martin Havenhand, Chairman |
| 1100 | 442/18 | Date of next meeting: **Tuesday 18 December 2018** | - | - | For noting | Martin Havenhand, Chairman |

*To ensure smooth transaction of business, the Chairman will invite questions from the public at the end of the meeting only.*

*In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting.*
Present: Mr M Havenhand, Chairman  
Mrs G Atmarow, Non-Executive Director  
Mr J Barnes, Non-Executive Director  
Mrs L Barnett, Chief Executive  
Mr G Briggs, Chief Operating Officer  
Mrs H Craven, Non-Executive Director  
Mr M Edgell, Non-Executive Director  
Dr C Gardner, Interim Medical Director  
Ms L Hagger, Non-Executive Director  
Dr D Hannah, Non-Executive Director  
Mr C Holt, Deputy Chief Executive  
Mr B Mellor, Non-Executive Director  
Mr S Sheppard, Director of Finance  
Ms A Wood, Interim Chief Nurse  

Apologies: Mrs C Clements, Director of Workforce  
Mr P Ferrie, Acting Director of Workforce  
Dr C Wareham, Medical Director  

In attendance: Ms A Milanec, Director of Corporate Affairs / Company Secretary  
Miss D Stewart, Corporate Governance Manager (minutes)  

Observers: Governors x1  
Colleagues x2  
Mr M Wood, RSM (observing the Board as part of the external well-led governance review)  

385/18 CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE  
The Chairman welcomed those present to the meeting with any apologies having been received and noted.  
Dr Gardner and Ms Wood were each welcomed to their first meeting of the Board of Directors.  

386/18 DECLARATIONS OF CONFLICTS OF INTERESTS  
No conflicts of interest were declared.  
The Chair requested that should any become apparent during discussion, that they be raised accordingly.
QUALITY AND SAFETY
387/18 PATIENT STORY

The Board of Directors received the patient story presented by the Interim Chief Nurse.

Ms Wood explained that the story started with the admission of a frail elderly patient, with a number of medical conditions, to the Stroke Ward due to a lack of beds on more appropriate wards. Due to a deterioration in his condition, the patient was subsequently transferred to the intensive care unit and then back to a medical ward.

The Board was advised that the patient and family had been complimentary of the care provided outside of the stroke unit. However, a formal complaint, extracts of which were provided to the Board, had been received regarding the care on the stroke unit, specifically relating to staff attitudes and poor communication.

A number of actions had been taken to address the matters raised following the complaint investigation which had been detailed in the formal response to the complainant.

In concluding the patient story, Ms Wood took the opportunity to read in its entirety the letter from the family following receipt of the formal response where they had stated that they had been reassured by the investigation and the actions taken.

It was suggested that the Quality Assurance Committee seek further assurance on the actions arising from this case.

ACTION: Interim Chief Nurse

PROCEDURAL ITEMS
388/18 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 25 September 2018 were agreed as a correct record, subject to a number of minor typographical amendments.

389/18 MATTERS ARISING FROM THE PREVIOUS MEETING

i. Matters arising from the previous meeting (minute 349/18i)

The Board noted that the first meeting of the Clinical Ethics Committee had now taken place and that it would continue to meet on a monthly basis.

The Committee would be led by the Interim Medical Director, who was commended for facilitating its prompt establishment. Dr Gardner indicated that he would be discussing with the Director of Finance the creation of a financial budget to support the work.
The Board of Directors considered and discussed the Board action log, with a number of actions agreed to be formally closed whilst others would continue to be monitored.

**STRATEGY AND STRATEGIC PLANNING**

**391/18  REPORT FROM THE CHAIRMAN**

The Board of Directors received the report from the Chairman.

Mr Havenhand specifically reported that the South Yorkshire and Bassetlaw Integrated Care System had been officially launched on 1 October 2018. Whilst the Memorandum of Understanding had been approved by all partner organisations, discussions continued in order to finalise the overall governance framework.

Whilst the matter would be discussed later in the meeting, Mr Havenhand drew the Board’s attention to the continued challenging performance against the Trust’s 4-hour access standard. Although there remained significant focus on the required actions, sustained performance had yet to be seen.

As part of the Board’s intention to improve its own effectiveness, progress continued with the Board Development Programme. Additionally, an externally commissioned well-led governance review was currently underway. As a result, the Board meeting would be observed by a representative from RSM as part of the review.

The Board noted that one of the Trust’s nurses had been awarded the Pride of Britain Fundraiser of the Year regional award. On behalf of the Board the Chairman would send appropriate congratulations on this achievement to the nurse. **ACTION: Chairman**

The Board of Directors noted the Chairman’s Report.

**392/18  REPORT FROM THE CHIEF EXECUTIVE**

The Board of Directors received the report from the Chief Executive which outlined key strategic issues, operational issues and stakeholder engagement.

Mrs Barnett highlighted to the Board that overall, as demonstrated by appendix 3 to the report, the Trust was on track with delivery of the 2018/19 Operational Plan, however there were a number of areas which were behind plan with actions identified to address performance as shown in an appendix to the report.

Mrs Barnett confirmed that the Care Quality Commission (CQC) core services and well-led inspection visits had been completed and that the Trust was
continuing to work with the CQC as part of the ongoing process, prior to the finalisation and publication of the report, which was anticipated in early 2019.

Mrs Barnett confirmed that a number of technical notices relating to the withdrawal from the European Union, which may impact upon health and social care, had been issued by the Government. It was anticipated that before the withdrawal date of 29 March 2019, further notices or guidance would be issued.

The Board was informed that meetings continued to be held between the Head of Procurement and the Director of Finance to review contractual arrangements in light of Brexit. It was noted that from this piece of work a business continuity plan for medicinal products had been recently developed and would be submitted to the Finance and Performance Committee in due course.

Mrs Barnett confirmed that performance against the A&E four-hour access standard had been challenging in September and October 2018, with actions continuing to be taken to drive improvement. However, these had not yet had the desired impact in terms of performance, therefore further work was underway.

Clarity was sought with regard to the South Yorkshire and Bassetlaw Integrated Care System (ICS) performance against this standard. Mrs Barnett confirmed that the ICS performance measure for this standard was to achieve 90% at the end of September 2018 and overall to aim to achieve the 95% standard required nationally. With the exception of one Trust (Barnsley), the target was not being achieved across the local system. It was agreed that the ICS would have an important role in supporting delivery of the target in terms of providers sharing good practice and working to support each other during times of increased demand. The focus for Rotherham was to access areas of good practice which would add value and improve performance, without duplicating action already taken.

Mrs Craven sought clarity as to the status of the ICS system improvement plan. Mr Sheppard confirmed that a system-wide plan had yet to be developed, with only individual improvement plans currently being in place.

The Board considered that it was important to ensure that a system-wide improvement plan was developed, and at an increased pace. As such, the Board requested that Mrs Barnett raise the matter at the System Improvement Group/Collaborative Board.

Mrs Barnett was requested to obtain a copy of the ICS response to the NHS Long Term Plan consultation process, as mentioned in one of the appendices to her report, and to circulate this to the Board.

The Board of Directors noted the report from the Chief Executive.
FIVE YEAR STRATEGY REFRESH

The Board of Directors received the report presented by the Deputy Chief Executive which outlined the refresh of the Five Year Strategy, an operational objective to have been undertaken by the end of December 2018.

Mr Holt confirmed that the Strategy had been further updated in light of the discussions at the September 2018 Board meeting. A number of sections had been strengthened, including to the organisational response to the strategic context (section 2.8), the key challenges (section 3.8) and the SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis (section 5) following the Strategy and Transformation Committee meeting.

The Board agreed that the Strategy should reference the opportunities for continuous improvement, diversity and inclusion, and the strategy for medical equipment replacement. Additionally, there were a number of typographic corrections to be rectified.

**ACTION – Deputy Chief Executive**

Mrs Barnett also commented that she considered that there should be stronger statements in relation to the delivery of safe, high quality care. In addition, the aspiration to be ‘outstanding’ in the CQC well-led domain should be explicit and supported with further content in the governance section, which also required strengthening.

With regard to the review of clinical services, it was confirmed that all specialties had been reviewed at a high level, with feedback to be provided to the November 2018 Board Seminar.

The Board, in welcoming the revisions undertaken to date and those sections to be further strengthened, commented that the resulting strategy was excellent.

Once approved by the Board, two condensed documents and supporting posters would be produced and shared both within the organisation and with external stakeholders.

The Board supported the refreshed Five Year Strategy, as presented, subject to amendment to include the matters raised; the Board gave delegated authority to the Chairman, Chief Executive and Vice Chair acting together to approve the Five Year Strategy.

**ACTION - Chairman, Chief Executive and Vice Chair**

Once approved, a copy of the final version would be circulated to the Board of Directors.
The Board of Directors received and noted the monthly Integrated Performance Report (IPR) introduced by the Chief Executive.

Mrs Barnett outlined that the report detailed a number of areas of performance including ‘top achievements’, ‘most improved’, ‘key concerns’ and ‘most deteriorated’.

Worthy of note was the improved position with regard to dementia assessments, which now stood at 94.3%. This was better than both the Trust’s target and also the national average. Improvements also continued to be seen in the mortality rate, which stood at 104.3 in July. The aim remained to have a mortality rate lower than the national average of 99.

The most deteriorated areas were e-referral slot issues and diagnostic performance. Whilst overall performance in the latter remained within the national top quartile, a small backlog in sleep studies had resulted in breaches of the 6 week waiting time standard. Actions had been taken to achieve improved performance going forwards and to ensure earlier escalation in future.

The areas of key concern remained the A&E 4-hour access standard and initial health assessments for looked after children. Both areas continued to receive significant focus both within the Trust and through working collaboratively with partners to improve the position.

There were a number of areas where the Trust was in the upper quartile nationally for performance including: 18-week referral to treatment times; hip fracture best practice compliance; C. difficile; incident reporting culture - severe incidents; financial variance from plan and staff turnover.

With regard to the target for incident reporting culture, it was suggested that the rating should be green rather than red. However, Mrs Barnett and Dr Gardner expressed caution in the interpretation of this indicator.

The Board of Directors noted the Integrated Performance Report, with detailed information on a number of matters contained within subsequent reports.

The Board of Directors received the Quality Report presented by the Interim Chief Nurse and Interim Medical Director.

The report documented a number of areas including complaints, where it was noted that 77 concerns and 33 complaints had been received in September 2018.

Included in the complaint figures, was one which had been risk rated as red, subsequently declared as a Serious Incident (SI) and would therefore be
investigated as part of the SI process. However, the Board requested that more information be provided as to why the receipt of a formal complaint had been the initial trigger to undertake an SI investigation.

**ACTION – Interim Chief Nurse**

In addition to a number of performance standards which were also documented within the IPR, the report detailed the areas which had been visited as part of the CQC inspection process during September and October 2018. Following initial feedback from the CQC, action plans had been developed focussing on Non-invasive Ventilation (NIV) and the Paediatric Emergency Department. Mr Sheppard clarified that although the report indicated that recruitment had commenced to support the NIV actions, the business case had yet to be approved by the Board. Pending approval, no expenditure had been committed, although preliminary work had been undertaken in the recruitment process such as development of job descriptions. This work had been progressed to reduce delay, in recognition of the recruitment timeframes involved; should the business case be approved, however, Mr Sheppard confirmed that the work would cease should the business case not be approved.

With regard to the recruitment of registered sick children’s nurses, which was also an action following the CQC inspection, recruitment was ongoing to the vacant posts. For those already in post, Ms Wood confirmed that there was a commitment to improve the environment within the Paediatric Emergency Department, and access to additional training and actions were already underway to achieve this.

In terms of mortality, whilst the Trust’s Hospital Standardised Mortality Ratio (HMSR) rate continued to improve, currently standing at 104.3, further work was required. The aim remained to achieve the national peer rate average which had been rebased from 100 to 99.

There were a number of HMSR diagnosis code alerts which required further investigation within the Trust. The first related to ‘septicaemia (except in maternity)’ and the second to ‘other upper respiratory disease’. Whilst the Interim Medical Director advised that he considered the Trust’s mortality review process to be very good, it was being refreshed and strengthened with a focus in the Division of Integrated Medicine. This would include a dedicated lead for patient safety. Further information on the refresh would be provided in the November 2018 report.

The Finance and Performance Committee had discussed the CQUIN (Commissioning for Quality and Innovation) targets of sepsis and those relating to tobacco and alcohol. From a financial perspective there had been a £300k loss of income during the first half of the year, although risk had been anticipated in this area, with prudent financial forecasting such that the current progress constituted an upside to the Trust’s financial position. However, it was noted that more importantly, CQUINs were intended to improve both the quality of care provided and the overall health of the population thereby preventing the requirement for medical intervention. Ms Wood confirmed that she was leading the CQUIN programme and that actions were identified and
being progressed by the individual CQUIN scheme leads to drive improved performance going forwards.

Ms Wood confirmed that performance management arrangements for CQUINS had been reinvigorated, with improved leadership, which would support this delivery. Mr Sheppard indicated that although he was assured that the overall CQUIN position would return to plan, based upon the actions being taken, he was not in a position to confirm 100% delivery by year-end.

The Board noted that there had been three cases of tuberculosis, which, although diagnosed after admission, had not been hospital-acquired. Ms Wood confirmed that any colleagues who had potentially been exposed had been fully supported during the screening phase and they were now back at work.

The Board of Directors noted the Quality Report.

395/18(b) OPERATIONAL PERFORMANCE REPORT

The Board of Directors received the Operational Performance Report, which was presented by the Chief Operating Officer.

Mr Briggs reported that in terms of the sustainability and transformation standards, the area of challenge remained the A&E 4-hour access standard, which was below the Trust’s own 90% trajectory, with a year to date position of 87.42%. The report highlighted that there continued to be issues relating to staffing and long patient waits, particularly in general medicine. The latter had been exacerbated recently for a period of two weeks, when a number of wards had been closed due to confirmed Norovirus.

It was anticipated that establishment of a Winter Team, who would work closely with the site team, and the recently recruited overseas junior doctors would support the overall position going forward. Other actions, such as Home First, opening of more beds and additional trackers over the weekend were also being progressed.

In addition, Mr Briggs confirmed that detailed discussions would be undertaken with the Improvement Academy on 5 November 2018 to support the development of a coherent and sustainable plan for a continuous improvement programme. This would initially be with the Emergency Department.

With regard to the Board supporting engagement with the Improvement Academy, it was commented that similar external support had previously been provided through the Emergency Care Intensive Support Team (ECIST). Whilst initial improvements had been seen, these had not been sustained, and therefore, it was queried how working on a continuous improvement programme would achieve different results. It was considered that working with the Improvement Academy would support leadership, by using a continuous improvement methodology which was the key component to sustainable change in the Emergency Department.
The variance of performance on a daily basis with the Emergency Department was noted, and clarification was requested as to whether the availability of GPs had a direct impact on four-hour performance. It was agreed that provision of GP support to the Urgent and Emergency Care Centre and the impact of the establishment of the three GP hubs across Rotherham could be having a negative impact. Whilst these issues were being further discussed with Rotherham Clinical Commissioning Group and alternative GP providers were being considered, the main factor behind the breaches remained the triaging of patients.

In response to a question regarding whether the recommendations relating to the Paediatric Emergency Department (ED) following the CQC inspection would support improvement in the waiting times, the Chief Operating Officer, Mr Briggs, explained that the breaches mainly related to general medicine and flow through the hospital rather than to the Paediatric ED.

Mrs Barnett concluded that the position was complex. The organisation would embrace the continuous improvement approach, with culture and strengthened leadership being the key aspects of the work to be undertaken.

In conclusion, the Board of Directors reaffirmed their support to engaging with the Improvement Academy, which should be progressed as quickly as possible to ensure that performance was brought into line with the other sustainability and transformation standards.

With regard to other performance metrics, the cancer 62-day quarter 1 position was 83.3% after reallocations, and for quarter 2 stood at 85.2% (un-validated). The target being 85%. The position continued to be monitored on a daily basis.

Additionally, the Cancer Alliance had undertaken a review of the actions being taken and were supportive of the approach. They had also offered funding to recruit a nurse specialist in urology.

Whilst the Trust remained within the upper performance quartile for diagnostics (DMO1) there had been a number of breaches in September and October 2018, which highlighted the requirement for additional resources.

In terms of the stroke metrics, Mr Briggs confirmed that the ring-fencing of stroke beds had been reaffirmed within the Trust. Additionally, as a number of the stroke metrics had been below the target for consecutive months, a more sustainable approach was being considered. However, it should be noted that the position may change in March 2019 following the reconfiguration of stroke services within the Integrated Care System.

The Board of Directors noted the Operational Report.
395/18(c) **WORKFORCE REPORT**

The Board of Directors received the Workforce Report presented by the Director of Finance in the absence of the Acting Director of Workforce.

Mr Sheppard reported that performance, remained strong in terms of sickness absence, which currently stood at 3.70% for September 2018, and was 0.25% below the 3.95% target. The Divisions had given their continued assurance in the management of sickness absence at the Divisional Performance Meetings.

With regard to the Personal Development Reviews (PDRs), the operational objective to have completed 90% of PDRs by the end of September 2018 had been achieved. The current overall compliance rate stood at 92.04%.

Additionally, the overall Mandatory and Statutory Training (MaST), compliance rate was above trajectory at 89%, with the target being 85%.

Whilst the take up rate for the Senior Clinical Leadership Development Programme had been low, which had been reported to the Strategic Workforce Committee, Mrs Barnett reported that the proposed programme was being reviewed in conjunction with Dr Gardner. The aim would be to ensure balanced cohorts of delegates to include those key to the organisation both now and in the future and those who would form the new medical leadership structure reporting to the Medical Director.

The Strategic Workforce Committee continued to monitor progress on recruitment to the rolling programme of top 30 posts, with Dr Gardner commenting that he had some ideas to support targeted medical recruitment, which he would be progressing with Executive colleagues.

The Board of Directors noted the Workforce Report.

395/18(d) **FINANCE REPORT**

The Board of Directors received and noted the month six Finance Report presented by the Director of Finance.

Mr Sheppard reported that the Trust was ahead of plan for the year to date by £180k. The forecast remained that the year-end financial plan would be delivered. The deficit to September 2018 was £11.75m against the plan of £11.93 which was a favourable variance of £0.18m year-to-date.

With regard to the capital programme, as reported at the last meeting the year-end monthly forecast had been re-profiled, and as such Mr Sheppard was assured that it would be delivered.

The Cost Improvement Programme was ahead of the plan by £949k at the end of September 2018, currently standing at £4,224k. The end of year forecast was to deliver in excess of the £9.7m year-end target.

The Finance and Performance Committee continued to receive presentations from each of the Divisions regarding their plans, potential risks and
opportunities. It was considered that there was an improved level of clarity within the Divisions of the requirements compared to 2017/18. The Committee continued to ensure focus remained on the CQUIN targets as there were a number of areas of challenging performance.

With regard to the agency spend targets and specifically the Trust’s own target, Mr Sheppard indicated that although there remained potential risks there was no reason that the Trust’s internal target could not be achieved by the financial year-end.

With regard to the financial implications of carrying out the CQC recommendations, Mr Sheppard confirmed that the Divisions would incorporate any financial requirements into their plans. However, this may result in decisions having to be made on other areas of their budget to balance the financial position.

The Board of Directors noted the Finance Report, which continued to be monitored in detail by the Finance and Performance Committee.

**ASSURANCE FRAMEWORK**

**GOVERNANCE REPORT**

396/18

The Board of Directors received the Governance Report presented by the Director of Corporate Affairs.

Ms Milanec specifically highlighted to the Board publication by NHS Improvement of their consultation document on Wholly Owned Subsidiaries. It was the intention that the Trust would respond to the consultation which closed on 16 November.

The report outlined the case law relating to non-medical staff working in A&E departments owing a duty of care to patients to provide accurate information relating to the provision of medical assistance. Ms Milanec advised the Board that the Trust’s reception staff received a full induction upon joining the Trust, with Mr Briggs agreeing to provide further information as part of the next Operational Report. It was further requested that the report provide clarity as to how the duty of care requirement was conveyed to non-medical staff.

**ACTION – Chief Operating Officer**

The Board of Directors noted the Governance Report.

**OUTCOME OF THE IMPLEMENTATION OF E-ROSTERING**

397/18

The Board of Directors received the report which aimed to describe for the Board the benefits realised following implementation of the E-Rostering system which had been initially implemented in 2016.

The Board, in noting the positive report, requested that the HR Systems Manager be informed that the Board had been pleased with progress to date. This had culminated in a Healthcare People Management Association award
for use of data from HR Systems. Next steps in further embedding the system were outlined and confirmed.

REGULATORY AND STATUTORY REPORTING

398/18 RESPONSIBLE OFFICER REPORT

The Board of Directors received the report presented by the Interim Medical Director which detailed activity related to Medical Appraisal and Revalidation as required by NHS England and GMC Regulations.

Dr Gardner reported that he continued to work closely with the Interim Responsible Officer on the requirements, and confirmed that the statement of compliance had been submitted by the deadline.

There would be a requirement to review and refresh the case investigator and appraisal training, both for those currently undertaking the role and for any new staff appointed following ongoing recruitment. This was particularly relevant as new guidance would now require long-term locums to be appraised by the Trust.

As also highlighted by the Guardian of Safe Working Hours report, the themes from the appraisals related to the intensity of work, and the ability to be released to complete continuing professional development. Actions were being taken as a result of feedback received to further support trainees and their experience at the Trust.

The Board of Directors noted the report.

399/18 GUARDIAN OF SAFE WORKING HOURS REPORT

The Board of Directors received the quarterly Guardian of Safe Working Hours report presented by the Interim Medical Director.

Dr Gardner confirmed that he met the Guardian of Safe Working Hours on a regular basis, with a current focus of discussions being the acute medicine and obstetrics / gynaecology services. He was also attending the junior doctor forums to discuss any particular concerns and to reiterate the open door policy for any specific concerns or provisional of pastoral support.

In light of some of the comments which had been made by the junior doctors as detailed within the report, Dr Gardner confirmed that the consultant body, including locum consultants, remained supportive in their interactions with junior colleagues.

Whilst the exception reports, which had increased in number, were retrospective reflections from the junior doctors, further questions were also asked such as action taken to triangulate information to ensure the full picture was understood.
As the exception reports were produced specifically as part of the safe working hours process, they did not provide an accurate picture of the pressures within the usual working hours.

The Board of Directors noted the report.

**400/18 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL STATEMENT OF COMPLIANCE**

The Board of Directors received the report presented by the Chief Operating Officer which outlined the Trust’s annual self-assessment of compliance against NHS England’s Emergency Preparedness, Resilience & Response (EPRR) Core Standards.

Mr Briggs reported that, against the sixty-four individual standards, the Trust had self-assessed as being fully compliant against sixty, with four being partially compliant.

The self-assessment, compliance statement and improvement plan had all been through the governance routes, culminating in them being recommended for Board approval.

Mr Barnes, as Chair of the Audit Committee, questioned whether the recommendations resulting from the business continuity review undertaken by the Internal Auditors in 2017/18, which had resulted in a ‘limited assurance’ rating, had been addressed and factored into the self-assessment process. As Mr Briggs was not in a position to confirm if this had formed part of the self-assessment, clarification would be sought outside the meeting.

In order to accommodate this additional matter, the Board gave delegated authority to the Chairman, Chief Executive, Chief Operating Officer and Audit Committee Chair to approve the annual self-assessment of compliance.

**ACTION - Chairman, Chief Executive, Chief Operating Officer and Audit Committee Chair.**

In order to provide additional assurance to the Board with regard to emergency preparedness arrangements, Mr Briggs and Ms Wood highlighted the recent decontamination incident in the Urgent and Emergency Care Centre (UECC). This had required immediate implementation of the emergency plan, including relocation of parts of the service to another area of the Trust. The plan had worked well and had been commended by the CQC inspectors, who were in the UECC at the time.

**BOARD GOVERNANCE 401/18 ANY OTHER BUSINESS**

There were no items of any other business.
DATE OF NEXT MEETING

The next meeting of the Board of Directors would be held on Tuesday, 27 November 2018.

At this point the Chairman opened the meeting to any questions from those observing the proceedings in relation to the agenda items, for which there were none.

Martin Havenhand
Chairman                   date
<table>
<thead>
<tr>
<th>Log No</th>
<th>Meeting</th>
<th>Report/Agenda title</th>
<th>Minute Ref</th>
<th>Agenda item and Action</th>
<th>Lead Officer</th>
<th>Timescale/ Deadline</th>
<th>Comment/ Feedback from Lead Officer(s)</th>
<th>Open /Close</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>25-Jul-17</td>
<td>Escalations from Governors</td>
<td>269/17</td>
<td>To be added to action log: 3 staff governor vacancies out of 5 remain vacant. Execs to consider options available to co-op colleagues to ensure they are engaged and represented through CoG.</td>
<td>Co Sec</td>
<td>30/09/2018 (re constitution)</td>
<td>November 2018: Constitution now completed with section related to Governor classes amended. Two colleagues, to be co-opted to Council in January 2019, met with CEO, and Chair earlier this month. Action progressing.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>61</td>
<td>31-Jul-18</td>
<td>Operational Performance Report</td>
<td>275b</td>
<td>'Fragile' services to be included as part of the forthcoming review of clinical services by the Trust</td>
<td>COO</td>
<td>30/10/2018 14/11/2018</td>
<td>Discussed at Board Seminar on 14 November 2018</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>78</td>
<td>28-Aug-18</td>
<td>Operational Performance</td>
<td>314/18(c)</td>
<td>Board to be assured by ongoing actions relating to annual leave management policy/procedures (to go through SWC first)</td>
<td>COO</td>
<td>30-Oct-18</td>
<td>Update from 30 October: item to remain open and be provided at Board: agenda item 431/18(b) (OPS REPORT)</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>80</td>
<td>28-Aug-18</td>
<td>BAF</td>
<td>316/18</td>
<td>Future reports to Board to include improved narrative as to why committees recommend amendments regarding BAF risk scores.</td>
<td>CoSec</td>
<td>30/10/2018 27/11/2018</td>
<td>Agenda item 433/18</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>86</td>
<td>30-Oct-18</td>
<td>Chairman’s report</td>
<td>391/18</td>
<td>Write to Pride of Britain Fundraiser of the Year regional award winner to express congratulations on behalf of the Board</td>
<td>Chair</td>
<td>30-Nov-18</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>86</td>
<td>30-Oct-18</td>
<td>CEO Report</td>
<td>392/18</td>
<td>Escalate to ICS the expectation that a system wide improvement plan is developed at pace</td>
<td>CEO</td>
<td>27-Nov-18</td>
<td></td>
<td>Recommend to close</td>
</tr>
<tr>
<td>87</td>
<td>30-Oct-18</td>
<td>CEO Report</td>
<td>392/18</td>
<td>SYB ICS response to the NHS Long Term Plan (appendix 1, item 2.6) to be circulated to board members</td>
<td>CEO</td>
<td>30-Nov-18</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>88</td>
<td>30-Oct-18</td>
<td>Five Year Strategy Refresh</td>
<td>393/18</td>
<td>Strategy to be updated as per Board feedback, approved with delegated authority to Chairman, CEO and Vice Chair, and final copy circulated to Board.</td>
<td>DCEO</td>
<td>18-Dec-18</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>Log No</td>
<td>Meeting</td>
<td>Report/Agenda title</td>
<td>Minute Ref</td>
<td>Agenda item and Action</td>
<td>Lead Officer</td>
<td>Timescale/Deadline</td>
<td>Comment/ Feedback from Lead Officer(s)</td>
<td>Open /Close</td>
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</tr>
<tr>
<td>89</td>
<td>30-Oct-18</td>
<td>Quality Report</td>
<td>395/18</td>
<td>Learnings to be shared with the Board following an investigation of the complaint / SI.</td>
<td>IChN</td>
<td>27-Nov-18</td>
<td>Verbal update to be provided at the meeting.</td>
<td>Open</td>
</tr>
<tr>
<td>90</td>
<td>30-Oct-18</td>
<td>Governance Report</td>
<td>396/18</td>
<td>Next Operational Report to provide further information on training received by UECC reception staff, and clarify how the duty of care requirement was conveyed to non-medical staff.</td>
<td>COO</td>
<td>27-Nov-18</td>
<td>Agenda item 431/18(b) (ops report)</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>91</td>
<td>30-Oct-18</td>
<td>EPRR statement of compliance</td>
<td>401/18</td>
<td>Confirmation to be provided to Audit Chair that internal audit recommendations from business continuity review had been factored into the self assessment process. Delegated authority to approve the document to Chair, CEO, COO and Audit Chair, one clarification of above provided.</td>
<td>COO</td>
<td>27-Nov-18</td>
<td>emailed out to JB, LB, MH on 21 November with evidence that audit recommendations had been completed.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>92</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Open</td>
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<tr>
<td>93</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Agenda item

| 428/18 |

### Report

**Report from the Chairman**

### Executive Lead

n/a

### Link with the BAF

The Chairman’s report covers

### Purpose

<table>
<thead>
<tr>
<th>Decision</th>
<th>To note</th>
<th>Approval</th>
<th>For information</th>
</tr>
</thead>
</table>

### Executive Summary

(including reason for the report, background, key issues and risks)

This report provides information on key events and activities since our October board meeting.

- Progress continues to be made with the formal governance arrangements for the South Yorkshire and Bassetlaw Integrated Care System. The HSR is progressing with clinical working groups meeting to discuss the potential hosted networks.

- The A&E 4-hour target remains challenging.

- During November, the Trust celebrated its proud week which showcased the amazing and excellent work provided by our colleagues to our patients.

### Recommendations

The Board is asked to note this report with particular recognition of those receiving awards during the Trust’s Proud Week.

### Appendices

1. Recognition of Learning Awards winners
2. Long Service Awards winners
3. 2018 Proud Awards Winners’ List
1.0 Introduction

1.1 This report provides an update since the last Board Meeting on 30 October 2018.

2.0 South Yorkshire and Bassetlaw Integrated Care System (ICS)

2.1 A further workshop with acute health and mental health trusts Chairs and Chief Executives, which was about the ongoing governance review, relating to collaborative working and how to support the ICS as a ‘live’ level 2 ICS. It is anticipated that the detailed governance structure will be agreed in principle by December 2018, ready for implementation on 1 April 2019.

2.2 Work relating to the Hospital Services Review continues. Clinical Working Groups are meeting and beginning to look at what the proposed Hosted Networks will look like. It is anticipated that the work will progress until the go live of the Hosted Networks from 1 April 2019.

3.0 4 Hour Access Standard Performance

3.1 The Board remains concerned about our non-achievement of the 95% target against the 4-hour access standard. From 1 November, a new winter team has been put in place with responsibility to improve performance in this area.

4.0 Proud Week

4.1 Our annual Proud Week provides the TRUST with the opportunity to recognise OUR COLLEAGUES who have undertaken some form of learning, training or personal development, those who provide their time to volunteer with us, those who have served the NHS for many years, and those who have been nominated by colleagues and the public for ‘going the extra mile’.

4.2 The Trust encourages all of our colleagues to pursue their own personal development, and we recognised those colleagues who had achieved their learning aims this year at our ‘Recognition of Learning Awards’ Event. A list of those receiving awards is provided at appendix 1.

4.3 It is incredible to think that some of our colleagues have dedicated their working lives to the NHS and have reached 40 years of service. The commitment and dedication shown by these colleagues, was celebrated at our Long Service Awards, and a list of those receiving thanks for their hard work, can be found at appendix 2.

4.4 Another group of individuals who dedicate their time with us, are our volunteers who support and enhance the experience of our patients and visitors alike. A small celebratory afternoon tea was held during Proud Week to thank our volunteers personally for the time they spend, unpaid, supporting us to help our patients.

4.5 Finally, an awards ceremony was held at Magna to celebrate our Proud Awards nominees and winners, on 8 November 2018.

4.6 An incredible 152 nominations were received from members of the public for the Public Recognition category, and over 300 nominations being received for the remaining 20 categories.

4.7 A list of the winners can be found at appendix 3. A big ‘congratulations’ goes to all of those who were nominated.
5.0 Other Chairman’s activities

5.1 Details of engagements undertaken since the last Board meeting include:

5 – 9 November: Proud Week:
- Long Service Awards
- Volunteers Lunch
- Recognition of Learning Event
- Annual Proud Awards Event

5 November – ICS Governance Workshop

9 November – Wentworth Woodhouse Yorkshire Masterplan Launch

13 November – Monthly meeting with Lead Governor

13 November – Medical Physics Visit

16 November – Quarterly Staff Governors’ meeting

Martin Havenhand
Chairman
November 2018
Recognition of Learning Awards winners

Mary Dougan – MSc in Healthcare Education
Jill Ellis – Introduction to Diabetes Care and Management Module
Jenny Maughan (Mourn) – Year 2 of Advanced Paediatric Clinical Practitioner Course
Kerry Melbourne - Year 2 of Advanced Paediatric Clinical Practitioner Course
Angie Pennycook - Year 1 of Advanced Paediatric Clinical Practitioner Course
Lucy Beevers – Community Practitioner Nurse Prescribing
Sarah Bittles-Kincaid – Non-Medical Prescribing
Amanda Fairbourn – MSc in Healthcare Education
Natalie Green – Advanced Practice Modules
Delilah Muzulu – Sonography
Rachel Perkins – MSc Biomedical Sciences
Andrew Crookes – MSc Biomedical Sciences
Cerise Stubbings – Non-Medical Prescribing
Leanne Shortt – National Clinical Coding Qualification
Carla Brown – Non-Medical Prescribing
Rachel Holehouse - Ear Care Diploma
Kerry Burns – Non-Medical Prescribing
Kate Sharland – Evidence Based Stroke Care
Kate Lambert – Advanced Physical Assessment and Consultation Skills
Madeline Ward – Managing Long Term Conditions

Mentor Preparation for the Healthcare Professional

Joanne Mellars – 0-19 Service
Lorna Moreman – UECC
Cara Butterley – UECC
Crystal Bishop – Midwifery
Lesley Bullen – Community Nursing
Danielle Foster – 0-19 Service
Lucy Freeman – Midwifery
Kate Griffiths – Fitzwilliam Ward
Aaron Hutley – Community Nursing
Emma Maxwell – Ward B5
Nicola Burgin – Ward B5
Apprenticeships and Vocational Courses

Joely Bettridge – Apprenticeship in Business Administration

Daniel Brown – Apprenticeship in Business Administration

Elyse Hubbard – Apprenticeship in Health and Social Care

Melissa McTague – Assistant Practitioner

Marie Whyke – Assistant Practitioner

Elisha Freeman – Ward A3 - Trainee Nurse Associate Year 1

Cheryl Greenwood – Ward A5 - Trainee Nurse Associate Year 1

Nicole Loxley – Fitzwilliam – Trainee Nurse Associate Year 1

Natalie Critchlow – Stroke Unit – Trainee Nurse Associate Year 2

Mobin Matthew – Ward A1 - Trainee Nurse Associate Year 2

Deborah Santiago – AMU - Trainee Nurse Associate Year 2
Appendix 2

Long Service Awards (40 years)

Valerie Aspin                      Patricia Mitchell
Dianne Daniells                   Fiona McNaughton
Susan Dearing                     Karen Preston
Heather Ellis                     Julie Rendi
Jane Fairweather                  Stephen Roscamp
Alma Gaukrodger                   Rena Smith
Ann Grand                         Maria Taylor
Sandra Greene                     Karen Ward
Keith Jones                       Ian Weldon
Mandy Kingston                    Audrey Woodcock
Janet Liversidge
2018 Proud Awards Winners

Strategic Objectives Award - Patients
Winner: Immunisation and Vaccination Team, 0-19 Service

Strategic Objectives Award - Colleagues
Winner: Dr Kim Russon, Day Surgery

Strategic Objectives Award - Governance
Winner: Derek Stowe, Information Governance

Strategic Objectives Award - Finance
Winner: Lynette Evans, Dermatology

Strategic Objectives Award - Partners
Winner: The Winter Beds Project Team, Care Coordination Centre, CCG, private care homes

Values Award - Ambitious
Winner: Paediatric Acute Rapid Response Outreach Team, Children's Community Nursing

Values Award - Caring
Winner: Jennifer Turedi, Learning Disabilities

Values Award - Together
Winner: Sitwell Ward, Urology

Outstanding Volunteer
Winner: Samina Nawaz, Macmillan Cancer Information and Support Service

Learning and Development
Winner: Mary Dougan, Chief Nurse Team

Unsung Hero
Winner: Janet King, Labour Ward
Runner up: Allen Blore, Estates

Our Top Leader
Winner: Sandra Whiting, Community Occupational Therapy SPA

Team of the Year - Clinical
Winner: AMU

Team of the Year - Non-Clinical
Winner: Pharmacy Stores and Procurement Team

Public Recognition Award
Winner: Kelly Guest, Early Attachment Service
Runner up: Alcohol Liaison Service
Shining Star Award
Winner: Samantha Pritchard, Wentworth South District Nurses

Innovation Award
Winner: Joanne Cook and Midwives, Maternity

Chief Executive's Award
Winner: Radiology Team, Clinical Support

Chairman’s Award
Winner: Alison Cooper, Anaesthetics

Lifetime Achievement
Winner: Dr Dave Harling, Critical Care
### Agenda item

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>429/18</th>
</tr>
</thead>
</table>

### Report

<table>
<thead>
<tr>
<th>Report</th>
<th>Report from the Chief Executive</th>
</tr>
</thead>
</table>

### Executive Lead

<table>
<thead>
<tr>
<th>Executive Lead</th>
<th>Chief Executive</th>
</tr>
</thead>
</table>

### Link with the BAF

<table>
<thead>
<tr>
<th>Link with the BAF</th>
<th>The Chief Executive’s reports provide an oversight on a range of matters, and a number of strategic links to various BAF items will arise.</th>
</tr>
</thead>
</table>

### Purpose

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Decision ☐ To note ✔ Approval ☐ For information ☐</th>
</tr>
</thead>
</table>

### Executive Summary

(INCLUDING REASON FOR THE REPORT, BACKGROUND, KEY ISSUES AND RISKS)

This report outlines progress regarding a number of key strategic and operational issues, and stakeholder engagement, since the Board Meeting.

The key issues are:

- Strategic and operational planning is underway to ensure sign off of the operational plan by the board of directors in accordance with the agreed timetable.
- Overall the Trust continues to make positive progress towards delivering the 2018/19 Operational Plan.
- The Winter Team is in place to support delivery of the Winter Plan.
- Quality Strategy “Safe and Sound” is developing well.
- The 2018/19 Proud Awards took place in November.

Risks to delivery of the 2018/19 operational plan are identified with associated actions to mitigate / reduce risks.

### Recommendations

It is recommended that the Board of Directors **note** the report.

### Appendices

1. Operational Objectives Progress
1.0 Introduction

1.1 This paper outlines progress regarding a number of key strategic and operational issues, and stakeholder engagement, since the Board Meeting on 30 October 2018.

2.0 Strategic Issues

2.1 The Five Year Strategy has been reviewed, the Five Year Plan developed and the production of the 1-year operational plan is well underway. These will be signed off by the Board of Directors in accordance with the agreed timetable.

2.2 Clinical divisions and corporate colleagues have been instrumental in the development of the operational plan which will be shared with the board of directors in draft form in December 2018. Significant progress has been made in the identification and preparation of cost improvement plans to support the anticipated annual efficiency improvement, as part of the three-year programme being developed.

2.3 Overall the Trust continues to make positive progress towards delivering the 2018/19 Operational Plan. Performance against the operational objectives, enablers and key priorities is set out in appendix 1 following scrutiny at the board assurance committees earlier in the month. Risks to delivery of the 2018/19 operational plan are identified with associated actions to mitigate / reduce risks.

2.4 The Quality Strategy “Safe and Sound” is developing well, following positive engagement and feedback from stakeholders. This will provide the framework within which the 2019/20 quality priorities will be agreed as part of the operational plan.

2.5 Progress continues to be made in key areas to ensure the delivery of safe high quality services. The regular CQC relationship meeting took place earlier this month at which the Chief Nurse and I shared the progress that the Trust is making, including actions taken following the feedback from the unannounced focused inspection.

2.5 The Rotherham Winter Plan has been further strengthened and preparatory actions are being taken by partners as set out in the plan. The Trust’s Winter Team is now in place. This team will lead and support the implementation of the winter plan. Furthermore, the approach compliments and reinforces the actions required to drive improvement in flow which should result in better and sustained performance against the 4-hour access target.

3.0 Stakeholder Engagement

3.1 Trust colleagues continue to work with partner organisations across Rotherham Place through the Integrated Care Partnership (ICP) and across South Yorkshire and Bassetlaw (SYB) through the Integrated Care System (ICS) to improve the quality and sustainability of health and care for the population we serve.

3.2 Rotherham partners are continuing to make progress against the priorities set out in the Rotherham Place Plan, fostering positive relationships to support collaborative working to improve patient experience and outcomes.

3.3 On 15 November 2018, I attended a really informative event chaired by the CQC, at which I was able to learn more about good practice in a number of other organisations, which will benefit the development and implementation of our quality strategy.

3.4 Trust colleagues continue to actively engage with the Getting It Right First Time (GIRFT) team to improve the quality of care for our patients through reducing warranted variation. The programme of speciality reviews is well underway, with feedback received and action plans in place in a number of areas.
4.0 Training and Development

4.1 The Trust was among the first group of organisations to complete a new pilot training programme in a regional for healthcare employers. Sixty-eight Trainee Assistant Practitioners (TAPs) at eight healthcare providers in South Yorkshire have achieved the Healthcare Assistant Practitioner Diploma at Level 5 and graduated this month. This included three colleagues from the Trust.

4.2 The higher apprentices, also known as TAPs, have studied for 18 months, spending four days a week in the workplace and one day a week at The Sheffield College. Their role bridges the skills gap between an experienced health care assistant and a registered nurse, and is a stepping stone to nurse training resulting in a recognised qualification and confirming the employers’ commitment to investing in their staff. A graduation ceremony was held on 12 November to celebrate their achievements.

5.0 Awards

5.1 The Trust’s 2018/19 Proud Week took place in November. This included our Volunteer awards, the Recognition of Learning Event and Long Service Awards and culminating in the Trust Proud Awards Ceremony on 8 November 2018.

5.2 Thanks to an incredible response from members of the public and Trust colleagues, over 60 individuals and teams were shortlisted from over 460 nominations in total. 152 nominations were received in the Public Recognition category alone, nominated by patients and members of the public. There was 20 categories including the Chairman’s Award, Chief Executive Award and Lifetime Achievement Award.

5.3 The Proud Awards was a fantastic event, attended by over 250 colleagues, volunteers and partners, which enabled me and members of the Board to personally show our huge appreciation to some of our amazing colleagues, who demonstrate such dedication and compassion in caring for our patients each and every day. We are all very proud of the positive contribution that these colleagues have made for patients, either directly or as a result of their work behind the scenes.

6.0 Conclusion

6.1 The Trust continues to make progress to deliver the Operational Plan, whilst planning for the future and work with partners in Rotherham and the SYB ICS to improve the quality, resilience and sustainability of services for the population we serve.

Louise Barnett
Chief Executive
November 2018
Appendix 1 – Operational Objectives Progress
## Table 2: Operational Objectives

<table>
<thead>
<tr>
<th>Objective 1: Implement the 9 quality priorities for 2018/19</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Agree the baseline measures and improvement trajectories</td>
<td>Apr-18</td>
<td></td>
<td>CN</td>
<td>Green</td>
</tr>
<tr>
<td>1.2 Produce report on progress since last CQC inspection report and recommended new key actions</td>
<td>Jun-18</td>
<td>Aug-18</td>
<td>CN</td>
<td>Green</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 2: Deliver the financial plan and the contract</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Deliver the activity, clinical and operational performance targets</td>
<td>Monthly</td>
<td></td>
<td>COO</td>
<td>Green</td>
</tr>
<tr>
<td>2.2 Deliver the CQUIN and local incentive schemes in full</td>
<td>Mar-19</td>
<td></td>
<td>CN</td>
<td>Red</td>
</tr>
<tr>
<td>2.3 Operate within the agreed expenditure budgets</td>
<td>Monthly</td>
<td></td>
<td>DoF</td>
<td>Green</td>
</tr>
<tr>
<td>2.4 Deliver the 2018/19 cost improvement plans</td>
<td>Mar-19</td>
<td></td>
<td>DoF</td>
<td>Green</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 3: Implement year 1 of the Transformation &amp; Efficiency Programme</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Business case presented to Trust Board to determine whether to proceed with the Wholly Owned Subsidiary</td>
<td>Jul-18</td>
<td>Sep-18</td>
<td>DoST</td>
<td>On Hold</td>
</tr>
<tr>
<td>3.2 If decision is to proceed with the WOS, to undertake implementation in line with the agreed implementation plan</td>
<td>Dec-18</td>
<td></td>
<td>DoST</td>
<td>On Hold</td>
</tr>
<tr>
<td>3.3 Produce a draft outline 5-year sustainability plan</td>
<td>May-18</td>
<td></td>
<td>CEO</td>
<td>Delivered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 4: Implement year 2 of the Rotherham Place Plan with partners</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Locality service specification and model and implementation timescales signed off by CP Board</td>
<td>May-18</td>
<td></td>
<td>DoST</td>
<td>Delivered</td>
</tr>
<tr>
<td>4.2 Locality model fully operational across Central Partnership</td>
<td>Jan-19</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Amber</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Objective 5: Review our clinical strategy in light of the Hospital Services Review</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Review and agree the clinical service review process and timetable for clinical service reviews and clinical strategy refresh</td>
<td>Apr-18</td>
<td></td>
<td>DoST</td>
<td>Delivered</td>
</tr>
<tr>
<td>5.2 Complete clinical service review and strategy refresh</td>
<td>Sep-18</td>
<td>Dec-18</td>
<td>MD</td>
<td>Amber</td>
</tr>
</tbody>
</table>

**Legend:**
- **Delivered**: Completed as planned
- **Green**: On track
- **Amber**: Off track but remedial plan in place
- **Red**: Will not deliver as planned
## Table 3: Enablers for 2018/19

<table>
<thead>
<tr>
<th>Enablers and Milestone Plan</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enabler 1: Recruit to the top 30 key posts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Agree the top 30 posts and a strategy to fill with clear timescales</td>
<td>Apr-18</td>
<td>DoW</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td>1.2 Produce corporate Trust video to support recruitment</td>
<td>Jun-18</td>
<td>DoW</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td>1.3 Fill key posts with agreed risk and mitigation strategies as required</td>
<td>Mar-19</td>
<td>DoW</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td><strong>Enabler 2: Implement Service Line Management across 10 specialties</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Identify and agree the 10 specialties for implementation</td>
<td>Apr-18</td>
<td>DoST</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td>2.2 Agree detailed implementation plans with clinical leads along with detailed success criteria</td>
<td>Jun-18</td>
<td>DoST</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td>2.3 Deliver implementation plans</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td><strong>Enabler 3: Train key people across the organisation in service improvement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Agree wave 2 training cohort and training plan and deployment plan for wave 1 and 2</td>
<td>May-18</td>
<td>CN</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td>3.2 Undertake service improvement training for all Trust Board members</td>
<td>Jul-18</td>
<td>CN</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td>3.3 Complete training for wave 2 and identify wave 3 cohort</td>
<td>Sep-18</td>
<td>CN</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td><strong>Enabler 4: Optimise the Corporate Estate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Review and present proposal to Trust Board for future use of RCHC</td>
<td>Jul-18</td>
<td>Dec-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>4.2 Implementation in line with agreed timetable</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td><strong>Enabler 5: Replace the core IT Infrastructure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 Community laptop replacement programme complete</td>
<td>Jun-18</td>
<td>Jul-18</td>
<td>DoST</td>
<td>Delivered</td>
</tr>
<tr>
<td>5.2 All Workstation-On-Wheels (WOW’s) in inpatient areas replaced</td>
<td>Jul-18</td>
<td>Dec-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>5.3 Business case for data and WiFi upgrade agreed</td>
<td>Sep-18</td>
<td>Jan-19</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>5.4 NHS Mail 2 migration completed</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Green</td>
<td></td>
</tr>
</tbody>
</table>
# Table 6: 2018/19 Priority Objectives for Patients

<table>
<thead>
<tr>
<th>Topic</th>
<th>Objective</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Priorities</td>
<td>To deliver the Quality Priorities (as outlined in Appendix D of the Operational Plan)</td>
<td>Mar-19</td>
<td></td>
<td>CN</td>
<td>Green</td>
</tr>
<tr>
<td>4 Hour Access</td>
<td>Achieve month-on-month performance improvement</td>
<td>Monthly</td>
<td></td>
<td>COO</td>
<td>Red</td>
</tr>
<tr>
<td></td>
<td>Achieve 90% 4 hour access performance</td>
<td>Monthly</td>
<td></td>
<td>COO</td>
<td>Red</td>
</tr>
<tr>
<td></td>
<td>Achieve 95% 4 hour access performance</td>
<td>Monthly</td>
<td></td>
<td>COO</td>
<td>Red</td>
</tr>
<tr>
<td>CQUINS</td>
<td>Deliver forecast CQUIN outcome framework</td>
<td>Mar-19</td>
<td></td>
<td>CN</td>
<td>Red</td>
</tr>
<tr>
<td>Mortality (HSMR)</td>
<td>To maintain HSMR below 100</td>
<td>Monthly</td>
<td></td>
<td>MD</td>
<td>Amber</td>
</tr>
</tbody>
</table>
## Table 7: 2018/19 Priority Objectives for Colleagues

<table>
<thead>
<tr>
<th>Topic</th>
<th>Objective</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 30 posts</td>
<td>Recruit to the top 30 key posts (as per Operational Objective (Enabler) No.1)</td>
<td>Mar-19</td>
<td></td>
<td>DoW</td>
<td>Red</td>
</tr>
<tr>
<td>NHS National Survey</td>
<td>Improve overall engagement score by 5%</td>
<td>Sep-18</td>
<td>Feb-19</td>
<td>DoW</td>
<td>Red</td>
</tr>
<tr>
<td>Sickness Absence</td>
<td>To have sickness absence levels of no greater than 3.95% of total workforce.</td>
<td>Monthly</td>
<td></td>
<td>DoW</td>
<td>Green</td>
</tr>
<tr>
<td>PDR / Appraisal</td>
<td>PDR / Appraisal target of 90%</td>
<td>Jul-18</td>
<td>DoW</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Band 7 and above – compliance by end Q1</td>
<td>Sep-18</td>
<td>DoW</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td>MAST</td>
<td>MAST Training levels to be:</td>
<td>Monthly</td>
<td></td>
<td>DoW</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>- 85% for MAST</td>
<td></td>
<td></td>
<td>DoW</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>- 95% for Information Governance</td>
<td></td>
<td></td>
<td>DoW</td>
<td>Green</td>
</tr>
<tr>
<td>Leadership Programme</td>
<td>Maintain the Band 7 programme to ensure all relevant colleagues have successfully attended the programme</td>
<td>Mar-19</td>
<td></td>
<td>DoW</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>Develop and introduce a Medical Leadership programme</td>
<td>Jul - 18</td>
<td>Jan-19</td>
<td>DoW</td>
<td>Amber</td>
</tr>
</tbody>
</table>
## Table 8: 2018/19 Priority Objectives for Governance

### Strategic Theme - Governance: Trusted, Open Governance

<table>
<thead>
<tr>
<th>Topic</th>
<th>Objective</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Line Management</td>
<td>Implement Service Line Management across 10 specialties (as per Operational Objective (Enabler) No. 2)</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>Data Quality Standards</td>
<td>Data quality standards to be completed for all Divisional performance dashboard indicators</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>Well-Led Review</td>
<td>To undertake and complete a well-led review with an agreed implementation plan</td>
<td>Dec-18</td>
<td>Comp. Sec.</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>GDPR</td>
<td>Internal audit of GDPR implementation and compliance completed and agreed</td>
<td>Dec-18</td>
<td>Comp. Sec.</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>Performance Framework</td>
<td>To refresh and strengthen the performance framework and associated dashboards and implement changes</td>
<td>Jun-18</td>
<td>DoST</td>
<td>Delivered</td>
<td></td>
</tr>
</tbody>
</table>
### Table 13: 2018/19 Priority Objectives for Finance

<table>
<thead>
<tr>
<th>No.</th>
<th>Objective</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Deliver the financial plan and the contract (as per Operational Objective No. 2)</td>
<td>Monthly</td>
<td></td>
<td>COO</td>
<td>Green</td>
</tr>
<tr>
<td>2)</td>
<td>Produce a draft outline 5-year sustainability plan (as per Operational Objective No. 3 (Part 3.3))</td>
<td>May-18</td>
<td></td>
<td>CEO</td>
<td>Delivered</td>
</tr>
<tr>
<td>3)</td>
<td>Deliver against the cash flow profile by delivering the I&amp;E plan and managing debtors and creditors</td>
<td>Monthly</td>
<td></td>
<td>DoF</td>
<td>Green</td>
</tr>
<tr>
<td>4)</td>
<td>Secure appropriate funding to support the 3 year plant and equipment replacement plan</td>
<td>Oct-18</td>
<td>Nov-18</td>
<td>DoF</td>
<td>Amber</td>
</tr>
<tr>
<td>5)</td>
<td>Fully implement Patient Level Costing for all service lines / CSU’s</td>
<td>Mar-19</td>
<td></td>
<td>DoF</td>
<td>Amber</td>
</tr>
<tr>
<td>6)</td>
<td>Demonstrate compliance and deliver against Carter Efficiency Plan</td>
<td>Mar-19</td>
<td></td>
<td>DoF</td>
<td>Green</td>
</tr>
</tbody>
</table>
### Table 15: Transformation Programme 18/19 – Across the Trust

<table>
<thead>
<tr>
<th>Programme</th>
<th>Key Milestone</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust bed base configuration</td>
<td>Trust bed base configuration plan completed (Phase 2)</td>
<td>Oct-18</td>
<td>Feb-19</td>
<td>COO</td>
<td>Amber</td>
</tr>
<tr>
<td>Development of Assessment facilities</td>
<td>Business case for SAU, GAU and revised AMU agreed</td>
<td>Jul-18</td>
<td>Oct-18</td>
<td>COO</td>
<td>Delivered</td>
</tr>
<tr>
<td>Implementation of AEC and Frailty pathways</td>
<td>Ambulatory service model defined and agreed</td>
<td>Jul-18</td>
<td>Nov-18</td>
<td>COO</td>
<td>Amber</td>
</tr>
<tr>
<td>Review of a Wholly Owned Subsidiary</td>
<td>Business Case and recommendation presented to Trust Board</td>
<td>Jul-18</td>
<td>Sep-18</td>
<td>DoST</td>
<td>On Hold</td>
</tr>
</tbody>
</table>

**RAG**
- **Green**: On track
- **Amber**: Off track but remedial plan in place
- **Red**: Will not deliver as planned
### Table 15: Transformation Programme 18/19 – Across the Place

<table>
<thead>
<tr>
<th>Programme</th>
<th>Key Milestone</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Single Point of Access</td>
<td>Service model for Integrated SPA agreed with ICP Board</td>
<td>Sep-18</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>Integrated Rapid Response</td>
<td>Service model for Integrated Rapid Response agreed with ICP Board</td>
<td>Sep-18</td>
<td>Dec-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>Integrated Discharge Team (IDT)</td>
<td>IDT joint provider post in place</td>
<td>Aug-18</td>
<td>Oct-18</td>
<td>DoST</td>
<td><strong>Delivered</strong></td>
</tr>
<tr>
<td>Integrated Localities</td>
<td>Locality service specification and model signed off by ICP Board</td>
<td>May-18</td>
<td></td>
<td>DoST</td>
<td><strong>Delivered</strong></td>
</tr>
<tr>
<td>Community &amp; Intermediate Care bed base</td>
<td>Proposal on use of Intermediate Care beds presented to ICP Board</td>
<td>Oct-18</td>
<td>Dec-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>Integrated Care Home support</td>
<td>Model for Integrated Care Home Support agreed by ICP Board</td>
<td>Dec-18</td>
<td></td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>Programme</td>
<td>Key Milestone</td>
<td>Due</td>
<td>Revised Due</td>
<td>Exec Sponsor</td>
<td>RAG</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>------</td>
<td>-------------</td>
<td>--------------</td>
<td>---------</td>
</tr>
<tr>
<td>Across the ICS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical specialty and strategy reviews</td>
<td>Complete clinical service review and strategy refresh</td>
<td>Sep-18</td>
<td>Dec-18</td>
<td>MD</td>
<td>Amber</td>
</tr>
<tr>
<td>Local partner collaboration</td>
<td>Collaboration arrangements agreed with key partner(s)</td>
<td>Jun-18</td>
<td></td>
<td>DoST</td>
<td>Delivered</td>
</tr>
<tr>
<td>Children and Young People’s services collaboration</td>
<td>Partnership arrangements agreed with SCH</td>
<td>Dec-18</td>
<td></td>
<td>DoST</td>
<td>Green</td>
</tr>
<tr>
<td>Topic</td>
<td>Headline Milestone</td>
<td>Due</td>
<td>Revised Due</td>
<td>Exec Sponsor</td>
<td>RAG</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>---------</td>
<td>-------------</td>
<td>--------------</td>
<td>-----</td>
</tr>
<tr>
<td>1) Optimise the Corporate estate</td>
<td>Optimise the Corporate Estate (as per Operational Objective (Enabler) No.4)</td>
<td>Mar-19</td>
<td></td>
<td>DoST</td>
<td>Red</td>
</tr>
<tr>
<td>2) WOS</td>
<td>Determine whether to pursue the development of a Wholly Owned Subsidiary</td>
<td>Dec-18</td>
<td></td>
<td>DoST</td>
<td>On Hold</td>
</tr>
<tr>
<td>3) Trust Bed Configuration</td>
<td>3.1 - Proposal on Phase 2 bed base configuration agreed</td>
<td>May-18</td>
<td></td>
<td>COO</td>
<td>Delivered</td>
</tr>
<tr>
<td></td>
<td>3.2 - Trust bed base configuration plan completed (Phase 2)</td>
<td>Oct-18</td>
<td>Feb-19</td>
<td>COO</td>
<td>Amber</td>
</tr>
<tr>
<td>4) Plant &amp; Equipment replacement strategy</td>
<td>4.1 - Develop a risk assessed plant and equipment replacement plan</td>
<td>Jun-18</td>
<td>Oct-18</td>
<td>DoF</td>
<td>Amber</td>
</tr>
<tr>
<td></td>
<td>4.2 - Develop options and funding solutions to support implementation of the plant and equipment replacement strategy</td>
<td>Oct-18</td>
<td>Nov-18</td>
<td>DoF</td>
<td>Amber</td>
</tr>
</tbody>
</table>
# Table 17: Digital Implementation Milestones 2018/19

<table>
<thead>
<tr>
<th>Topic</th>
<th>Headline Milestone</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Clinical Backbone</td>
<td>1.1 - Deployment and funding agreed for Electronic Prescribing and Medicines Administration (EPMA)</td>
<td>Jun-18</td>
<td>Oct-18</td>
<td>DoST</td>
<td>Delivered</td>
</tr>
<tr>
<td></td>
<td>1.2 - Paper on recommendation for post-March’19 Electronic Patient Record contract</td>
<td>Sep-18</td>
<td>Dec-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>2) Rotherham Health Record</td>
<td>2.1 - Adult Social Care Services Care Packages viewable within Rotherham Health Record</td>
<td>Oct-18</td>
<td>Nov-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td></td>
<td>2.2 – South Yorkshire &amp; Bassetlaw eDischarge correspondence viewed via Rotherham Health Record (RHR)</td>
<td>Dec-18</td>
<td></td>
<td>DoST</td>
<td>Green</td>
</tr>
<tr>
<td>3) Information Management &amp; Analytics</td>
<td>3.1 - 90% of spells coded within 5 days</td>
<td>Jul-18</td>
<td></td>
<td>DoST</td>
<td>Delivered</td>
</tr>
<tr>
<td></td>
<td>3.2 - Automated IPR data acquisition</td>
<td>Dec-18</td>
<td></td>
<td>DoST</td>
<td>Green</td>
</tr>
<tr>
<td>4) Infrastructure</td>
<td>4.1 - Cyber Management tools fully deployed</td>
<td>Dec-18</td>
<td></td>
<td>DoST</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>4.2 - TRFT call centre upgrade business case completed and agreed</td>
<td>Sep-18</td>
<td>Dec-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>5) People</td>
<td>5.1 - Secure 2nd Graduate Management Training post</td>
<td>May-18</td>
<td></td>
<td>DoST</td>
<td>Delivered</td>
</tr>
<tr>
<td>Agenda item</td>
<td>430/18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>--------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report</td>
<td>Strategy and Transformation Update</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Chris Holt – Deputy Chief Executive / Director of Strategy &amp; Transformation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B11 &amp; B8: This report provides an update on a number of the Place Plan initiatives with partner organisations. Where appropriate it also reports on the digital agenda and potential resilience in delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision [ ] To note [✓] Approval [ ] For information [ ]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Executive Summary (including reason for the report, background, key issues and risks)**

- The purpose for this report is to provide the Board with an update across the transformation, digital and estates & facilities agenda
- Work continues across the transformation agenda, with updates provided across a number of schemes. We continue to work with Partners across Rotherham Place to negotiate and agree the models of care which we are looking to roll out
- NHSmail has been one of the primary initiatives which has gone live since the last update, and overall has gone according to plan
- Work continues on the reconfiguration of the Assessment Floor and following the removal of the asbestos on B1, work has recommenced in this area

**Recommendations**

To note

**Appendices**

N/A
1.0 **Introduction**

1.1. This report provides an update on the transformation, digital and estates & facilities agenda including the key priorities within the operational plan.

2.0 **Annual Planning Cycle**

2.1. Following presentation of the 5-year strategy to the Board in October, work is underway with the communications team to create a user-friendly 1-page version for wider sharing and dissemination across the organisation. It is proposed to have this available by the end of the calendar year.

2.2. The 5-year business plan is presented to the Board this month (November) following the discussions at the Board Seminar. The next steps with this plan are detailed within the document, but one of the primary actions is translating the relevant sections into the 1-year operational plan.

2.3. Planning is well underway with the 1-year operational plan with activity plans, planning assumptions and operational priorities all being developed. We remain on track to present a draft plan to the Board in December.

3.0 **Transformation Update**

3.1. Within the Acute Care programme, progress has been made across a number of areas. The headline updates are:

3.1.1. The Gynaecology Assessment Unit continues to be embedded, and outcomes are showing positive results, and in particular that the number of medical outliers on GAU and Ward B11 have reduced from 5.6 per week on average down to 1.0.

3.1.2. The Ambulatory Care Assessment (medical) Unit has been temporarily relocated to accommodate the B1 refurbishment. Q&A sessions have been held with staff on the development of SAU and the Estates and Facilities mobilisation plan has commenced with a view to opening SAU on 7th January 2019.

3.2. Within the Community Care programme, work progresses across the reconfiguration of the community bed base, the implementation of integrated localities and the integrated single point of access:

3.2.1. We remain on track to finalise the proposal on the initial reconfiguration of the community bed base. We are working closely with partner organisations on a joint approach, which is consistent with our 5-year strategy to move away from a bed-based approach a model where we focus on recovery at home.

3.2.2. We continue to work with partners on the development of the Integrated Localities model, and seeking agreement around the approach for adult provision. The Urgent and Community Transformation Group has recently approved a revised Project Initiation Document which sets out the key work-streams for the next year. These include

- Review of the Rotherham CCG Case Management programme
- Review of social care high intensity users with a view to reducing the costs of care packages
- The development of a Trusted Assessor role within the localities
- The development of Partnership Hubs and associated leadership models

3.2.3. Within the Integrated Point of Contact (IPoC), the Integrated Rapid Response (IRR) team and the Care Coordination Centre (CCC) have now been co-located at Woodside (see 5.3 below). Working arrangements with the local authority’s Single Point of Access have also been agreed for this year and are currently being piloted to look at the development of an integrated service model which brings together their Single Point of Access with the CCC/IRR team. Work has also been undertaken to review the mental health referrals that are being undertaken by the CCC (with RDaSH) to ensure this is appropriately managed.
3.3. The final update is with regards to the Hospital Pharmacy Transformation Programme (HPTP):

3.3.1. Following the announcement that TRFT has been successful in securing part of the national capital allocation for the roll out of Electronic Prescribing and Medicines Administration (EPMA), the EPMA Project Group has been established. It is currently revising the scope and definition of the project in light of recent decision on funding.

3.3.2. Ward based dispensing has been established on AMU. From 1st to 20th July, 48% of all TTO's (To Take Out drugs) were dispensed at ward level with a further 44% being clinically checked on the ward. Consequently, the average turnaround for AMU has reduced significantly, with TTO turn-around time at 48mins compared with 94 mins across the Trust.

3.3.3. HPTP CIPs are also set to deliver £725k with further schemes identified which will see total CIPs exceeding £1m in this financial year. CIP work is ongoing and additional schemes are being worked through to support the Pharmacy CIP work-stream for 19/20.

4.0 Digital Update

4.1. Following many months of planning, the Trust, now joins the rest of the Rotherham health system to be live on the national email platform NHSMail. The migration commenced on the 29th October and entailed the migration of over 5,200 email accounts from the rothgen.nhs.uk to the nhs.net email account. Overall the migration was a success albeit there still remains a number of issues that are still being worked through by the support team and some accounts to transfer as part of the planned mop up exercise.

4.2. The Trust now has electronic radiology ‘results acknowledgement’ live for all radiology results ordered via MediTech. This means that we are no longer printing out radiology reports and results are showing directly in the MediTech EPR. The benefits of this change include improving the speed of access to critical patient data at the point of care reducing the clinical risk and improving the patient experience and is saving around 60 sets of results being printed every day. This also brings additional safety and assurance improvements, as reporting radiologists now know if results have been received and ‘acknowledged’ by the requesting clinician. The project is now starting to move in to the next phase of pathology reporting This will see the solution implemented in Labs and should be going live in Q4 2018/19.

4.3. Patient flow display screen deployment has commenced, and 2 wards have gone live (Kepple and Wharncliffe). The plan is to have this fully completed by end of Q4 2018/19, which will see all wards with patient flow screens available for the use of the clinical teams on the ward. The information presented can cover a number of dashboards depending on the particular wards requirements such as electronic observations and current bed state. Work has also commenced designing and building organisational wide digital patient flow systems for use with site teams.

4.4. The Health Informatics team are progressing with the national pilot in direct systems integration between hospital and RMBC social services, with a plan to be live by Q1 2019/20. This is providing a two-way data feed between the RMBC Social Care system (LiquidLogic) and the Trusts EPR (MediTech) covering notices for admissions, discharges and withdrawals for patients who have a link between the Trust and Social Services.

4.5. Electronic nursing observations (eObs) is now fully live across inpatient wards in both Surgery and Family Health (covering wards B4, B5, Fitzwilliam, Keppel, Sitwell, Wharncliffe, B11). The plan to roll-out across the division of Integrated medicine is underway and planned to be complete by Q4 2018/19.

4.6. Pre-assessment electronic documentation continues in live operation within MediTech for some staff (in Theatres) and an electronic version of Sepsis management is in pilot within UECC, with the aim that this will be available for a wider deployment by Q4 2018/19.
4.7. Following work which has been underway for a number of months, the Corporate Informatics Committee have supported the commitment to stay on MediTech EPR, post the expiry of the current contract in March 2019. The team remain on track to present this case through the appropriate governance arrangements in order for the Board to receive the proposal and recommendation in December.

5.0 Estates & Facilities Update

5.1. Work on the assessment units continues at pace. Enabling works on Ward B10 (Phlebotomy and Discharge Lounge) is due to complete week commencing 26th November, with teams transferring across on the 1st December. This will free up the diagnostic area of SAU to enable the work to commence. The work to clear the asbestos on B1 is now complete and the refurbishment works are now progressing along with the AMU works on Ward B2. Equipment lists are currently being collated and prioritised. Overall, the target date for completion is the beginning of January 2019.

5.2. The Carbon Energy Fund proposal is now at preferred bidder stage following approval of the Outline Business case at the October Board and the agreement to move to the preferred bidder negotiations. The next milestone is to have a full business case, contract and scheme design completed and signed off by the end of February/early March 2019 to allow the scheme to then progress into the construction phase in April 2019.

5.3. Work is now well underway on the moves at Woodside with the Care Coordination Centre (CCC) transferred from UECC to Woodside and the Transport team moved into the UECC in their place. Part of the Integrated Rapid Response (IRR) team and management team is moving this week to the first floor and Outpatients Contact Centre will move to their new accommodation early next week. This will then allow further moves of the IRR team to collocate with existing team and the CCC. Moving dates for the RICC teams (Rotherham Intermediate Care Centre) are being finalised along with any equipment moves.

5.4. New leases and licences are currently being negotiated for New Street (Dental) in Barnsley, Opal Centre (Dental) in Doncaster and rent reviews are currently being negotiated for Woodlands (RDaSH) and the Boots retail unit on the concourse.

5.5. Estates are currently working with the new REWS (Rotherham Equipment and Wheelchair Services) provider to enable a smooth transition regarding them taking over occupation of the existing building when the contract transfers on the 1st February 2019.

5.6. The Trust is currently working with the CCG on the feasibility of what services could potentially be relocated to RCHC (Rotherham Community Health Centre) in order to ensure appropriate utilisation of the facility and to determine the cost of refurbishing vacant areas to suit individual service needs, and a proposal will be available in December.

Chris Holt
Deputy Chief Executive / Director of Strategy & Transformation
November 2018
## Integrated Performance Dashboard (November 2018)

### Key Performance Indicator

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Target</th>
<th>Performance</th>
<th>Trend</th>
<th>Benchmark</th>
<th>Data Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1 A&amp;E % Left without being seen</td>
<td>Sep-18</td>
<td>5.00%</td>
<td>5.79%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2 IP Friends &amp; Family Test (% Positive)</td>
<td>Oct-18</td>
<td>95.0%</td>
<td>97.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C3 % LAC assessments reported &lt;20 days</td>
<td>Oct-18</td>
<td>95%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4 New Complaints per WTE</td>
<td>Oct-18</td>
<td>7.6</td>
<td>4.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E1 Ambulance Turnaround Times % &gt; 60 mins</td>
<td>Sep-18</td>
<td>0.0%</td>
<td>1.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E2 Cancelled Operations</td>
<td>Oct-18</td>
<td>0.8%</td>
<td>0.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E3 Delayed Transfer of care</td>
<td>Oct-18</td>
<td>3.5%</td>
<td>4.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E4 Dementia Assessment</td>
<td>Sep-18</td>
<td>90.0%</td>
<td>75.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E5 Hip Fracture Best Practice Compliance</td>
<td>Sep-18</td>
<td>65.0%</td>
<td>93.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E6 Mortality (HSMR Rolling 12 Month)</td>
<td>Aug-18</td>
<td>100</td>
<td>104.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E7 Stroke: admitted to ward within 4 hours</td>
<td>Oct-18</td>
<td>60.0%</td>
<td>47.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R1 Urgent Care (4 Hour)</td>
<td>Oct-18</td>
<td>95.0%</td>
<td>88.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R2 Cancer Standards 62 Day</td>
<td>Sep-18</td>
<td>85.0%</td>
<td>86.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R3 Cancer Standards 62 Day Screening</td>
<td>Sep-18</td>
<td>90.0%</td>
<td>88.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R4 Diagnostics (DM01)</td>
<td>Oct-18</td>
<td>1.0%</td>
<td>0.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R5 18 weeks (RTT Incomplete)</td>
<td>Oct-18</td>
<td>92.0%</td>
<td>94.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R6 e-Referral Slot Issues Rate</td>
<td>Sep-18</td>
<td>4.0%</td>
<td>4.74%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S1 Access to Antenatal Services within 90 days</td>
<td>Oct-18</td>
<td>90.0%</td>
<td>93.0%</td>
<td></td>
<td>TBC</td>
</tr>
<tr>
<td>S2 C.Diff incidence rate per 100,000 bed days</td>
<td>Oct-18</td>
<td>12.9</td>
<td>9.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3 Emergency Caesarean Section Rate</td>
<td>Oct-18</td>
<td>16.5%</td>
<td>15.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S4 Harm Free Care</td>
<td>Oct-18</td>
<td>95.0%</td>
<td>94.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5 MRSA bacteraemia rate per 100,000 bed days</td>
<td>Oct-18</td>
<td>0.6%</td>
<td>1.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S6 Potential under reporting of incidents</td>
<td>Oct-18</td>
<td>43.3%</td>
<td>35.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S7 Readmissions (Non Elective 28 day)</td>
<td>Sep-18</td>
<td>13.3%</td>
<td>12.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S8 VTE Assessment Completion %</td>
<td>Sep-18</td>
<td>95.0%</td>
<td>96.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W1 Incident Reporting Culture - % Incidents Severe</td>
<td>Oct-18</td>
<td>0.35%</td>
<td>0.21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W2 Variance from Plan</td>
<td>Oct-18</td>
<td>0.0%</td>
<td>0.33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W3 Proportion of Temporary Staff</td>
<td>Oct-18</td>
<td>4.99%</td>
<td>7.20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W4 Sickness Rates (12 Month Rolling)</td>
<td>Oct-18</td>
<td>3.95%</td>
<td>4.17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W5 Staff Turnover</td>
<td>Oct-18</td>
<td>0.88%</td>
<td>0.41%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Top Achievements

- **18 weeks (RTT Incomplete)**
  - Performance for October has shown a slight improvement on September as the elective activity begins to recover following summer. Performance for September was the 6th best and as the activity continues to pick up in the coming months so will performance and ranking.

### Most Improved

- **Hip Fracture Best Practice Compliance**
  - Performance for September has demonstrated continued excellence on the trauma pathway. This raises the 12 month rolling performance to 81% (15th best nationally).

### Key Concerns

- **% LAC assessments reported <20 days**
  - The performance in completion of Initial Health Assessments for Looked After Children has risen to 50% but a backlog of assessment short of the standards required.

### Most Deteriorated

- **Cancelled Operations**
  - The rate of cancelled operations has continued to improve and is 61% lower than April 2018. This level of performance is one of the lowest cancellation rates in the country.

### In Month Activity (M7)

<table>
<thead>
<tr>
<th>In Month Activity (M7)</th>
<th>YTD Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan</strong></td>
<td><strong>Actual</strong></td>
</tr>
<tr>
<td>Elective Inpatient</td>
<td>473</td>
</tr>
<tr>
<td>Elective Day case</td>
<td>2,369</td>
</tr>
<tr>
<td>Non Elective</td>
<td>2,207</td>
</tr>
<tr>
<td>ED Attendance</td>
<td>8,469</td>
</tr>
<tr>
<td>Outpatient New</td>
<td>5,144</td>
</tr>
<tr>
<td>Outpatient FU (CL)</td>
<td>9,222</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>4,748</td>
</tr>
<tr>
<td>Adult Critical Care</td>
<td>336</td>
</tr>
<tr>
<td>Paediatric Critical Care</td>
<td>418</td>
</tr>
<tr>
<td>Assessments</td>
<td>976</td>
</tr>
</tbody>
</table>

### Outcomes

- **Cancer 62 Day**
  - Following three successive quarters of under performance TRFT met the cancer 62 day standard for quarter two. A standard met by only 30 other trusts.

- **Diagnostics DM01**
  - Whilst performance remains compliant with the national standard and TRFT is actively supporting other organisations with endoscopy, a backlog in sleep studies has resulted in 34 breaches of the 6 week waiting time standard. Actions are in place to manage the backlog but this is an area of concern.

- **Delayed Transfer of Care**
  - The number of patients experiencing delays to their transfer of care has continued to be higher than target levels for 3 successive months. This deterioration is an area for concern particularly noting the challenging demand expected for winter.
### Appendix 1  Stroke Metrics 2018/19

<table>
<thead>
<tr>
<th>METRIC</th>
<th>Target</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>YTD 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Stroke patients who spend at least 90% of their time on a stroke unit</td>
<td>&gt;= 80%</td>
<td>23/36</td>
<td>23/25</td>
<td>33/37</td>
<td>33/39</td>
<td>33/39</td>
<td>28/37</td>
<td>30/36</td>
<td>201/244</td>
</tr>
<tr>
<td>% of non-admitted higher risk TIA cases who are treated within 24 hours of first contact with any healthcare professional</td>
<td>&gt;= 60%</td>
<td>60%</td>
<td>70%</td>
<td>66%</td>
<td>75%</td>
<td>62%</td>
<td>64%</td>
<td>66%</td>
<td>63%</td>
</tr>
<tr>
<td>% of People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital</td>
<td>&gt;= 90%</td>
<td>9/15</td>
<td>7/10</td>
<td>2/3</td>
<td>6/8</td>
<td>8/15</td>
<td>9/14</td>
<td>4/6</td>
<td>45/71</td>
</tr>
<tr>
<td>Proportion of patients presenting with stroke with AF anti-coagulated on discharge</td>
<td>&gt;= 60%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within one hour of hospital arrival</td>
<td>&gt;= 50%</td>
<td>44%</td>
<td>45%</td>
<td>58%</td>
<td>59%</td>
<td>60%</td>
<td>38%</td>
<td>58%</td>
<td>52.0%</td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within 24 hrs of hospital arrival</td>
<td>&gt;= 100%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>94%</td>
<td>99%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke</td>
<td>&gt;= 40%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of patients and carers with joint care plans on discharge from hospital</td>
<td>&gt;= 85%</td>
<td>8/8</td>
<td>7/7</td>
<td>3/3</td>
<td>6/6</td>
<td>5/5</td>
<td>8/8</td>
<td>10/10</td>
<td>47/47</td>
</tr>
<tr>
<td>Proportion of stroke patients that are reviewed six months after leaving hospital</td>
<td>&gt;= 95%</td>
<td>91%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98.86%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of patients supported by a stroke skilled ESD team</td>
<td>&gt;= 40%</td>
<td>19%</td>
<td>52%</td>
<td>64%</td>
<td>52%</td>
<td>30%</td>
<td>34.4%</td>
<td>28.1%</td>
<td>39.2%</td>
</tr>
<tr>
<td>% of patients who receive thrombolysis following an acute stroke</td>
<td>&gt;= 11%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5%</td>
<td>10.0%</td>
<td>5.3%</td>
<td>5.1%</td>
<td>5.3%</td>
<td>4.71%</td>
</tr>
</tbody>
</table>
### Appendix 2 - September Tumour Site Breakdown*

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>62 Day from 2ww Target 85%</th>
<th>62 day CUG Target TBC</th>
<th>62 Day Screening Target 90%</th>
<th>31 Day 1st Treated Target 96%</th>
<th>31 Day Subsequent Surgery Target 94%</th>
<th>31 Day Subsequent Drug Target 98%</th>
<th>31 Day Subsequent Palliative Target TBC</th>
<th>2WW Target 93%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
</tr>
<tr>
<td>Acute Leukaemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Brain/Central Nervous System</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Childrens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecological</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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</tr>
<tr>
<td>Haematological</td>
<td>60.0%</td>
<td>60.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Head and Neck</td>
<td>44.4%</td>
<td>44.4%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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<tr>
<td>Lower Gastrointestinal</td>
<td>78.6%</td>
<td>73.3%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>50.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Lung</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
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</tr>
<tr>
<td>Other</td>
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</tr>
<tr>
<td>Sarcoma</td>
<td>50.0%</td>
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<td>100.0%</td>
<td>100.0%</td>
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</tr>
<tr>
<td>Skin</td>
<td>100.0%</td>
<td>100.0%</td>
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<td>100.0%</td>
<td>100.0%</td>
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<tr>
<td>Testicular</td>
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<tr>
<td>Upper Gastrointestinal</td>
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<td>91.7%</td>
<td>84.6%</td>
<td>100.0%</td>
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<tr>
<td>Urological</td>
<td>87.9%</td>
<td>87.9%</td>
<td>64.3%</td>
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*Pre-validation - subject to change
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**Admitted** 90%  **Non Admitted** 95%  **Incomplete** 92%
## Diagnostics (DM01) - Patients Still Waiting at Month End
### October 2018

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## Agenda item
431/18(a)

## Report
Quality Report

### Executive Lead
Angela Wood, Interim Chief Nurse  
Callum Gardner, Interim Medical Director

### Link with the BAF
BAF: B1, B4, B7  
Corporate Risk Register: 3908, 4733, 4174, 4080

### Purpose
<table>
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<th>Decision</th>
<th>To note</th>
<th>Approval</th>
<th>For information</th>
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### Executive Summary
**Executive Summary**
This report is provided to enable the Board Members to summarise a set of quality indicators and to provide assurance to the Board of Directors.

The majority of quality indicators for this month are static or improving including harm free care scores, hospital acquired infection rates, mortality, complaints responsiveness and Friends and Family scores.

Challenges remain in relation to achievement of Initial Health Assessments for Looked After Children, Mortality Reviews and nurse staffing.

The Mortality Review process will be picked up under a separate agenda item.

### Recommendations
It is recommended that the Board of Directors note the contents of the report and endorse the ‘Safe and Sound’ Initiative.

### Appendices
1. Harm Free Care  
2. Hospital Acquired Infections  
3. Dementia, Delirium and Patient-centred Care  
4. Patient Equality and Inclusion  
5. Nurse Staffing Report
1.0 Patient Safety

1.1 Harm Free Care – The overall Trust score for October 2018 is 94.40% a slight increase from 94.19% in September 2018. This continues to be above the national average score which is currently at 94.12%. The breakdown of the scores shows that the acute areas had a harm free score of 96.82% with 92.42% for the community. The increase reflects a slight decrease in pressure ulcers and new catheter related urinary tract infections. See Appendix 1.

1.2 Hospital Acquired Infection - The Trust continues to monitor and report all hospital acquired infections as shown in Appendix 2 with no notable areas of concern. The first influenza case for this season has been reported in November.

1.3 Looked After Children (LAC) - The number of Initial Health Assessments (IHA) completed within 20 working days (statutory) has increased between September (36%) and October (50%). 28 IHAs were completed in October, of which 14 were within 20 working days.

1.4 Mortality – It is encouraging to report that the Trust position on 12-month rolling HSMR has continued to remain static, in line with the national static picture. However, it is important to make improvements rather than continue to remain in the same position each month. The current position (Sep17 to Aug 18) is that our HSMR sits at 104, which is the same position as last month’s figure. The national figure has been rebased to 99 this month, which is also static; as such, the Trust remains in a good position. SHMI is published as 106, which is an improvement on the last rebasing figure.

2.0 Patient Experience

2.1 Complaints - The Trust received 100 concerns (77 in September) and 18 formal complaints (31 in September) in the month of October. 42 complaints were closed of which 8 were local resolutions meetings. Complaints responded to within the agreed timescale was 97% which is an improvement from 87% in September.

The one case under investigation with the Parliamentary and Health Service Ombudsman (PHSO) was closed. The recommendation of the PHSO was not to uphold the complaint in respect of TRFT.

2.2 Friends and Family Test (FFT) - The Trust FFT positive score for October is 97.3% for inpatients (95.3% in September), and 97.9% for day case (99.5% in September). The combined national average for these two areas remains at 96%. Maternity services achieved 98.4% in October (99% in September / 96% national average), 96.7% for outpatients (97.3% in September / national average 93%). The Urgent and Emergency Care Centre achieved 93.1% against a target of 85% in October (88.5% in September / national average 86%). The Community positive score for October is 92.8% against a target of 95% (97.8% in September / national average 96%).

2.3 Dementia, Delirium and Patient-centred Care – Progress is monitored monthly via the Dementia, Delirium and Patient-centred Care Group, led by the Associate Medical Director for Person-Centred Care and Innovation. See Appendix 3 for details of key achievements in October.

2.4 Patient Equality and Inclusion – The Trust supports and promotes appropriate care for patients with protected characteristics on a daily basis. It has been identified that provision of this support, monitoring and reporting needs to be strengthened. See Appendix 4 for further details.

3.0 Clinical Effectiveness

3.1 Nurse Staffing - There has been an increase in Registered Nurse fill rates on both days and nights when compared to those for September. There has been a small reduction in Healthcare Support Worker shift fill rates on both days and nights in October. Please see Appendix 4 for details.

The overall vacancy rate has slightly reduced during October 2018; the largest number of vacancies continues to be in the Division of Medicine. Recruitment events took place during August and September particularly aimed at nurses due to qualify in March 2019. 26 conditional offers have been made.

3.2 CQUIN - Most of the CQUIN programme is now on track, however further focused work is required on the specific schemes identified. The Interim Chief Nurse is discussing this with the relevant Executive Director and supporting a recovery plan.
3.2.1 The income for 2018/19 for CQUIN is £3,852,487 and Local Incentive Schemes is £1.2m.
3.2.2 Quarter two data submission has occurred.
3.2.3 Progress is currently being made with all but two of the CQUIN schemes (Sepsis and Alcohol & Tobacco). These two schemes, have been discussed with the Interim Medical Director to enable him to provide further leadership support to these areas and recovery plans are being developed.

3.3 **Research & Development (R&D)** – Research Activity Report - The number of recruits into clinical research studies on the National Institute for Health Research (NIHR) Clinical Research Network portfolio at The Rotherham NHS Foundation Trust is 903, including 434 for Yorkshire Health Study, against a target of 550 for the financial year 2018/19 [data cut 12 November 2018, taken from NIHR].

There are 90 studies that are currently active (recruiting or in follow up), with 10 new studies in set up including 2 commercially sponsored studies.

Current funding for R&D includes the Clinical Research Network 17/18 allocation of £218,780, £20 000 Research Capability Funding and commercial and non-commercial research income of £42 074 in the financial year 18/19 to date.

4.0 **Quality Developments**

4.1 Quality Governance is the overarching framework which provides assurance on compliance with standards and statutory obligations, continuous quality improvement and enables a risk and escalation process.

4.2 To allow delivery of this and to provide a coherent and consistent approach a Quality Framework entitled ‘Safe and Sound’ has been developed which will be supported by a Quality Strategy.

4.3 The Framework is identified below:

![Safe & Sound Framework](image)

5.0 **Conclusion**

5.1 The majority of areas are reporting similar performance to last month with some minor variation.

5.2 The Interim Medical Director and Interim Chief Nurse have reviewed the current governance and patient safety structure, to ensure that robust governance and scrutiny processes are in place to support quality. This has resulted in a ‘Safe and Sound’ Quality Governance & Patient Safety Culture Initiative being developed.
Appendix 1

'Harm Free' Care

Pressure Ulcers (All)– Grade 2-4

VTE Assessment & Prophylaxis
Hospital Acquired Infections

- The 2018/19 trajectory is for zero cases of Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia. The Trust continues to report 1 hospital acquired case from April.
- Blood culture contamination: reduction in blood culture contamination is being monitored via the Infection Prevention and Control Committee. The national benchmark for blood culture contamination is a maximum of 3%; TRFT are reporting 4.13% for September (4.12% in August). A review of line colonisation versus line contamination is being completed to ensure the Trust is only reporting contaminated samples. The numbers reported are relatively small so only a couple of cases can impact on the overall monthly figure.
- Clostridium difficile infection: The 2018/19 hospital trajectory is 25 cases. There have been 6 hospital acquired cases under the 2018/19 Public Health England (PHE) reporting algorithm which is what will be reported nationally.
- Gram negative bacteraemia: National mandatory surveillance of gram negative bacteraemia is for the specific organisms of E.coli, Klebsiella species and Pseudomonas aeruginosa. No trajectory for providers was set but CCG’s were challenged to reduce cases by 2020 within each CCG by 50%.

Q1-11 hospital acquired cases (50 community acquired cases)
Q2-11 hospital acquired cases (56 community acquired cases)
Q3- 2 cases to date. (22 community acquired cases to date)

There are a number of risk factors for gram negative bacteraemia with the best recognised being urinary catheterisation. A review of each case includes checking if the patient is under the care of the Continence team and very few of the cases identified through the Rotherham Microbiology laboratory have been under the team’s care.

- Tuberculosis (TB) – All patients and staff that were potentially exposed to TB from the three unconnected patients diagnosed after admission have been contacted by post with appropriate follow by the TB nurse specialist in line with NICE guidance. Confirmation is awaited from the PAM occupational health providers that all staff reviews are complete and that no further action is currently required. Following a shortage of TB vaccination there is an unknown number of staff who have not received occupational vaccination, the PAM group have been informed that vaccine is now available so they can review records and determine who requires the vaccine, the IPC team and TB nurse specialist are awaiting confirmation of when vaccination will commence.

- Influenza (Flu) - The annual flu season covers Q3 and Q4. The current levels reported within the region are as expected at the beginning of the season and are low. All positive cases identified from in-patients will be reported to PHE as TRFT is a voluntary sentinel reporting site. Point of care testing for flu in the UECC department is planned for this year to support rapid identification, effective isolation where indicated and to improve patient flow. Staff vaccination plans are fully in place using the recommended quadrivalent vaccine and vaccination has commenced with 56% of front line staff vaccinated by the end of week 1 in November.

- Norovirus and Rotavirus - The winter months are more likely to see cases of gastroenteritis with the main viral causes of Norovirus or Rotavirus. These are highly infectious with rapid spread once introduced into a populated area such as a hospital ward. Prompt isolation and cohorting of symptomatic or incubating people is required along with scrupulous hand hygiene and environmental cleaning in order to reduce onwards spread.

- Endophthalmitis-Approximately 250 intravitreal injections are carried out on a weekly basis with very low infection rates. Two infections were seen recently within two weeks of each other which is a rare occurrence. The investigation didn’t identify any links between the two cases and there were no concerns regarding practice and quality of care. Public Health England were informed and were not aware of any other cases in the region.
Dementia, Delirium and Patient-centred Care

- A further frailty nurse specialist has been recruited to the team. All new appointees will start work over the next couple of months.

- Early results from the National Audit of dementia have shown that as an organisation we are performing within the expected range for multidisciplinary working, those receiving person-centred care and wards being perceived as able to provide good care to people living with dementia but has fallen below expected levels in relation to dementia and delirium assessments. The audit was completed before the introduction of the new assessment documents on AMU which place this section in a more prominent position.


- The Associate Medical Director for Person-Centred Care and Innovation is leading a South Yorkshire trainee session in collaboration with the RCP focusing on the recently published NICE guidance on Tuesday the 13th of November in Sheffield.

- The Associate Medical Director for Person-Centred Care and Innovation has submitted a charity application for a tepee to support patient, carer and staff experience in the hospital over the winter.

- The Associate Medical Director for Person-Centred Care and Innovation chaired a national webinar discussing the new NICE guidance for dementia in collaboration with the Y&H Clinical Network on the 18th of October.

- Unfortunately, a problem with data collection in relation to dementia and delirium assessments has been identified and our performance is 70% rather than 90% as previously reported. Dr Kersh is meeting with relevant people to investigate and work on improving performance.
Patient Equality and Inclusion

The Trust has statutory obligations under the Equality Act 2010 protecting the equality, diversity and inclusion of its staff and patients. The public sector equality duty (PSED) is the requirement that public sector bodies have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct that is prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The Trust supports and promotes appropriate care for patients with protected characteristics on a daily basis through trust wide activity and the application of reasonable adjustments. Some of the activity that occurs across the Trust in this area includes:

- Analysis and publication of the Trust’s Patient Equality Data
- Interpreting support for patients who are deaf or hard of hearing, patients from black and minority ethnic communities, particularly those who do not speak English sufficiently, to discuss and understand their care.
- Care provision for patients with dementia involving social services, primary care, community hospitals and Age UK, Dementia Action Alliance, Alzheimer’s Society and others.
- Provision of Sexual health clinics in the local community to support patients
- Recording incidents using Datix to identify if a patient’s care has been affected; for example, monitoring of incidents involving patients with learning disabilities.
- Provision of safeguarding training to staff.
- Measures taken to improve the safe provision of care for patients lacking in mental capacity according to the Mental Capacity Act (MCA) 2005.
- Individualised care plans and hospital passports used for patients with complex needs.

It has been identified that provision of this support, monitoring and reporting needs to be strengthened, this will be enabled by:

- Continuation of the Trust Equality Inclusion Group
- Development of a Trust Patient and Public Involvement Strategy
- Recruitment of a Patient Engagement and Inclusion officer
- Involvement with local 3rd sector agencies and Healthwatch
Appendix 5

Nurse Staffing Report

1. Registered Nurse/Midwife (RN/M) shift fill rates (daytime) were 95.2% in October 2018 compared to 90.6% in September 2018 and 95.6% on nights compared with 94.7%. Healthcare Support Worker (HCSW) fill rates were 102.7% on days compared with 106.1% in September and for nights were 108.7% compared with 111.2%

The improvement in RN fill rates can in part be attributed to the ward and staffing reconfigurations which took place in the Division of Medicine during July 2018. The revised planned staffing has been amended on the roster templates to reflect the reconfigurations and as a result fill rates have improved. In addition, actual staffing figures for Unify are now being collected from e-Roster for the Division of Medicine. At present the data is also collected manually and being manually validated to ensure data accuracy.

2. Five in-patient areas had Registered Nurse fill rates (days) below 90%. These were A1, A5, A7, Fitzwilliam and Keppel. Of these, one had a day time shift fill rate less than 80% and this was Keppel at 74.5% compared with 68.3% in September.

3. One area had a fill rate below 80% on nights this was Keppel at 77.9%.

4. There were 9 shifts in the month with over 50% of RNs on duty being within the 12 month preceptorship period compared to 0 in September. There has been an increase in the percentage of Registered Nurses/Midwives flexible staffing (internal bank) in the Division of Medicine and a reduction in the Divisions of Surgery and Family Health resulting in an overall increase. RN/M agency usage has reduced in the Divisions of Medicine and Surgery and increased slightly in the Division of Family Health October. The percentage of shifts not staffed to plan has reduced to 17.84% in October as compared with 23.59% in September.

5. There were no internal staffing never events relating to one Registered Nurse on duty during October 2018.

6. In the Community, sickness absence has reduced with 4.1% currently absent from work compared with 8.2% last month. The majority of which are long term sickness, maternity related sickness and colleagues having planned surgery/treatment. There was 0.5% of District Nursing day shifts below plan, the number of nurses that this equates to is 0.1% of nurses against plan, which represents an improved position compared with September.

7. Care Hours per Patient Day (CHpPD) is a metric introduced following Lord Carter’s review of efficiency in the NHS[1] to record a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. During October the overall actual CHpPD was 7.17 as compared with 7.2 in September.

8. The overall Registered Nurse and HCSW vacancy remains in a negative position at -169.88 wte compared with -175.33 wte last month. The position when recruitment plans are included is -64.34 wte as at 31 October 2018 compared with -106.33 wte at 30 September 2018.

The overall band 5 vacancy remains in a negative position of -80.18 wte compared with -80.74 wte at 30 September 2018. There are 33.83 wte band 5s in the recruitment process.

Band 2 vacancy is in a negative position at -44.01 wte. There are 29.51 wte band 2s in the recruitment process.

The large number of vacancies continues to pose a challenge across the divisions to ensure safe, effective and sustainable staffing. The substantive workforce is supported by bank and agency staff to ensure safe and effective staffing. There is a correlation between safe staffing and patient outcomes and this is monitored on a daily basis by the Matrons and all incidents reported by the trusts Datix system.

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9. A recruitment open day took place on 18 August 2018 particularly aimed at nurses due to qualify in March 2019. 18 conditional offers were made on the day and further interviews took place on 19 September 2018 with a further 8 conditional offers made. Colleagues are maintaining regular contact with those offered posts in an attempt maintain their interest in TRFT as their preferred place to work and to convert the conditional offers to actual starters.
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<th>431(b)/18</th>
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<tr>
<td>Report</td>
<td>Operational Performance Update</td>
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<tr>
<td>Executive Lead</td>
<td>George Briggs Chief Operating Officer</td>
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<td>B1 B2 B4 and B5: Q3 Risk scores for the above have remained static.</td>
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<td>Sustainability and Transformation Standards</td>
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<td>(including reason for the report, background, key issues and risks)</td>
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<td>- Emergency 4-hour Access target –October 2018 position: 88.7% the submitted trajectory was 90.%. The year to date position is 88.1% up from the previous month.</td>
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<td>- The Rotherham Cancer 62 Day position for quarter 2 2018 is 85.7% un-validated against the 85% compliance target.</td>
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<td>- Diagnostics (DMO1) – the un-validated position for DMO1 for October 2018 is 0.90% this reflects 33 breaches.</td>
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<td>- 18 week RTT incomplete pathway – un-validated position for October 2018 is sustained at 94.4%</td>
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1.0 **Introduction:**

This paper covers key operational indicators, an overview of performance in October 2018, summarising headline progress and actions being taken to address areas of concern and deliver improvements.

2.0 **Four-hour emergency access target**

2.1. October 2018 performance against the 4-hour access target was 88.7% this shows an improvement in the last month. The agreed local trajectory is 91% we are below our locally agreed trajectory however I have included a focused target based on the team’s recovery plans.

The year to date position is at 88.1% up from 87.4% (as at end of October 2018).
2.2 Discharge timings

Discharge Total 14.40% Nos Discharged 16494 Nos Discharged pre noon 2372

2.3 Overview of UECC activity and performance

Performance has been reliant upon patient flow across wards as well as staffing in primary care and the ED. Over the last 6 weeks a number of wards have been closed due to confirmed Norovirus with up to 27 beds closed and 2-6 empty. We have had 1 case of confirmed flu who was correctly identified and segregated. The activity has remained on plan and within expected parameters. The UECC reception staff are undertaking training in patients and customer support and awareness to interact and deal with complex patient support issues.

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</table>
The ability to get GP cover for shifts has shown in the fill percentage which has deteriorated within the UECC GP services over the last month at 63%. Other grades have remained consistent.

The number of breaches as below show the marked difference in numbers across specialties with high numbers in red.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>182</td>
<td>146</td>
<td>115</td>
<td>138</td>
<td>135</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>50.0%</td>
<td>40.9%</td>
<td>31.8%</td>
<td>34.2%</td>
<td>35.8%</td>
<td>26.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>16.7%</td>
<td>66.7%</td>
<td>33.3%</td>
<td>20.0%</td>
<td>30.0%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Medicine</td>
<td>120</td>
<td>90</td>
<td>88</td>
<td>92</td>
<td>108</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>57.1%</td>
<td>49.2%</td>
<td>42.9%</td>
<td>41.6%</td>
<td>50.7%</td>
<td>37.1%</td>
</tr>
<tr>
<td>Surgery</td>
<td>28</td>
<td>22</td>
<td>13</td>
<td>21</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>45.2%</td>
<td>34.4%</td>
<td>17.1%</td>
<td>30.0%</td>
<td>16.4%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>17</td>
<td>12</td>
<td>8</td>
<td>12</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>60.7%</td>
<td>44.4%</td>
<td>29.6%</td>
<td>38.7%</td>
<td>24.0%</td>
<td>26.9%</td>
</tr>
<tr>
<td>Paeds</td>
<td>10</td>
<td>11</td>
<td>0</td>
<td>11</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>24.4%</td>
<td>22.0%</td>
<td>0.0%</td>
<td>19.3%</td>
<td>8.3%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>30.8%</td>
<td>20.0%</td>
<td>20.0%</td>
<td>0.0%</td>
<td>13.6%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Stroke</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>50.0%</td>
<td>25.0%</td>
<td>0.0%</td>
<td>16.7%</td>
<td>50.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>ENT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Haematology</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Engage with the NHS Improvement Academy.
To develop a longer paced continuous improvement program. Discussion and the planning for such a program has commenced the Academy have agreed to undertake an initial diagnostic across UECC with plans to then roll it out across the patient pathways.

Winter team
A team of 8-10 staff have been recruited to develop the winter team.
The team is in place from November 2018 acting as delivery and support for key actions and deliverables reinforcing actions and driving changes in processes, the focus will need to be on 5-7 key actions over the medium term taken from the actions being developed.

The GM for medicine has agreed to undertake the lead role full time to drive the team and the site, focusing on delivery of the short term actions. Executive colleagues will be identified to support the key medium term actions, within agreed timescales.

Annual leave templates have been distributed across all operational areas and returned to the operational groups the winter team are now clarifying gaps and areas of capacity, a copy of the CSS template has been included in FPC papers for reference.

### 3.0 Cancer

#### 3.1. The Rotherham 62-day cancer position for Quarter 2 is 85.2%. Quarter 2 has achieved the national 85% compliance target

<table>
<thead>
<tr>
<th>Target</th>
<th>JUL 2018 Validated</th>
<th>AUG 2018 Validated</th>
<th>SEP 2018 Validation ongoing</th>
<th>Q2 2018/19 TO DATE</th>
<th>Operational standard (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2ww</td>
<td>93.8</td>
<td>93.9</td>
<td>94.1</td>
<td>93.9</td>
<td>93</td>
</tr>
<tr>
<td>2ww Breast Symptoms</td>
<td>89.8</td>
<td>94.2</td>
<td>88.9</td>
<td>90.9</td>
<td>93</td>
</tr>
<tr>
<td>62 Day from GP</td>
<td>84.4</td>
<td>83.8</td>
<td>85.2</td>
<td>82</td>
<td>86.2</td>
</tr>
<tr>
<td>62 Day Consultant Upgrade</td>
<td>88.1</td>
<td>89.7</td>
<td>79.7</td>
<td>82.9</td>
<td>92.2</td>
</tr>
<tr>
<td>62 Day from Screening</td>
<td>95.7</td>
<td>95.7</td>
<td>100</td>
<td>100</td>
<td>88.2</td>
</tr>
<tr>
<td>31 Day First Treatment</td>
<td>98.2</td>
<td>97.8</td>
<td>98.9</td>
<td>98.3</td>
<td>96</td>
</tr>
</tbody>
</table>

3.2 The current forecast position against the 62-day cancer pathway is that Month 7 will be at 84% compliance. The position is complex and reliant upon a number of factors.

Summary – Q2 was achieved with quarter 3 now being the area of continued focus.
4.0 18 Week RTT Incomplete

4.1 The un-validated position for September 2018 is 94.4% against the 92% 18 week RTT Incomplete target. This represents a continued strong operational performance against this performance metric.

4.2 This puts TRFT in the upper quartile performance in the country. Over 60% of Trusts are failing the standard nationally.

4.3 Gynaecology

Gynaecology is the main area of concern within our 18-week program. 196 patients were showing at 18 weeks plus with a performance of 84.4%. The service has implemented the following actions to ensure recovery:

- The additional full day list has continued on alternate weeks within our theatres which has maintained the long waits without deterioration but has not markedly reduced the numbers.

- Theatre staff have commenced additional theatre sessions.

- The waiting list for Gynaecology patients is now showing 146 patients at 90.2%

Treated /seen within 18 weeks

<table>
<thead>
<tr>
<th>Treatment Function</th>
<th>Recommended Technical Adjust</th>
<th>% within 18 weeks</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>March</td>
<td>Sept</td>
</tr>
<tr>
<td>General Surgery</td>
<td>518</td>
<td>92.9%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>229</td>
<td>97.5%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td></td>
<td>93.4%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td></td>
<td>93.8%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
<td>99.9%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>74</td>
<td>94.6%</td>
<td>93.9%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>30</td>
<td>88.2%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td>94.7%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>46</td>
<td>93.4%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>157</td>
<td>96.3%</td>
<td>97.8%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>47</td>
<td>77.4%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
<td>91.9%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>100.0%</td>
<td>99.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>97</td>
<td>87.6%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>98.7%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Total</td>
<td>1198</td>
<td>93.2%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

4.4 Cancelled operations October 2018
October 15 Cancelled operations down from 26 in September

5.0 6 Week Wait Diagnostic Tests

5.1 The un-validated position for DMO1 for October 2018 is 99.1%, which shows 33 people waited 6 weeks or longer for sleep diagnostic tests. These patients who have breached due to staff issues. This is still within the national target but the team are keen to support respiratory to resolve the issue.

6.0 Improvement Planning

6.1 The Trust has completed the “Action on AE” program with a focus on Home first “Why not today why not now”. Recruitment has commenced this month for therapists and nursing staff.

6.2 Planned Internal Bed reconfiguration update: -

The Acute plans centre on creating a Surgical Assessment Unit (SAU) on Ward B1 next to AMU and Ambulatory Care, which will allow the closure of Ward B5. The Surgical Team will move the present SAU and admission beds on Ward B5 to Ward B1.

The next phase of the reconfiguration to create the NIV respiratory Assessment area is under development, this phase will create flexibility and control for the medical divisions staff.

7.0 Conclusion

Performance against the 4-hour access standard in October 2018 has been challenged considerably and we are under trajectory. We have seen some failures in performance over the last 2 months, with key operational points of failure around capacity within the ED and increased numbers of medically fit patients. Performance against the DMO1 diagnostic target in month has seen the expected rise in sleep breaches but has remained good.

Performance against the Cancer 62-day target remains challenged as a result of both activity demand and access across a number of pathways delays. Whilst action continues, to achieve quarter 3, this continues to remains a high risk.

Trust performance against the 18-week RTT incomplete target for the month continues to perform well with Gynaecology on track to hit 92% in December 2018.

G Briggs
Chief Operating Officer
22 November 2018
**Board of Directors’ Meeting**  
**27 November 2018**

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>431/18(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Workforce Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Paul Ferrie – Acting Director of Workforce</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B4, B5</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision [ ] To note ✓ Approval [ ] For information [ ]</td>
</tr>
</tbody>
</table>

### Executive Summary
**(including reason for the report, background, key issues and risks)**
- The staff in post figure for October 2018 is 3762.89 whole time equivalent (WTE), an increase of 12.60 WTE compared to September 2018.
- This month’s sickness absence is 4.33% for October 2018, this is 0.38% above the 3.95% target.
- The Trust delivered the PDR operational objective; achieving an overall compliance rate of 92.47% by the end of October; against the target of 90%.
- The Trust improved its overall Mandatory and Statutory Training (MaST) performance is currently 88% against the 85% target.
- National Staff Survey (NSS) launched on the 08 October 2018 there have been issues with NHS Digital and Picker which has resulted in delayed delivery of a number of email surveys. In addition migration to NHS net has created additional challenges. We have a completion rate on just 27% at present.
- The Flu campaign commenced in October, with over 1300 colleagues vaccinated during the first week.

### Recommendations
It is recommended that the Board of Directors note the content of the report.

### Appendices
1. Workforce Report  
2. Workforce Report (5 year plan)
1.0 *Recruitment and Retention*

1.1. Turnover in October 2018 is 0.41% (99.59% retention), 0.15% decrease against October 2017. The Trust’s staff retention rate continues to compare favourably with national benchmarks.

1.2. There were 12.10 WTE Qualified Nurses and 13.20 Newly Qualified Nurses (awaiting registration) appointed in October 2018.

1.3. There were 24 (18.20 WTE) leavers in October 2018, 8 (6.66 WTE) were Nursing & Midwifery followed by 5 (3.93 WTE) Clinical Support Staff.

1.4. National recruitment challenges and the impact this has on the Trust is analysed further at Appendix 1.

2.0 *Sickness Absence*

2.1. The Trust’s sickness absence for October 2018 increased to 4.33% (4.31% Oct 2017), which is above the 3.95% target.

2.2. Short term absence has increased to 1.43% from previous month (1.15%) and long term sickness absence has increased to 2.90% from (2.55%).

3.0 *Mandatory and Statutory Training (MaST)*

3.1 The Trust core MaST compliance rate is 88.44% and remains 3.44% above the Trust target of 85%.

3.2 The table below highlights the Trust’s overall mandatory and statutory core training compliance by division at 05 November 2018.

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>165 Clinical Support Services L3</td>
<td>92.29%</td>
</tr>
<tr>
<td>165 Corporate Operations L3</td>
<td>90.24%</td>
</tr>
<tr>
<td>165 Corporate Services L3</td>
<td>83.79%</td>
</tr>
<tr>
<td>165 Family Health L3</td>
<td>91.83%</td>
</tr>
<tr>
<td>165 Medicine L3</td>
<td>85.33%</td>
</tr>
<tr>
<td>165 Surgery L3</td>
<td>86.83%</td>
</tr>
</tbody>
</table>

3.3 The table below highlights the Trust’s mandatory and statutory core training compliance for each subject by division at 05 November 2018.

<table>
<thead>
<tr>
<th>Division</th>
<th>Conflict Resolution</th>
<th>Equality, Diversified Human Rights -1 Year</th>
<th>Equality, Diversified Human Rights -Non-Specified Renewal</th>
<th>Infection Prevention and Control Level 1-3 Years</th>
<th>Preventing Radicalisation Level 1 &amp; 2 Basic Prevent Awareness -3 Years</th>
<th>Preventing Radicalisation Level 1 &amp; 2 Basic Prevent Awareness -No Renewal</th>
<th>Dementia Awareness -No Renewal</th>
<th>Fire Safety -1 Year</th>
<th>Hand Hygiene -1 Year</th>
<th>Information Governance -1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>165 Clinical Support Services L3</td>
<td>90.28%</td>
<td>95.64%</td>
<td>94.09%</td>
<td>90.21%</td>
<td>91.62%</td>
<td>98.10%</td>
<td>96.76%</td>
<td>85.35%</td>
<td>85.25%</td>
<td>83.82%</td>
</tr>
<tr>
<td>165 Corporate Operations L3</td>
<td>91.81%</td>
<td>97.42%</td>
<td>95.05%</td>
<td>98.49%</td>
<td>73.94%</td>
<td>83.36%</td>
<td>93.05%</td>
<td>87.53%</td>
<td>89.44%</td>
<td>80.89%</td>
</tr>
<tr>
<td>165 Corporate Services L3</td>
<td>85.56%</td>
<td>88.45%</td>
<td>87.73%</td>
<td>88.45%</td>
<td>81.55%</td>
<td>87.73%</td>
<td>83.56%</td>
<td>70.76%</td>
<td>77.26%</td>
<td>84.68%</td>
</tr>
<tr>
<td>165 Family Health L3</td>
<td>91.55%</td>
<td>95.93%</td>
<td>93.58%</td>
<td>97.50%</td>
<td>92.64%</td>
<td>95.46%</td>
<td>97.03%</td>
<td>82.43%</td>
<td>82.43%</td>
<td>84.35%</td>
</tr>
<tr>
<td>165 Medicine L3</td>
<td>83.01%</td>
<td>87.04%</td>
<td>87.04%</td>
<td>95.26%</td>
<td>85.17%</td>
<td>90.38%</td>
<td>90.89%</td>
<td>71.91%</td>
<td>76.94%</td>
<td>82.84%</td>
</tr>
<tr>
<td>165 Surgery L3</td>
<td>85.56%</td>
<td>88.26%</td>
<td>86.03%</td>
<td>94.84%</td>
<td>85.56%</td>
<td>93.19%</td>
<td>52.25%</td>
<td>81.81%</td>
<td>73.71%</td>
<td>87.05%</td>
</tr>
</tbody>
</table>

3.4 Following the publication of the Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018 Intercollegiate Document the training requirements for all positions have been reviewed. This will affect training requirements for both Safeguarding Adult and Preventing Radicalisation.
4.0 PDR

4.1 The PDR compliance level is 92% for the Trust. The table below shows overall PDR compliance by division at 05 November 2018.

<table>
<thead>
<tr>
<th>Division</th>
<th>Assignment Count</th>
<th>Reviews Completed</th>
<th>Reviews Completed %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>880</td>
<td>817</td>
<td>92.84</td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>461</td>
<td>432</td>
<td>93.71</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>235</td>
<td>223</td>
<td>94.89</td>
</tr>
<tr>
<td>Family Health</td>
<td>600</td>
<td>549</td>
<td>91.50</td>
</tr>
<tr>
<td>Medicine</td>
<td>1,020</td>
<td>916</td>
<td>89.80</td>
</tr>
<tr>
<td>Surgery</td>
<td>737</td>
<td>700</td>
<td>94.98</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>3,933</strong></td>
<td><strong>3,637</strong></td>
<td><strong>92.47</strong></td>
</tr>
</tbody>
</table>

5.0 Leadership, Culture and Engagement

5.1 Cohorts 8 and 9 of the LEAD programme were delivered successfully during October as planned. Cohort 10 is fully booked and will take place 26 Nov – 30 Nov. Initial feedback continues to be very positive; evaluation continues to measure impact to individual and team levels.

5.2 The LEAD forum took place in early November, the main feature being a well-received workshop from a Neuro Linguistic Programming (NLP) expert on the subject of ‘Leading Yourself’.

5.3 The Trust’s Management Skills Programme will be launched before Christmas.

5.4 Learning and Development delivered 360 degree appraisal facilitator training on behalf of Health Education England, for colleagues across Yorkshire and the Humber.

5.5 TRFT Health Ambassadors attended a careers event at Dinnington High School during October. Learning and Development invited schools from across Rotherham to the AHP event on 15 October. Support is also planned for local events at Clifton and Brinsworth Academies during November.

5.6 The current Trainee Nurse Associate’s (TNA’s) continue to make good progress. We are currently scoping out for a TNA cohort to start in January 2019 with the University of Sheffield and are currently planning recruitment for this.

5.7 TRFT submitted its Talent 4 Care, Widening Participation and Volunteering 2018/19 data for Quarter 2 as requested by Health Education England (HEE). An Employer Contracting Meeting took place with the latter to consider the strategic planning for the Apprenticeship offering in 2019 – more details to follow.

6.0 Communication & Engagement

6.1 The Communications Team supported a number of teams to recognise national awareness events including the first annual Freedom to Speak Up month, and the first Allied Health Professionals Day. Both of these raised the profile of these key groups of colleagues within the Trust and externally.

6.2 The Trust’s Proud Week took place in early November and included four separate events: Long Service Awards, Volunteer Celebration, Recognition of Learning event and culminated in the Proud Awards ceremony. The whole week was a fantastic celebration of the achievements, hard work and dedication of colleagues, volunteers and partners from across the Trust. The Proud Awards ceremony was held at Magna on 8 November, and saw more than 250 guests in attendance to recognise their colleagues. Proactive communications on all award winners will continue over the coming weeks and months.
6.3 The seasonal Flu campaign commenced on 03 October. The Trust has currently vaccinated 63% of its frontline workforce, the CQUIN target 75%.

6.4 The Trust's approach is to offer vaccination to its entire workforce and is compliant with best practice (NICE guidance 2018). Over 2680 vaccines have been administered to colleagues.

6.5 The National Staff Survey was launched on 08 October. The launch was delayed due to technical challenges outside the control of TRFT. A number of Trusts have been affected and the NHS Survey Co-ordination centre has extended the survey period by a week. This will have some impact on preliminary report finding in the new year. Some Trust colleagues have not received their surveys. This is being addressed on a case by case basis as we are unable to identify due to confidentiality restriction. The HR business partners receive a weekly report on uptake numbers and a series of communications have been issued to encourage participation. A short series of improvement videos are being produced and issued reporting changes since previous surveys. This is being undertaken by the Communication and Graphics team.

6.6 A series of ‘Together We can’ 5 steps toolkit, educational briefings have taken place to support innovation week colleagues to support delivery of the 40 Bright Ideas submissions identified in innovation week.

Paul Ferrie
Acting Director of Workforce
November 2018
Executive Summary

This report considers the current context within which to consider TRFT workforce issues and the baseline position within which future workforce planning activity and considerations need to be set. Current employment and vacancy rates are reviewed, along with previous TRFT leaver rates and patterns and the potential impact of training initiatives in place. The aim is to provide further insights as to what might reasonably be expected to impact upon and happen within the workforce over the 5 year planning period, and the report concludes with a summary of key points and an outline of the next steps required to create the workforce plan.

This summary sets out the main points addressed and findings in each of the sections of the report:

Current Staffing Profile:

- The finance data shows that there is a total ‘budgeted establishment’ of 4,080.7 WTE posts within TRFT, with currently 3,774.8 ‘WTE Staff in Post’. This WTE figure is based on the total WTE worked by all staff, including the combined hours of part time workers who individually work less than a whole WTE unit.

- Of TRFT’s permanent staff, half (50.6%) are contracted to work on a part time basis, which results in a higher figure of individual or ‘headcount’ staff in post. TRFT currently directly employs 4,545 people on substantive contracts, and an additional c.500 ‘bank only’ workers.

- There is an ageing workforce profile across all staff groups with just under half of all permanent staff aged 46 and over. Staff who are in the NHS pension scheme can generally retire from the age of 60 with no actuarial reduction, and some categories (particularly nursing) can retire with full pension at 55 years old. c.977 of our current substantive staff are eligible to retire with full NHS pension benefits (assuming membership) during the lifetime of the 5-year plan; 317 of whom are already over the age of 60.

Vacancy Analysis:

- As at the end of September 2018, TRFT has an overall vacancy level of 305.2 budgeted WTE. Given that c.50% of staff opt to work on a part time basis, the actual numbers of individuals that would need to be recruited to fill this 305.2 WTE gap will be higher than this figure.

- The majority of vacancies are in ‘difficult to recruit to’ national skills shortage roles within the medical and dental, nursing and midwifery and healthcare scientist staff groups, with a high vacancy level also in nursing support worker roles.

- Gaps in staffing are mainly being filled on the basis of bank, agency and locum workers, and by additional sessions being worked by medical and dental staff. However, this is a very costly model and not a stable, reliant or high quality long term solution to staffing, and even with temporary worker support, the WTE staffing level required for registered nursing and midwifery cannot be filled. Additional nursing support workers were required to fill this gap by taking the total numbers over establishment via bank engagements to achieve this.

- The vacancy levels and resultant reliance on additional temporary workers in medical and dental and registered nursing and midwifery will not be resolved by traditional recruitment methods or traditional staffing models, as there are insufficient staff to fill vacancies across the UK.
Whilst there have been additional training places and schemes put in place by the Government/HEE in recent years, these will not be sufficient within the lifetime of the five-year plan to resolve the staffing difficulties. New and extended roles and ways of working, innovative recruitment and improved development and retention will all be key to ensure stable and adequate staffing numbers to provide the delivery of safe care and service continuity.

Leavers Analysis and Trends:

- 1,312 permanent staff have left TRFT in the past 3 years; an average of 437 p.a. Of these, 45% have been aged 51 or over (592 staff), with the largest loss of staff being between the ages of 51-60.

- The most popular reason for leaving was retirement, followed by voluntary resignation to relocate and reasons connected with work/life balance and dependents. Of those who left, the majority moved on to NHS or other public sector employment; over 200 stopped working (mainly due to retirement) and 117 joined the private sector.

- Extrapolating this forward, based on average leavers of 437 p.a., we could expect to lose a further 2,185 staff over the next 5 years. If the previous pattern is replicated with 45% of these being retirees, this would mean that we would potentially lose 983 of our older, and generally most experienced workforce.

Conclusions:

- Following the trajectory of the past three years, we can assume we will need to recruit on average c. 437 substantive staff p.a. due to attrition, just to keep within current (inadequate) staffing levels. This is before any increased service activity levels or business plans that may require additional/ different models of staffing. In addition, we already have 305.9 WTE vacancies in the system.

- We will not be able to recruit to all qualified Medical, Nursing and Healthcare Scientist vacancies/ turnover due to national skills shortages., and will remain reliant on bank and agency temporary worker support

- We can assume from the current profile and previous leaver patterns that our leavers will include a similar proportion (c.45%) of retirements from our older and more experienced workforce, and that the largest losses will be from registered nursing and midwifery, admin and clerical and additional clinical services.

- We will have to develop new and innovative recruitment, development and retention strategies and invest in training for new roles and staffing models to achieve sustainable workforce levels required for safe care and additional activity. We cannot continue with ‘more of the same’.

Next Steps to develop a locally sensitive 5-year workforce plan will need to include working with managers to identify:

- Future workforce requirements to meet service demand and address anticipated challenges
- Learning and development activity, plans and timelines, to establish future staffing pipelines
- Recruitment opportunities, methods and plans to attract greater numbers of applicants
- Retention issues and means to address attrition rates
- Workforce utilisation improvements, e.g. Job planning & e-rostering
- ‘top priority’ service-specific and cross-cutting workforce issues and workable long-term solutions
1. Introduction and Context

This report seeks to establish the current workforce position and profile within TRFT, clarifies some of the main workforce challenges affecting the Trust over the 5-year planning period and initiatives in place to address these. The aim is to provide further insights as to what factors might reasonably be expected to affect the workforce over the 5 year planning period, and the report concludes with a summary outline of the next steps required to create the workforce plan.

The report is divided into the following sections for ease of reference:

- Current baseline and staffing profile
- Vacancy analysis
- Leavers analysis
- Training and development initiatives
- Conclusions
- Next steps

1.1 Workforce Context: Overview of Key Challenges

National Challenges

- National and local skills shortages: Consultants and middle grade medical staffing, Healthcare Scientists, Registered nurses, midwives & health visitors, qualified AHPs including physiotherapists, experienced/trained clinical and nursing support workers.
- Drop in the number of nurse recruits following loss of University subsidy; apprenticeship degree route into nursing still in relatively early stages
- National training programmes for increased medical, nursing and clinical staff underway, but won’t produce the required number of newly qualified recruits to meet UK skills gaps within the next 5 years.
- Impact of Brexit: Fall in the number of registrations to work in UK, and loss of staff across the sector due to potential future uncertainty and failure to meet minimum earnings test

Regional Challenges: Potential Impact of ICS and HSR

- Healthcare policy/ strategy: further development of integrated health and social care policy and localised care affects future service design and delivery of services and skill mix required in both acute and community
- Negative impact on recruitment, retention, staff engagement & morale in services affected by ICS uncertainties: particularly stroke, maternity, gastro, dermatology and pathology
- Agreements in place to restrict use of recruitment and retention premia and hold procurement of equipment during ICS review compounding recruitment and retention issues

Internal Challenges: Recruitment, Retention and Deployment

- Role of DGH, reputation, CQC rating, TRFT employer ‘brand’ and competitor landscape: attractiveness as an ‘employer of choice’
- Agile recruitment methods and flexible working opportunities required to better ‘fit’ candidate needs and expectations:
- Decisions and investment are required to enable TRFT to participate in and benefit from trainee recruitment and development opportunities
• Overseas nurse recruits – previous poor quality and retention rates. May need to look at new markets/partners for the future.
• Ageing workforce profile & anticipated retirements leading to loss of experienced staff. Impact of changing workforce demographic: staff looking for more flexible working and career development
• Overall retention figures are comparatively good but we have a high proportion of potential retirees and high levels of staff dissatisfaction in staff survey and FFT markers.
• Implementation of e-rostering and job planning designed to facilitate improved workforce utilisation and increased productivity, but takes time, resources, training and support to implement in gain full impact

2. Current TRFT Workforce Baseline and Staffing Profile

At the point of writing this report (October 2018), TRFT employs 4,545 ‘substantive’ staff (i.e. excluding NEDs and ‘Bank only’ workers); 2,520 of whom are ‘substantive only’ workers, with the other 2,025 substantive employees also registered to work additional hours on the internal bank. In addition, there are 493 ‘bank only’ non-substantive workers active on the staffing database.

The data used in this analysis is based on the 4,545 substantive staffing figure, which is the actual ‘headcount’ of directly employed substantive staff provided by the ESR payroll system. As such, the staffing numbers are higher than those seen in workforce data generated by the finance system (3,950 WTE), as this measures ‘Staff in Post’ as combined units of WTE only, and does not therefore take account of the number of individual part time workers that make up the overall combined WTE figure.

2.1 Contracted Hours

A breakdown of the contracted hours worked by the current substantive workforce indicates that there are a total of 2,247 full time staff, with 2,298 having part time working arrangements. Part time workers therefore form roughly half of the workforce, and the profile of full time working in each of the divisions is as follows:

Family Health employs more part time workers (66%) than full time, and Medicine also has more part timers (54%) than full timers. In the remaining divisions the workforce is evenly split, but with a slightly higher proportion of full time workers in CSS (51%), Corporate services/operations (54%) and surgery 57%.
To better understand the implications of this level of flexible working, it is helpful to analyse the patterns of working by staff group:

![Staff Group: Working arrangements](chart)

It can be seen from this that part-timers outnumber full-timers in 4 of the 8 main staff groups:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>% staff working part time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and Ancillary</td>
<td>69%</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>56%</td>
</tr>
<tr>
<td>AHPs</td>
<td>53%</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>51%</td>
</tr>
<tr>
<td>Admin and Clerical</td>
<td>49%</td>
</tr>
<tr>
<td>Additional Prof Scientific and Technical staff</td>
<td>30%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>31%</td>
</tr>
<tr>
<td>Medical and Dental staff</td>
<td>33%</td>
</tr>
</tbody>
</table>

This level of flexible working creates additional management responsibilities and pressures and has potentially major implications for future workforce recruitment and utilisation, as more than one individual person is likely to be required to fill each WTE vacancy or carry out each WTE unit of work, and restrictions on staff availability need to be built into team scheduling, e-rostering and job planning.

### 2.2 Age profile

The staff demographics in terms of age profile is presented below by staff group rather than by division, in order to better show the potential effects of future retirements resulting from an ageing workforce across the different professional and occupational areas.

The overall breakdown of current staff ages shows that 2,162 staff (48%) are over the age of 45, with 2,383 staff (52%) aged up to 45, which appears to be a fairly even age split. However, when analysed further by 5 yearly age bands and professional/occupational groups, the patterns indicate that there are categories of workers that are more at risk as a result of an ageing workforce and potential retirements over the next 5 years, and the possible effects of this in skills shortage areas:
Current Staffing by age group:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>&lt;=20</th>
<th>21-25</th>
<th>26-30</th>
<th>31-35</th>
<th>36-40</th>
<th>41-45</th>
<th>46-50</th>
<th>51-55</th>
<th>56-60</th>
<th>61-65</th>
<th>66-70</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>10</td>
<td>19</td>
<td>15</td>
<td>16</td>
<td>18</td>
<td>10</td>
<td>17</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>117</td>
<td></td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>10</td>
<td>4</td>
<td>63</td>
<td>102</td>
<td>95</td>
<td>77</td>
<td>90</td>
<td>120</td>
<td>153</td>
<td>137</td>
<td>58</td>
<td>11  920</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>21</td>
<td>6</td>
<td>47</td>
<td>72</td>
<td>85</td>
<td>96</td>
<td>110</td>
<td>127</td>
<td>165</td>
<td>161</td>
<td>64</td>
<td>14  968</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>51</td>
<td>56</td>
<td>63</td>
<td>54</td>
<td>39</td>
<td>46</td>
<td>44</td>
<td>23</td>
<td>12</td>
<td>1</td>
<td>389</td>
<td></td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>5</td>
<td>3</td>
<td>18</td>
<td>17</td>
<td>19</td>
<td>28</td>
<td>22</td>
<td>45</td>
<td>69</td>
<td>64</td>
<td>45</td>
<td>6  341</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>7</td>
<td>14</td>
<td>16</td>
<td>19</td>
<td>12</td>
<td>10</td>
<td>11</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Medical and Dental Nursing and</td>
<td>4</td>
<td>33</td>
<td>65</td>
<td>42</td>
<td>50</td>
<td>59</td>
<td>54</td>
<td>31</td>
<td>27</td>
<td>19</td>
<td>6</td>
<td>390</td>
</tr>
<tr>
<td>Midwifery Registered</td>
<td>1</td>
<td>75</td>
<td>160</td>
<td>179</td>
<td>159</td>
<td>174</td>
<td>178</td>
<td>209</td>
<td>131</td>
<td>47</td>
<td>6</td>
<td>1319</td>
</tr>
<tr>
<td>Students</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>36</td>
<td>18</td>
<td>304</td>
<td>505</td>
<td>514</td>
<td>500</td>
<td>524</td>
<td>590</td>
<td>699</td>
<td>556</td>
<td>252</td>
<td>47  4545</td>
</tr>
</tbody>
</table>

For the majority of staff groups, retirement without actuarial reduction under the NHS Pension scheme can be taken at 60 years of age. On this basis there would be the potential for the following numbers of staff aged over 55 to choose to retire within the next 5 years (assuming full scheme membership):

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>staff aged over 55</th>
<th>% total staff group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>12</td>
<td>10.3%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>210</td>
<td>22.8%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>245</td>
<td>25.3%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>36</td>
<td>9.3%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>118</td>
<td>34.6%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>11</td>
<td>11.0%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>56</td>
<td>14.4%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>185</td>
<td>14.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>873</td>
<td>19.2%</td>
</tr>
</tbody>
</table>

This gives a total of 873 staff with the option to retire. It can be seen from the above that the areas most ‘at risk’ of future staff losses due to an ageing workforce profile are Estates and ancillary, admin and clerical and additional clinical services. Whilst these categories may not be classed as ‘higher risk’ shortage clinical occupations, all are necessary to enable and support the clinical services to function, and additional clinical services includes unqualified carers delivering hands on care to support registered nursing and clinical staff to carry out their professional workloads.
Whilst the initial figure of 14% potential registered nurse and midwifery and 14.4% of medical and dental are lower, these are areas of national skill shortage that are critical to patient care, and which already have vacancy levels which TRFT struggle to fill. This picture may also be worsened by the provisions of the pension scheme for its longer serving members. For nursing staff, the retirement age drops to 55 years for those with special class (SC) status under the original pension scheme arrangements, which remained in force until March 1995, when SC status was removed for new joiners. If it is assumed as an estimate that at half of all of the registered nursing and midwifery staff who are currently aged 50+ have remained in the NHS and maintained SC status as part of the original scheme, this would give a potential increase of up to an additional 104 qualifying to retire within the next 5 years, giving a total of 289 (22%) potential nursing retirements and 977 possible retirements overall.

2.3 Length of Service profile:

The chart below shows the length of service of current staff with up to 6 years of service. The medical and dental workforce have been split out into those who are fixed term temporary (e.g. on rotational/training contracts) and those who are permanent, to give a clearer picture of the overall service of the planned transient vs permanently contracted workforce. In all other categories the numbers represent the permanent substantive staff group as a whole.

There is a common trend that applies across all staff groups (excluding Medical and Dental fixed term), with an initial noticeable drop in staff numbers in the second year of service, which is quite common within most organisations due to what is referred to as an ‘induction crisis’ period in the first two years, where newer staff are more likely to move on. However, in TRFT there are staff groups indicated in which service continues to steadily drop, with a marked decrease between 4-5 years before reaching a plateau after 5 years. Given the steep drop in staff numbers during the 1-5 years’ service period in professions that are critical to service delivery, such as registered nursing and midwifery and AHPs, this has implications for seeking to address such losses in future retention strategies/initiatives.
At the other end of the length of service spectrum, there are noticeably steep drops in the numbers of registered nurses and midwives, additional clinical services and medical & dental staff with service between 10 -15 and 15-20 years, with the numbers in admin and clerical, estates and ancillary and healthcare scientist categories remaining relatively steady until 15 years’ service, when they then begin to decline. This partly reflects the increased proportion of staff reaching an age at which they become entitled to retire. There are currently 164 staff in post with over 30 years’ service; 76 of whom are registered nursing and midwifery.
3. **Vacancy Analysis**

As at the end of September 2018, the WTE staffing position against established posts was as follows: *(NB: budgeted and ‘in post’ WTE figures from the finance system are used for this table and not the higher figure of individual ‘headcount’ staff in post)*

<table>
<thead>
<tr>
<th>Establishment WTEs</th>
<th>GP Training Funding WTEs</th>
<th>GP Training WTEs</th>
<th>Lead Unit WTEs</th>
<th>Secondment WTEs</th>
<th>Total WTEs</th>
<th>Contracted WTEs</th>
<th>Extra Sessions WTEs</th>
<th>Bank WTEs</th>
<th>DE Agency WTEs</th>
<th>Locum/Agency WTEs</th>
<th>Other WTEs</th>
<th>Total WTEs</th>
<th>Variance WTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Members</td>
<td>15.0</td>
<td>0.0</td>
<td>14.8</td>
<td>0.0</td>
<td>0.0</td>
<td>14.8</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>14.8</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff</td>
<td>443.2</td>
<td>26.6</td>
<td>300.0</td>
<td>26.6</td>
<td>59.5</td>
<td>387.8</td>
<td>25.0</td>
<td>0.0</td>
<td>23.2</td>
<td>36.4</td>
<td>0.0</td>
<td>84.5</td>
<td>472.3</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery Registered</td>
<td>1,226.5</td>
<td>0.0</td>
<td>1,106.3</td>
<td>0.0</td>
<td>0.0</td>
<td>1,106.3</td>
<td>0.0</td>
<td>0.0</td>
<td>61.3</td>
<td>0.0</td>
<td>0.0</td>
<td>99.2</td>
<td>1,205.6</td>
</tr>
<tr>
<td>Additional Clinical Support Workers</td>
<td>247.4</td>
<td>0.0</td>
<td>249.2</td>
<td>0.0</td>
<td>0.0</td>
<td>249.2</td>
<td>0.0</td>
<td>3.4</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>3.4</td>
<td>252.6</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>310.0</td>
<td>0.0</td>
<td>311.7</td>
<td>0.0</td>
<td>0.0</td>
<td>311.7</td>
<td>0.0</td>
<td>2.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>7.2</td>
<td>318.9</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>99.0</td>
<td>0.0</td>
<td>89.1</td>
<td>0.0</td>
<td>0.0</td>
<td>89.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>89.1</td>
</tr>
<tr>
<td>Add Prof Scientific &amp; Technic - Pharmacists</td>
<td>49.7</td>
<td>0.0</td>
<td>47.6</td>
<td>0.0</td>
<td>0.0</td>
<td>47.6</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>47.6</td>
</tr>
<tr>
<td>Add Prof Scientific &amp; Technic</td>
<td>71.2</td>
<td>0.0</td>
<td>60.1</td>
<td>0.0</td>
<td>0.0</td>
<td>60.1</td>
<td>0.0</td>
<td>1.6</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>61.7</td>
</tr>
<tr>
<td>Admin &amp; Clerical</td>
<td>831.2</td>
<td>0.0</td>
<td>789.5</td>
<td>0.0</td>
<td>0.0</td>
<td>789.3</td>
<td>0.0</td>
<td>27.5</td>
<td>0.0</td>
<td>7.5</td>
<td>0.0</td>
<td>35.0</td>
<td>824.2</td>
</tr>
<tr>
<td>Nursing Support Workers</td>
<td>554.6</td>
<td>0.0</td>
<td>479.6</td>
<td>0.0</td>
<td>0.0</td>
<td>479.6</td>
<td>0.0</td>
<td>102.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>102.2</td>
<td>581.8</td>
</tr>
<tr>
<td>Estates &amp; Ancillary</td>
<td>250.4</td>
<td>0.0</td>
<td>239.4</td>
<td>0.0</td>
<td>0.0</td>
<td>239.4</td>
<td>0.0</td>
<td>1.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.3</td>
<td>240.8</td>
</tr>
<tr>
<td>Other (CIP/Reserves)</td>
<td>-17.4</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>-17.4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4,080.7</strong></td>
<td><strong>26.6</strong></td>
<td><strong>3,687.4</strong></td>
<td><strong>26.6</strong></td>
<td><strong>59.5</strong></td>
<td><strong>3,774.8</strong></td>
<td><strong>25.0</strong></td>
<td><strong>199.5</strong></td>
<td><strong>23.2</strong></td>
<td><strong>86.8</strong></td>
<td><strong>0.0</strong></td>
<td><strong>334.5</strong></td>
<td><strong>4,109.3</strong></td>
</tr>
</tbody>
</table>
The vacancy analysis table shows that, as at September 2018, there were 3,774.8 WTE ('headcount of 4,545') 'staff in post' against a total establishment of 4,080.7 WTE. This equates to a vacancy rate of 305.9 WTE posts, and is mainly due to 'difficult to fill' skills shortage roles in registered nursing/medical and dental roles, and nursing support worker vacancies.

It has been shown earlier in this report that roughly half of our staff work part time; if this pattern continues with new recruits, we would expect to need to recruit over 400 individual staff if we were to be able to fill our current vacancies.

In the main clinical staff groups, the highest vacancy rates, and therefore areas of highest risk, are:

- Registered Nursing and Midwifery: 120.2 WTE (9.8% of establishment.)
- Medical and Dental: 55.4 WTE (12.5% of establishment.)
- Healthcare Scientists: 9.9 WTE (10% of establishment.)
- Additional Prof Scientific and Tech: 9.5 WTE (15% of establishment.)

For non-clinical staff the highest rate is for Nursing support workers at 75 WTE (13% of establishment).

There is a heavy reliance on bank, locum or agency workers to fill the substantive gaps in both medical and dental and registered nursing and midwifery staff; at premium costs and with the risks to quality/stability that temporary staffing brings to long term service provision and sustainability.

The table shows that for bank, agency and locum use in Sept 18:

- 84.5 WTE were used in Medical and Dental (including 25 WTE extra sessions, but primarily via agency)
- 99.2 WTE temporary staffing cover was used in registered nursing and midwifery, which included 37.9 agency WTE that were unable to be covered by lower cost bank workers, and a further 20.9 WTE vacancies remained unfilled.
- To support these gaps in registered nursing, additional temporary nursing support workers were engaged, with the 75 WTE vacancies being over-filled by 102.2 WTE bank staff to provide an additional 27.3 WTE support workers over establishment.

We will not be able to recruit to all qualified Medical, Nursing and Healthcare Scientist vacancies/turnover, and will remain reliant on bank and agency support, due to national skills shortages. We will have to develop new and innovative recruitment, development and retention strategies and new roles, staffing models and training pipelines to achieve a sustainable workforce model and staffing levels required for safe care and additional activity. We cannot continue with ‘more of the same’.

4. Leavers Analysis

This section of the report provides an analysis of leavers for the 3 years to date as at October 2018, based on ESR data for the previous three 12 month periods, to give an indication of average leavers and any trends that have emerged that may be helpful for future workforce planning purposes. The leavers for the previous 3 years to date have totalled 2,758; an average of 929 leavers p.a., which breaks down as follows:

<table>
<thead>
<tr>
<th>Year to Date</th>
<th>Total Leavers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 – 2016</td>
<td>875</td>
</tr>
<tr>
<td>2016 – 2017</td>
<td>937</td>
</tr>
<tr>
<td>2017 – 2018</td>
<td>946</td>
</tr>
</tbody>
</table>
Whilst this may appear to be a relatively high number of leavers for a workforce of c.4,500, the breakdown of leavers by contract type clarifies the proportion of leavers from substantive roles:

The data used for the rest of this section excludes bank and fixed term workers and focuses instead on the staff who left permanent posts, to give an indication of where our biggest losses of substantive staff have been, their future destinations and the reasons given for leaving, and to then consider the implications of this for future staff turnover.

4.1 Leavers by staff group

Of the permanent staff who left in the previous three years to date, the breakdown into staff groups shows a consistent pattern of the top three areas of loss being nursing and midwifery, admin and clerical and additional clinical services. This is to be expected as they also have high numbers of staff, and although the numbers in nursing and midwifery appear high, it is encouraging that these have decreased year on year over the reference period.
4.2 Leaver reasons

A small proportion of leavers each year do so on non-voluntary grounds, and in the past three years the figures for these have been as follows:

<table>
<thead>
<tr>
<th>Reason for leaving</th>
<th>2015 - 2016</th>
<th>2016 - 2017</th>
<th>2017 - 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dismissed</td>
<td>26</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>Transferred</td>
<td>24</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Death in Service</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>36</td>
<td>34</td>
</tr>
</tbody>
</table>

Of those who left on voluntary grounds, the main reasons for leaving are recorded as shown below:

The pattern of leaver reasons has remained similar for the three years, with retirement, relocation and work/life balance or dependents being the top three causes, with the next three most popular reasons of promotion, lack of opportunities and health grounds falling some way behind.
On average over the 3 years to date, the Trust has lost 437 staff p.a. across all age groups. There is a sharp increase in leavers each year for staff in the age group of 51-55. Average leavers by age group over the three years (excluding the small numbers of under 20’s and over 65’s):

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2015-2016</th>
<th>2016-2017</th>
<th>2017-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-25</td>
<td>38</td>
<td>45</td>
<td>41</td>
</tr>
<tr>
<td>25-30</td>
<td>40</td>
<td>36</td>
<td>35</td>
</tr>
<tr>
<td>31-35</td>
<td>36</td>
<td>35</td>
<td>67</td>
</tr>
<tr>
<td>36-40</td>
<td>41</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>41-45</td>
<td>38</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>46-50</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>51-55</td>
<td>67</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>56-60</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>61-65</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
</tbody>
</table>

4.3 Leaver destinations

Of those who left in the past 3 years, an overview of the main destinations after leaving shows that the highest proportion left to take up alternative posts with other NHS bodies. The rates being lost to private sector roles have remained steady at around a third of the amount that left to go elsewhere in the NHS, and only small numbers have gone to other public sector employers.

Very few of the staff who retired chose the option to ‘retire and return’ to TRFT (14 in total), although 51 staff indicated that they took the flexible retirement option and 39 of these are registered as continuing to work in the NHS (i.e. 25 moved to other NHS employers post-retirement). A high proportion of those leaving to ‘no employment’ in the chart below were also retirees, with the remainder being mainly those who did not leave on voluntary grounds.

It has been shown that TRFT has a high level of staff approaching retirement age, and most of these can be assumed to represent long serving and more experienced staff. It is important therefore to consider not only external recruitment and retention of staff, but also further training and development of our available internal talent pool as key sources for the pipeline of future recruits we will need to fill roles that are vacated.

5. Training and Development Initiatives

TRFT has already developed a number of training schemes to establish new roles, career pathways and routes into extended or advanced practice as a means of developing new pipelines of future staff and addressing skills shortages through creating more sustainable workforce models. These are in line with National initiatives, and the Learning and Development team and professional leads are looking into the potential of engaging in further schemes as and when these become available on a national basis, such as Nursing and AHP degree level apprenticeships that are currently in either the early stages of implementation or still require some aspects of development.
Some of the key schemes that TRFT are already implementing are as follows:

- **Trainee Nursing Associates (TNA):** 5 TNA apprentices in place on medical & surgical wards; ward based level 5 qualification, with time spent on placement across district nursing, integrated rapid response team and MH via RDaSH, plus 1 day p/w at university. Work being done on a 1-2 year plan to increase TNA cohort as part of future workforce model.

- **Trainee Assistant Practitioner (TAP):** foundation degree course running in TRFT with 2x12 person cohorts, and 20 more staff studying to progress to TNA and TAP roles.

- **Physicians Associates:** A plan has been prepared to appoint 18 across the Trust (6 p.a. on a 3-year rolling programme). Confirmation is still needed on license to prescribe and funding for this to go ahead.

- **TRFT AHP Lead:** is developing the regional AHP workforce strategy, including graduate apprenticeships when these are made nationally available.

- **Healthcare Scientist Apprentices:** 3 staff are undertaking the Healthcare Science Degree Apprenticeship BSc (Hons) in Cardiovascular, Respiratory and Sleep Science. Lower level apprenticeships already in use.

- **MTI Programme:** in place offering rotational experience and 2 year competency development package to support further development through application to CESR programme as a potential career pathway to consultant level. Fills gaps at middle grade for 2 years and may provide a pipeline of Consultants.

**Advanced & Extended Practice:**

- **The L&D team:** are supporting 26 ANP and Assistant Practitioners in 2 cohorts of training with further 2 cohorts planned annually.

- **Acute:** Trainee ANPs are in place in both Emergency Care and Obstetrics, with the aim of filling middle grade gaps and joining the mixed rota. Qualified ANP staff already taking part in mixed surgery/medical grade rota in Trauma and Orthopaedics. Plans to develop ANP roles are being progressed in Gynae and Urology.

- **Community:** Qualified ANP supporting patients to remain at home for procedures normally carried out in the hospital setting (e.g. PIC lines) – Vascular. Also looking at community matron role being remodelled into Advanced Clinical Practitioners with extended skills in the future.

- **Radiology:** national shortage in reporting – strategy includes looking to address through extended use of radiographers in advanced practice roles.

- **HCAs:** are adopting extended roles at bands 2/3 in family health to create nursing capacity at band 5+, and ED are looking to convert HCAs as junior doctor assistants to support the medical team.

- **Radiology:** consideration is being given to the potential for extended nursing practice to enable point of care sonography.

Other current TRFT development initiatives that support improved recruitment and retention in addition to the building of future skills required include:
- High quality ‘Compass’ 12 month rotational/preceptorship support programme to attract and further develop newly qualified nurses - need to build further upon this to improve longer term nurse retention

- Band 7 Leadership development Programme (LEAD)

6. Conclusions

Although our workforce ‘establishment’ figure is set at 4080.7 WTE, we only have a combined total of 3774.8 WTE ‘staff in post’ and a vacancy level of 305.2 WTE unfilled posts. Due to the amount of flexible working, in ‘headcount’ terms this translates to a current workforce of 4,545 staff employed on a substantive basis, supported by nearly 500 bank workers.

This report indicates that we have key areas of skills shortages that mirror the national picture in critical clinical staff groups such as nursing and midwifery, medical and dental and healthcare scientists. We also have a high level of vacancies to fill in patient facing support worker roles.

Roughly half of the workforce work part time and this is most marked in estates and ancillary, additional clinical services, AHPs, nursing and midwifery and admin and clerical. This creates additional recruitment, management and workforce utilisation challenges.

Staff turnover indicates that we will need to recruit on average c.437 staff each year just to fill roles required to maintain current service provision without any increase in activity or service developments. This is also set against the background of 305 WTE unfilled existing vacancies. We can also assume from previous leaver patterns that our leavers will include a similar proportion (c.45%) of retirements form our older and more experienced workforce, and that the largest losses will be from registered nursing and midwifery, admin and clerical and additional clinical services. The main reason for leaving has been retirements, and we have an ageing workforce profile with the potential for a high level of experienced staff losses due to retirement over the next 5 years.

Leaver destinations show that our main competitor for staff remains other NHS bodies, and reasons for leaving give indications that we may need to offer staff improved access to career development and promotional opportunities that they are accessing elsewhere in the NHS, and more flexible working options to enable them to achieve a work life balance and /or care for dependents in a way that enables them to remain in work.

The current reliance on, and future continued use of temporary staffing through bank and agency workers to fill skills shortage gaps that cannot be recruited to on a substantive basis is inevitable. However, this is a costly resource and does not present a long term stable staffing solution to guarantee service delivery and safe levels of staffing.

National schemes to train additional nursing and medical staff to address skills shortages will not be sufficient to produce the workforce numbers required to ‘fill the gaps’ at TRFT during the lifetime of the 5 year plan. There is a need to create and invest in both new workforce models that address long term skills shortages, and in development opportunities and career pathways to attract, retain and upskill staff to undertake new, extended or advanced roles to deliver the care required to ensure the long term viability of services.

In addition to the training and development activities already listed, other initiatives that support an improved and more resilient workforce position and present some potential solutions to address the problems of the future are already being worked on, such as:

- Overseas recruitment of middle grade doctors from India. This does not provide a permanent solution as the doctors are issued with a 2-year Visa, and there may still therefore need to be a rolling overseas recruitment programme to address future gaps. However, non-EU visas enable workers only to work with their sponsoring employer, which provides a more
sustainable model than EU overseas recruits who are not restrained by visas and free to move to other employers at any time.

- Overseas non-EU nurse recruitment plans in discussion (Philippines/ India with 2 year visas as above)
- Recruiting flexibly around applicants to reduce agency/ bank and improve quality— e.g. ‘Allocate on Arrival’ roles, and using non-traditional routes for recruitment e.g. social media.
- Radiology Strategy being formulated: national shortage in reporting - looking to address locally through extended use of radiographers in advanced practice roles.
- HCAs adopting extended roles at bands 2/3 and training for band 4 roles to create nursing capacity at band 5+

The training activities and all of the above are contributing to a more sustainable future workforce, but are not enough in themselves to achieve this and will have to be further built upon, rolled out, scaled-up, invested in and developed over the course of the coming years to have a real impact on achieving the staffing numbers and skill levels required for service delivery.

7. Next Steps

The next stage of the process will be to work with key service managers and professional leads, business partners, medical staffing, learning and development, workforce information and others as required to carry out further workforce analysis and develop a draft workforce plan for key staff groups, which is aligned to clinical/ service development plans and takes account of internal/external influencing factors, including e.g.:

- Future workforce requirements to both meet service demand and address anticipated challenges arising from e.g. skills shortages, loss of key staff, changes to service delivery models or activity, technological developments, etc.
- Learning and development activity, plans and timelines, to establish future staffing pipelines arising from both national and local training & development programmes
- Recruitment opportunities, methods and plans to attract greater numbers of applicants, e.g. overseas recruitment, career development roles, flexible work offering
- Retention issues and means to address short-service leavers and anticipated retirement attrition rates
- Workforce utilisation improvements, e.g. Job planning & e-rostering – anticipated timelines and expected workforce outcomes of full implementation

As part of the above, it is aimed to establish ‘top priority’ service-specific and cross-cutting workforce issues and seek to develop workable long-term solutions.

M Wise
Interim Programme Manager
October 2018
## Agenda item
431/18(d)

## Report
Finance Report

## Executive Lead
Simon Sheppard, Director of Finance

## Link with the BAF
B9 and B10:
This report provides assurance regarding the delivery of the financial plan including the Cost Improvement Programme

## Purpose
(Tick only one box)
|
---
| Decision | To note | Approval | For information |
---

To note

## Executive Summary
(including reason for the report, background, key issues and risks)

The detailed integrated finance report provides the details around the M7 (end of October) financial performance and the year-end forecast.

The key indicators are:

- At the end of October the Income and Expenditure position is ahead of plan by £0.2m
- The deficit to 31 October is £12.69 against a plan of £12.90m, a favourable variance from plan of £0.20m year to date.
- The Trust is forecasting delivery of the year end £20.3m deficit plan
- Cost Improvement Programme is ahead of the year to date trajectory by £0.9m, with £5.1m of schemes delivered by 31 October
- The Capital programme is underspent
- Cash balance at the end of the month is £1.41m

Senior members of the finance and operational teams have met the Divisions following the M7 results and agree a number of specific actions to ensure delivery of the financial plan

Whilst the M7 position encouraging and the Trust is forecasting to deliver the year end position there are a number of risks and actions senior members are taking to ensure deliver of this target.

## Recommendations
It is recommended that the Board of Directors note the financial position, year-end forecast, risk and mitigating actions

## Appendices
1. Income & Expenditure Account
2. Activity
3. Cost Improvement Programme
1. Key Financial Headlines

1.1. The key financial metrics for the Trust are shown in the table below. These are;

- Performance against the monthly income and expenditure plan
- Performance against the internal agency spend and against the NHSI ceiling
- Cost Improvement Programme
- Capital
- Cash

1.2. As at the end of October 2018 (month 7) the Trust is reporting favourable variances against all of the key metrics with the exception of agency spend. The following sections provide further information against these financial metrics, with the Income & Expenditure Account shown in Appendix 1.

2. Income & Expenditure (in month)

2.1. As the Board of Directors is aware, the Trust submitted its final operational and financial plan on the 30 April 2018. The financial plan for 2018/19 is to deliver a £20.3m deficit or better.

2.2. The key points to highlight to the Board at the end of October are;

Clinical Income & Activity

2.3. Clinical income is £2,015K favourable to Plan at the end of October. Adjusting for the additional pay award funding and GP schemes (see Pay and Non Pay section), the Trust is showing a small under-performance to date (£33k), predominately due to critical care activity.

2.4. The activity performance year to date is shown in the appendix 2. The key points to draw from the table are;

- For the main points of delivery, elective, non-elective and ED attendances, the Trust is on Plan at the end of October. This reflects the robust planning process and profiling by the clinical management teams.
- Under performance on critical care, both paediatrics and adults, although the October performance on paediatric critical care was 11% above plan.
- Over-performance on outpatients and assessments – these areas continue to be the focus for ongoing discussions and actions with the internal teams and Rotherham CCG, linked to referral trends.

Pay and Non Pay

2.5. Pay costs are showing an overspend of £1,954k year to date. However, the following factors must be noted;
• The Agenda for Change (AfC) pay award was agreed in July, with back pay in August. The Trust is receiving additional income above the planned level to fund this (£1,555k year to date). This was in addition to the new pay rates being paid in July.  
• The Trust is now the lead employer for the GP Vocational Training Scheme. This is fully funded for the pay costs incurred, £424k for August - October.

2.6. The total impact of the 2 factors above year to date is £1,979k. In line with the agreed financial reporting budgets are fixed for the financial year to align with the 2018/19 submitted financial and operational plan, and so the £1,979k is showing as an over-performance on income. Adjusting for these factors would show the pay position being favourable to budget.

2.7. Whilst the pay position year to date is on budget, there needs to be continued focus on the use of temporary workforce across the remaining months of the year to ensure the year-end financial plan is delivered.

2.8. Non pay costs are showing an adverse position, £1,700k against budget predominately due to excluded drugs and devices and premises, which are offset by income.

2.9. To support delivery of the financial plan, there are now monthly Financial Operational Meetings with each Division, led by the Director of Finance and supported by the Chief Operating Officer and senior members of the finance team.

These meetings with Divisional teams have focused on;

• Year-end forecast including risks and opportunities. These risks and opportunities, including actions to mitigate the risk or secure the opportunity have been discussed at the Finance & Performance Committee.
• Accuracy of forecasts for both the monthly reports and year end position
• Clear actions required to improve performance and/or mitigate any risks.
• Escalation of any issues to the Executive Management Committee

2.10. Whilst the financial performance to date is encouraging there is continued focus on delivering the monthly profiles throughout the remaining months of 2018/19. It is critical to the delivery of the overall financial plan that the Trust continues to deliver against the monthly profiles.

3. Agency Expenditure

3.1. As was the case in 2016/17 and 2017/18 providers have received an agency target from NHSI for the new financial year. The target for 2018/19 is an annual spend of £8.8m which is a reduction of £1.4m from the £10.2m target in 2017/18.

3.2. Whilst the Trust will strive to meet the target, this ambition needs to be set in the context of 2017/18 costs being in excess of £11m. These costs were predominately driven by medical vacancies and the requirement to use agency staff. In light of the spend in 2017/18 the Trust has therefore set an internal budget for agency expenditure profiled across the financial year to reflect forecast costs.

3.3. During 2018/19 performance against both the NHSI ceiling and internal budget will be monitored.

3.4. At the end of October 2018 the Trust incurred costs of £7,219k inclusive of supporting the additional capacity. This year to date spend is above the internal budget, £484k, and £2,120k adverse to the NHSI ceiling.

3.5. Further actions implemented to support delivery against these targets include;

• Agreement and monitoring of the key vacant posts – individual recruitment strategies
• Working with external partners to secure permanent recruitment including from overseas
• Expansion of the direct engagement model
• Overseas recruitment to key posts

90
• Enhanced controls in certain areas
Progress against these actions and the impact on the agency spend will be reported through the operational committees and assurance committees.

4. Cost Improvement Programme

4.1. The Trust has a cost improvement (CIPs) target for 2018/19 of £9.7m, 3.6% of costs.

4.2. The month end and year to date position is shown in Appendix 3 and includes both cash releasing and efficiency schemes, the headlines being;

- Performance in October of £901k, £28k adverse to plan.
- Year to date performance £907k above the plan of £4,205k

4.3. In addition to the in-month performance, continued focus and action is being taken to secure the £9.7m in year target and the full year effect of £13.1m

4.4. Total schemes identified for 2018/19 are now £10.2m in excess of the annual target, with a full year effect value of £12.6m.

5. Capital

- Total capital expenditure plans have been produced in accordance with the maximum internally generated funds available to the Trust and in conjunction with appropriate colleagues throughout the Trust
- The Trust has a planned capital expenditure programme for 2018/19 of £5,800K
- Expenditure year to date (to 31 October 2018) is £1,365K representing an under-spend of £1,546K against the year to date budget.
- The Trust as part of the South Yorkshire & Bassetlaw Integrated Care System is currently awaiting feedback on several draft business cases as part of the national capital programme.
- The Trust has been successful in securing an additional £2.1m to support increased capacity in winter and improved emergency care performance.

6. Cash

- The trust ended October 2018 with a bank balance of £1.41m compared to a planned level of £1.35m which is an £0.06m favourable variance
- All non NHS and NHS suppliers are paid within the payment terms approved by the Board of Directors (45 days)

7. Finance & Performance Committee

7.1. The Finance & Performance Committee met on Wednesday 21 November 2018 to discuss the year to date financial and operational performance. The meeting focussed on;

- Financial performance year to date and forecast, including risks and mitigating actions.
- Operational performance against the constitutional standards, particularly the 4 hour standard, Cancer 62 day target, and the total waiting list numbers
- Performance against CQUIN (Commissioning for Quality and Innovation)
- Winter Planning
- Progress for the implementation of Service Level Reporting and Patient Level Costing
- Demand and capacity planning for both acute and community services
- 5 Year Plan
- Progress for the 2019/20 Operational and Financial Plan
### Appendix 1 – Income & Expenditure Account to 31 October 2018

<table>
<thead>
<tr>
<th>Summary Income and Expenditure Position</th>
<th>Monthly Position (October - Month 7)</th>
<th>Year to Date Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £000s</td>
<td>Actual £000s</td>
</tr>
<tr>
<td>Total NHS Clinical Income</td>
<td>19,371</td>
<td>20,067</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>1,587</td>
<td>2,196</td>
</tr>
<tr>
<td>Total Income</td>
<td>20,958</td>
<td>22,264</td>
</tr>
</tbody>
</table>

**EXPENDITURE**

<table>
<thead>
<tr>
<th></th>
<th>Plan £000s</th>
<th>Actual £000s</th>
<th>Variance £000s</th>
<th>Plan £000s</th>
<th>Actual £000s</th>
<th>Variance £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Pay Costs</td>
<td>(14,708)</td>
<td>(15,467)</td>
<td>(759)</td>
<td>(104,702)</td>
<td>(106,656)</td>
<td>(1,954)</td>
</tr>
<tr>
<td>Total Non Pay Costs</td>
<td>(6,311)</td>
<td>(6,875)</td>
<td>(564)</td>
<td>(44,015)</td>
<td>(45,714)</td>
<td>(1,700)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>(61)</td>
<td>(79)</td>
<td>(18)</td>
<td>(5,979)</td>
<td>(6,041)</td>
<td>(62)</td>
</tr>
<tr>
<td>Non Operating Costs</td>
<td>(885)</td>
<td>(871)</td>
<td>13</td>
<td>(6,061)</td>
<td>(6,027)</td>
<td>34</td>
</tr>
<tr>
<td>Central Costs</td>
<td>(25)</td>
<td>2</td>
<td>27</td>
<td>(861)</td>
<td>(630)</td>
<td>231</td>
</tr>
<tr>
<td>RETAINED SURPLUS / (DEFICIT)</td>
<td>(971)</td>
<td>(948)</td>
<td>23</td>
<td>(12,901)</td>
<td>(12,698)</td>
<td>203</td>
</tr>
</tbody>
</table>

**Agency % Total Pay**

- 6.0% | 7.2% | (1.2%) | 6.4% | 6.8% | (0.3%) |

**EBITDA % Income**

- (0.3%) | (0.4%) | (0.1%) | (4.2%) | (4.1%) | 0.1% |

**Net Deficit % Income**

- (4.6%) | (4.3%) | 0.4% | (9.0%) | (8.7%) | 0.4% |
## Appendix 2 – Activity Performance to 31 October 2018

<table>
<thead>
<tr>
<th>In Month Activity (M7)</th>
<th>YTD Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
</tr>
<tr>
<td>Elective Inpatient</td>
<td>473</td>
</tr>
<tr>
<td>Elective Day case</td>
<td>2,369</td>
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<tr>
<td>Non Elective</td>
<td>2,207</td>
</tr>
<tr>
<td>ED Attendance</td>
<td>8,469</td>
</tr>
<tr>
<td>Outpatient New (CL)</td>
<td>5,144</td>
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<tr>
<td>Outpatient FU (CL)</td>
<td>9,222</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>4,748</td>
</tr>
<tr>
<td>Adult Critical Care</td>
<td>336</td>
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<tr>
<td>Paediatric Critical Care</td>
<td>418</td>
</tr>
<tr>
<td>Assessments</td>
<td>976</td>
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</tbody>
</table>
## Appendix 3 – Cost Improvement Programme

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>In-Year Plan (£,000)</td>
<td>929</td>
<td>901</td>
<td>-28</td>
<td>4,205</td>
<td>5,112</td>
<td>907</td>
<td></td>
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<tr>
<td>In-Year Actual (£,000)</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>In Month Variance (£,000)</td>
<td>245</td>
<td>167</td>
<td>-77</td>
<td>1,030</td>
<td>860</td>
<td>-171</td>
<td>83 %</td>
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<tr>
<td>YTD In-Year Plan (£,000)</td>
<td>206</td>
<td>183</td>
<td>-23</td>
<td>927</td>
<td>1,196</td>
<td>269</td>
<td>129 %</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>YTD Actual (£,000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>YTD Variance Actual/Plan (£,000)</td>
<td>122</td>
<td>116</td>
<td>-6</td>
<td>730</td>
<td>675</td>
<td>-55</td>
<td>92 %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% YTD Performance to Plan</td>
<td>120</td>
<td>48</td>
<td>-72</td>
<td>224</td>
<td>545</td>
<td>321</td>
<td>243 %</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Corporate</td>
<td>114</td>
<td>263</td>
<td>149</td>
<td>434</td>
<td>975</td>
<td>542</td>
<td>225 %</td>
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<td>Central</td>
<td>123</td>
<td>123</td>
<td>0</td>
<td>860</td>
<td>861</td>
<td>1</td>
<td>100 %</td>
<td></td>
<td></td>
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</tbody>
</table>

In Month Performance to Plan: **97 %**

YTD Performance to Plan: **122 %**
**Agenda item** 432/18

**Report** Job Planning

**Executive Lead** Dr Callum Gardner, Interim Medical Director

**Link with the BAF** B4, B5

**Purpose**

<table>
<thead>
<tr>
<th>Decision</th>
<th>To note</th>
<th>Approval</th>
<th>For information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
<td></td>
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</tr>
</tbody>
</table>

(Tick only one box)

**Executive Summary** (including reason for the report, background, key issues and risks)

This report is provided to update Board Members with the progress of e-Job Plan implementation, highlighting any risks for non-delivery along with mitigation to manage those risks.

**Recommendations**

It is recommended that Members note the content of the report.

**Appendices**

1. Job Planning Status Summary
1. Introduction

1.1 Implementation and training of the e-Job Plan module commenced in April 2018 and has been carried out utilising in-house resources. Good progress was being made; however, the staff member responsible within Medical Workforce was successful in obtaining another post in the Trust and has not yet been replaced. This is having an adverse impact on continuation of training and support for Divisions in the job planning process. As mitigation, it has been agreed temporary support is required to ensure implementation of job planning and job plan completion is brought back on track.

1.2 In addition, the Head of Medical Workforce now has direct responsibility for the Human Resources (HR) Systems Team and therefore can manage a more collaborative working arrangement between Medical Workforce and HR Systems. Recruitment to the vacant post, additional temporary support and refocusing of priorities will not only ensure e-Job Plan implementation and training is brought up to the standard required it will provide the necessary resource required for other Allocate modules such as E-Rostering for junior doctors.

1.3 For each Allocate module a bespoke project plan will be developed with support from the Project Management Office (PMO); this will be overseen by the Head of Medical Workforce as the Senior Responsible Officer (SRO).

2. Job Plan Status

2.1 The Job Planning Status Summary as at November 2018 can be found at Appendix 1.

2.2 The figure relating to those who have never logged in reflects the outstanding training required. However, a review of those not trained is being undertaken to ascertain the reason(s) why (we are aware of absence related to long-term sick and maternity for example), after which we will be able to provide necessary training once resourced to do so.

2.3 It should be noted contractual notice periods mean that when changes have been agreed they will require 3 months’ notice before they can be effected.

3. Summary

3.1 Implementation of the e-Job Plan module has been completed and is assessed as green as the system is fully functional and being utilised across the Trust. Training is currently assessed red for the reasons stated. Job Plan completion and sign off is also assessed as red, with mitigating action as detailed in this paper.

Callum Gardner
Interim Medical Director

November 2018
e-JobPlan - Job Planning Status Summary - November 2018

The Rotherham NHS Foundation Trust

Date of report: 04 November 2018

Consultants

<table>
<thead>
<tr>
<th>Total number of consultants</th>
<th>129</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job plans signed off since implementation commenced and training has been delivered</td>
<td>9</td>
</tr>
</tbody>
</table>

Job plans not signed-off or not updated

<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never logged in</td>
<td>45</td>
<td>34.9%</td>
</tr>
<tr>
<td>In draft stage</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>In discussion stage</td>
<td>83</td>
<td>64.3%</td>
</tr>
<tr>
<td>In mediation</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>In appeal</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Awaiting 1st sign off</td>
<td>10</td>
<td>14%</td>
</tr>
<tr>
<td>Awaiting 2nd sign off</td>
<td>9</td>
<td>7%</td>
</tr>
<tr>
<td>Signed off longer than 12 months ago</td>
<td>10</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

Consultants by status

[Bar chart showing the distribution of consultants by status, with bars for each status category as follows:
- Signed off within the last 12 months
- Never logged in
- In draft stage
- In discussion stage
- In mediation
- In appeal
- Awaiting 1st sign off
- Awaiting 2nd sign off
- Signed off longer than 12 months ago]
<table>
<thead>
<tr>
<th>Clinical Support Services</th>
<th>Total</th>
<th>Signed off within the last 12 months</th>
<th>Never logged in</th>
<th>Draft</th>
<th>Discussion</th>
<th>Mediation</th>
<th>Appeal</th>
<th>Awaiting 1st sign off</th>
<th>Awaiting 2nd sign off</th>
<th>Signed off longer than 12 months ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>13</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Family Health</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Consultants</td>
<td>21</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medicine</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Consultants</td>
<td>31</td>
<td>3</td>
<td>9</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>2</td>
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</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultants</td>
<td>64</td>
<td>1</td>
<td>20</td>
<td>0</td>
<td>42</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

**SAS Doctors**

Total number of SAS doctors: 34

Job plans signed off since implementation commenced and training has been delivered: 1 (2.9%)
Job plans not signed-off or not updated
- Never logged in: 16 (47.1%)
- In draft stage: 0 (0%)
- In discussion stage: 24 (70.6%)
- In mediation: 0 (0%)
- In appeal: 0 (0%)
- Awaiting 1st sign off: 3 (8.8%)
- Awaiting 2nd sign off: 1 (2.9%)
- Signed off longer than 12 months ago: 5 (14.7%)

SAS doctors by status

Clinical Support Services

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Signed off within the last 12 months</th>
<th>Never logged in</th>
<th>Draft</th>
<th>Discussion</th>
<th>Mediation</th>
<th>Appeal</th>
<th>Awaiting 1st sign off</th>
<th>Awaiting 2nd sign off</th>
<th>Signed off longer than 12 months ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAS Doctors</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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</tr>
</tbody>
</table>

Family Health
<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Signed off within the last 12 months</th>
<th>Never logged in</th>
<th>Draft</th>
<th>Discussion</th>
<th>Mediation</th>
<th>Appeal</th>
<th>Awaiting 1st sign off</th>
<th>Awaiting 2nd sign off</th>
<th>Signed off longer than 12 months ago</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAS Doctors</strong></td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Medicine</strong></td>
<td>7</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>23</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>3</td>
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**Board of Directors’ Meeting**  
**27 November 2018**

<table>
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<th>Agenda item</th>
<th>433/18</th>
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<tbody>
<tr>
<td>Report</td>
<td>Board Assurance Framework</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Anna Milanec, Company Secretary</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>This report sets out the proposed current risk scores for all 12 of the BAF items for Quarter 2 2018/19. It is proposed that the scores for items B1, B2 and B4 are increased whilst the score for B9 is reduced.</td>
</tr>
</tbody>
</table>

### Purpose

<table>
<thead>
<tr>
<th>Decision</th>
<th>To note</th>
<th>Approval</th>
<th>For information</th>
</tr>
</thead>
</table>

The Board Assurance Framework (BAF) is the mechanism through which the Board of Directors identifies and manages the principal risks to the achievement of its strategic objectives.

The BAF is updated quarterly through meetings with each of the Executive Directors. It is then presented to the relevant Board Assurance Committee which confirms and challenges its content and the proposed risk scores. This version is then presented to the Board of Directors for approval.

For Quarter 2 the following changes to current risk scores are proposed:

- B1: an increase to $4 \times 5 = 20$
- B2: an increase to $4 \times 4 = 16$
- B4: an increase to $5 \times 5 = 25$
- B9: a reduction to $3 \times 5 = 15$

No changes are proposed to the current risk scores of the following BAF items: B3, B5, B6, B7, B8, B10, B11 and B12.

### Recommendations

It is recommended that the Board of Directors approve the Quarter 2 current risk scores as they appear in the grid at Appendix 1.

### Appendices

1. Risk appetite and current risk scores for all BAF items
1.0 Introduction

1.1 Following the approval of the risk descriptions by the Board in May 2018, the BAF was updated for 2018/19 and this Q2 update is presented to the Board to consider the end of Q2 risk scores which have been proposed by lead executives, and reviewed by Board Committees.

2.0 Q2 Outcome

2.1 Details of the Q2 risk ratings are provided in Appendix 1, and include any revisions made by Board Assurance Committees.

3.0 Recommendations from Committees

3.1 The Quality Assurance Committee recommended the following:
- **B1**: an increased current risk score from 3(L) x 5(C) = 15 to 4(L) x 5(C) = 20. This increase was recommended because the Care Quality Commission (CQC) undertook an unannounced inspection in July 2018 which revealed issues in relation to Non-Invasive Ventilation and the management of children in the Urgent & Emergency Care Centre and from some concerns raised by members of staff in those respective areas. In addition, the CQC undertook their unannounced inspection of Urgent and Emergency Care; Medical Care; Maternity and Children and Young People (Acute) from 25 to 27 September 2018. Due to remaining concerns surrounding staffing of the paediatric Emergency Department, whilst the CQC were assured regarding the action plan put in place following the 17 July inspection, they have since put conditions on the Trust’s licence with specific requirements for nursing and medical staffing in the paediatric Emergency Department.
- **B2**: an increased current risk score from 3(L) x 4(C) = 12 to 4(L) x 4(C) = 16. This increase was recommended because as a result of the CQC review and ongoing concerns within the Division, a business case was developed for additional paediatric nursing and medical cover in the Emergency Department. Approval of the business case is envisaged by end Q3, with recruitment during Q4.
- **B3**: the Committee recommended no change in current risk score [3(L) x 3(C) = 9].

3.2 The Strategy & Transformation Committee recommended the following:
- **B11**: the Committee recommended no change in current risk score [2(L) x 4(C) = 8]
- **B12**: the Committee recommended no change in current risk score [3(L) x 4(C) = 12]

3.3.1 The Strategic Workforce Committee recommended the following:
- **B4**: an increase in current risk score from 4(L) x 5(C) = 20 to 5(L) x 5(C) = 25 since the Committee considered that it had seen no evidence and therefore was not assured that the gap in control relating to the GP out-of-hours service staffing was being addressed.
- **B5**: the Committee recommended no change in current risk score [5(L) x 4(C) = 20]

3.4 The Audit Committee recommended the following:
- **B6**: no change in current risk score for Q2 [3(L) x 5 (C) = 15]
- **B7**: no change in current risk score for Q2 [4(L) x 4(C) = 16]
- **B8**: no change in current risk score for Q2 [3(L) x 4(C) = 12]

3.5 The Finance & Performance Committee considered the BAF and the following was recommended:
- **B9**: a reduction in current risk score was recommended from 4(L) x 5(C) = 20 to 3(L) x 5(C) = 15. This reduction was recommended due to embedded, strengthened financial governance, the forecast CIP value being above the year-end target, and also plans already being in place for the 2019/20 efficiency programme.
- **B10**: the Committee recommended no change in current risk score [4(L) x 5(C) = 20].
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk title</th>
<th>Risk Owner</th>
<th>Oversight Committee</th>
<th>Date on which oversight Committee agreed Q2 BAF scores</th>
<th>Q4 current risk score</th>
<th>Q1 current risk score</th>
<th>Q2 current risk score</th>
<th>Q1 current risk score</th>
<th>Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements</td>
<td>ChN / MD</td>
<td>QAC</td>
<td>19 Oct 2018</td>
<td>4x5</td>
<td>3x5</td>
<td>4x5</td>
<td>3x5</td>
<td></td>
</tr>
<tr>
<td>B2</td>
<td>Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards</td>
<td>COO</td>
<td>QAC</td>
<td></td>
<td>4x5</td>
<td>3x4</td>
<td>4x4</td>
<td>2x4</td>
<td></td>
</tr>
<tr>
<td>B3</td>
<td>Changes to clinical pathways required to make services sustainable in the ICS, may initially lead to a decrease in the quality of care locally. Uncertainty over future services configuration.</td>
<td>MD</td>
<td>QAC</td>
<td></td>
<td>N/A</td>
<td>3x3</td>
<td>3x3</td>
<td>2x3</td>
<td></td>
</tr>
<tr>
<td>B4</td>
<td><em>The Trust cannot deliver the range of services and / or Trust plans it is commissioned to deliver due to insufficient workforce capability and / or capacity</em></td>
<td>DoW</td>
<td>SWC</td>
<td>22 Oct 2018</td>
<td>5x5</td>
<td>4x5</td>
<td>5x5</td>
<td>4x4</td>
<td></td>
</tr>
<tr>
<td>B5</td>
<td>Workforce costs cannot be reduced nor workforce productivity improved</td>
<td>DoW</td>
<td>SWC</td>
<td></td>
<td>5x5</td>
<td>5x4</td>
<td>5x4</td>
<td>3x4</td>
<td></td>
</tr>
<tr>
<td>B6</td>
<td>Insufficiently robust Trust-wide (internal) governance arrangements impede the delivery of a number of plans / objectives</td>
<td>DoF / DoST / Co Sec</td>
<td>Audit</td>
<td>16 Nov 2018</td>
<td>3x5</td>
<td>3x5</td>
<td>3x5</td>
<td>2x4</td>
<td></td>
</tr>
<tr>
<td>B7</td>
<td>Misaligned governance and decision-making may arise from divergent Trust, Place and ICS interests and objectives</td>
<td>Co Sec</td>
<td>Audit</td>
<td></td>
<td>N/A</td>
<td>4x4</td>
<td>4x4</td>
<td>2x3</td>
<td></td>
</tr>
<tr>
<td>B8</td>
<td>Risk to delivery of business as robust business resilience planning is not fully embedded (increased focus on potential cyber-attacks)</td>
<td>COO / DoST</td>
<td>Audit</td>
<td></td>
<td>2x4</td>
<td>3x4</td>
<td>3x4</td>
<td>2x4</td>
<td></td>
</tr>
<tr>
<td>B9</td>
<td>Planned efficiencies are not delivered</td>
<td>DoF</td>
<td>FPC</td>
<td>24 Oct 2018</td>
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<td>4x5</td>
<td>3x5</td>
<td>2x5</td>
<td></td>
</tr>
<tr>
<td>B10</td>
<td>The financial plan is not delivered</td>
<td>DoF</td>
<td>FPC</td>
<td></td>
<td>5x5</td>
<td>4x5</td>
<td>4x5</td>
<td>2x5</td>
<td></td>
</tr>
<tr>
<td>B11</td>
<td>Implementation of the Rotherham Place Plan cannot be achieved because partner organisations are unable to agree on integrated service models</td>
<td>DoST</td>
<td>STC</td>
<td>19 Oct 2018</td>
<td>N/A</td>
<td>2x4</td>
<td>2x4</td>
<td>2x4</td>
<td></td>
</tr>
<tr>
<td>B12</td>
<td>The Integrated Care System priorities cannot be addressed due to partner organisations being unable to agree on a sustainable service model across the SYB footprint</td>
<td>DoST</td>
<td>STC</td>
<td></td>
<td>3x5</td>
<td>3x4</td>
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</tbody>
</table>

1 Revised risk identity agreed at Board of Directors on 25 September 2018
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>434/18</th>
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<tbody>
<tr>
<td>Report</td>
<td>Risk Management Report - Including the Risk Register (with risks scoring 15 and above)</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Angela Wood, Interim Chief Nurse</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B1-12</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision [ ] To note [✓] Approval [ ] For information [ ] (Tick only one box)</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>To present the Risk Register. The report is based on the risk register from Datix as at 19 November 2018. The key points arising from the report are: • The Interim Chief Nurse is now in post and has identified the current approach will continue at present until the CQC report is published and the Safe and Sound initiative is implemented. • The corporate risk register is being produced. • The management of the risks scoring 15 or above is being reviewed.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>It is recommended that: The Board receive this report for noting</td>
</tr>
<tr>
<td>Appendices</td>
<td>1. Corporate Risks 2. Risk Register 3. TRFT Risk Appetite</td>
</tr>
</tbody>
</table>
1. **Introduction**

1.1 This report provides an update to the Board for the purpose of providing assurance with regards to Risk Management.

2. **Review of Risk Management Arrangements**

2.1 A report was presented to the April 2018 Board of Directors meeting detailing the review that was proposed to improve the management of risks within the Trust.

2.2 The review is currently progressing, however due to the Provider Information Request from the Care Quality Commission (CQC) and the recent inspections, the timescales for the delivery of the review have been adjusted as outlined below.

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Timeframe</th>
<th>Status</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Produce phase 1 of the Corporate Risk Register</td>
<td>Quarter 1 (April)</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Review the role and function of the Risk Management Committee and hold the first meeting of the new format meeting</td>
<td>End of Quarter 1</td>
<td>The initial meeting of the Risk Analysis Group was due to be held within Quarter One. However, due to the receipt of the Provider Information Request from the CQC, the meeting was postponed and then held on 11 July. The meetings have continued and there is an improved discussion and challenge of the risks on the register. However, further improvements are recommended.</td>
<td></td>
</tr>
<tr>
<td>Arrange to visit other organisations to review their arrangements for risk management</td>
<td>End of Quarter 1</td>
<td>One visit has been undertaken and was very beneficial. Two are yet to be held but are in the process of being arranged.</td>
<td></td>
</tr>
<tr>
<td>Develop and implement a process for the systematic review of potential risks to the delivery of key objectives or performance targets</td>
<td>End of Quarter 1</td>
<td>Discussed at the initial meeting of the Risk Analysis Group.</td>
<td></td>
</tr>
<tr>
<td>Produce phase 2 of the Corporate Risk Register</td>
<td>End of Quarter 3</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Complete a review of the functionality of the risk management software system, implementing all improved functionality</td>
<td>End of Quarter 3</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Devise and implement a process for ensuring that risks occurring frequently at a low level are identified, assessed and reflected for their total impact in the risk register</td>
<td>End of Quarter 3</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Invite external risk management experts to review and comment on the revised arrangement for risk management within the Trust</td>
<td>End of Quarter 3</td>
<td>It is recognised that the CQC may identify improvements that could be made during their inspection, particularly due to the previous regulation breach. Therefore, this will not be undertaken until the outcome of the inspection is received.</td>
<td></td>
</tr>
</tbody>
</table>
3. **Corporate Risk Register**

3.1 As a first step towards delivering a Corporate Risk Register, the risk of failing to deliver each of the 2018/19 operational and enabling objectives has been assessed and is detailed at Appendix 1.

3.2 The top 9 corporate risks have also been agreed by the Executive Team and risk assessments have been completed. The risks are as follows:

- Failure to deliver the financial plan for 2018/19
- Nurse Staffing
- Medical Staffing
- Loss of service, or inefficient service or suboptimal quality of service due to aging equipment & Estate
- Care of patient in an inappropriate setting
- Quality of the service
- Failure to meet specific performance targets
- Cyber security & informatics infrastructure
- Infection Control

3.3 The risks will be presented to the December 2018 Trust Management Committee for approval and then to the December 2018 Board of Directors for information.

3.4 The process for risk management will be that any new or existing risks recommended to be approved as scoring 15 or above will be reviewed by the Risk Analysis Group to identify whether they link to an existing corporate risk. If they do then the risk form for that corporate risk will be amended to reflect it. If not the Risk Analysis Group should recommend the addition of a new risk to the corporate risk register.

3.5 The Corporate Risk Register will be updated and formally approved by TMC and reviewed quarterly by Assurance Committees and the Board of Directors. In the two intervening months a paper will be presented to TMC from the Risk Analysis Group to identify which risks have been added to or removed from the Risk Register of 15 or above and whether that warrants a change to the existing Corporate Risk Register.

4. **Risk Register**

4.1 For the remainder of the risk register, they are detailed in Appendix 2, and there are 26 approved risks scoring 15 or above.

5. **Conclusion**

5.1 The Risk Analysis Group seeks to see risks with a score of 15 or more being managed or mitigated within 6 months.

5.2 The focus throughout Q3 will be on reviewing the Trust approach to managing risks particularly those with a score of 15 or more and on the role and function of the Risk Analysis Group, along with ensuring compliance with the concerns raised by the Care Quality Commission in relation to risk management.

*Anne Rolfe, Quality Governance, Compliance and Clinical Risk Manager*

*November 2018*
<table>
<thead>
<tr>
<th>ID</th>
<th>Owner's Role</th>
<th>Specialty</th>
<th>Title</th>
<th>Risk level (initial)</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Date Reviewed</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>5516</td>
<td>Chief Nurse</td>
<td>Chief Nurse</td>
<td>Failure to deliver operational objective 1 – implement the 9 quality priorities for 2018/19</td>
<td>High Risk 9</td>
<td>High Risk 9</td>
<td>Moderate 6</td>
<td>27/08/2018</td>
<td>27/11/2018</td>
</tr>
<tr>
<td>5517</td>
<td>Director of Finance</td>
<td>Director of Finance</td>
<td>Failure to deliver operational objective 2 – Deliver the financial plan and contract</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>High Risk 10</td>
<td>22/10/2018</td>
<td>22/01/2019</td>
</tr>
<tr>
<td>5518</td>
<td>Director of Strategy and Transformation</td>
<td>Strategy and Transformation</td>
<td>Failure to deliver operational objective 3 – Implement year 1 of the Transformation &amp; Efficiency Programme</td>
<td>Significant 12</td>
<td>Significant 12</td>
<td>High Risk 8</td>
<td>28/08/2018</td>
<td>29/10/2018</td>
</tr>
<tr>
<td>5519</td>
<td>Director of Strategy and Transformation</td>
<td>Strategy and Transformation</td>
<td>Failure to deliver operational objective 4 – Implement year 2 of the Rotherham Place Plan with partners</td>
<td>High Risk 8</td>
<td>High Risk 8</td>
<td>Moderate 4</td>
<td>22/06/2018</td>
<td>21/09/2018</td>
</tr>
<tr>
<td>5520</td>
<td>Medical Director</td>
<td>Medical Director</td>
<td>Failure to deliver operational objective 5 – Review our clinical strategy in light of the Hospital Services Review</td>
<td>High Risk 9</td>
<td>High Risk 9</td>
<td>Moderate 6</td>
<td>18/05/2018</td>
<td>18/07/2018</td>
</tr>
<tr>
<td>5521</td>
<td>Director of HR</td>
<td>Director of Workforce (HR)</td>
<td>Failure to deliver enabler 1 – Recruit to the top 30 key posts</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>High Risk 10</td>
<td>22/10/2018</td>
<td>22/12/2018</td>
</tr>
<tr>
<td>ID</td>
<td>Owner's Role</td>
<td>Specialty</td>
<td>Title</td>
<td>Risk level (initial)</td>
<td>Risk level (current)</td>
<td>Risk level (Target)</td>
<td>Date Reviewed</td>
<td>Review date</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>5522</td>
<td>Director of Strategy and Transformation</td>
<td>Strategy and Transformation</td>
<td>Failure to deliver enabler 2 – Implement Service Line Management across 10 specialities</td>
<td>Moderate 6</td>
<td>Moderate 6</td>
<td>Moderate 4</td>
<td>28/08/2018</td>
<td>26/11/2018</td>
</tr>
<tr>
<td>5523</td>
<td>Director of Strategy and Transformation</td>
<td>Strategy and Transformation</td>
<td>Failure to deliver enabler 3 – Train key people across the organisation in service improvement</td>
<td>Moderate 6</td>
<td>Moderate 6</td>
<td>Moderate 4</td>
<td>28/08/2018</td>
<td>29/10/2018</td>
</tr>
<tr>
<td>5524</td>
<td>Director of Strategy and Transformation</td>
<td>Estates</td>
<td>Failure to deliver enabler 4 – Optimise the Corporate Estate</td>
<td>Significant 12</td>
<td>High Risk 8</td>
<td>High Risk 8</td>
<td>05/11/2018</td>
<td>04/01/2019</td>
</tr>
<tr>
<td>5525</td>
<td>Director of Strategy and Transformation</td>
<td>Health Informatics</td>
<td>Failure to deliver enabler 5 – Replace the core IT Infrastructure</td>
<td>Moderate 6</td>
<td>High Risk 9</td>
<td>Low Risk 1</td>
<td>23/08/2018</td>
<td>15/10/2018</td>
</tr>
</tbody>
</table>
## Appendix 2 – Risk Register

26 approved risks on the Trust risk register with a score of 15 or above

<table>
<thead>
<tr>
<th>ID</th>
<th>Title</th>
<th>Risk level (initial)</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Date Reviewed</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3203</td>
<td>Physical Layout of Endoscopy Decontamination Facility</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>Low Risk 1</td>
<td>12/10/2018</td>
<td>12/12/2018</td>
</tr>
<tr>
<td>3997</td>
<td>Ability to Deliver the TB Service in line with National Guidance (NICE)</td>
<td>Extreme Risk 16</td>
<td>Extreme Risk 16</td>
<td>Significant 15</td>
<td>23/10/2018</td>
<td>23/11/2018</td>
</tr>
<tr>
<td>4174</td>
<td>Clinicians do not always recognise the deteriorating patient</td>
<td>Extreme Risk 16</td>
<td>Extreme Risk 16</td>
<td>High Risk 8</td>
<td>18/05/2018</td>
<td>28/09/2018</td>
</tr>
<tr>
<td>4514</td>
<td>Lack of Substantive Gastro Consultant - Locum led service</td>
<td>Extreme Risk 20</td>
<td>Significant 15</td>
<td>Low Risk 2</td>
<td>23/10/2018</td>
<td>21/12/2018</td>
</tr>
<tr>
<td>4630</td>
<td>Reliability of Infrastructure</td>
<td>Extreme Risk 20</td>
<td>Significant 15</td>
<td>High Risk 10</td>
<td>30/07/2018</td>
<td>01/03/2019</td>
</tr>
<tr>
<td>4632</td>
<td>Risk to patient safety with high number of reported incidents relating to omitted or delayed medication</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>High Risk 9</td>
<td>30/09/2018</td>
<td>30/11/2018</td>
</tr>
<tr>
<td>4740</td>
<td>Risk of Service Interruption due to low staffing levels</td>
<td>Significant 12</td>
<td>Extreme Risk 16</td>
<td>Low Risk 3</td>
<td>07/11/2018</td>
<td>23/11/2018</td>
</tr>
<tr>
<td>4762</td>
<td>Lack of pharmacy staff due to sickness and high vacancy rate affecting all areas of pharmacy service</td>
<td>Significant 12</td>
<td>Extreme Risk 16</td>
<td>High Risk 8</td>
<td>16/11/2018</td>
<td>14/12/2018</td>
</tr>
</tbody>
</table>

109
<table>
<thead>
<tr>
<th>ID</th>
<th>Title</th>
<th>Risk level (initial)</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Date Reviewed</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4959</td>
<td>The Divisions ability to ensure that there are adequate numbers of suitable qualified, competent and experienced nurses</td>
<td>Extreme Risk 20</td>
<td>Extreme Risk 20</td>
<td>Moderate 6</td>
<td>23/10/2018</td>
<td>23/11/2018</td>
</tr>
<tr>
<td>5052</td>
<td>Loss of Interventional Radiology service due to aging imaging equipment and failure – room 4 and room7</td>
<td>Significant 12</td>
<td>Extreme Risk 20</td>
<td>Moderate 4</td>
<td>07/11/2018</td>
<td>10/12/2018</td>
</tr>
<tr>
<td>5066</td>
<td>Failure to meet the targets for initial health assessments of children being brought into care</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>Moderate 6</td>
<td>31/10/2018</td>
<td>31/12/2018</td>
</tr>
<tr>
<td>5076</td>
<td>Failure to achieve the 4 hour access standard</td>
<td>Extreme Risk 20</td>
<td>Extreme Risk 20</td>
<td>Moderate 6</td>
<td>22/10/2018</td>
<td>22/11/2019</td>
</tr>
<tr>
<td>5080</td>
<td>waiting times for bone health clinics</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>11/10/2018</td>
<td>11/12/2018</td>
</tr>
<tr>
<td>5084</td>
<td>Inadequate governance resource across the Trust</td>
<td>Extreme Risk 20</td>
<td>Significant 15</td>
<td>Significant 12</td>
<td>22/10/2018</td>
<td>14/01/2019</td>
</tr>
<tr>
<td>5100</td>
<td>Operational challenge in the delivery of the 4 hour access target (linked to BAF 1 and 2) and underpinned by 4936 and 5345</td>
<td>Extreme Risk 20</td>
<td>Extreme Risk 20</td>
<td>High Risk 9</td>
<td>09/08/2018</td>
<td>17/12/2018</td>
</tr>
<tr>
<td>5268</td>
<td>Non-compliance with CQC Regulation 18 must do action</td>
<td>Extreme Risk 16</td>
<td>Extreme Risk 16</td>
<td>Extreme Risk 16</td>
<td>01/11/2018</td>
<td>30/11/2018</td>
</tr>
<tr>
<td>5331</td>
<td>Failure to manage within the Trusts approved budget and reduce deficit</td>
<td>Extreme Risk 25</td>
<td>Significant 15</td>
<td>High Risk 8</td>
<td>16/10/2018</td>
<td>16/12/2018</td>
</tr>
<tr>
<td>5422</td>
<td>There is a risk of loss of Pathology capacity due to the age of equipment</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>Low Risk 3</td>
<td>10/10/2018</td>
<td>10/12/2018</td>
</tr>
<tr>
<td>ID</td>
<td>Title</td>
<td>Risk level (initial)</td>
<td>Risk level (current)</td>
<td>Risk level (Target)</td>
<td>Date Reviewed</td>
<td>Review date</td>
</tr>
<tr>
<td>-----</td>
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</tr>
<tr>
<td>5442</td>
<td>Inability to fill high number of registered nurse vacancies leading to potentially a reduction in patient experience and safety.</td>
<td>Extreme Risk 20</td>
<td>Extreme Risk 16</td>
<td>Moderate 6</td>
<td>23/10/2018</td>
<td>17/12/2018</td>
</tr>
<tr>
<td>5517</td>
<td>Failure to deliver operational objective 2 – Deliver the financial plan and contract</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>High Risk 10</td>
<td>22/10/2018</td>
<td>22/01/2019</td>
</tr>
<tr>
<td>5521</td>
<td>Failure to deliver enabler 1 – Recruit to the top 30 key posts</td>
<td>Significant 15</td>
<td>Significant 15</td>
<td>High Risk 10</td>
<td>22/10/2018</td>
<td>22/12/2018</td>
</tr>
<tr>
<td>5536</td>
<td>Medical Staffing</td>
<td>Extreme Risk 20</td>
<td>Extreme Risk 20</td>
<td>Significant 12</td>
<td>23/10/2018</td>
<td>23/11/2018</td>
</tr>
<tr>
<td>5557</td>
<td>Cubicle Doors on Children's Ward</td>
<td>Extreme Risk 16</td>
<td>Extreme Risk 16</td>
<td>Moderate 4</td>
<td>24/08/2018</td>
<td>30/11/2018</td>
</tr>
<tr>
<td>5609</td>
<td>Absence due to illness key member of staff</td>
<td>Significant 15</td>
<td>High Risk 8</td>
<td>High Risk 8</td>
<td>28/09/2018</td>
<td>01/01/2019</td>
</tr>
</tbody>
</table>
Appendix 3 – TRFT Risk Appetite

The Rotherham NHS Foundation Trust operates within the South Yorkshire and Bassetlaw Integrated Care System (ICS) footprint; the Sheffield City region and is central to the Rotherham PLACE plan.

As a provider of healthcare in the home, across the community and in hospital the Foundation Trust is regulated by NHS Improvement and the Care Quality Commission.

Delivering high quality services is at the heart of The Rotherham NHS Foundation Trust’s ways of working. As such the Trust is committed to the provision of personalised, safe and effective services and the Board has a low appetite for risk that could compromise the quality and safety of services.

The Trust recognises that its long term service and financial sustainability depends upon the delivery of its strategic objectives and its relationship with its patients, the public, staff (colleagues) and strategic partners.

The Trust is committed to developing partnerships with statutory, voluntary and other organisations that bring value and opportunity to the Trust’s current and future services. Working collaboratively requires a degree of risk to be accepted as the Trust develops longer term strategic plans to make local services resilient and sustainable.

The Trust is supportive of innovation and recognises that it may need to tolerate a higher level of risk whilst pursuing innovation and challenging current ways of practice in order to reduce future risk. The Trust therefore has an appetite for a controlled increase in the level of risk in the short term whilst attaining longer term solutions to the resilience and sustainability of local health and care services.

The Trust is committed to recruiting, developing and retaining its colleagues and has a low appetite for risks concerning staff safety. The Trust also has a low appetite for non-delivery of quality improvement priorities.

The Trust has a low appetite for financial risk in respect of meeting statutory duties but recognises that in order to invest to avoid compromising the quality of care, or maximising opportunities consistent with longer-term service and financial plans some flexibility is required and this could worsen the financial position in the short-term, whilst giving a longer-term return on investment.

In terms of risk to organisational reputation and branding the Trust will take a cautious approach and any decisions that are likely to have significant repercussions will be subject to a thorough risk assessment and will be signed off by a member of the Executive Team.
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>435/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Governance Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Anna Milanec, Director of Corporate Affairs (non-voting) / Company Secretary</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B7 and B8</td>
</tr>
</tbody>
</table>

### Purpose

This report provides an overview / horizon scan of pertinent governance matters arising since the last board meeting which may affect the ability of the Trust to accomplish its objectives.

- NHSI's consultation on wholly owned subsidiaries closed on 16 November, with a copy of the Trust's response, and for comparison, a response from DAC Beachcrofts, provided at appendices 1 and 2 respectively.
- A publication from NHSI relating to findings of the first year reviews of the well led framework provides details of themes arising from those reviews.
- The GMC has updated its guidance for boards and governing bodies in ensuring effective clinical governance.
- Home Office / NHS Digital MOU has been withdrawn after challenge from the Migrants' Rights Network.
- The Kings Fund publish their thoughts regarding a change in legislation.
- The list of the Trust's statutory, regulatory and in-house persons has been reviewed and updated and is provided at appendix 4
- Proposed timings and arrangements for committee meetings in December is provided at appendix 5, and the Board is asked to approve the arrangements outlined in the paper.

### Recommendations

The Board is asked to note the content of the report and appendices 1 – 4.

The Board is asked to approve the proposals relating to board committees, in §7.

### Appendices

1. Trust response to NHSI's consultation on wholly owned subsidiaries
2. DAC Beachcroft LLP response to NHSI's consultation on wholly owned subsidiaries
3. Findings from NHSI's review of the first year of well led reviews
4. Trust Statutory and Regulatory Post Holders
5. December 2018 committee meetings planner
1.0 Introduction

1.1 This report provides an update since the last Board Meeting on 30 October 2018.

2.0 NHS Improvement

Consultation on wholly owned subsidiaries

2.1 The Trust’s response on the wholly owned subsidiary consultation was submitted to NHSI, with details being provided to the Audit Committee. A copy can be found at appendix 1.

2.2 For comparison, a more detailed response from DAC Beachcroft LLP, is provided at appendix 2.

2.3 Updated guidance is expected at the end of December 2018.

Well Led Guidance - update

2.4 On 15 November, the regulator published their report into findings of the first year of their Well Led Reviews guidance, which highlights the findings of organisations who have been asked to undertake the independent reviews for Trusts.

2.5 The themes arising from the findings of the report are provided at appendix 3.

2.6 Whilst the draft report from its own independent review has not yet been received by the Trust, the issues identified from other organisations and included below, provide themes that similar boards may identify with.

Annual Reporting Timelines, 2019/20

2.7 NHSI have published the Foundation Trust Annual Reporting Manual (FT ARM) for 2018/19, with no significant changes from the previous year. 

3.0 General Medical Council (GMC)

3.1 The GMC has published a revised handbook for organisations that employ, contract or oversee the practice of doctors in the UK.

3.2 The Handbook outlines the role of boards and governing bodies in ensuring effective clinical governance for doctors and how this can contribute to high quality patient care. It also provides clear advice about clinical governance processes for doctors including annual appraisal, managing concerns and pre-employment checks.

4.0 Home Office MOU regarding non-British patients

4.1 An earlier Governance Report presented in May 2018 (agenda item 200/18), referred to the serious concerns that had been raised by the Commons’ Health and Social Care Committee in its report into a Memorandum of Understanding on data-sharing between NHS Digital and the Home Office, for the purpose of tracing immigration offenders.

4.2 In May, the government agreed to suspend most of the data-sharing arrangement and limit its use to tracing those being considered for deportation because they had committed a serious crime.

4.3 The Board of Directors was advised that the Trust had not provided requested information on the basis of the legitimacy of the requests.

4.4 It has now been reported that, in the face of a legal challenge brought by the Migrants’ Rights Network, the original Memorandum of Understanding is being scrapped and NHS Digital has now confirmed it will completely withdraw from the data-sharing deal that was made in November 2016.
5.0 Health and Well Being Bulletin

5.1 The Local Government Association have published their 44 page report, ‘Shifting the centre of gravity: making place based person-centred health and care a reality’. [Link](https://www.local.gov.uk/sites/default/files/documents/1.84%20-%20Shifting%20the%20centre%20of%20gravity%20WEB_0.pdf?utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=10006641_NEWSL_HWB%202018-11-19&dm_i=21A8,5YH69,P4WA4Y,ND62A,1)

5.2 The report builds on the ‘Shifting the Centre of Gravity report’, published two years ago, and features some of the work that Rotherham has undertaken in bringing a new perspective to collaborative working in the healthcare sector.

6.0 Amending the Health and Social Care Act 2012: can it be done?

6.1 The Kings Fund have published an article relating to whether amendments to the legislation could be made in the near future. [Link](https://www.kingsfund.org.uk/publications/amending-2012-act-can-it-be-done)

6.2 Issues with the Act relate to the division between provider side (NHSI) and commissioning side (NHSE) being viewed as an obstacle, over-regulation and assurance, the perception that CCG put out too many contracts to tender, unnecessarily, driving expense and delay into the system, the accountability of a more integrated systems and the lack of ability to delegate within that system.

6.3 There are possible options for change. Two of the most recent and substantive ones came just ahead of, and just after, Theresa May’s funding announcement. First the House of Commons Health and Social Care Select Committee put forward recommendations (Health and Social Care Committee 2018); and second, Lord Darzi’s review of health and care for the Institute for Public Policy Research also proposed legislation.

6.4 What is evident, is that even the most modest of proposals would involve major legislative change, and any proposed changes raise fundamental questions concerning the format of the provision of health care. The implications of moving away from the purchase-provider split have been highlighted by some who claim that the relationship brought real gains. One of the goals of the current structure was that locally led, more freestanding bodies would not just compete for NHS services but would have a greater ability to innovate than was perceived to be possible in the more directly managed hospital service that this approach replaced. Despite their greater statutory independence however, history has repeated itself in that foundation trusts have, in practice, lost many of their operational freedoms as the money has once again become very tight.

6.5 Given the widespread dissatisfaction with the current legislation, the Government’s invitation to the NHS to propose changes, makes sense. But even if ‘the NHS family’ can, by next Spring, agree what those changes should be, and if the cross-party Health Select Committee felt able to endorse them, it is far from clear that there is the necessary majority in parliament to deliver primary legislation.

6.6 For as long as the UK remains in the EU, and during any transition period that is finally agreed, legislation may need to be extensive. It is also worth noting that even if there were agreement by next Spring on legislative change, and the government felt able either to facilitate legislation or enact it, this would not be passed before 2020 at the very earliest. Depending on how extensive the changes are, it is likely to be at least 2021 and possibly 2022 before legislative change is implemented.

6.0 Statutory, regulatory and in-house positions held

6.1 Provided at appendix 4 is a refreshed list of statutory, regulatory and in-house positions held by Trust personnel, for information.

7.0 Proposed timings for December board committees

7.1 It is recognised that holding the December board meeting so early in-month presents problems that may not be encountered at other times. Therefore, a revised timetable of proposed submission deadlines, which includes the provision of only one set of papers being sent out for each of the meetings, is provided at appendix 5.
Consultation on NHSI’s Proposed Extension to the Review of Subsidiaries

Trust Response

1. **Do you agree that all subsidiary proposals should be reported to NHS Improvement regardless of value? Yes/No.**

It is assumed that this question relates only to foundation trusts as all non-foundation trust applications to incorporate, already go through a process to be approved by the Secretary of State?

In that case, then yes, agreed. Whilst some subsidiary proposals may well be relatively small in value initially, they are likely to expand in the future if they are deemed to be successful in achieving their initial objectives and more services will ultimately be transferred in due course.

The establishment of subsidiaries is controversial e.g. concerning staff terms and conditions, staff potentially transferring out of the NHS, VAT implications, etc. and they will fundamentally change the way services are delivered within the NHS if successful. Therefore, they need to be established in a planned and controlled manner with clear timelines and objectives for measuring their success or otherwise.

Finally, the reporting window should be defined as to which stage of a process this should be reported, e.g. after/before decision by the board to proceed with the establishment of a company, and whether Council of Governors’ approval is required before the Trust should approach NHSI.

2. **What criteria or threshold do you think should make the creation of a subsidiary a ‘reportable’ transaction?**

Use the existing criteria contained in the document “Transactions guidance - for trusts undertaking transactions, including mergers and acquisitions” updated by NHSI in November 2017. There does not seem to be any specific reasons why there should be separate rules governing the establishment of subsidiaries and provide consistency with other reportable transactions.

However, more clarity on how “our perceived level of its inherent risk”1 is defined, is required, e.g. will the restrictions of sector segmentation have an impact regarding this one transaction?

3. **Do you agree that a ‘material change’ to a subsidiary should also be reported as a transaction? Yes/No. If you do not agree, why not?**

Disagree. Whilst the foundation / trust is governed under ‘NHS’ legislation, the subsidiary, once incorporated, is subject to the Companies Acts, and associated (e.g. insolvency), legislation. i.e. the company is subject to company legislation, and the (NHS) foundation / trust is subject to ‘NHS’ legislation.

Processes would have to be place for reporting to NHSI to be made from the shareholder of the subsidiary (the NHS body), not from the subsidiary itself. As a result, the content of Articles / Matters Reserved would need to be considered.

The directors of the subsidiary company would be bound by Companies Acts legislation. There may be circumstances where actions required by NHSI relating to the shareholders, (after they have reported a material change (if appropriate reporting routes are established), may cause conflict with the duties of the subsidiary’s directors.

Caution required with this proposal.

4. **How do you think a ‘material change’ should be defined?**

This question does not define whether it refers to a ‘material change’ (however defined) in the (NHS) shareholder or the company. It is likely that whilst a material change to one, would affect the other, this is not clear.

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1 Consultation on our proposed extension to the review of subsidiaries, pg 5
As above, using the existing criteria contained in the document “Transactions guidance – for trusts undertaking transactions, including mergers and acquisitions” updated by NHSI in November 2017. There does not seem to be any specific reasons why there should be separate rules governing “material change” to a subsidiary and provides consistency with other reportable transactions.

However, this may also need to be influenced by the historical financial results for an existing subsidiary, as additional services should only be transferring into financially viable subsidiaries with a proven successful financial performance.

5. Do you agree that a panel review is an appropriate way to determine whether a proposal for a subsidiary should be classified as ‘material’ or ‘significant’ and reviewed accordingly? Yes/No. If you agree that a panel review is appropriate, what risk factors should the panel consider to determine whether the proposal is ‘material’ or ‘significant’? If you do not agree, what do you consider is the appropriate way to determine this classification, e.g. set criteria?

Disagree – a panel could be subjective. Instead, we would propose clear, published criteria, perhaps drawing on existing assurance processes such as the single oversight framework.

6. Do you agree with the proposed make-up of the panel? Yes/No. If you do not agree, who should be included on the panel?

If a panel approach is to be considered, then proposals for the panel to include subject matter experts across a number of areas (e.g. pharmacy, pathology and estates) as well as members of NHSI’s transactions review team, seems eminently sensible

N/a – see response to 5.

7. What risk factors should the board certification cover?

The risk factors should align with the requirements of the Single Oversight Framework, Transactions Guidance, and in the case of Foundation Trusts, the provider licence.
Consultation on NHSI’s Proposed Extension to the Review of Subsidiaries

DAC Beachcroft Response

1. Do you agree that all subsidiary proposals should be reported to NHS Improvement regardless of value? Yes/No

Having reviewed the proposals, we do not consider it appropriate for all subsidiaries to be reported to NHSI regardless of value. Furthermore, we do not consider the current proposals to be consistent with NHSI 2020 Objectives. In particular, we refer to Objective 16 which seeks to “focus on high value interactions with providers, minimising any low value or disproportionate regulatory burden”.

We have advised a number of NHS Trusts and Foundation Trusts on the incorporation of wholly and partly-owned subsidiaries for a range of purposes, including to establish integrated care, as well as the provision of services, such as pathology, pharmacy, primary care and estate management. While we accept some transactions of this nature may be novel or complex, the vast majority are relevantly straightforward commercial transactions in line with the respective function of the NHS Trust or Foundation Trust.

Furthermore, it is our view that establishing a regulatory framework where all subsidiary proposals are reportable to NHSI creates an onerous regulatory burden on both Trusts and NHSI. It is important that a balance is struck between the autonomy of Trusts and the requirement for regulatory oversight. Foundation Trusts, in particular, have a statutory right to create, or participate in, corporate bodies and such powers should not be unduly fettered. Similarly, NHS Trusts already require Secretary of State approval for subsidiary arrangements to confirm they are income generating.

The proposals, as set out in the Consultation, are likely to increase pressure on resources, time and professional support for the Trusts involved, as well as NHSI. We understand NHSI’s concerns regarding tax avoidance structures (a matter ultimately reserved for HMRC) and the fact that business cases are required to stand regardless of any consequential VAT savings is of course essential. Notwithstanding this, we also understand that it is essential that subsidiaries are structured in an efficient way to provide the relevant services and therefore specialist support and advice will always be required. Organisations in the private sector would always seek independent financial advice regarding a proposed structure prior to building a business case, it is an essential part of managing risk.

At its best, regulatory oversight should ensure that Trusts are offered guidance and support, and held to account so that they are well-governed and therefore services are of high quality, risks are managed, providers are financially secure, and of course, arrangements are in line with respective statutory functions. The autonomy of Foundation Trusts should not be unduly compromised.

All regulatory oversight should be proportionate to the aims to be achieved and in accordance with best regulatory practice also be transparent from the outset. As currently proposed, much of the proposed regime will be finalised during the first year of operation, after which it will be reviewed. This is likely to have a negative effect on innovation, with many Trusts potentially holding off on their projects as a result.

The consultation also does not seem to consider collaborations between Trusts and Teckal compliant subsidiaries. Such companies are essential in the NHS landscape to make savings and efficiencies for the benefit of patients. Trusts should instead be clearly guided on the governance requirements for such collaborations rather than having a further approval stage.

We would also note that external investment is likely to be stifled if additional regulatory burdens are imposed for subsidiary companies. It is widely accepted that engaging with the NHS to foster innovation is difficult (see for example the Accelerated Access Review and other related policies). The approach being proposed here would add to those difficulties, and has the potential to stifle the subsidiaries working in a nimble and agile way. Start-ups, typically take a number of years to become established and profit generating and sometimes fail. Subsidiaries should be given the latitude to take time to generate profit, and to fail.

It is our overall view that the majority of subsidiary arrangements should not fall into the review process given the current legislative framework. NHSI’s role should be to provide clear guidance to facilitate the set-up of subsidiaries with clear commercial drivers. Clear guidance is key, particular around governance practicalities to ensure successful subsidiary operation. If clearer guidance was available, this may have avoided some of the negative press around certain subsidiaries and the assumptions that are made about them being a “back door to privatisation” and bad news for employees.
We would propose that Trusts (and in particular FTs) are empowered to self-report proposals that are ‘material’ or ‘significant’. We do not agree that there is a need for NHSI to take that decision. Where proposals would be material or significant, then NHSI would be involved, in line with the existing Transactions Guidance.

2. What criteria or threshold do you think should make the creation of a subsidiary a ‘reportable’ transaction?
We would propose that material or significant transactions would be reportable. If NHSI require absolute assurance that any tax savings are only incidental to the primary purpose of every new subsidiary, we consider it would be proportionate for NHSI to direct Trusts to explicitly confirm the same at the board meetings where the subsidiary proposals are approved. We consider this to be within the powers of NHSI given that this would relate to ensuring that subsidiaries are used in accordance with the functions of the Trust.

Additionally, NHSI could link its oversight into the Single Oversight Framework (“SOF”) and seek to regulate arrangements where a particular Trust is within SOF segment 3 or 4 as part of its mandated support.

3. Do you agree that a ‘material change’ to a subsidiary should also be reported as a transaction?
Yes/No. If you do not agree, why not?
No.

“Material changes” should not be reportable as a matter of course, such changes should only be reportable where it would be proportionate to do so, or where a Trust requires additional support from NHSI. Instances where it may be considered proportionate are where such changes in themselves would amount to material or significant transactions (or would change the whole transaction from being one that is below threshold, to one that is above threshold), or where the subsidiary’s parent is within SOF segment 3 or 4.

In respect of any material change to existing subsidiaries, like any subsidiary in the private sector, the subsidiary would have to obtain the consent of its parent/shareholder and it seems excessive to the have to also have such changes approved by NHSI, adding an unnecessary hurdle which could prevent growth and the exploitation of commercial opportunities.

Changes to corporate bodies may be required to reflect changes in law, best practice or governance arrangements as well as changes to reflect current requirements e.g. the Teckal exemption. Requiring Trusts to engage with NHSI may result in a loss of efficiency as it will increase the timescales in which changes are approved in accordance with internal governance requirements and implemented. In our experience clients carefully consider all changes to their subsidiaries and ensure they have clear governance arrangements throughout their group structure to manage and mitigate risks associated with the same.

4. How do you think a ‘material change’ should be defined?
As per above, we do not consider that material changes should be reported as a transaction.

The Consultation states that the proposals will also apply to “material” changes to existing subsidiaries, however, no indicative definition has been provided. NHSI has stated that this will be defined “following consultation feedback and initial reviews.” We consider this to be problematic from a transparency point of view given that, assuming the proposals are implemented as drafted and therefore contained in the next version of the Transactions Guidance, providers are unable to comment on proposed approaches, for example, will “material” be linked to financial thresholds or will there be indicative examples of what may be considered a “material” change? This could result in all providers needing to incur additional costs to determine whether the change is reportable, which may in turn result in further losses due to the requirement to report and progress through the review process. Again, this is likely to be a turn off to potential external investment.

We recommend that NHSI provides some indicative definitions prior to implementing the proposals for comment from Trusts and interested parties so that an initial definition is clear from the outset, acknowledging that this may change as the review process becomes more established.

5. Do you agree that a panel review is an appropriate way to determine whether a proposal for a subsidiary should be classified as ‘material’ or ‘significant’ and reviewed accordingly? Yes/No
No

If you agree that a panel review is appropriate, what risk factors should the panel consider to determine whether the proposal is ‘material’ or ‘significant’? N/A
If you do not agree, what do you consider is the appropriate way to determine this classification, e.g. set criteria?

We would propose that Trusts (and particularly FTs) be empowered to determine this classification.

6. Do you agree with the proposed make-up of the panel? Yes/No. If you do not agree, who should be included on the panel?

No. Where panels are used they should be selected on a case-by-case basis to represent the expertise and experience required for the particular transaction.

7. What risk factors should the board certification cover?

Risk factors should be addressed as they are currently i.e. in accordance with internal governance arrangements. We consider that the following should be covered as part of any board certification process:

- the business case can clearly articulate how the subsidiary will create genuine value for the Trust. This would be consistent with using such structures in accordance with Trust functions;
- the business case stands in the absence of any VAT savings. Again, this is consistent with Trust functions;
- the Trust can clearly articulate how the subsidiary will be established, managed and monitored, including a considered exit strategy and appropriate governance arrangements;
- appropriate licences will be obtained for the purposes of the subsidiary, including the requirement for an NHS provider licence, where relevant;
- confirmation specialist advice and regulatory support has been sought. In our experience with the ISAP, it has been a requirement for commissioners to confirm they have received professional advice (legal and financial) and we would recommend this is a clear requirement.
- Ultimately, however, it is for an individual Trust board to decide that risks have been mitigated or can be effectively managed and so any board certification should not require lengthy reports because this will seek to further increase costs to trusts in terms of advice and resource.

Published 19 November 2018
Findings from NHSI’s review of the first year of well led reviews

KLOE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?

- While boards are generally well run with robust challenge and professional diversity becoming increasingly common, the boards of some organisations struggle to act collectively around genuinely shared priorities. This is especially true when organisations are under operational pressure, are newly formed or have high board turnover.
- Many organisations understand the principles of collective/distributed leadership and inclusivity but find it difficult to realise them in practice. Staff below board-level report limited autonomy and freedom to act, and dominance by some professions at the expense of others.
- System working as STP development accelerates creates a significant and increasing time pressure on boards, and work is often unevenly distributed between board members.
- Succession planning and talent management are generally underdeveloped, though some organisations are doing it very well usually because of board members’ commitment seen in mentorship, coaching and development.
- The balance of business conducted in public and private board meetings can be overly weighted towards private meetings in some organisations.
- There can be a disconnect between the board’s perception of itself and how it is perceived by others, including staff and external stakeholders.

KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

- The tension between organisational and system responsibilities continues to show up as a lack of alignment between trust and local system partner vision. Engagement with local partners in developing strategy is seen as an important opportunity to enhance alignment.
- Staff engagement in strategy development is reported as generally improving, but is not consistent. It was noted that some boards find it difficult to evidence the collaborative approach they say they have taken.
- Understanding by staff below board level of the organisation’s strategic priorities and objectives is inconsistent and probably hampers delivery.
- Particularly in more challenged organisations, the balance between board focus on strategy and current operational pressures is often tilted too much towards the latter.

KLOE 3: Is there a culture of high quality, sustainable care?

- Attention to high quality care and sustainability through a focus on culture and behaviours is generally improving in many organisations but remains challenging. It was noted that some boards find it difficult to evidence what they are doing and assess progress.
- There can be a significant difference between espoused values and leadership behaviours and those that can be seen in practice. Accountability for these differences can be limited in some organisations, and this can perpetuate behavioural patterns especially, for example, where staff turnover is low. In other organisations, by contrast, commitment to espoused values is very clear and embedded in all activities, internally and with external partners.
- Board member approachability and visibility to the wider organisation varies considerably, but lack of approachability is not always perceived by board members themselves.

KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?

- The clarity of accountability frameworks is variable. In some cases, boards were unclear about accountabilities below board level, and in others senior leaders were unclear about the difference between board and executive responsibilities.
- Empowering the sub-executive tier with a complementary and supportive delivery management approach that is maintained during operational pressure came up as a clear development priority.
- Some organisations have overly complex governance structures, which leads to confusion and delayed decision making.
KLOE 5: Are there clear and effective processes for managing risks, issues and performance?

- While focus on risk is generally improving, high quality risk-management is relatively rare. The Board Assurance Framework is underused, and risk registers can focus on operational issues rather than genuine risks, if they are maintained at all.
- Risk management activities can be unco-ordinated and disconnected. They may be seen as burdensome administration, rather than a way to proactively identify and respond to emerging challenges to the achievement of strategic objectives, informing priorities and actions.

KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?

- Board reports are often too long, providing unsynthesised and under-narrated data rather than qualified information. They are also insufficiently focused on the future and on outcomes to enable strategic decision making.
- Board challenge over information presented can tend to focus on data quality rather than what should be done in response to the issues the data is raising.
- Information could be better used to support strategic planning, particularly through the analysis of data over time for improvement rather than just for judgement.
- There are opportunities to improve the triangulation of quality, financial and operational data, including staff and patient surveys to identify opportunities for development.

KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

- Engagement with external partners, including STP partners and local councillors, is noted as a priority improvement area considering the fast-changing and complex nature of system-working. This can be particularly resource intensive and challenging for ‘hub’ organisations such as ambulance trusts that feed into several planning footprints.
- Public engagement is generally good with some innovative approaches; there is some variation in how well less-heard voices are considered.
- Staff engagement is also generally good, though in some cases this is felt to be tokenistic. It was also suggested there could be more support for staff going through more challenging change initiatives.
- Engagement with foundation trust governors varies hugely, with some approaches described as excellent and some as not fulfilling their statutory roles.

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

- Silo working is common and the need for more cross-divisional learning and sharing of good practice is noted as a priority. This extends to working with other organisations.
- Use of quality improvement (QI) methodologies is inconsistent, and QI approaches aren’t aligned to other organisational strategies.
- Board capability regarding using data for improvement and benchmarking varies greatly. Sometimes this data is used in isolation rather than as part of triangulated intelligence.
- Feeding back on concerns, and action in response to internal and external reviews could be improved.
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<thead>
<tr>
<th>Name of regulatory / statutory position</th>
<th>Individual undertaking this regulatory / statutory position</th>
<th>Name of regulation / statute under which they hold this position</th>
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<tbody>
<tr>
<td><strong>Chairman</strong></td>
<td>Martin Havenhand</td>
<td>National Health Service Act 2006, Schedule 7, §16, 1 (b)</td>
</tr>
<tr>
<td><strong>Senior Independent Director</strong></td>
<td>Joe Barnes</td>
<td>Monitor's The NHS Foundation Trust Code of Governance</td>
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<td><strong>Lead for Freedom to Speak Up</strong></td>
<td>Joe Barnes</td>
<td>Sir Robert Francis' Freedom to Speak Up review, February 2015</td>
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<tr>
<td>Lead to oversee and assure delivery of the learning from deaths Non-Executive Director lead for mortality</td>
<td>Mark Edgell</td>
<td>National Guidance on Learning from Deaths (National Quality Board March 2017)</td>
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<tr>
<td>(Lay) NED Lead for End of Life Care</td>
<td>Gabrielle Atmarow</td>
<td>Recommendation from Royal College of Physicians End of Life Care Audit, Dying in Hospital 2016 (national report)</td>
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<td>Board Champion for Dementia</td>
<td>Gabrielle Atmarow</td>
<td>DoH, Living well with dementia: a national dementia strategy 2009, gateway reference 11198, Objective 8 (Leadership in general hospitals)</td>
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<tr>
<td>NED Lead for Procurement</td>
<td>Barry Mellor</td>
<td>DoH, NHS Procurement: Raising our Game, gateway reference 17646, page 19</td>
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<tr>
<td>NED Lead on Lord Carter Review</td>
<td>Barry Mellor</td>
<td>Recommendation from Lord Carter review re Leadership Strategy</td>
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<td>NED Representative on Resuscitation Committee</td>
<td>Gabrielle Atmarow</td>
<td>Health Service Circular 2000/028</td>
</tr>
<tr>
<td>Lead for Maternity &amp; Gynaecology</td>
<td>Gabrielle Atmarow</td>
<td>Recommendation from CQC / RCG</td>
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<tr>
<td>NED Lead on Supporting Clinical Performance</td>
<td>David Hannah</td>
<td>Non-statutory / Non-regulatory</td>
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<tr>
<td>NED Lead on Voluntary Sector Engagement</td>
<td>Lynn Hagger</td>
<td>Non-statutory / Non-regulatory</td>
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<tr>
<td>Chair of Organ Donation Committee</td>
<td>Barry Mellor</td>
<td>Non-statutory / Non-regulatory</td>
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<tr>
<td>NED Lead on developing relationship with local Healthwatch</td>
<td>Joe Barnes</td>
<td>Non-statutory / Non-regulatory</td>
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<td>NED liaison for Division of Family Health</td>
<td>Gabrielle Atmarow</td>
<td>Non-statutory / Non-regulatory</td>
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<td>NED liaison for Division of Integrated Medicine</td>
<td>David Hannah</td>
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<td>NED liaison for Division of Surgery</td>
<td>Joe Barnes</td>
<td>Non-statutory / Non-regulatory</td>
</tr>
<tr>
<td>NED liaison for Division of Clinical Support</td>
<td>Barry Mellor</td>
<td>Non-statutory / Non-regulatory</td>
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**Executive Directors**

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<th>Name</th>
<th>Individual undertaking this regulatory / statutory position</th>
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<tbody>
<tr>
<td><strong>Chief Executive</strong></td>
<td>Louise Barnett</td>
<td>National Health Service Act 2006, Schedule 7, §16, 1 (a)</td>
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<tr>
<td><strong>Accounting Officer</strong></td>
<td>Louise Barnett</td>
<td>National Health Service Act 2006, Schedule 7, §16, 1 (a)</td>
</tr>
<tr>
<td><strong>Director of Finance</strong></td>
<td>Simon Sheppard</td>
<td>National Health Service Act 2006, Schedule 7, §16, 1 (a)</td>
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<tr>
<td><strong>Registered Nurse or Registered Midwife</strong></td>
<td>Angela Wood</td>
<td>National Health Service Act 2006, Schedule 7, §16, 2</td>
</tr>
<tr>
<td><strong>Registered medical practitioner or registered dentist</strong></td>
<td>Callum Gardner</td>
<td>National Health Service Act 2006, Schedule 7, §16, 2</td>
</tr>
<tr>
<td><strong>Caldicott Guardian</strong></td>
<td>Callum Gardner</td>
<td>Health Service Circular: HSC 1999/012</td>
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<tr>
<td><strong>Responsible Officer</strong></td>
<td>Dr Alison Cooper</td>
<td>The Medical Profession (Responsible Officers) Regulations 2010</td>
</tr>
<tr>
<td><strong>Executive Director with responsibility for the learning from deaths agenda</strong></td>
<td>Callum Gardner</td>
<td>National Guidance on Learning from Deaths (National Quality Board March 2017)</td>
</tr>
<tr>
<td><strong>Executive Director for mortality</strong></td>
<td>Callum Gardner</td>
<td>National Guidance on Learning from Deaths (National Quality Board March 2017)</td>
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<td>Individual undertaking this regulatory / statutory position</td>
<td>Name of regulation / statute under which they hold this position</td>
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<td>----------------------------------------</td>
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<tr>
<td>Accountable Emergency Officer (responsible for Emergency Preparedness, Resilience and Response)</td>
<td>George Briggs</td>
<td>Health &amp; Social Care Act 2012, §46 (9)</td>
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<tr>
<td>CQC Nominated Individual</td>
<td>Angela Wood</td>
<td>Health &amp; Social Care Act 2008 (Regulated Activities) regulations 2014 - Regulation 6</td>
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<td>Executive Lead for safeguarding</td>
<td>Angela Wood</td>
<td>Children Act 2004 §11 / Working Together to Safeguard Children 2015 (statutory guidance)</td>
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<tr>
<td>Executive Lead for Sustainable Development Plan</td>
<td>Chris Holt</td>
<td>Non-statutory / Non-regulatory</td>
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<tr>
<td>Executive Lead for End of Life Care</td>
<td>Angela Wood</td>
<td>NHS Protect: 1.1 A member of the executive board or equivalent body is responsible for overseeing and providing strategic management and support for all security management work within the organisation.</td>
</tr>
<tr>
<td>Executive Lead for Security</td>
<td>Simon Sheppard</td>
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<tr>
<td>Senior Information Risk Owner</td>
<td>Anna Milanec</td>
<td>David Nicholson letter dated 20 May 2008 (Gateway reference 9912) / version 6 of the NHS IG Toolkit</td>
</tr>
<tr>
<td>Named nurse (Safeguarding Adults) Trust-wide</td>
<td>Jean Summerfield</td>
<td>The Care Act 2014</td>
</tr>
<tr>
<td>Named Nurse</td>
<td>Karen Holgate</td>
<td>Looked After Children: Knowledge, Skills and Competences of Health Care Staff (Intercollegiate Role Framework March 2015)</td>
</tr>
<tr>
<td>Data Protection Officer</td>
<td>Derek Stowe</td>
<td>Data Security &amp; Protection Toolkit / DPA 2018</td>
</tr>
<tr>
<td>Designated Individual</td>
<td>Kath Lowe, Senior BMS Histopathology</td>
<td>Human Tissue Act 2004</td>
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<tr>
<td>Lead for Transfusion Medicine</td>
<td>Richard Went, Consultant Haematologist</td>
<td>Medicine Healthcare Regulatory Agency - Blood Safety and Quality Act</td>
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<tr>
<td>Blood Bank Manager</td>
<td>Rob Stirk</td>
<td>Blood Safety and Quality Regulations 2005,</td>
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<tr>
<td>Medical Physics Expert (Nuclear Medicine)</td>
<td>Duncan White</td>
<td>Ionising Radiation (Medical Exposure) regulations 2000</td>
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<tr>
<td>Radiopharmacy Production Manager</td>
<td>Carolyn Day</td>
<td>Medicines (Standard Provisions for licences and Certificates) regulations 1971, EU Good Manufacturing Practice, MHRA Specials</td>
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<tr>
<td>Radiopharmacy Responsible Person for Quality Control</td>
<td>Duncan White</td>
<td>Medicines (Standard Provisions for licences and Certificates) regulations 1971, EU Good Manufacturing Practice, MHRA Specials</td>
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<tr>
<td>Radiation Protection Supervisor</td>
<td>Pamela Rockett</td>
<td>Ionising Radiation Regulations 1999</td>
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<td>Radiation Protection Supervisor</td>
<td>Lisa Hickling</td>
<td>Health &amp; Safety Executive</td>
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<tr>
<td>Radiation Protection Supervisor</td>
<td>Mark Buckley</td>
<td>Health &amp; Safety Executive</td>
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<td>Bernie Chamber</td>
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**Board of Directors’ Meeting**  
**27 November 2018**

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**Executive Summary (including reason for the report, background, key issues and risks)**

To present a report on the Trust’s current Mortality Review Process and performance, and to provide the Board with an update on planned next steps.

The key points arising from the report are:

- The concept of reviewing deaths and reporting to NHS improvement within a national framework for case record reviews is now embedded within the Trust.
- However, challenges remain in place as regards the timeliness and proportion of deaths undergoing a mortality review process, particularly in medicine.
- Whilst there have been sustained improvements within our mortality data by concentrating on themes and trends, the national mortality picture has also improved.
- There is a real opportunity to revise, refresh, and reinvigorate our current mortality review processes.

**Recommendations**

It is recommended that:

The Board receive this report for noting

**Appendices**

1. Mortality Review Screening tool Nov 2016
2. NMCRRP_Guide for reviewers
3. NMCRR Annual Report 2018
4. NQB National Guidance Learning From Deaths
5. Trust Mortality Policy
6. Mortality toolkit
1. Introduction

1.1 It is encouraging to report that the Trust position on 12-month rolling HSMR has continued to remain static at 104, in line with the national static picture. However, it is important to make improvements rather than continue to remain in the same position each month, and there are opportunities to drive further improvement by tightening up on our mortality review process, and the subsequent imbedding of any learning and reflection (both positive and negative) that fall out of them.

1.2 The purpose of this report is to give the Board an update on the Trust’s current Mortality Review Process and performance, and to provide an overview on planned next steps.

2. Background

2.1 The trust has developed the mortality governance process to be structured in a way whereby issues can be highlighted and acted upon, and whereby both the Medical Director and the Board have visibility of all aspects of mortality within the Trust.

2.2 The Trust’s “Mortality Policy” highlights the review process, the escalations required of divisions following these reviews, and the actions to be taken if problems are been identified. This policy also includes the process of learning from those deaths and the dissemination of the actions taken across the organisation.

2.3 The “National guidance on learning from deaths” and the “Serious incident Framework” are complementary. When a death meets serious incident criteria, the onset of the investigation is not delayed by waiting for a case record review, as a review of the record will inevitably be undertaken as part of the investigation process.

3.0 Current Trust Process

3.1 The Trust currently aims to review all mortality cases by using the case record review; these processes have a significant resource attached to it and, at present, can only review a proportion of cases in depth. Some divisions are more readily able to review all cases, simply due to having a lower number of deaths in their respective specialties, such as in maternity and surgery. Indeed, as most deaths occur in the division of integrated medicine, it is a significant challenge to review all deaths. In this situation, it has been deemed appropriate for a proportion to be reviewed, in addition to reviewing the notes of all identified serious incidents and inquests, and when diagnosis codes trigger a review in-depth review.

3.2 All paediatric deaths are reviewed within the division and the wider paediatric community for areas of improvement and learning, and does not follow the same process currently as the adult population within the Trust. A national review of the paediatric process is also due at a later date, following which we will aim to follow any updated guidance once published.

3.3 The Learning from death review in learning disabilities patients has also been introduced within the Trust, which is a more in-depth review than simply the hospital admission and medical management. Indeed, it involves all services from birth to death, including the opinions of families and carers.

3.4 The Trust uses the PRISM scoring system, which has a scale for “avoidability”, and a score for both clinical care given and organisational aspects of the care given. It is worthy of note that the Improvement Academy has been lobbying the Department of Health in order to try to remove the concept of “avoidability”, as this is not seen to be a helpful indicator, to which the Department of Health have agreed in principle.

3.5 The Trust’s “Mortality Policy” states that mortality reviews “will take the format of Structured Judgement Review [SJRs], with comments regarding the care given at all stages of the patient journey. Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase,
and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.”

3.6 Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care. With the help of the bereavement and Patient Experience team, the Trust can now capture the views of patient’s families if they wish to comment on the patient’s admission before death.

4.0 Current Performance in Learnings from Reviews

4.1 The policy is in line with the national stance on reviews and actually goes further than national guidance, in that the NCEPOD scoring is calculated following in-depth reviews, which Dr Kelly, Trust Mortality Lead, believes is the most powerful outcome of such reviews, as “this is where quality of care at all stages of the admission is considered rather [just] than the ‘avoidability’.”

4.2 The majority of deaths are unavoidable (nationally only 3% of deaths are avoidable), but if the quality of care prior to that predicted death was undesirable, than that is where a Trust can improve considerably. As a Trust, we therefore need to ensure that we focus most of our attention on this element.

4.3 Despite the fact that our current policy states that “it is expected that all deaths... will be subjected to a mortality review”, this is not happening consistently. Indeed, mortality reviews have declined in medicine and this needs to be a clear area of focus. Whilst I am told that this is in part due to the sheer volume of reviews required, there is also a perception that there may have been some active disengagement. Whether this is the case or not, it is evident that we need to get through any outstanding backlog (I am trying to establish the extent of this), and to review our current policy and review process.

4.4 As sepsis remains an area of focus, and the fact that we had an alert on sepsis in July, Dr Kelly has done a superficial audit on diagnosis codes for sepsis for patients admitted in 2018. Following this, there are a few more in-depth case note reviews that she is going to conduct, after which she will report her findings to me. However, the case note reviews that have already been done have shown that all cases reviewed were NCEPOD 1 (where care was good) and PRISM score 1 (which highlights that there was no avoidability), which is encouraging.

5.0 Future improvement opportunities

5.1 Whilst Dr Kelly has also worked very hard at trying to improve the number and quality of our mortality reviews, particularly focusing on medicine, and to ensure that there is appropriate learning from deaths, we need to further tighten up our current processes. Indeed, only by doing so can we hope to ensure that all available learning is realised and used constructively and appropriately in order to drive continuous quality and safety improvements.

5.2 In-depth mortality reviews of all deaths is not practical, not least as it should take up to an hour per review to get a good review, and nowhere nationally is doing this. Indeed, we believe that Newcastle is the closest to achieving this, and they pay 2 consultants 2 PAs per week to review as many deaths as possible, as well as certain diagnosis codes etc.

5.3 If all the medical consultants reviewed 2 deaths per month, which should at least in theory be more than achievable, a reasonable cohort of deaths could be reviewed. However, there are many consultants who do not review any mortality and is particularly educational to review mortality cases. Indeed, everyone should be learning from deaths, not least as it forms part of consultant's revalidation process, for which they get SPA time.

5.4 I also think we need to consider adopting a stage 1 and stage 2 approach to mortality reviews (see appendices 1-5), with only those flagging any potential concerns going on to have a more
detailed review; on the back of this, we also need to consider adopting the national Improvement Academy’s Structure Judgement Review (SJR) process, which involves identified clinicians undergoing national SJR training. Either process we adopt should in turn lead to more actual learning from such deaths, rather than just tick a box to say it has been reviewed, thus in turn further improving clinical outcomes for other patients and our overall mortality indices.

5.5 Although the Trust does have a mortality group, they have been ad hoc and attendance has often been poor. For the foreseeable future, I am going to chair these meetings moving forward, and am also reviewing the standing agenda, membership and Terms of Reference. In particular, it is essential that all divisions are routinely represented.

5.6 Through the reinvigorated mortality group, I am aiming to obtain consensus as to our mortality review process moving forward; this will also need to involve our Divisional Directors, who will be invited to the next meeting.

5.7 With the new senior medical leadership structure, there will also be an Associate Medical Director (Patient Safety), one of whose roles will be to lead on mortality. It is also imperative that there is attendance from all divisions, in particular their respective mortality leads. On this basis, there is also a need to review what mortality leads we currently have, whether they are the right individuals and/or fulfilling their respective roles and responsibilities, and where there are gaps.

5.8 There is likely scope to further improve our mortality data by improving the identification of patients who are at the end of their life and who require palliation and DNACPR, rather than active treatment. Dr Rod Kersh is currently undertaking an audit on cardiac arrest deaths, which should help inform us as to where we need to focus our improvement efforts.

5.9 There is also a need to quality assure the reviews being done and the scoring accuracy. There will be rolling training programmes for reviewers to ensure that reviews are within reasonable boundaries, taking into account that differing reviewers will have differing considerations to the case record review. Ultimately, the scoring should not deter from the learning, which is the key to the process and should have the greatest focus.

6.0 **Summary**

6.1 The concept of reviewing deaths and reporting to NHS improvement within a national framework for case record reviews is now embedded within the Trust. However, the proportion of deaths reviewed overall has dropped, particularly in medicine, and needs a particular refocus.

6.2 The improvement within the mortality data has shown that by concentrating on themes and trends, and continual review of the mortality data, that the national mortality picture can be improved. However, as the national mortality picture is improving, we need to be cognisant that other Trusts may be making faster improvements. There is therefore a real opportunity to revise, refresh, and reinvigorate our current mortality review processes, which I will continue to drive forward.

Dr Callum Gardner  
Interim Medical Director  
November 2018
Mortality Review screening tool

**Cause of death:** (as recorded on the Death Certificate)
1a..............................................................................................................................................................................................

Date of admission | Please affix patient label:
--- | ---
Source of admission | 
Date of death | 
Consultant | 

1b..............................................................................................................................................................................................................
1c..............................................................................................................................................................................................................
2..............................................................................................................................................................................................................

**Clinician’s assessment:**
- Reason for admission
- Main treating diagnosis

**Brief summary of case.**

Was the admission potentially avoidable? Y/N

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<td>Failed/delayed escalation of deteriorating patient</td>
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<td>Inadequate fluid balance monitoring</td>
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<td>Learning disability/mental health problem</td>
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*If answered YES to any of the above, to go for full Structured Judgment Review*
Using the Structured Judgement Review method
A guide for reviewers
2017
Dr Allen Hutchinson

Emeritus professor in public health
University of Sheffield

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Structured Judgement Review

1 Background to the method and its strengths

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, review methods need to be standardised, yet not rigid, and usable across services, teams and specialties.

Structured Judgement Review (SJR) blends traditional, clinical-judgement based, review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The object of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. In order to ask these questions, there is a need to look at the whole range of care provided to an individual; holistic care approaches; the nuances of case management; and the outcomes of interventions.

Structured judgement case note review can be used for a wide range of hospital-based safety and quality reviews across services and specialties, and not only for those cases where people die in hospital. For example, it has been used to assess care provided for people who have had a cardiac arrest in hospital, to review safety and quality of care prior to and during non-elective admission to intensive care settings and to review care for people who are admitted at different times of the week.

An important feature of the SJR method is that the quality and safety of care is judged and recorded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that has been judged to be problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learnt from the evaluation of high-quality care.

2 How the Structured Judgement Review method works

2.1 Who does what and when?

There are two stages to the review process. The first stage is mainly the domain of what might be called ‘front-line’ reviewers, who are trained in the SJR method and who undertake reviews as part of the hospital mortality review programme. There is evidence of a wide range of approaches being taken to case and reviewer choice, including cases being selected through the governance process or within a reviewer’s own services or directorates; reviews sometimes taking the form of morbidity and mortality (M&M) reviews and sometimes taking the form of a team looking at the care of groups of cases. This is where the bulk of the reviewing is done and most of the reviews are completed at this point.

A second-stage review is recommended where care problems have been identified by a first-stage reviewer and an overall care score of 1 or 2 has been used to rate care as ‘very poor’ or ‘poor’ or where harms have been identified. This second-stage review is usually undertaken within the hospital governance process, using a variety of approaches, which could include a repeat ‘validation’ SJR by a second reviewer.
2.2 Phases of care – the ‘structure’ part of the method

The phase of care structure provides a generalised framework for the review and also allows for comparisons among groups of cases at different stages of care. The principal phase descriptors are shown in Box 1. However the use of the phase structure depends a lot on the type of care and service being reviewed – not all phase of care headings will be used for any particular case. Thus the procedure-based review sections may only be required in a limited number of medical cases (e.g., lumbar puncture, a chest drain or non-invasive ventilation) but are likely to be used in most surgical cases. It is up to the reviewer to judge which phase of care forms are appropriate in a particular case.

Box 1 Phase of care headings
- Admission and initial care – first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative / procedure care
- End-of-life care (or discharge care*)
- Assessment of care overall

*Note that discharge care is included because this method is just as applicable for the review of care for people who do not die during an admission.

2.3 Explicit judgement comments – the core of the method

The purpose of the reviews is to provide information from which teams or the organisation can ask ‘why’ questions, and to support quality improvement. Explicit judgement commentaries serve two main purposes. First, they allow the reviewer to concisely describe how and why they assess the safety and quality of care provided. Second, they provide a commentary in a way that other health professionals can readily understand if they subsequently look at the completed review.

When asked to write comments on the quality and safety of care, clinical staff often tend to write a resume of the notes or make an implicit critique of care. This is not helpful when others try to understand the reviewer’s real meaning. So the central part of the review process comprises short, written, explicit judgement statements about the perceived safety and quality of care that is provided in each care phase.

This review guide does not include a glossary of explicit terms that reviewers might choose from, because this approach would inevitably be constraining or would fail to cover all eventualities in the complexities of clinical practice. Instead, reviewers are asked to use their own words in a way that explicitly states their assessment of an aspect of care and gives a short justification for why they have made the assessment.

Explicit statements use judgement words and phrases such as ‘good’ or ‘unsatisfactory’ or ‘failure’ or ‘best practice’.
Box 2 Examples of phase of care structured judgement comments

- Continued omission to provide oxygen and respiratory support – poor care.
- Team still failed to discuss potential diagnosis with patient – unsatisfactory.
- Referral to the intensive treatment unit (ITU) was too late.
- There was some evidence of good management by overnight team, with prompt review and intervention.
- Although the patient was discussed with a consultant once and an SpR once, for 4 days they were only seen by junior doctors. This is completely unsatisfactory.
- Very good care – rapid triage and identification of diabetic ketoacidosis with appropriate treatment.

These judgement words are included in short statements that provide an explicit reason why a judgement is made – eg ‘unsatisfactory because, etc’ and ‘for example, resuscitation and ceiling of treatment decisions made far too late in course of admission – poor care’. The purpose here is not to write long sentences but to encapsulate the clinical process in a few explicit statements.

Box 2 contains some examples.

Judgement comments should be made on anything the reviewer thinks is important for a particular case. Among other things, this will include the appropriateness of management plans and subsequent implementation together with the extent to which, and how, care meets good practice. In some cases, there may be care in a phase that has both good and poor aspects. Both should be commented on.

Commentary on holistic care is just as important as that on technical care, particularly where complex ceiling of treatment and end-of-life care discussions might be held. Judgements should be made on how the teams have managed end-of-life decision making and to what extent patients and their relatives have been involved. Thus, for example, a judgement comment might be couched as ‘end-of-life care met recommended practice, good ceiling of treatment discussion with patient and family’. Similar approaches and levels of detail are required when care is thought not to have gone well, or where aspects of care are judged only just acceptable. Then words such as ‘unsatisfactory’, ‘poor’ or ‘doesn’t meet good practice standards’ might be necessary.

Sometimes it is not possible to get a clear view from the records about why clinical decisions have been made, or there appears to be a lack of decision making or guidance. Here, judgement words such as ‘delay’, ‘poor planning’, ‘lack of leadership’ etc may be used. Where this lack of clarity is due to the level of documentation, comments such as ‘inadequate record keeping’ may apply.

Overall phase of care comments are intended to bring a focus to the review by asking for an explicit, clear judgement on what the reviewer thinks of the whole care episode, taking all aspects into consideration. It is not necessary to repeat all of what has been commented on before, although it is sometimes useful to repeat some key messages – that is a reviewer’s choice. Again, however, it is important to make clear and explicit what the overall judgement is and why. Examples are given in Box 3.
Box 3 Examples of overall care structured judgement comments

- Overall, a fundamental failure to recognise the severity of this patient’s respiratory failure.
- Good multidisciplinary team involvement.
- On the whole, good documentation of clinical findings, investigation results, management plan and discussion with other teams.
- Poor practice not to be aware of the do not attempt resuscitation (DNAR) status of patient, especially when it has been discussed with the family, clearly documented when first put in place and reviewed later on.

Cause of death information should if possible form part of the review framework. If, on review, the certified cause of death causes the reviewer some concern, this should be explicitly stated, since there may be a clinical governance question involved.

So, the overall message about review language is that it should be explicit and clear, in order that you, the reviewer, feel you have made the points clearly and that others who read the review will be able to understand what you have said and why.

2.4 Giving phase of care scores

Box 4 Phase of care scores

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Care scores are recorded after the judgement comments have been written, and the score is in itself the result of a judgement by the reviewer. Only one score is given per phase of care: it is not necessary to score each judgement statement.

Scores range from ‘Excellent’ (Score 5) to ‘Very poor’ (Score 1) – see Box 4 – and are given for each phase of care commented on and for care overall.

These scores have a number of uses. For the individual reviewer, scores help them to come to a rounded judgement on the phase of care, particularly when there may be a mix of good and unsatisfactory care within a phase. The reviewer must judge what their overall decision is about the care provided for each phase and for care overall. Scoring makes this very explicit.

Overall care scores are particularly important in the review process. A score of 1 or 2 is given when the reviewer decides that care has been ‘very poor’ or ‘poor’. Research evidence suggests that this might happen in upwards of 10% of cases in some circumstances, but less in others. A score at this level should trigger a second-stage review through the hospital clinical governance process (see Section 2.1).

The full data collection tool is available from the Royal College of Physicians (RCP) website: www.rcplondon.ac.uk/mortality
2.5 Judging whether problems in care have caused harm

Problems in care take many forms and may have a range of impacts, some of which are potential rather than actual. Some of these events cause harms, but many do not.

The first-stage reviewer has an important role here in assisting the hospital to identify both actual and potential threats to patient safety.

The assessment of problems makes two important contributions. First, it is of importance in clarifying the issues within individual reviews. Second, the information that is aggregated within the hospital across reviews may pick up more fundamental care process issues that require attention.

Reviewers are asked three questions in relation to problems identified in care. These are in the following format.

A) Were there one or more problems in care during this admission? Yes or no
B) If so, in which area(s) of the care process and care phases did this/these occur?
C) For each of these problems, did any cause harm?

There is a free text box for a description of the problem. The data collection format is outlined further in Appendix 1.

2.6 Judging the quality of recording in the case notes

Case note review of course depends critically on the content and the legibility of the records. Safety of care also depends to some extent on good record keeping. Therefore, as part of the overall care assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records, again using a score of 1–5.

3 The review in practice

Case note review takes up expensive clinical resource so that time spent on establishing the purpose and desired outcome of the review is important. Case selection is increasingly being seen as a hospital policy issue and many organisations are now formalising review governance and management.

In some hospitals, the majority of mortality reviews take place in an M&M context and so they are often already being considered to be potentially problematic cases. SJR has been found to be of value in providing a reproducible process for these M&Ms.

However the challenge for hospitals has often been the gathering together of the material from these M&M reviews so that it can be used to examine care processes beyond the individual case. Data from M&M cases should be entered into the hospital reviews database. Aggregated information is more powerful in the longer term than the data from individual cases.

Another approach to case selection is to evaluate care for all or some patients who come to a particular service, or to explore the care provided for the majority of people who die in hospital over a particular time period in particular services; for example, all elective surgery deaths or cases dying from acute kidney injury might require review.
For many situations, given the constraints on reviewer availability and the need to produce usable information from the reviews, the principle of ‘less done better is more’ applies.

In some situations a simple time-based longitudinal sample of around 40–50 cases will produce a rich source of quantitative and qualitative information about what goes right and what is not working properly. Timely review, rather than review after a delay, provides better information.

Time spent on the analysis and information presentation outweighs the benefit of adding a few more cases to the sample. The textual information allows for themes to be developed and that then allows a focus for the next improvement steps. Such an approach also has the benefit of being able to learn from, and celebrate, the cases where care has gone well.

An e-learning guide to undertaking the analysis of the quantitative and qualitative data provided by SJR will be available through the Royal College of Physicians National Mortality Case Record Review Programme later in 2018.
Appendix 1 – Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here)  Yes ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls):* Yes ☐
   Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic):* Yes ☐
   Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE):* Yes ☐
   Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

4. **Problem with infection control:** Yes ☐
   Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

5. **Problem related to operation/invasive procedure** *(other than infection control):* Yes ☐
   Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes):* Yes ☐
   Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR)):* Yes ☐
   Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐

8. **Problem of any other type not fitting the categories above:** Yes ☐
   Did the problem lead to harm? No ☐ Uncertain ☐ Yes ☐


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Editorial note

This document has been adapted with permission from: Hutchinson A, McCooe M, Ryland E. A guide to safety, quality and mortality review using the structured judgement case note review method. Bradford: The Yorkshire and the Humber Improvement Academy, 2015. (Copyright The Yorkshire and the Humber Improvement Academy.)

The case note review methods discussed in this guide were primarily developed in a research study published as: Hutchinson A, Coster JE, Cooper KL, McIntosh A, Walters SJ, Bath PA et al. Comparison of case note review methods for evaluating quality and safety in health care. Health Technol Assess 2010;14(10):1–165.

All clinical examples and structured judgement comments in this document are taken from hypothetical scenarios.

References


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Annual report
2018
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Dr Roderick Harvey – Board medical director – NHS Highland, Scotland
Other acknowledgments

The NMCRR programme team would like to thank colleagues who supported the delivery of SJR training sessions throughout England:

Dr Emma Redfern – Consultant in emergency medicine and associate medical director for patient safety – West of England Academic Health Science Network

Dr Mark Callaway – Interim medical director – University Hospitals Bristol NHS Foundation Trust

Dr Peter Wanklyn – Consultant physician – York Teaching Hospital NHS Foundation Trust

Dr Nigel Kennea – Associate medical director – St George’s Healthcare NHS Trust, London

Dr Stephen Webb – Consultant in anaesthesia and intensive care – Royal Papworth Hospital NHS Foundation Trust

Dr Wojtek Rakowicz – Consultant neurologist – Hampshire Hospitals NHS Foundation Trust

In addition the NMCRR programme team would like to thank:

Beverley Slater – Director – Yorkshire and Humber Improvement Academy

Michael Rooney – Senior improvement analyst – Yorkshire and Humber Improvement Academy

Professor John Wright – Clinical director – Yorkshire and Humber Improvement Academy

Phillip Taylor – Chief operating officer – Datix

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The NMCRR Programme team would also like to thank Dr Kevin Stewart and Rhona Buckingham for their early commitment to the programme.
Foreword

Just under half of deaths in England occur in hospital and around one in three hospital beds is occupied by someone who is in the last 12 months of their life. A large and growing proportion of the hospital population is people living with age-related problems including frailty and dementia, and there are adults of all ages living with (often multiple) long-term medical conditions.

With a growing focus on early front door assessment, treatment, earlier transition from hospital and alternatives to admission for unscheduled care of acute patients, those patients who are admitted have increasing levels of acuity and medical complexity. Even in patients admitted electively overnight for procedures and surgery, the patient case mix is growing older and more medically complex.

We could doubtless do more to ensure fewer people are in hospital towards the end of their life by providing alternative services and planning outside hospitals. However, with the landscape as it is, we must place a strong focus on doing more to improve the quality of care within hospital for those people continuing to require admission.

The National Survey of Bereaved people has shown that while most families find the experience of end-of-life care ‘good’ or ‘excellent’, there are failings which we could do more to avoid. National Clinical Audit of End-of-Life Care in Hospitals has confirmed this impression. There is also evidence from the National Confidential Enquiry into Perioperative Deaths, the National Sepsis Campaign – from the work used to develop Early Warning Scores and Critical Care Outreach Services, and from hospitals’ own internal audits around resuscitation calls, of care gaps in the run up to patient deaths.

A number of national audits as well as emerging data from the Getting it Right First Time and NHS ‘Right Care’ Atlas have shown that we still have major variation in care processes and outcomes including mortality across NHS hospital systems.

In 2015, Hogan et al published a study based on a review of 100 case notes from each of 34 randomly selected hospitals, using detailed case note review and statistical regression analysis, concluding that approximately 3.6% of deaths in NHS hospitals had at least a 50% chance of being avoidable. The authors acknowledged that especially in older, frailer, people this determination required nuanced, skilled judgment and could not be certain. A major lesson of this work and the national audits is that it does require structured, skilled case note review to identify gaps, delays or failings in care and to determine to what extent a death might have been preventable.

Meanwhile, national NHS leadership, in the form of the secretary of state for health, NHS Improvement and NHS England, have been active in driving national policy to ensure that we investigate deaths in hospital more closely and use the learning from deaths to help drive systematic improvements. One initiative is the planned introduction by April 2019 of Medical Examiners in every NHS trust to examine all death certificates. Another is The National Quality Boards’ (representing NHS Improvement, NHS England, the Care Quality Commission and Public Health England) national Learning from Deaths Programme. This includes information and guidance for trusts on learning from deaths and reporting.
Learning from Deaths required all trusts to carry out mortality reviews by 2017 and to publish a quarterly dashboard reporting their data on deaths, including data on preventable deaths and reports on their actions to learn and improve. Sometimes the political and media narrative has focussed on the relatively small percentage of deaths which appear preventable. It has also rightly majored on the need for better information and support for the bereaved – not only those who have raised complaints or concerns or been through coroners’ inquests.

To support the work at a national level on deaths in hospital, the National Mortality Care Record Review Programme (NMCRR) was launched in 2016 to review retrospectively the quality of a deceased patient’s care from hospital admission to death.

Commissioned by the Healthcare Quality Improvement Partnership (HQIP) with funding from NHS Improvement and the Scottish Government, the Royal College of Physicians NMCRR programme is contracted to develop and offer to all NHS hospitals in England and Scotland a validated Structured Judgment Review (SJR) tool for case notes of patients who have died, alongside delivering educational support for local reviewers and trainers of those reviewers.

At the time of writing, 106 trusts in England and 1 health board in Scotland are using the SJR as a key part of their wider national mortality case record review work.

The feedback from practitioners using the tool, and from organisational leaders using its findings to learn from deaths and use the learning for improvement, has been overwhelmingly positive. Many trusts have now used the learning as the starting point for locally led quality improvement work. Some of the learning and improvement examples are presented in this report and will feature at our inaugural NMCRR conference, hosted by the RCP in October 2018.

We have co-ordinated public involvement so far in the steering group and IAG meetings, and RCP Patient and Carer Network members have read and commented on the annual report.

For 2018/19 as the use of SJR becomes embedded in trusts and may be adopted by more of them, we plan to publish a further evaluation and update report on its adoption and use to improve care.

Professor David Oliver – Clinical vice president, Royal College of Physicians
Executive summary

The National Mortality Case Record Review (NMCRR) programme is a 3-year programme which began in 2016, was commissioned by the Healthcare Quality Improvement Partnership (HQIP) and is funded by NHS Improvement (NHSI) and the Scottish Government. The programme was created and is delivered by the Royal College of Physicians (RCP) in conjunction with partners at the Yorkshire and Humber Improvement Academy and the software company Datix.

This report is intended to be of general interest to all healthcare professionals but specifically is aimed at those who are responsible for patient safety and quality improvement (QI) within healthcare in addition to patient groups and healthcare users.

The programme’s primary aim is to introduce a validated method of retrospectively reviewing deaths in the acute hospital setting. It uses a structured judgement methodology tool known as the Structured Judgement Review (SJR).

The purpose of introducing such a methodology is to allow organisations to analyse the results of mortality reviews and to create and implement QI initiatives that improve healthcare.

This report sets out to describe the aims and objectives, the detail of the development and implementation of the programme and specifically focuses on how the findings from mortality reviews are translated into improvements in healthcare. We use a series of case studies collected from early implementers of the SJR to illustrate this process.

The NMCRR programme has a number of phases which are described in greater detail later in the report:

- Launch the programme in England and Scotland
- Select pilot sites and implement a pilot phase
- Develop training tools
- Implement SJR training
- Develop an electronic platform for analysis
- Develop adjuncts to support the NMCRR

The programme team have delivered training events in over 25 cities in England and Scotland, teaching around 480 clinicians who have in turn cascaded the training to at least 1,500 healthcare professionals.

The development principles of the RCP National Mortality Review tool (online platform) and its analysis capabilities are described, along with an initial analysis of data from a variety of hospitals covering the topics of sepsis and end-of-life care.

The programme has a three year duration and aims to consolidate the work that has been done, support healthcare providers to embed the processes within their organisations and where needed continue to train individuals in the methodology.
NMCRR programme milestones

- **November 2016**: NMCRR Programme officially launched
- **July 2016 to January 2017**: Pilot phase
- **June 2017**: Platform implementation begins
- **November 2017**: Pilot reports published
- **By July 2018**: 107 English acute trusts are using SJR
  - 480 Tier One trainers
  - More than 1500 hospital reviewers
- **By September 2018**: 56 trusts/health boards have implemented the platform, with another 32 having expressed an interest
  - 763 users registered for platform, representing 58 trusts/health boards
  - 1290 SJRs entered onto the platform
Introduction

The Healthcare Quality Improvement Partnership (HQIP) was asked by NHS England and the Scottish government to commission a programme to investigate the potential for learning from retrospective mortality reviews. A scoping exercise and associated options appraisal was undertaken by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) between December 2014 and May 2015. This explored how hospitals could improve the standardisation of and learning from case note reviews of deceased patients, and considered how this local approach could support the establishment of the National Mortality Case Record Review (NMCRR) programme for hospital deaths. The options were reviewed by an NHS England programme board.

In 2015, bids were invited to establish a process to implement a standardised methodology for retrospective case record review for adult acute deaths in English and Scottish hospitals, in order to improve learning about problems in care that may have contributed to a patient’s death.

A partnership led by the Royal College of Physicians (RCP), along with the Yorkshire and Humber Improvement Academy (IA) and Datix, secured the contract to implement the NMCRR programme in England and Scotland. It was commissioned by HQIP, funded initially by NHS England and latterly by NHS Improvement, and commenced in June 2016.

HQIP created a robust governance process to ensure timely progression through the various phases of the programme, which included regular contract reviews and scrutiny of the programme by a multi-partnership independent advisory group (IAG). In addition, the NMCRR programme receives input from a multi-partner, multi-professional steering group that has representation from national medical organisations and includes patient groups as key members.

We acknowledge that patient and public involvement (PPI) in safety and improvement programmes is vital to ensure that their perspectives inform development and progress. To this end the NMCRR programme has also engaged with PPI at IAG meetings, during drafting text for a collaborative public leaflet with NHS Improvement, and to review a draft of this annual report. The programme team plans to support trusts and health boards to involve bereaved families in the SJR process to ensure their opinion of the care received by their loved one is incorporated into the mortality review, and also to ensure that learning and consequent improvement initiatives are shared.

A key aspect of the development and implementation of this work has been the notion of iteration. The function of the programme team as a responsive, dynamic collaboration has allowed the constant improvement of training materials, the training model and the development of the online platform. Furthermore, the core themes of feedback, collaboration, anticipation and learning have been present throughout.

Effective engagement and network building has also been vital to the programme’s success. For example, a substantial communications and media effort has promoted the programme throughout the NHS and aligned organisations, including talks at a variety of meetings and events such as at the Royal College of Surgeons and the Royal College of Physicians of Edinburgh. Relationships with the Academic Health Science Networks (AHSNs) have been important in engaging with hospitals and clinicians and in supporting some of the training sessions.
The programme team have also instigated a national first in hosting meetings with the collective mortality review/enquiry programmes (invited teams include: the Confidential Enquiry into Maternal Deaths, the Confidential Enquiry into Neonatal Deaths, the Learning Disability Mortality Review Programme, NCEPOD, NHS England and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness) to explore sharing intelligence, collaboration opportunities and the potential for future reporting across the programmes.

Establishing links within the developing medical examiner community has also been necessary to support future collaboration and alignment.

**Programme governance**

Table 1 sets out the team members responsible for managing the programme and Fig 1 the organisational structure of the programme.

### Table 1 Current team members (June 2018)

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
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<td>Clinical director for quality improvement and patient safety</td>
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<td>Datix UK</td>
</tr>
</tbody>
</table>
**Fig 1** NMCRR programme organisational structure. QIPS = Quality Improvement and Patient Safety Department; HQIP = Healthcare Quality Improvement Partnership; IA = Improvement Academy; IAG = Independent Advisory Group; NMCRR = National Mortality Case Record Review; RCP = Royal College of Physicians.

### NMCRR Independent Advisory Group (IAG)

The NMCRR Independent Advisory Group act as an independent advisory group to HQIP as commissioners of the programme and act as a forum for discussion with funders and key stakeholders.
NMCRR Steering Group

The NMCRR Steering Group provides engagement and challenge across allied organisations and facilitate the dissemination of key programme information.

NMCRR Programme Delivery Team

The NMCRR Programme Delivery Team oversees delivery of the programme, ensuring that governance structures are in place. This team also provides a link to RCP Quality Improvement (RCPQI), to embed QI throughout trusts and hospitals that are implementing the NMCRR programme.

NMCRR Contract Review Group

The NMCRR Contract Review Group meets quarterly, to inform HQIP of progress against agreed deliverables and of any variance that may have occurred.

Aims and objectives

Aims

The aim of the programme is to establish and roll-out a standardised methodology and process for retrospective case record review (RCRR) for adult acute care deaths in England and Scotland in order to support improvement by understanding and learning about problems in care that may have contributed to patients’ deaths.

This work is not designed to generate data to compare trusts’ performance or to contribute to a national measure of the number of avoidable deaths. The data that are generated from this programme are primarily for use by trusts to support their own learning and improvement.

Objectives

- To develop and promote a single standardised mortality review process: SJR, across all acute care hospitals in England and Scotland.
- To promote and support SJR within acute hospitals’ wider clinical governance systems, ensuring that deaths that are thought to result from problems in healthcare are reported to local risk management systems.
- To design and deliver training for clinicians to become patient note reviewers in hospitals and to support them to cascade training to healthcare colleagues.
- To engage with patient group representatives, healthcare professionals, commissioners and regulators to support the high-quality local reporting of outcomes and learning from SJRs.
• To promote and inform national and local learning and improvement within acute hospitals as a result of SJRs.

• To develop and promote an online platform to support the local and national collection and analysis of SJRs to support learning and QI.

The SJR tool

The purpose of introducing SJR into the acute hospital setting is to allow organisations to analyse the results of their reviews of acute hospital deaths and to then create and implement QI initiatives that improve healthcare.

Contact made with English trusts in July 2018 confirmed that 107 have implemented SJR with 11 using an alternative method. 23 did not respond.

Mortality case note review – using SJR

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, review methods need to be standardised, yet not rigid, and usable across services, teams and specialties.

SJR blends traditional, clinical-judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase and to score care for each phase. The outcome is a relatively short but rich set of information about each case, in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulties in the care process. In order to ask these questions, there is a need to look at the following: the whole range of care provided to an individual; holistic care approaches; the nuances of case management; and the outcomes of interventions.

Structured judgement case note review can be used for a wide range of hospital-based safety and quality reviews, across services and specialties, and not only for cases where people die in hospital. For example, it has been used to assess the care of people who have had a cardiac arrest in hospital; to review safety and quality of care prior to and during non-elective admission to intensive care settings; and to review the care for people who are admitted at different times of the week.

An important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case, and that good care is judged and recorded in the same detail as care that has been judged as being problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learnt from evaluating high-quality care.
The scientific basis of SJR

SJR builds on an international history of retrospective case note review methods development. Hulka et al contributed to the methods debate by using two forms of quality measurement in a study of ambulatory care peer review: explicit criteria and implicit judgements. Explicit review criteria were developed to ask binary questions – for example ‘was the blood pressure measured, yes or no’ or ‘was the systolic blood pressure above 140 mm hg, yes or no’.

Implicit judgements took the form of statements about the treatment of the blood pressure, such as ‘treatment given to manage the blood pressure is x’, but the statement did not usually include an explicit comment about what the reviewer thought of the value of the treatment. It was often left to the subsequent reader of the review to try to determine whether or not the reviewer thought the treatment was appropriate.

The concept of using a process of care framework to provide a phase of care structure for case note review was developed in 1989 by Rubenstein et al. A phase of care framework was subsequently used in the assessment of nursing care quality, using both explicit criteria and implicit statements, and in the assessment of cardiac surgery mortality rates.

In the early 1990s the by-now well-established trend of using implicit review judgements as a key component of peer review and quality assessment began to raise concerns about the replicability (ie the repeatability) of written implicit judgements of care. A study was therefore commissioned by the NHS Health Technology Research Programme in England to explore which review methods were most appropriate for quality and safety review. Evidence-based review criteria and structured implicit review methods were to be used to review the quality and safety of care for over 3,400 acute care patients across 20 hospitals. Early results indicated that the written implicit review criteria statements did not include enough clarity on whether care was expressly thought to be good or poor: a problem that was already acknowledged in previous research. The review process was therefore modified to enhance the understandability of the judgement comments through reviewers being more explicit: a form of review that was subsequently titled ‘Structured Judgement Review’ (SJR).

The NMCRR and the National Learning from Deaths Programme

In March 2017, the National Quality Board (NQB) published the first national guidance on Learning from deaths, drawing on the recommendations of the CQC in its report, Learning, Candour and Accountability, published in December 2016. The guidance set out the approach of the NHS to learning from deaths and the new responsibilities on acute and community trusts. These included the requirements to: publish a ‘Learning from Deaths’ policy, develop their approach to reviewing deaths in their care, strengthen their ways of engaging with bereaved families and ensure support is available to staff. Trusts are required to publish quarterly information through their board reports on deaths in their care and reviews undertaken and to summarise this information, together with an account of their learning, as part of their annual quality accounts. The Department of Health has responsibility for the overall Learning from Deaths programme, which comprises a number of work streams, including the Learning Disability Mortality Review (LeDeR), the development of a
methodology to support mental health trusts to review deaths in their care, and work to support trust boards with Learning from Deaths implementation.

The NMCRR programme is referenced in the NQB guidance *Learning from deaths*, and it is important to clarify the purpose of the NMCRR programme in the context of this guidance. Central in this clarity is the definitions of the terms ‘review’, ‘structured judgement review (SJR)’ and ‘investigation’. These terms appear frequently in the NQB guidance and they have the following meanings.

A ‘review’ of the case notes, which is also in some cases referred to as a ‘screening’ of the case notes, is any non-validated variously structured and usually relatively brief review of the case notes. These reviews are variable in quality and do not create a validated care score, even when they are lengthy and complex.

The ‘SJR’ is an example of a validated research methodology that when used appropriately can create an overall care score. The methodology and validation of the SJR is explained in more depth earlier in this document.

Both simple reviews and the SJRs are retrospective analyses of case notes and they both have the ability to generate comment on the quality of care that is delivered, albeit to different levels of confidence. However, and additionally, the SJR methodology allows the reviewer to comment on whether harm had occurred to the patient. Both methods can be used to flag up poor care and can trigger further enquiry into the quality of care that is delivered.

It is important to recognise that neither the simple retrospective review nor the SJR methodology can generate an outcome that describes whether the care that was observed was more likely than not to have contributed to the death of the patient. This is a much more complex judgement.

An ‘investigation’ is a formal process where it is established, what happened and why, and in the context of patient safety is designed to elicit learning to reduce the risk of the incident in question happening again. The investigation will usually draw on evidence from a variety of sources, which will in many circumstances include the outcome of the validated SJR. As with SJR, a judgement about the death can be made thereafter but is not the aim of the investigation.

An investigation into the quality of care received by patients is therefore a fundamentally different process from either of the retrospective case note reviews described earlier.
Case studies

A number of the early adopters of this methodology have already determined themes which have established work streams within their organisations that have led to QI work. Some of these have been translated into case studies which are described in this section. These case studies have, in some cases, identified common themes and concerns across the sector, but they have also demonstrated specific problems and unique solutions. The themes identified in these case studies include work on:

- end-of-life care
- resuscitation issues and decisions
- sepsis care
- deteriorating patients
- improving death documentation
- analysis of fractured neck of femur mortality
- mortality and stroke
- differential admissions from nursing care homes.

The case studies and implementation strategies outlined below articulate the quality improvements that have been achieved so far when using the standardised review of deaths in acute hospitals. In addition, the methods by which the regional spread of training and trainer engagement was achieved are described in an English AHSN and a Scottish health board.

Two further case studies on sepsis management and end-of-life care describe how thematic analysis is used to draw information together from groups of structured judgement case note reviews to provide material for Quality Improvement initiatives.

Overview of case studies

Cases one and two: These case studies demonstrate how the West of England AHSN created a collaborative to implement a regional initiative using SJR to standardise their approach to mortality review as well as identifying the need for earlier recognition of the end of life and its management.

Cases three and four: These cases highlight the transformational work at Doncaster and Bassetlaw NHS Foundation Trust in utilising the SJR methodology as a central component of their mortality review process as well as describing how concerns over the management of the end of life were discovered using the process.

Case five: One aim of the City Hospitals Sunderland NHS Foundation Trust Mortality Review Panel (MRP) has been to encourage that the resuscitation status of hospital in-patients is appropriate and effectively communicated among all relevant staff at all times.

Case six: At Mid Yorkshire Hospitals NHS Trust, the deputy medical director for quality and safety led an initiative to incorporate using SJR alongside demographic analysis to identify areas for improvement in the care of patients with acute cerebrovascular disease.
Case seven: NHS Highland has incorporated the use of SJR into their process aimed at reducing overall mortality. SJR underpins the ‘primary’ drivers in leading to the aim of mortality reduction.

Cases eight and nine: York Teaching Hospital NHS Foundation Trust has used the methodology in reviewing deaths over four years using SJR with a focus on essential processes of care.

Cases ten and eleven: Buckinghamshire Healthcare NHS Trust have described how they have embedded SJR into their process and articulated the introduction of the Medical Examiner. Of particular interest is how they have linked SJR to the LeDeR programme.

Case twelve: Describes how Barking, Havering and Redbridge NHS Trust have implemented SJR using a mortality faculty with plans to develop a faculty of junior doctor mortality reviewers.

Case thirteen: Describes how Barking, Havering and Redbridge NHS Trust have used SJR to drive QI in the management of biliary sepsis.
Case one

West of England AHSN approach to implementation

'Safe space': discuss experiences, share best practice, address issues

High level support ensures: open, honest culture and means improvement work remains high on regional agenda

Strong approach: multi-level, multi-disciplinary collaboration – recommended for trusts implementing SIR

Collaboration includes GPs, public contributors, community care and mental health colleagues

Collaborative approach across six trusts
Case two
West of England
AHSN quality improvement

Opportunity: co-designed work with patients, families, community, and GP services to create conditions for open conversations about future emergency care.

Need to improve: patients sent to hospital inappropriately, and limited conversations happening with the patient, families or carers about their wishes.

Quality Improvement work: improve recognition of EOL, using symptom triggers and conversations with patients, families and carers.

Strongest themes from SIR: need earlier decision making when patients deteriorate and need conversations about end of life care earlier during admission.

In the emergency department, need to consider EOL care rather than purely focussing on emergency care.
Case four
Doncaster and Bassetlaw
Teaching Hospitals
NHS FT quality improvement

Result: 22% increase in inappropriate and timely start of end-of-life care pathways since January 2016

Theme: Inappropriate admissions from care homes and other community care settings

Outcome: Unnecessary interventions for dying patients

Most common theme: Missed opportunities in recognising end of life

Led to: Awareness raising campaign

Led to: Cases being analysed and information feedback via clinical commissioning groups (CCGs)

Result: Aim to reduce inappropriate admissions and reduce patient anxiety
Case five
City Hospitals Sunderland
NHS FT quality improvement

Example one:
Mortality Review Panel (MRP) aim: the resuscitation status of patients to be appropriate and effectively communicated among relevant staff at all times

Absence of a DNACPR (when one should be in place) may result in: inappropriate investigations and treatments, which may mean an undignified and uncomfortable death

DNACPR decisions with a consultant signature:
- 2014: 50%
- 2016: 89%

DNACPR decisions issued on the day of death:
- 2014: 10%
- 2016: 4%

Between 2014 and 2016, the MRP observed significant improvement in senior clinician involvement with timely DNACPR determination

Conclusion: a standardised mortality review process can lead to new insights into performance and prompt improvements in the quality of care

Example two:
In 2014, MRP identified a lack of senior doctor involvement when determining ceilings of care with patients where DNACPR discussions were indicated

SJR review comments associated with ‘resuscitation management’ included: issues surrounding ceilings of care; issues with DNACPR; end-of-life initiation being dealt with exclusively by the F2, including all conversations with the family

Result: In 2016 SJR comments demonstrated an improvement in resuscitation management
Case six
Mid Yorkshire Hospitals
NHS Trust quality improvement

136 deaths in the index period
- Average age: Male 80.5, Female 75.3

77 deaths
77 deaths (≤60 years old)
- Male: 19%
- Female: 5.2%

59 deaths
59 deaths (≥54 years old)
- 3% Notable
- 7% Mid Yorkshire Hospitals NHS Trust

Issue:
In April 2016, there was a high standardised mortality ratio (130) for acute cerebrovascular disease.

Aim: identify lessons and implement actions within 8 weeks
- Identify index cases and compare with a similar time period 1 year later
- Conduct demographic analysis
- Select 30 cases for SJR— including all deaths in patients less than 60 years old
- Share with CCG and send letters to GP practices

Result: the trust’s SMR for acute cerebrovascular disease was 130 initially but reduced to 114 a year later

Learning points:
- Combination of statistical review and SJR: process issues and specific care problems are identified
- Training of adequate numbers of clinicians in SJR vital
- Quality assurance of case note reviews needed
- Active forum to discuss internal and external process issues is a necessity
Case seven
NHS Highland (Scotland) implementation and quality improvement

Aim
Reduce HSMR by 10% by the end of 2018
Achieve high reliability of safe, person-centred and effective clinical care processes

10%

Secondary drivers
- Full-scale implementation of the applicable 10 patient safety essentials to all clinical areas
- ≥55% or > reliability of the 10 patient safety essentials
- Reliability of internal and external validation of self-reported data
- Patient safety essentials reviewed as part of daily management of ward and hospital management levels
- A system to identify process reliability and enable appropriate step down or escalation of data reporting
- Reliability of person-centred response to deteriorating patients
- Reliable recognition and care delivery for patients with sepsis
- Reliable risk assessment to prevent venous thromboembolism
- Reliable care delivery for patients with heart failure
- Reduce surgical site infections (SSI)
- Prevent catheter associated urinary tract infections (CAUTI)
- Reduce falls
- Prevent avoidable pressure ulcers
- Reliable implementation of medication reconciliation and interventions to improve safety with high risk medicines
- A reliable system for all emergency patients to be seen and assessed by a consultant within 14 hours of admission
- A reliable system for all emergency patients admitted before 7pm to be seen and assessed in person by a consultant on the day of admission
- A reliable system for all patients referred for ambulatory emergency care assessment to be seen in person by a consultant before any decision is taken not to admit them
- A clear record maintained of the status of all investigations that are required and requested
- Investigation results actioned in a timely manner commensurate with the urgency and within 24 hours of availability
- A structured consultant review and management plan to be recorded at initial assessment and all ward rounds
- A robust system in place for all medical handovers
- A reliable system to accurately record the patient classification code on PMS on admission
- An IDL to be sent to the GP for all patients discharged/transferred and completed prior to discharge/transfer
- A final discharge letter containing a care dataset to be sent to the GP within a maximum of 2 weeks of discharge
- Following urgent ambulatory assessment (not admitted) a typed electronic assessment and management plan to be sent to the GP within 24 hours
- Accurate coding to take place within 6 weeks of patient discharge with a validation system in place
- Each hospital site to identify a core leadership team to oversee and drive implementation of this plan
- Produce a hospital and organisational communication plan to inform frontline staff of prioritised QI activities
- Each hospital site to identify QI capacity and capability to ensure proactive, demonstrable progress against aims
- Review of SPSP and KPO core team infrastructure to optimise central QI capacity and capability
- Maintain a data platform to ensure that QI data are available and accessible to all healthcare staff to inform improvements
- Develop a data dashboard to facilitate daily management with the aim of improving overall quality
- Collate thematic analysis from case note review, SAERI, RCAs for organisational learning and improvement

In NHS Highland a team of clinicians have incorporated the SIR methodology into a wider system of quality and patient safety articulated in a ‘Mortality Reduction Driver Diagram’

Primary drivers
Comprehensive implementation of the 10 patient safety essentials
Implementation of nine point-of-care priorities
Implementation of reliable structured clinical review
Implementation of reliable administrative recording processes
QI infrastructure and communication

10

9

0

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Case nine
York Teaching Hospital NHS FT
quality improvement

Results: Concomitant fall in inappropriate cardiac arrest calls led to a marked increase in ACP decisions being documented.

A patient with traumatic subdural haematoma and anticoagulation therapy suffered harm when warfarin was restarted in error too soon.

There was a case of poor communication of a severely low potassium result.

Action: Repeatedly fed back to medicine for older people meetings.

Translanguag with CPR audit showed few survivors to discharge among in older, frail patients with multimorbidity.

Led to development of a new protocol for traumatic brain injury patients.

Complete review of the communication procedure for laboratory staff.

Development of a situation, background, assessment, recommendation (SBAR).

Failure to identify and treat deteriorating patients.

The emergency department, the acute medical unit including key medical hours identified as key risk areas.

Failure to consider and incorporate advance care planning (ACP).

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Case ten
Buckinghamshire Healthcare NHS Trust implementation

Regional AHSN Mortality group created to share learning and standardise practice

Training in SJR facilitated by regional AHSN

Cases presented at M & M meetings for shared learning and multi-disciplinary review

Introducing medical examiners and structured judgement review (SJR) process

Objectives met: Screen all deaths, meaningful engagement with bereaved relatives

60+ SJRs completed and entered onto the RCP National Mortality Review Tool (online platform)

80+ users have access to the online platform allowing transparency of reporting and data sharing across primary and secondary care

Results: during first six months
97% of deaths were screened
12% of all cases had SJR
Case 12
Barking, Havering and Redbridge NHS Trust
Implementation
**Case 13**
Barking, Havering and Redbridge NHS Trust
quality improvement

BHRUT was identified as being an outlier for mortality in patients with pneumonia and in patients with biliary sepsis.

The ability to reach to all specialties with complex pathways remains a challenge, but the use of the SJR highlights the ongoing need for improving care pathways.

Engaged the clinical teams responsible for the care of these patients to undertake SJR and develop a quality improvement strategy based on their learning.

SJR was used to inform and develop a new biliary sepsis management strategy and a review of service provision of endoscopic retrograde cholangiopancreatography (ERCP).

Held QI workshops.
Using structured judgement review comments to assess local care quality – two demonstration case studies

Background

The written review commentaries produced using the SJR method have a value beyond the individual cases themselves because, when grouped together, they can be used to create a snapshot of the quality and safety of care provided for a particular group of patients or for a particular clinical problem.

In this section we demonstrate how this process of information aggregation can work through the use of thematic analysis of textual data (also known as thematic review). This form of analysis is used to group commentaries together around a topic or theme (for example: recognition) and to group those comments within a theme according to whether the clinical reviewers judged the care good or otherwise. The purpose of doing this is to identify what care is good and where it is good (the hospitals have information about the teams, but the online platform does not), and also to identify where care does not go so well; QI action may require implementation to improve a situation where a regular issue is identified.

Although hospitals undertaking thematic review will naturally use their own SJR data held locally in electronic or paper formats, the two demonstration analyses here draw on a range of cases from the RCP National Mortality Review Tool (online platform). The platform contains over 1,000 cases on a wide spectrum of clinical problems and diagnoses and from a range of hospitals (currently >30).

These analyses draw on the programme team’s privileged access to reviews that are entered by all the hospitals contributing to the platform. There is no access to any identifiable patient information nor is there any information to indicate what proportion of any particular hospital’s deaths is included in the dataset. It is also not possible to determine what selection criteria hospitals used to choose the cases that have been entered. The results from this analysis therefore cannot be attributed to the work of any particular hospital.

Choosing the two exemplar thematic review topics

In hospital practice, the prioritisation of which thematic review to undertake will depend on a range of local factors. In the two case studies illustrated here the priorities are different, the objectives being (1) to test how well the database could facilitate the thematic review process and (2) to demonstrate both the similarities and differences in thematic review approach and output across two different clinical issues. One clinical syndrome topic has been chosen – the issue of ‘Sepsis’ – together with one process of care topic – the management of end-of-life care.

Two senior clinical analysts from the programme team undertook the analyses, each taking responsibility for one analysis following prior discussion on the data selection and analytical approach to be taken. There followed subsequent discussion on the emerging findings.
It is important to reiterate here that the analysts have not conducted the SJRs themselves. Instead, they are acting as clinical analysts would do in a hospital – that is they are drawing material from mortality reviews already undertaken using the SJR approach.

**Case study 1: The management of sepsis**

Sepsis management has become a high priority in acute hospitals. Perhaps for this reason, when the database ‘word analysis’ tool is used to search for the top 50 words in the SJR initial management/admission phase, ‘sepsis’ is the only diagnostic word that stands out. Currently more than 150 cases are selected when ‘sepsis’ is used as the search criterion (around 20% of the dataset).

**Case selection**

A thematic review of judgement comments was undertaken on a sample of 50 SJR cases that were selected from the platform in June 2018. This number was chosen because it was known from previous experience in the Yorkshire and the Humber Mortality Review Programme that 40–50 reviews of a service or a particular patient journey (such as that relating to sepsis) is likely to provide what is needed for the organisation both to praise staff for their care and to provide a focus for quality improvement (QI) initiatives where required.

This subset of ‘sepsis cases’ were selected by using the NMCRR word analysis tool (part of the online platform) to identify cases within the whole dataset in which the word ‘sepsis’ was written in the initial management judgement comments. Fifty cases were then selected from the total 150 ‘sepsis cases’, by commencing with a random number and then further selecting every third case.

**Undertaking the review**

Three SJR phases of care were included in the analysis:

1. admission/initial management
2. ongoing care (with procedures where appropriate)
3. end-of-life care.

The first stage of the thematic review involved reading each of the 50 SJRs in full across all phases of care, so that the analyst could understand the type of language the reviewers were using to describe their views on care. This enabled the analyst to use the textual data to develop some initial thematic review headings, which act as ‘clustering words’. For example, these clusters included ‘recognition’, ‘sepsis 6 pathway’ and ‘communication with relatives/patients’. Some of the theme headings were the same across each of the three phases of care.

Experience shows that the themes themselves are not static but build over time. Some emerge from the review data, for example ‘missed opportunities’, but prove to be only occasionally used in this data set and are discarded. In other areas, such as commentaries on therapy, two closely related themes were brought together later when there seemed to be an artificial separation between the two.

Themes also contain contrasts because they are built from multiple cases. Therefore, in a theme that might be labelled ‘recognition’, there will be review data from some cases that went well and from
others where care was not so good. While the cases in this analysis come from multiple sources and the individual hospital ‘why’ questions therefore cannot be addressed in detail, it is still possible to get a sense of the diversity of the quality of care because there are clusters of judgements of both good and poor care under the same theme heading. Some reviews also pick up that care in a phase might go well at some points but is judged to be poor at another point, even within a 24-hour period. This appropriately influences the ‘count’ of the number of comments because it reflects what can be the reality of acute care. Overall, there are many more comments than there are cases.

The material supporting each theme can be seen as akin to layers in a triangle. Figure 2 uses the theme of ‘recognition’ to exemplify the idea. First comes the theme title. Then the analyst has grouped judgement comments into judgements of poor, adequate and good care to demonstrate where the ‘weight’ of the commentary lies, and finally there is the rich text below this which assists with asking the ‘why’ or ‘what if’ questions. Each theme is rich in judgement comments that explain how care went well or otherwise.

**Fig 2** Layers of information contained within review themes.

**Thematic review of sepsis care – overview results**

Overall, 25 initial themes emerged in the admission phase analysis, though some containing only a few judgement comments were merged during the analysis.

The ten themes with the most applicable judgement comments for the admission and ongoing phases of care are shown in Table 2. In most of the judgement comments, there is a binary feel to
them when they are read – usually either the care is judged to be good or it is judged to be poor. There are relatively few comments in the ‘adequate’ judgement column.

**Admission/initial management phase (approximately first 24 hours)**

**Table 2** Ten most common themes, with judgement weightings

<table>
<thead>
<tr>
<th>Theme</th>
<th>Poor care judgements</th>
<th>Good care judgements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Recognition</td>
<td>6</td>
<td>28</td>
</tr>
<tr>
<td>Sepsis pathway use</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Sepsis management</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Antibiotic management</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>Management plans</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Senior review</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Escalation</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Referral/handover</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Documentation – failure to record or missing for review</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

**Ongoing care**

**Table 3** Ten most common themes, with judgement weightings

<table>
<thead>
<tr>
<th>Theme</th>
<th>Poor care judgements</th>
<th>Good care judgements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escalation</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Recognition</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Management plans</td>
<td>6</td>
<td>16</td>
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<td>Review process</td>
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<tr>
<td>Decision making</td>
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<td>10</td>
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<tr>
<td>Senior review</td>
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<td>18</td>
</tr>
<tr>
<td>Investigations</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Communications with patient and/or relatives</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Medication/therapy</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Appropriate care/ management</td>
<td>13</td>
<td>14</td>
</tr>
</tbody>
</table>

**End-of-life care**

In the dataset of 50 cases, some patients died of their acute illness before their end-of-life needs were recognised, so there are fewer entries than in the ongoing care section. Additionally, there is a tendency among these reviewers to provide a briefer commentary on the quality of end-of-life care than in the preceding phases of care. Thus there are only four themes that contain ten or more judgements are reported in Table 4.
Table 4 Four most common themes, with judgement weightings

<table>
<thead>
<tr>
<th>Theme</th>
<th>Poor care judgements</th>
<th>Poor or only adequate care judgements</th>
<th>Good care judgements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of end of life</td>
<td>3</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Discussion with patient/relatives</td>
<td>5</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>End-of-life care overall</td>
<td>9</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Use of palliative care plan/path</td>
<td>5</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

Regarding the quality of the SJR reports, the great majority that are available in the dataset are undertaken well in line with the NMCRR guidance and are insightful and explicit. Phrases such as ‘timely appropriate antibiotics’, ‘deterioration well managed’, ‘failure to recognise end of life’ and ‘timely end-of-life care plan commenced’ are exemplars.

Reviewers sometimes also pick up on ‘care management issues’, commenting adversely, for example, on lack of a side ward when a patient is in need of palliative care or when a patient has been in the emergency department for an extended period of time. These are not comments about individuals (there are no patient or staff names in the 50 reviews), but they are instead comments on the fact that the system is unable to provide what the reviewers judge to be appropriate care.

The value of thematic review is its focus on demonstrating how such a review can identify ranges of care quality and perhaps enable a focus on particular clinical issues or care quality issues (for example, the institution’s ability to respond rapidly or otherwise to a person who has rapidly deteriorating health).

SJRs from the online platform cannot, however, demonstrate what is happening in individual hospitals. Only a thematic review of the cases from each hospital, undertaken by staff in the hospital who know the clinical settings and the available services, can provide the real information for the ‘why’ questions about variations in care.

Case study 2: End-of-life care

Every SJR has an end-of-life care phase which, depending on the specific detail of the case, may be short or long but often provides an opportunity for learning or asking questions. The analyst recognises that the reviews contained on the online platform represent only a portion of the SJRs that have taken place in acute hospital trusts and health boards across England and Scotland, but this analysis nevertheless has the potential to shed some light on those themes pertinent to the provision of care for all who die.

While the platform dataset is a potentially rich source of information, the analyst did not have access to the thought processes or motivation of individual acute hospitals with regard to case selection. As such, cases may or may not have been selected with ‘end-of-life care’ as the focus or driver for the review and hence no overarching conclusions can be drawn by the analyst on either a global or trust level. The real value of this material, as stressed throughout the entirety of the NMCRR programme is to individual acute care providers who can see the reviews and their
judgments in the context of a real and varied clinical environment. This analysis draws on reviews from approximately half of the hospitals who have contributed cases to the online database.

The choice of the end-of-life care phase as one of the case studies was prompted by two key factors. Firstly, as discussed above, it forms part of all reviews, delivering the potential for themes to be derived from almost every SJR. Secondly, during the training sessions for the programme, end-of-life care generated some of the most vibrant and engaging debate amongst clinicians. Several large reviews have shown that the vast majority of deaths within our hospitals are inevitable; hence, many of the reviews in this thematic analysis elicited valuable themes around holistic care, such as the provision of good end-of-life/palliative care and the support and communication received by relatives and carers.

**Review approach**

A further sample of 50 SJR cases was selected from a total of more than 700 available on the platform in July 2018. As with the sepsis review, records were chosen by commencing with a random number and thereafter selecting every third case. No cases were rejected after employing this selection process.

To maintain the fidelity of the analysis, the case selection, as far as possible, employed the same process as that undertaken for sepsis reviews. As all reviews necessarily contained judgment comments on end-of-life care, the analyst elected to review those cases in which death occurred more than 24 hours after presenting to hospital. This was not a judgment on the quality of end-of-life care provided for those patients; indeed, there was clear evidence of exemplary palliative care for patients who had spent only a short time in hospital. However, a number of patients who died within the first 24 hours of attending hospital were clearly very unwell on first presentation, receiving much more focus on active care rather than end-of-life support.

**Analysis process**

The thematic review of records was a relatively uncomplicated process, aided greatly by the functionality of the RCP National Mortality Review tool. The searching and analytical capabilities of the package allowed easy identification and exclusion of those patients who had died within 24 hours of attendance to hospital. Of the 50 cases selected, analysis of the free text specifically relating to the ‘End-of-life care’ section was combined with review of the ‘Ongoing care’ and ‘Problems in care’ sections to verify that useful information was not missed.

As highlighted in the Sepsis review, and in spite of removing the records of patients who died within 24 hours of attendance, there were cases of patients dying acutely without their end-of-life needs being recognised. These cases, however, often produced themes around the holistic elements of care, such as communication with a patient’s family and friends.

The analysis again used the good/poor judgement around each of the themes, as this best represented the tone of the comments collected. The context of the judgement comments around these themes is also important and the analyst felt that the inclusion of some judgment comments is of value to demonstrate how clinicians express their judgements when using SJR.
**End-of-life care – thematic review overview results**

There were 22 themes that emerged from the end-of-life care phase, some of which were closely related and are hence presented under one theme for the purposes of this analysis. Again, only those themes with 10 or more judgment comments are included here in Table 5.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Poor care judgements</th>
<th>Good care judgements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of end of life</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Discussion with patient/relatives</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>End-of-life care overall</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Use of palliative care plan/path</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Documentation</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>

The value of such qualified judgments on the quality of care received by patients is better demonstrated by the comments themselves. The statements below are of the type made in reference to the end of life care received.

Examples of positive comments:
- Excellent communication with the patient and relatives – followed the patient’s wishes around end of life care as much as possible.
- Early and appropriate involvement of the palliative care team.
- Regular and thorough conversations with patient’s relatives in the context of sudden deterioration and death.

Examples of negative comments:
- Lack of communication leading to cardiac arrest team being called in spite of a patient and family request for no resuscitation.
- Limited recognition that patient was dying in context of steady deterioration.
- Poor documentation of end-of-life discussions.

Such judgment comments when combined with further specific and local knowledge such as timings, locations and resources can provide targets for the type of quality improvement initiatives and service developments that the review process seeks to stimulate.

These reviews were, on the whole, focused and explicit in their judgments on the quality of care received by dying patients. The potential for learning is clear with the onus resting on the hospitals and local support networks to deliver systematic improvement on the basis of this valuable resource. The NMCRR programme can continue to support these efforts by, where possible, demonstrating the relatively uncomplicated nature of thematic analysis and the continued roll-out and online support for the data collection and analytics package.
The NMCRR programme – delivery

Programme implementation

The NMCRR programme has been implemented in specific phases:

Official programme launch: November 2016

The programme was officially launched at three sites in November 2016: Harrogate on 21 November, London on 22 November and 23 November, and Edinburgh on 29 November.

A substantial multi-media communications effort accompanied the launches, led by the RCP and the Improvement Academy, aimed at alerting clinicians to the upcoming NMCRR programme. The communications ensured maximum reach to relevant parties in England and Scotland. The programme team and colleagues from the pilot sites delivered presentations and workshop sessions at the launch events and hosted Q&A sessions. In addition, Datix demonstrated early versions of the web-based platform to clinicians, who gave their input to inform further iterations.

The pilot phase

The purpose of the pilot phase was to assess the feasibility of performing retrospective reviews of case records across a wide range of hospitals. Organisations were selected on the basis of their varied structures, which included the size and complexity of the organisation as well as the type of medical record in use (paper and/or electronic). The pilot phase ran from July 2016 to January 2017 inclusive and involved the following sites: NHS Highland (Scotland); York Teaching Hospital NHS Foundation Trust; Harrogate and District NHS Foundation Trust; University Hospital of South Manchester NHS Foundation Trust; St George’s University Hospitals NHS Foundation Trust; and West of England AHSN (Bristol, Bath and Swindon). The pilot reports are available online: www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources.
SJR training

Previous experience of training over 700 health professionals in Yorkshire and the Humber in the use of the SJR method demonstrated that professionally led face-to-face training should be integral to the NMCRR programme.

The training framework

The training programme consists of either:

1. A 4-hour interactive session for local hospital reviewers comprising a presentation and discussion of the review method, together with two practical case note review sessions based on small group work involving review and discussion of constructed case notes or

2. A 7-hour intensive session delivered by paired senior trainers expanding on the core training programme by providing more national context, discussion on a variety of training approaches and an expanded discussion about the use and value of the information provided by the hospital review programme. This is usually provided for ‘Tier One’ review trainers who are then able to cascade training to colleagues.

SJR training has mainly been delivered by the NMCRR programme team, four of whom had prior experience of the training methods derived from the Yorkshire and the Humber AHSN mortality review programme. The core team trainers were also supported by six additional colleagues who were recruited from early adopter hospitals. These additional national-level trainers have continued to offer valuable support in 2018.

The content and delivery of the training was identical on all occasions and differed only as a result of the differing styles of the multiple trainers.

A day programme is available in Appendix 1.

Training and recruitment of reviewers

The training of reviewers at the hospital level commenced during the pilot phase in mid-2016. Communications sent from the programme team to NHS organisations throughout England and Scotland promoted the NMCRR programme asking hospitals to identify key individuals with an interest in learning from mortality reviews to attend training sessions. Hospitals selected reviewers, with guidance from the programme which suggested that participation should be multidisciplinary and include both medical and nursing staff and other healthcare professionals. Following amendments to the training programme undertaken as a result of the pilot phase, national hospital-level training commenced in November 2016. The plan was for this training to continue throughout the life of the programme.

Acceleration of the training programme

Following the publication of the National Guidance on Learning from Deaths by the National Quality Board in March 2017, the programme team were asked by HQIP to amend the approach to training
in England. This would enable trusts to start to review deaths using SJR more rapidly than originally planned. To facilitate this, the team decided not to visit trusts and health boards to provide reviewer training but rather to train Tier One trainers; that is, clinicians with the ability to conduct SJRs and to cascade the training in SJR reviewing to others.

The programme team agreed to hold a minimum of 15 sessions from May 2017 to February 2018, to ensure that hospitals wishing to adopt SJR had opportunities to engage with training. The team delivered 24 sessions and continue to respond to training needs where they arise. Where possible, training was delivered in collaboration with either an AHSN in England or a health board in Scotland. Where this was not possible, the programme team selected specific cities to host the training days, which were attended by clinicians from a wide geographical area. Tier One trainers now total around 480 and sit throughout England and Scotland as a resource to sustain the training aspect of the programme. Details of the Tier One trainers can be found online: www.rcplondon.ac.uk/mortality.

Throughout the programme the team have encouraged the active participation of the AHSNs. These networks have been critical to the dissemination of information and have helped regional groups and hospitals to create collaborative working and learning environments. The collective endeavours of the mortality collaboratives that have emerged across England have also contributed positively to the iterative learning from the programme.

Fig 3 Scottish health boards. © Skills for Health, reproduced with permission.
The impact of training

To gauge the success of the cascade method of training, a request was sent to Tier One trainers in March 2018 to ask them how many colleagues they had trained in SJR. Less than 20% responded, reporting that they had trained 1,500 hospital-level trainers.

Although the programme team offers guidance to hospitals and Tier One trainers about who might be trained as reviewers, the final decision is made by each hospital. The largest group of those who are trained are consultant medical staff, some of whom hold senior management positions. Additionally, the team has welcomed a significant number of nursing staff (often specialist nurses) and some allied health professionals to the training sessions.

All attendees are asked to provide feedback about the training sessions. Around 85% of attendees do so, using a structured feedback form derived from the Yorkshire and the Humber programme. Five global statements form part of the feedback form (Appendix 2), together with choices of structured one-word comments.
Feedback that leads to changes in processes and materials has most often been verbal feedback received during training sessions. Some feedback has also resulted in small but important changes to data collection methods.

The training of hospital-level reviewers was able to begin early in the programme, due to the availability of initial versions of the training materials from the Yorkshire and Humber training programme. However the move from ‘local’ to national training led to the need for materials of appropriate quality, which could be adapted as the national agenda on Learning from Deaths evolved.

This enhancement of the materials required significant effort during the first 15 months of the programme, and came in two phases. In the early phase, the focus was to provide higher-quality materials for the case note review training. In particular, the production of three ‘constructed’ sets of case notes on which SJR can be practised and the ‘real’ clinical scenarios can be debated.

As the programme moved towards training Tier One trainers, it was necessary to create documents that included presentations and FAQs with supporting materials, eg What makes a good review? All Tier One trainers are provided with this suite of materials to enable them to cascade their training.

The RCP National Mortality Review Tool (online platform)

The RCP National Mortality Review Tool was created by Datix and coproduced with significant input from the programme team and also clinical colleagues who joined two WebEx sessions providing input to inform development. The platform is free and includes a number of key functions: to allow the data from SJRs to be inputted and aggregated; to log the care scores generated by the review; and to analyse multiple case record reviews to generate themes. These themes are used to identify areas of potential clinical concern and opportunities for improvement. The platform is interactive and allows clinicians to look at their collated data on a hospital-by-hospital basis. Clinicians can only review the data from their own organisation through secure data protection methods.

Figure 5 depicts an output from the tool, which shows how often specific words and phrases are used within the explicit comments in the first phase of care of a case.
Design and support principles

Principles were finalised at an early stage in the review programme.

- The platform must be freestanding and not aligned to any one commercial system.
- The collected data are confidential and sensitive, so additional password protection is required and no identifiable information is recorded. Confidentiality is also enhanced through the decision to protect patient identities by clustering some of the admission data.
- The technical development was undertaken by Datix, which also supports users and manages security.
- Regular checks are made to ensure that no identifiable data are inadvertently recorded by reviewers, and a system exists to rectify such an occurrence.
- The platform, training and support are provided through the NMCRR programme and are free of charge to users.
- The platform is constructed around the SJR format of phases of care, and thus it collects both quantitative and qualitative data. The functionality includes the ability for a second review to be recorded where a first review raises any concerns.
- An analysis function is integrated into the platform to enable reporting of quantitative data and provide the basis for thematic review of qualitative data. This function is enhanced through the provision of a novel, interactive, visual word-association method that allows rapid access to clusters of similar cases or clinical issues.

Testing and refining the tool

In early 2017, members of the development team undertook extensive testing of the tool, using a set of 120 dummy reviews. Not only did this lead to refinements to the platform but it also led to refinements that have proved to be successful in enhancing the available review information. The enhancements are outlined below.

1. Expanding the ‘Problems in care’ section

Other than in main international studies of problems and harms in care (for example, Hogan et al), relatively little is known about problems that occur regularly at a severity level below those classed as ‘significant events’, in particular those that do not cause harm. The platform has been enhanced to enable the recording of both quantitative and qualitative data on such events.

2. Enabling interactive word analysis of qualitative data

Drawing themes of care processes from qualitative data is a time-consuming process when it is undertaken without specialist software support. The software development team have created an easy-to-use, screen-based system that allows for: the screening of key words (for example ‘sepsis’); the association of those words with judgement comments, eg ‘good care’; and fast tracking to groups of cases where these associations are recorded. This word association function, depicted in Figure 5, was used in the two case studies on thematic analysis (page 31).
Implementation

Since June 2017, the RCP National Mortality Review Tool has been implemented in 56 trusts and health boards. In July 2018 the programme team attempted to contact all English NHS trusts, of those that responded 66 said that they were either using the tool or would like to begin implementation.

During the first phase of implementation, several trusts and one Scottish health board were involved in piloting the platform, regular follow-up was undertaken by senior Datix staff to ensure that staff received sufficient training and support throughout the process. Users provided valuable feedback to the team, to help to improve the platform and training materials before the system was offered to all acute trusts and health boards wishing to implement.

Training – WebEx and e-learning

Since June 2017 online training sessions for the platform have been provided to trusts and health boards via WebEx. Each session lasts around 1 hour and is accompanied by training manuals that are available to download: www.rcplondon.ac.uk/mortality

With the aim of supporting staff that are undertaking SJRs and using the platform, an e-learning package has been designed by external company DayOne in collaboration with the programme team. Throughout the programme it has been important to develop credible partnerships to collaborate with external expertise as demonstrated through the programme team’s relationship with DayOne.

This interactive package uses three clinical scenarios, and reinforces the use of explicit language when making review judgements. The package also includes an interactive module to support staff who will be involved in the analysis of the quantitative and qualitative data that are provided by the reviews, which also demonstrates how effectively the initial review material can be brought together to identify areas for improvement. The e-learning package is available at: https://lms.dayonetech.uk/spaces/nmcrr
Toolkit

The development of the toolkit was a collaborative piece of work between the RCP, the Improvement Academy and the West of England AHSN. It aims to support the implementation of SJR at organisational level and the translation of emergent themes into practical quality improvement initiatives for real and lasting change. The toolkit brings together the learning from the NMCRR programme’s pilot phase, of which West of England AHSN was a pilot site, and from the Yorkshire & Humber mortality programme set up in 2013 which provided the foundation for the NMCRR programme.

It is for those wishing to implement the SJR process at a regional or local level, with specific reference to clinicians, managers, commissioners and trainers in secondary and tertiary care. It should also be useful as a reference for community and primary care providers.

The toolkit, entitled Implementing Structured Judgement Reviews (SJR) for Improvement, was launched on 7 June 2018 and demonstrates the programme team’s ability to visualise opportunities beyond the contract and to respond to need.

The toolkit aims to support the implementation of the SJR process to effectively review the care that was received by patients who have died. It also provides information and links to resources on change management and QI methodologies.

Implementing Structured Judgement Reviews (SJR) for Improvement is available online: www.rcplondon.ac.uk/guidelines-policy/mortality-toolkit.
Conclusion

This first annual report from the NMCRR programme describes the successful, phased implementation of standardised methodology to retrospectively review acute hospital deaths. In addition the report demonstrates, through a variety of case studies, that quality improvement projects do emerge as a result of retrospective case record review and make positive contributions to improving healthcare.

The report also explains the principles of analysis of large data sets that will accrue as clinicians enter SJR reports on to the electronic platform. The themes of ‘sepsis’ and end-of-life care are explored in some detail.

The report also highlights the significant efforts required to implement the programme nationally as well as describing the many interdependencies that are required for such a cohesive and successful plan. In addition, and through the auspices of the RCP, the report identifies the enthusiasm encountered across the commissioned mortality reviews with a commitment from those involved to work collaboratively.

Looking ahead the programme will continue to support organisations in this process and continue to foster links with other mortality review programmes as well as describe areas of work that might naturally lead on from the initial programme. This might include establishing a ‘community of support’, extending relationships to general practice and secondary care, as well as to other healthcare systems both within the UK and overseas.

In addition, opportunities for supporting other mortality review programmes might be explored, for example, a team from the Royal College of Psychiatrists have created and piloted a modified version of the SJR. As of yet, bespoke training has not been undertaken by the Royal College of Psychiatrists but the Yorkshire and Humber Improvement Academy have performed four mental health specific training sessions in the North of England. The NMCRR programme team are working with the Royal College of Psychiatrists to explore opportunities for collaboration in delivering SJR training to mental health services colleagues.
References


Glossary

**Acute cerebrovascular disease** Includes a variety of medical conditions affecting the blood vessels of the brain, including stroke

**Acute hospital** Where patients receive active short-term treatment for severe injury or illness

**Ambulatory care** Medical care provided on an outpatient basis

**Anticoagulant** Agent used to prevent the formation of blood clots

**Cabaret style** Room set-up whereby tables are used to sit 8–10 people together to encourage group work and discussion

**Ceiling of care** Provides information about appropriate limitations to interventions likely to be futile, burdensome or contrary to the patient’s wishes

**Clinical commissioning group (CCG)** Clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area

**Demographic analysis** Allows us to measure the dimensions and dynamics of populations; for example, often used in business plans to describe the population connected to the geographic location of the business

**DNACPR** ‘Do not attempt cardiopulmonary resuscitation’

**E-Learning** Learning conducted via electronic media, typically on the internet

**End-of-life care** Care given to patients in their final days or hours and also to those with a terminal condition that is advanced, progressive and incurable

**Escalation (of care)** A change in patient condition requiring additional review by healthcare professional(s) and possible modification to treatment plans

**F2** Foundation year 2 doctor (formerly house officer) undertaking a 2-year general post-graduate medical training programme that bridges the gap between medical school and specialist or GP training

**Fractured neck of femur** Occurs when the top of the femur (leg bone) is broken just below the ball and socket joint (hip)

**Governance process** Systematic approach to maintaining and improving healthcare quality

**Health board** NHS Scotland includes 14 regional health boards responsible for the protection and improvement of their population’s health and for the delivery of frontline healthcare services

**HSMR** Hospital standardised mortality ratio

**Immediate discharge letter (IDL)** A single discharge document that can be used both as the immediate discharge document and the final discharge summary

**Interactive module** Module in a training programme that typically includes games, simulations and drills to support learning

**NEWS2** A simple aggregate scoring system in which a score is given to physiological measurements already recorded in routine hospital practice. It is an early warning system for identifying acutely ill patients.

**NHS trust** An organisation within the English NHS, generally serving either a geographical area or a specialised function. In any location there may be several trusts involved in different aspects of healthcare.

**Non-executive director** Member of an organisation’s board, involved in policy making and planning but not in the day-to-day running of the organisation

**Options appraisal** A number of delivery model options are explored and evaluated against a set of agreed criteria leading to the selection of a preferred option

**Palliative care** Care for the terminally ill and their families

**Patient Safety Essentials (10)** Scottish list of the 10 most successful patient safety elements
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Pilot site</td>
<td>Hospital where structured judgement review underwent testing</td>
</tr>
<tr>
<td>Peer review</td>
<td>Evaluation of scientific, academic or professional work by others working in the same field</td>
</tr>
<tr>
<td>PMS</td>
<td>Patient Management System</td>
</tr>
<tr>
<td>Programmed activity (PA)</td>
<td>Relates to 4 hours of work done by a doctor; for example a doctor working a full time 40 hour week would require 10 PAs to be allocated within a job plan</td>
</tr>
<tr>
<td>Qualitative data</td>
<td>Any type of information recorded that is not numerical in nature</td>
</tr>
<tr>
<td>Quality improvement (QI)</td>
<td>A system aiming to make healthcare safe, effective, patient-centred, timely, efficient and equitable</td>
</tr>
<tr>
<td>Quantitative data</td>
<td>Numerical information that has been collected, usually for the purposes of analysis</td>
</tr>
<tr>
<td>RCA</td>
<td>Root Cause Analysis</td>
</tr>
<tr>
<td>Redacted</td>
<td>To censor or obscure part of a text for legal or security purposes</td>
</tr>
<tr>
<td>ReSPECT</td>
<td>A standardised approach to improve end-of-life care</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>The act of bringing someone back to life</td>
</tr>
<tr>
<td>Scoping exercise</td>
<td>To map literature and identify where gaps and innovative approaches lie</td>
</tr>
<tr>
<td>Senior review</td>
<td>Review of a patient by a senior clinician</td>
</tr>
<tr>
<td>Sepsis</td>
<td>The body’s overwhelming and life threatening response to infection that can lead to tissue damage, organ failure and death</td>
</tr>
<tr>
<td>Sepsis 6 pathway</td>
<td>Bundle of medical therapies designed to reduce mortality in patients with sepsis</td>
</tr>
<tr>
<td>Significant adverse event reviews (SAERS)</td>
<td>Carried out after following events that have resulted in unexpected harm or death</td>
</tr>
<tr>
<td>Situation background assessment</td>
<td>recommendation (SBAR)</td>
</tr>
<tr>
<td>Standardised mortality ratio (SMR)</td>
<td>Quantifies the increase or decrease in mortality of a population</td>
</tr>
<tr>
<td>Stroke</td>
<td>A medical emergency in which the blood supply to part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients and causing brain cells to die</td>
</tr>
<tr>
<td>Structured judgement review (SJR)</td>
<td>Methodology developed by NMCRR programme</td>
</tr>
<tr>
<td>Tier One trainer</td>
<td>Someone trained by the NMCRR team to carry out structured judgement review and to be able to train others to do so</td>
</tr>
<tr>
<td>Traumatic subdural haematoma</td>
<td>Head injury causing a collection of blood between the skull and the surface of the brain</td>
</tr>
<tr>
<td>Warfarin</td>
<td>Drug taken to prevent blood from clotting and to treat blood clots</td>
</tr>
<tr>
<td>Web-based</td>
<td>A program that can only be accessed via an internet connection and does not sit on a computer’s memory</td>
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<tr>
<td>WebEx</td>
<td>Online meeting and conference applications</td>
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## Associated organisations and programmes

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<tr>
<th>Organisation</th>
<th>Description</th>
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<tr>
<td><strong>Academic Health Science Network (AHSN)</strong></td>
<td>15 organisations in England that support improvement</td>
</tr>
<tr>
<td><strong>Academy of Medical Royal Colleges (AoMRC)</strong></td>
<td>Speaks on standards of care and medical education across the UK</td>
</tr>
<tr>
<td><strong>Action against Medical Accidents (AvMA)</strong></td>
<td>UK charity for patient safety and justice</td>
</tr>
<tr>
<td><strong>Confidential Enquiry into Maternal Deaths</strong></td>
<td>National programme investigating maternal deaths</td>
</tr>
<tr>
<td><strong>Confidential Enquiry into Neonatal Deaths</strong></td>
<td>National programme investigating neonatal deaths</td>
</tr>
<tr>
<td><strong>Datix</strong></td>
<td>Partner and sub-contractor of the NMCRR programme</td>
</tr>
<tr>
<td><strong>Department of Health</strong></td>
<td>Department of Government responsible for policy on healthcare</td>
</tr>
<tr>
<td><strong>Faculty of Medical Leadership and Management (FMLM)</strong></td>
<td>Established in 2011 by all the UK medical colleges and faculties, is the UK professional home for medical leadership</td>
</tr>
<tr>
<td><strong>Healthcare Quality Improvement Partnership (HQIP)</strong></td>
<td>Commissioner of the NMCRR programme</td>
</tr>
<tr>
<td><strong>Healthcare Improvement Scotland</strong></td>
<td>Set up in 2010 to support Scottish Government priorities and in particular the Healthcare Quality Strategy for NHS Scotland</td>
</tr>
<tr>
<td><strong>Improvement Academy (IA)</strong></td>
<td>Partner and sub-contractor of the NMCRR programme</td>
</tr>
<tr>
<td><strong>Independent Advisory Group (IAG)</strong></td>
<td>Meets twice yearly to offer advice to the NMCRR programme team</td>
</tr>
<tr>
<td><strong>Institute for Healthcare Improvement</strong></td>
<td>Independent not-for-profit based in Boston, USA, a leading innovator, convener, partner and driver of results in health and healthcare improvement worldwide</td>
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<tr>
<td><strong>Kaizen Promotion Office KPO</strong></td>
<td>A dedicated internal team driving the effort by teaching and implementing lean techniques</td>
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<td><strong>Learning Disability Mortality Review Programme (LeDeR)</strong></td>
<td>Reviews the deaths of people with learning disabilities</td>
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<td><strong>NHS Improvement (NHSI)</strong></td>
<td>Current funders of the NMCRR programme</td>
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<tr>
<td><strong>NHS England</strong></td>
<td>Initial funders of the NMCRR programme</td>
</tr>
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<td><strong>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</strong></td>
<td>National programme investigating suicides and homicides by people with mental illness</td>
</tr>
<tr>
<td><strong>National Confidential Enquiry into Suicide and Safety in Mental Health Programme</strong></td>
<td>Set up in 1993 to ensure quality research into the costs, effectiveness and impact of health technologies</td>
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<tr>
<td><strong>NHS Health Technology Research Programme</strong></td>
<td>Established to provide strategic oversight and leadership for quality across the NHS system and in joining up health and social care; membership includes NHS England, Care Quality Commission, NHS Improvement, Health Education England and Public Health England</td>
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<td><strong>National Quality Board (NQB)</strong></td>
<td>Host of the NMCRR programme and independent professional body and charity for physicians</td>
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<td><strong>Royal College of Physicians (RCP)</strong></td>
<td>Independent professional body and charity for physicians</td>
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<td><strong>Royal College of Surgeons (RCS)</strong></td>
<td>Independent professional body and charity for surgeons</td>
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<td><strong>Royal College of Psychiatrists (RCPsych)</strong></td>
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© Healthcare Quality Improvement Partnership 2018
Royal College of Nursing (RCN)  
Scottish Patient Safety Programme (SPSP)

The world’s largest nursing union and professional body  
A unique national programme that aims to improve the safety and reliability of healthcare
Appendix 1 – Review training day programme

National Mortality Case Record Review Programme

Structured Judgement Review – Training the trainers

[Date] – 9.30am–16.00pm

[Venue location]

Objectives: 1. To provide attendees with the knowledge and skills to undertake case record review using the Structured Judgement Method

2. To provide attendees with the information needed to undertake an SJR training session

The programme will be a full day of information exchange and interactive learning.

Programme for the day:

09.00–09.30 Registration and refreshments
09.30–10.00 Introductions and outline of the national programme
10.00–11.15 Presentation and discussion on SJR methods
11.15–11.30 Refreshment break
11.30–12.45 Case note review 1 and discussion on findings and approach (reviewer training)
12.45–13.15 Lunch
13.15–13.45 What does a good review look like?
13.45–15.00 Case note review 2
15.00–15.15 Refreshment break
15.15–15.30 The role of the Tier 1 and hospital trainer
15.30–16.00 Discussion on training approach, training materials and national programme support
16.00 Conclusions including local support
Appendix 2 – Review training feedback form

Mortality Case Record Review Training

Please respond to each question by circling the appropriate response.

Please rate your overall satisfaction with this workshop
(1 - totally dissatisfied, 5 - completely satisfied)

1 2 3 4 5

Would you recommend this workshop to others in your organisation?
(1 - definitely not, 5 - definitely)

1 2 3 4 5

How relevant was this workshop in helping you achieve your work goals?
(1 - not at all, 5 - highly relevant)

1 2 3 4 5

I have a greater understanding of how to perform case note reviews
(1 - definitely not, 5 - definitely)

1 2 3 4 5

I feel confident that I am able to provide explicit comments on patient care
(1 - definitely not, 5 - definitely)

1 2 3 4 5

Please circle at least 3 words below that best represent your overall experience of today.

interesting  exciting  challenging  old hat  fascinating  entertaining

boring  confusing  difficult  basic  rushed  clear  empowering

realistic  practical  theoretical  too long  useful  new

waste of time  enjoyable  valuable  inspiring  fun  unfocussed

over-ambitious  thought-provoking  exhausting  stimulating

Comments about the content and format of the workshop:

About your job title:

Your feedback is anonymous. If you would prefer that we do not use any of your comments in our promotional material please tick here: ☐
National Mortality Case Record Review Programme
Royal College of Physicians
11 St Andrews Place, Regent’s Park
London NW1 4LE
MORTALITY POLICY

SECTION 1
PROCEDURAL INFORMATION

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<td>Trust Document Ratification Group</td>
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<tr>
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<tr>
<td>Title of originator/author:</td>
<td>Associate Medical Director, Standards of Medical Care</td>
</tr>
<tr>
<td>Title of responsible committee/individual:</td>
<td>Hospital mortality and quality alerts group Clinical Governance Committee</td>
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<tr>
<td>Date issued:</td>
<td>September 2017</td>
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<td>Review date:</td>
<td>September 2020</td>
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<td>All Clinical Staff</td>
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## Section 1 Contents

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1. **INTRODUCTION**

Concern about patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures and patient safety ratings for NHS Trusts. Following the conclusion of the public enquiry into standards of care in some Foundation Trusts, a few were put into special measures to address concerns about the standard of care provided.

Recommendations from these hospital enquiries have led to an increased drive for NHS Trust boards to be assured that patient deaths are reviewed and appropriate changes made to ensure patients are safe.

The findings of the Care Quality Commission (CQC) report *learning, candour and accountability: a review of the way NHS trusts review and investigate deaths of patients in England* showed that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

The Rotherham NHS Foundation Trust (TRFT) is committed to continuously and systematically reviewing patient outcomes and this policy underpins this commitment. Based on national and local experience six criteria have been identified which characterise a successful review process

1. Clarify the purpose of the reviews
2. Conduct reviews regularly
3. Select cases systematically
4. Seek system issues and common themes
5. Share learning and feedback to clinical teams
6. Feed learning into strategy

2. **PURPOSE & SCOPE**

2.1 **Purpose**

This policy provides guidance for establishing a consistent, standardised and coordinated approach to the classification and review of deaths as part of a process based on the available evidence.

The Keogh report published July 2013 signalled the importance of monitoring mortality statistics to highlight any underlying issues around patient care and safety.

This policy recognises the need to consider mortality rates and national mortality indicators, available at diagnosis code level and patient safety indicator level.
2.1.1 Using mortality indices
Statistics on deaths of residents in England and Wales are published by the Office of National statistics (ONS) including age standardised mortality ratios (SMR). At population level, mortality trends are heavily influenced by lifestyle factors, socioeconomic circumstances, advances in healthcare, and preventative public health action. However trends relating to hospital mortality can contribute to the monitoring of healthcare quality and inform quality improvement action.

The monitoring of high level mortality indices is therefore an important component of quality assurance. A lack of attention to mortality indices was identified as one of the failings in the Mid Staffordshire NHS Trust and there is evidence that using mortality indices to identify quality issues could have also have helped detect other major high profile service failings, including child heart surgery at the Bristol Royal Infirmary and the criminal activity of GP, Harold Shipman.

Robert Francis QC chair of the Mid Staffordshire NHS Foundation Trust public inquiry himself said, ‘it is in my view misleading and a potential misuse of the figures to extrapolate from them a conclusion that any particular number, or range of numbers of deaths were caused or contributed to by inadequate care’ but until such time that a study is conducted into the relationship between ‘excess mortality rates’ and actual ‘avoidable deaths’ these indicators will serve as our trigger for review.

Although the extent of avoidable harm may be contentious its existence is not disputed and action is needed to reduce harm caused by suboptimal care.

The policy entreats us to develop a robust means of investigating avoidable deaths. This policy also recognises the role that staff and the public can play in identifying and reporting poor care.

2.1.2 Mortality case note reviews
The primary purpose of mortality case note reviews is governance and assurance to ensure that patients have not died because of unrecognised suboptimal care. However in addition to this high level assurance mortality reviews can reveal underlying themes about care quality, for example, poor communication between clinical staff, specific diagnosis and therapeutic issues, or situations where dignity and respect have been compromised.

As quality assurance mechanism, mortality reviews also complement other established sources of information for instance the post hoc reporting of incidents and near misses, and the investigation of complaints and service user feedback. This triangulation of information from different sources is an important method of assurance in itself. It confirms the extent of robustness of general reporting and learning systems in the wider organisation.

It is therefore clear that reviews are not intended to be used in isolation. Achieving the level of learning required must involve the integration and triangulation of information from differing sources including individual stories.
The policy details the processes which aim to identify issues with regards to mortality to reduce avoidable deaths by ensuring **all** inpatient deaths are systematically reviewed and that recommendations for improvement arising out of mortality (death) reviews are considered regularly for implementation. This must be considered monthly by departments depending on the caseload. The involvement of clinical coding staff working alongside clinicians has an important positive learning point. Clinical staff will develop a positive understanding of the value of coding expertise and the way in which high quality record keeping underpins accurate coding. Meanwhile coding staff will have an understanding in the way in which their work underpins the development of indices to provide organisational assurance.

Areas of good practice must also be identified through regular review and supported. These areas of good practice will be championed through Clinical Effectiveness and Research Group meetings and disseminated throughout the Trust for adoption at all directorates deemed appropriate.

The process will ensure that there are clear reporting mechanisms in place to escalate any areas of concern identified so that the Trust is aware and can take appropriate action to ensure that real care improvements and relevant clinical learning stems from mortality.

### 2.2 Scope

This document relates to the review of mortality and morbidity for patients under the care of TRFT at the time of death. It covers patient case reviews and the monitoring of data and trends. The Trust expects that all deaths are reviewed, and it will be possible to highlight certain diagnosis codes that warrant a “theme approach” to mortality reviews. It is the responsibility of the individual departments to list the mortality criteria specific to their subset of patients that warrant such themed review. For example surgical site infections as part of the surgical mortality review. The Hospital Mortality and Quality Alerts Group also holds responsibility to signpost the departments for themed review on receipt of mortality data sets.

### 3. ROLES & RESPONSIBILITIES

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| **Hospital Board of Directors**      | The Hospital Board of Directors should ensure that the organisation:  
Has an existing board level leader acting as Patient Safety Director (Medical Director) to take responsibility for the learning from deaths agenda and an existing Non-Executive Director to take oversight of progress (Chair of Quality Assurance Committee); |
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<td>• pays particular attention to the care of patients with a learning disability or mental health needs;</td>
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<td>• has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;</td>
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<td>• adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the Learning disabilities mortality review) (LeDeR) programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;</td>
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<td>• ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;</td>
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<td>• ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge.</td>
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<td>• ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts</td>
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<td>• shares relevant learning across the organisation and with other services where the insight gained could be useful.</td>
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<td>• ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths.</td>
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<td>• offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death.</td>
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|       | • acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some
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<td>circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Ensure that quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience and supporting cultural change.</td>
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<td>Medical Director (Executive Lead)</td>
<td>The Medical Director has overall responsibility for ensuring the organisation has an overarching policy for the review of mortality; ensuring processes are in place for the implementation and monitoring of the policy and acting upon escalated issues. Ensure that through a paper and an agenda item to a public board meeting quarterly publish specified information on deaths within the Trust. This will include total number of inpatient deaths including emergency department deaths and those deaths that the Trust has subjected to case record review. There will be estimates provided of how many deaths were judged more likely than not to have been due to problems in care (PRISM 5-6) These responsibilities are delegated as described below.</td>
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<tr>
<td>Associate Medical Director, Standards of Medical Care</td>
<td>• Promoting the requirements of the policy and ensuring Clinical mortality Leads take responsibility for implementation within their directorates. • Holding individual departments or groups of associated specialities to account in relation to their Mortality reviews and associated outcomes. • Facilitating the clinical effectiveness leads in the quality improvement projects decided by hospital mortality and quality alerts group.</td>
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<td>Roles</td>
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| **Hospital Mortality and Quality Alerts Group (a sub group of the Clinical Governance Committee)** | - Receive alerts from external agencies regarding mortality data.  
- Ensure that mortality data is reviewed and acted upon in a timely manner.  
- Receive action plans from mortality reviews  
- Peer review as a group predetermined diagnosis codes of concern to ensure Trust wide implementation of recommendations. These are subject to change, examples of such are patients who have died following an elective procedure, patients <50 years of age, all patients subjected to a never event, a serious untoward incident and a Datix incident  
- Decide quality improvement projects with regards to improving issues highlighted following mortality reviews in line with divisional and Trust strategy.  
- Ensure clinical effectiveness Department are aware of the planned quality improvement plans and the need to monitor progress. |
| **Clinical Effectiveness leads / mortality leads.** | - Maintaining the process for the review of mortality.  
- Responsible for chairing the review meeting or deputising a more appropriate clinician who will then take responsibility for alerting governance within the department and the divisional governance lead.  
- Ensuring appropriate multi-disciplinary mortality review meetings take place within their directorates (in an appropriate existing forum or standalone meeting).  
- Responsible for reviewing mortality trending data and taking action as appropriate, including discussion at, and escalation to governance leads. This will involve developing specified action plans. The learning from death reviews and the quality improvement from these will be the responsibility of the clinical effectiveness leads.  
- Ensuring appropriate representatives from other directorates are co-opted to the mortality meetings where appropriate. |
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| **Clinical governance leads**                  | • Develop and ensure actions plans are completed of the recommendations following the mortality reviews.  
• Ensure that directors of clinical services are aware of the recommendations and action plans to ensure escalation to Hospital mortality and quality alerts group (HMQAG).  
• Work with the divisional mortality leads and the directors of clinical services in learning from the mortality reviews and sharing the learning appropriately. |
| **Directors of Clinical Services**             | • The Directors of clinical services are overall responsible for divisional implementation of the agreed recommendations from mortality reviews within their division. They are responsible in alerting the hospital and quality alerts group when an avoidable death has been identified within their division or there are substandard levels of clinical or organisational care noted from mortality reviews.  
• Ensure action plans and recommendations are completed. And if warranted escalate to the hospital and mortality quality alerts group  
• Engage with bereaved families  
• Ensure learning from the mortality reviews within the division  
• share learning from the reviews within the division and within the trust. |
| **All clinical staff, including trainees and students involved in clinical work** | • Fully participate in the mortality review process relevant to their practice, as directed by their clinical mortality Lead. This must include highlighting any cases that require review, contributing to reviews, contributing to discussions and the implementation of actions and learning points. |
| **Clinical Effectiveness Department**          | • Support the quality improvement and the best practice development required within the divisions. Provide the governance structure surrounding the quality improvement projects.  
• Alerts the HMQAG when external agencies such as The National Confidential Enquiry into Patient Outcome and Death (NCEPOD), Mothers and Babies: Reducing Risk through Adults and Confidential Enquiries across the |
4. PROCEDURAL INFORMATION

It is expected that all deaths within The Rotherham NHS Foundation Trust will be subjected to a mortality review.

4.1 Review of Deaths

4.1.1 The national guidance on learning from deaths\(^1\) published in March states that at a minimum providers should require reviews of all deaths where:

- Bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.
- All inpatient, outpatient and community patient deaths of those with learning disability (LeDeR process) and with severe mental illness.
- All deaths in a service speciality, particular diagnosis or treatment group where an “alarm” has been raised with the provider through whatever means (for example via summary Hospital-Level Mortality indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator.
- All deaths where people are not expected to die for example in relevant elective procedures.
- Deaths where learning will inform the provider’s existing or planned improvement work for example if work is planned on improving sepsis care such deaths could be reviewed thematically.

4.1.2 The above minimum are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the mental health act 1983.\(^2\)

4.1.3 The Trust may decide that some deaths warrant an investigation and will be guided by the circumstances for investigation in the Serious Incident Framework.

4.1.4 Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. Where care will be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication is required to avoid problems.

---

\(^1\) National guidance on learning from deaths: a framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in Care National Quality Board March 2017.

\(^2\)
4.1.5 This mortality review will take the format of structured judgement review with comments regarding the care given at all stages of the patient journey. Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

4.1.6 Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

4.1.7 A nationally recognised score will then be given to the care and recorded within the review process. This scoring system has a scale for avoidability (PRISM) and a score for both clinical care given and organisation aspects of the care given (NCEPOD).

**PRISM SCORING:**

1. Definitely not preventable
2. Slight evidence for preventability.
3. Possibly preventable but not very likely, less than 50–50 but close call.
4. Probably preventable, more than 50-50 but close call.
5. Strong evidence for preventability.
6. Definitely preventable.

**NCEPOD SCORING:**

1: **Good practice:** A standard that you would accept from yourself, your trainees and your institution.

2: **Room for improvement:** Aspects of clinical care that could have been better.

3: **Room for improvement:** Aspects of organisational care that could have been better.

4: **Room for improvement:** Aspects of both clinical and organisational care that could have been better.

5: **Less than satisfactory:** Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.
4.1.8 It is also very important that good care is highlighted within the mortality review document so that the Trust can identify where this good practice may be transcribed elsewhere.

4.1.9 Standardised multidisciplinary mortality meetings held regularly at each clinical speciality level to review all deaths will be undertaken following an SBAR approach already adopted by the organisation. The goal being: to provide the team with the opportunity to discuss aspects of patient care where the outcome was not as intended, or anticipated, and to review errors and adverse events in an open and reflective manner. (APPENDIX 2)

4.1.10 The review meetings are a key component of work placed based learning and continuing professional development. They must be chaired by the clinical effectiveness leads or delegated to an appropriately qualified deputy (mortality leads). The flow chart for how mortality is reviewed at TRFT can be found at appendix 1.

4.1.11 The meetings structure must include presentation and review of patient death, review of the relevant literature to ensure evidence based practice is developed throughout the organisation. It must highlight recommendations made and clearly document learning points and action plans to prevent a future similar problem. These presentations can be undertaken by any member of the multidisciplinary team reviewing the death and not necessarily the most senior of that specific team but the discussion that ensues must involve senior medical members prior to agreement on the scoring applied to that death. Categorisation of the death must be done using the PRISM and NCEPOD scoring system. These meetings must be held monthly so learning points can be escalated promptly to avoid further patients being subjected to the same errors.

4.1.12 Following the individual department or associated groups of specialities mortality meeting escalation may be required to divisional governance leads and the director of clinical services. Escalation is also required to the Hospital mortality and quality alerts group if the scoring has shown an avoidable death (PRISM5-6) and/or organisational/clinical substandard care (NCEPOD4-5).

4.1.13 If the death is deemed unavoidable there may still be lessons to learn and these will be discussed within the individual CSU and carried forward though the relevant teams.

4.1.14 The HMQAG must receive escalations from the mortality review process and must expect an action plan and lessons to learn. It is the responsibility of HMQAG to agree those actions and generate quality improvement projects. The HMQAG will then inform the clinical effectiveness department of the proposed projects.

4.1.15 It is the responsibility of the clinical effectiveness leads to facilitate the quality improvement. It is the responsibility of the governance arm of the
division to complete the action plans from recommendations borne out of the mortality reviews.

4.1.16 Relevant time scales for both will be discussed within HMQAG and will remain on the group action log until completed and signed off.

4.1.17 It will be the responsibility of the clinical effectiveness group to monitor the quality improvement projects and progress will be monitored through this group and disseminated via the clinical effectiveness leads.

4.1.18 Both the minutes of the Clinical Effectiveness Group and the governance groups are received by the Quality Assurance Committee.

4.1.19 The Hospital Mortality and Quality Alerts Group will interrogate data relating to mortality, coded clinical data including crude and standardised data. It is the group responsibility to interrogate diagnosis codes of issue and action in depth review for themes and trends and learning.

4.1.20 It is the responsibility of this group to identify quality improvement projects using the themes and trends highlighted from mortality reviews. The clinical effectiveness leads will be available to oversee and manage these projects within their area and this will be fed back to the organisation through the clinical effectiveness department.

4.1.21 All issues highlighted by Clinical Effectiveness and Research Group will be escalated to the Quality Assurance Committee.

4.2 Deaths In Patients With Learning Disability

4.2.1 Since the 1990’s there have been numerous reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than those without learning disabilities. The confidential enquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who dies from a cause of death amenable to good quality care, 3 people with learning disability would do so. Overall people with learning disabilities currently have a life expectancy of at least 15-20 years shorter than other people. The lives of people with a learning disability often involve a complex array of service provision with multiple care and support staff. A cross sector approach to reviewing deaths of people with learning disability is imperative; one that includes families, primary and secondary healthcare, social and third sector care providers. This means that patients with learning disability will undergo a differing mortality review approach. This is covered in the Learning disabilities mortality review programme (LeDeR).

4.2.2 All deaths of patients with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review will receive an initial review of their death by independent, trained reviewer/reviewers. A full multi
agency review is required if the criteria for the current themed priority review are met. (Death of a person from a black and minority ethnic background or aged 18-24) or where an assessment of the care received by the person indicates deficiencies in one or more significant areas. The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so that the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

4.2.3 This policy does not cover the complexities of how the Trust investigates and reviews death of children and young people occurring within the Trust. NHS England is currently undertaking a national review of child mortality review processes both in the hospital and the community. The creation of a national child mortality database is currently being commissioned. A further supplementary mortality review policy specifically for children will be available which incorporates the expectations described within Working together to safeguard children (2015). New statutory guidance on child death review will be published late 2017.

4.3 **Learning From Deaths**

4.3.1 Learning from a review of the care provided to patients who die must be integral to a provider’s clinical governance and quality improvement work. To fulfil the standards and new reporting set by the national quality board it is important that the Trust ensures adequate governance arrangements and processes give due focus to review, investigation and reporting of deaths. The Trust is committed to sharing and acting upon the learning derived from these processes.

4.3.2 The learning from death reviews will be disseminated through various processes. Deaths that are deemed unavoidable and have no clinical or organisational issues remain in the individual CSU domain. There can be elements of these deaths that derive learning from and this will be disseminated through the CSU.

4.3.3 Escalations to divisional governance will ensure divisional involvement and learning dissemination at divisional level. The avoidable deaths and ones whose care was deemed substandard with or without organisational substandard performance will be escalated to HMQAG with learning vertically driven in both ways.

4.3.4 Other processes for learning follow the serious incident framework where a death of a patient may be subject to a serious incident. The involvement with families and carers with this process follows the serious incident policy.

4.3.5 Learning can come from a complaint or litigation process but this is out with the scope of this policy.

4.4 **Bereaved Families And Carers**
4.4.1 It is the Trust’s intention to engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death. Bereaved families and carers must expect a clear, honest compassionate and sensitive response to a death of a loved one. Bereaved families and carers must be informed of their right to raise concerns about the quality of care provided to their loved one. Their concerns will form questions asked within the mortality review process. The learning, candour and accountability identified that NHS providers are continuing to fail too many bereaved families and carers of those who die in their care. Paying close attention to what bereaved families and carers say can offer an invaluable source of insight to improve clinical practice. The principles of openness, honesty and transparency as set out in the duty of candour will be applied by the Trust in dealings with bereaved families and carers. The letter (Appendix 3) will form part of the bereavement pack so that concerns can be realised early.

5. DEFINITIONS AND ABBREVIATIONS

5.1 Definitions

Mortality – for the purposes of this policy, mortality relates to in-hospital deaths or deaths within 30 days of discharge from hospital.

5.2 Abbreviations

- **CEG** Clinical Effectiveness and Research Group
- **CHKS** Comparative Health Knowledge System
- **CIPOLD** Confidential Inquiry into Premature Deaths of People with Learning Disabilities
- **CSU** Clinical Service Unit
- **CQC** Care Quality Commission
- **HMQAG** Hospital mortality and quality alerts group
- **HSMR** Hospital Standardised Mortality Ratios
- **LeDeR** Learning Disabilities Mortality review
- **MBRACE** Mothers and Babies: reducing Risk through Adults and Confidential Enquiries across the UK
- **NCEPOD** National Confidential Enquiry into Patient Outcome and Death
- **SBAR** Situation, Background, Assessment, Recommendation
- **SHMI** Summary Hospital-level Mortality Indicator
- **HSMR** Hospital Standardised Mortality Ratio
- **TRFT** The Rotherham Foundation Trust

6. REFERENCES

- Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England Dec 2016 National guidance on learning from deaths: National quality board March 2017
• Independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 December 2015

7. ASSOCIATED DOCUMENTATION

• Clinical Effectiveness and Research Group (CEG) Terms of Reference
• Hospital Mortality and Quality Alerts Group (HMQAG) Terms of Reference
Outcome of mortality reviews discussed within a stand-alone mortality meeting or standing agenda item within other scheduled meeting such as clinical effectiveness/governance meeting.

All deaths and morbidity (CSU specific) are reviewed

(To ensure the attendance at these meetings is multidisciplinary and appropriate to ensure learning is cascaded to the whole service)

PRISM 1-4
NCEPOD 1-3

PRISM 5-6
NCEPOD 4-5

Lessons to learn and quality improvement projects facilitated by clinical effectiveness leads
Communication between clinical effectiveness and governance is essential.

Escalation of cases to HMQAG with predetermined diagnosis codes will undergo another review and agreement/amendment of the original action plan and recommendations.
Lessons to learn and action plans of recommendations from reviews generated. Action plans to be received by the HMQAG.
Agreement from group on action plans.
Quality improvement projects to be identified within the HMQAG and to alert CE department of these.
Clinical effectiveness leads to facilitate quality improvement projects.

Completed action plans to return from governance leads to HMQAG for final sign off once all actions have been completed. Plan to remain on HMQAG action log until completed.
Quality improvement projects to be discussed and facilitated by clinical effectiveness department and escalated to CEG with outcomes.

Clinical Effectiveness & Research Group to escalate where necessary
### MORTALITY MEETING ACTION PLAN

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Actions required (specify “None”, if none required)</th>
<th>Action by date</th>
<th>Person responsible (Name and grade)</th>
<th>Comments (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)</th>
<th>Status Enter: Abandoned, Complete, In progress, To start</th>
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Home address

Dear Mr/Mrs...

Please accept our condolences on the death of your loved one whilst undergoing care at The Rotherham General Hospital. It is with hope that you have found the care they have received to be of good quality and without issues.

As part of our good governance structure we are committed to reviewing all case notes of patients who have died under our care so as to learn from any areas where care may have been substandard or organisational issues where care could have been improved.

As part of the Trust’s on going learning from deaths we would like to involve patient’s families and carers in the mortality review process and it is our expectation that concerns raised by families will play a part in this.

If you have felt that the care your loved one received was not of good quality and would like to raise your concerns regarding any aspect of the episode of care please contact the department where they had died and it will form part of the future recommendations and action plan generated from the death review process.

This does not need to be in the form of a formal complaint unless you would wish this to be the case and will not form part of the Trust policy on responding to formal complaints but It can be extremely helpful in improving future care given to our patients when concerns are raised by those families that have suffered a death. If you do wish your concerns to become a formal complaint please could you contact the Patient Experience Team who will deal with it according to the Trust’s policy.

Yours sincerely

Associate Medical Director
Standards of Medical Care
MORTALITY POLICY

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING
8. **CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS**

This document was developed in consultation with members of the hospital mortality and quality alerts group.

9. **APPROVAL OF THE DOCUMENT**

This document was approved by the Trust’s Mortality and Quality Alerts Group and the Clinical Governance committee.

10. **RATIFICATION OF THE DOCUMENT**

This document was ratified by the Trust Document Ratification Group.

11. **EQUALITY IMPACT ASSESSMENT STATEMENT**

An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

12. **REVIEW AND REVISION ARRANGEMENTS**

This document will be reviewed by the Associate Medical Director, Standards of Medical Care 1 year after implementation in view of changing national picture and will be 3 years following unless such changes occur as to require an earlier review.

13. **DISSEMINATION AND COMMUNICATION PLAN**

<table>
<thead>
<tr>
<th>To be disseminated to</th>
<th>Disseminated by</th>
<th>How</th>
<th>When</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Ratification Group via policies email</td>
<td>Author</td>
<td>Email</td>
<td>Within 1 week of ratification</td>
<td>Remove watermark from ratified document and inform Document Ratification Group if a revision and which document it replaces and where it must be located on the intranet. Ensure all document templates are uploaded as word documents.</td>
</tr>
<tr>
<td>Communication Team (documents ratified by the Document Ratification Group)</td>
<td>Document Ratification Group</td>
<td>Email</td>
<td>Within 1 week of ratification</td>
<td>Communication team to inform all email users of the location of the document.</td>
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</tbody>
</table>
To be disseminated to | Disseminated by | How | When | Comments |
--- | --- | --- | --- | --- |
All email users | Communication Team | Email | Within 1 week of ratification | Communication team will inform all email users of the policy and provide a link to the policy. |
Members of CEG Staff with a role/responsibility within the document | Author | Meeting / Email as appropriate | When final version completed | The author must inform staff of their duties in relation to the document. |
All staff within area of management | Clinical Effectiveness Leads | Meeting / Email as appropriate | As soon as received from the author | Ensure evidence of dissemination to staff is maintained. Request removal of paper copies. Instruct them to inform all staff of the policy including those without access to emails. |

14. IMPLEMENTATION AND TRAINING PLAN

| What | How | Associated action | Lead | Timeframe |
--- | --- | --- | --- | --- |
Policy requirements | Presentation to members of CEG | Agenda item at CEG meeting | Research, innovation and Effectiveness manager, Associate Medical Director, Standards of Medical Care | Within 2 months of ratification |
Obtaining CSU data on trends for mortality and morbidity, including the use of CHKS | Offer of meeting/workshop with relevant leads | Contact Clinical effectiveness leads to offer meeting/workshop to relevant staff | Research, innovation and effectiveness manager, Associate Medical Director, Standards of Medical Care | Within 3 months of ratification |
15. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

15.1 Process for Monitoring Compliance and Effectiveness

<table>
<thead>
<tr>
<th>Audit / Monitoring Criteria</th>
<th>Process for monitoring e.g. audit, survey</th>
<th>Audit / Monitoring performed by</th>
<th>Audit / Monitoring frequency</th>
<th>Audit / Monitoring reports distributed to</th>
<th>Action plans approved and monitored by</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSUs are conducting case note reviews patient deaths</td>
<td>Monitor ELECTRONIC DATABASE</td>
<td>Research, innovation and Effectiveness manager, Associate Medical Director, Standards of Medical Care</td>
<td>On-going</td>
<td>CEG</td>
<td>CEG</td>
</tr>
<tr>
<td>CSUs are conducting MORTALITY activity in line with Trust Policy</td>
<td>Annual review report to HMQAG</td>
<td>Clinical Effectiveness Leads</td>
<td>Annually</td>
<td>CEG and HMQAG</td>
<td>HMQAG</td>
</tr>
</tbody>
</table>

15.2 Standards/Key Performance Indicators (KPIs)

None.
### Equality Impact Assessment (EIA) Initial Screening Tool

**Document Name:** Mortality Policy  
**Date/Period of Document:** Sep 2017 – Sep 2020  
**Lead Officer:** Associate Medical Director, Standards of Medical Care  
**Directorate:** Trust wide  
**Reviewing Officers:** AMD Standards of Medical Care

#### 1. Assessment of possible adverse impact against any minority group

<table>
<thead>
<tr>
<th>Area</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Sex (Male and Female?)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Disability (Learning Difficulties/Physical or Sensory Disability)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Race or Ethnicity?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Religion and Belief?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation (gay, lesbian or heterosexual)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and Maternity?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Gender Reassignment (The process of transitioning from one gender to another)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil Partnership?</td>
<td>Yes</td>
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</table>

### You need to ask yourself:

- Will the policy create any problems or barriers to any community of group? **No**
- Will any group be excluded because of the policy? **No**
- Will the policy have a negative impact on community relations? **No**

If the answer to any of these questions is yes, you must complete a full Equality Impact Assessment.

#### 2. Positive impact:

<table>
<thead>
<tr>
<th>Positive impact</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote equal opportunities</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Get rid of discrimination</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Get rid of harassment</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Promote good community relations</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Promote positive attitudes towards disabled people</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Encourage participation by disabled people</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Consider more favourable treatment of disabled people</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Promote and protect human rights</td>
<td>Yes</td>
<td></td>
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</table>

#### 3. Summary

On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>{HIGH, MEDIUM, LOW, NIL}</td>
<td>{LOW, MEDIUM, HIGH}</td>
</tr>
</tbody>
</table>

*Date assessment completed: 18th August 2017*  
*Is a full equality impact assessment required?*  
*Yes*  
*No* (documentation on the intranet)
National Guidance on Learning from Deaths

A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

National Quality Board

First edition March 2017
National Guidance on Learning from Deaths

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Foreword

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards “from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals”.

This was reinforced by the recent findings of the Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings.

This first edition of National Guidance on Learning from Deaths aims to kickstart a national endeavour on this front. Its purpose is to help initiate a standardised approach, which will evolve as we learn. Following the Learning from Deaths conference on 21st March 2017 we will update this guidance to reflect the collective views of individuals and organisations to whom this guidance will apply to ensure that it is helpful.

Professor Sir Bruce Keogh
National Medical Director
NHS England

Professor Sir Mike Richards
Chief Inspector of Hospitals
Care Quality Commission

Dr Kathy McLean
Executive Medical Director
NHS Improvement

On behalf of the National Quality Board.
Executive Summary

Introduction

1. For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

2. The following definitions apply for the purposes of this guidance:

(i) **Case record review**: The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.

(ii) **Investigation**: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

(iii) **Death due to a problem in care**: A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

Governance and Capability

3. Learning from a review of the care provided to patients who die should be integral to a provider’s clinical governance and quality improvement work. To fulfil the standards and new reporting set out in this guidance for **acute, mental health and community NHS Trusts and Foundation Trusts**, Trusts should ensure their **governance arrangements**
and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trusts should also ensure that they share and act upon any learning derived from these processes. The standards expected of Trust boards are set out at Annex A including having an existing executive director take responsibility for the learning from deaths agenda and an existing non-executive director take responsibility for oversight of progress. Guidance for non-executive directors is at Annex B.

4. Providers should review and, if necessary, enhance skills and training to support this agenda. Providers need to ensure that staff reporting deaths have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.

5. Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

Improved Data Collection and Reporting

6. The following minimum requirements are being introduced to complement providers’ current approaches in relation to reporting and reviewing deaths:

A. POLICY ON RESPONDING TO DEATHS

- Each Trust should publish an updated policy by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care, including:

  i. How its processes respond to the death of an individual with a learning disability (Annex D) or mental health needs (Annex E), an infant or child death (Annex F) and a stillbirth or maternal death (Annex G).

  ii. The Trust’s approach to undertaking case record reviews. Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die. The Structured Judgement Review (SJR)
case note methodology is one such approach and a programme to provide training in this methodology for acute Trusts will be delivered by the Royal College of Physicians over the coming year (the current version of the SJR approach is available at [https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources](https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources)). Other approaches also exist, such as those based on the PRISM methodology. Methods like SJR were not developed for mental health and community Trusts but can be used as a starting point and adapted by these providers to reflect their individual service user and clinical circumstances. Annex J provides a case study of how SJR is being adapted for mental health Trusts. Case record reviews of deaths of people with learning disabilities by acute, mental health and community Trusts should adopt the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme in those regions where the programme is available (details of the programme are available from Annex D).

iii. **Categories and selection of deaths in scope for case record review:** As a minimum and from the outset, Trusts should focus reviews on in-patient deaths in line with the criteria specified at paragraph 14(ii). In particular contexts, and as these processes become more established, Trusts should include cases of people who had been an in-patient but had died within 30 days of leaving hospital. Mental Health Trusts and Community Trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach. The rationale for the scope selected by Trusts will need to be published and open to scrutiny.

B. **DATA COLLECTION AND REPORTING**
- From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust’s policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). This data should include the total number of the Trust’s in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The dashboard provided with this guidance shows what data needs to be collected and a suggested format for publishing the information,
accompanied by relevant qualitative information and interpretation.

- Changes to the Quality Accounts regulations will require that the data providers publish be summarised in Quality Accounts from June 2018 (Annex L), including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken.

Further Developments

7. In 2017-18, further developments will include:

- **The Care Quality Commission** will strengthen its assessment of providers learning from deaths including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.

- **NHS England, led by the Chief Nursing Officer**, will develop guidance for bereaved families and carers. This will support standards already set for local services within the Duty of Candour¹ and the Serious Incident Framework² and cover how families should be engaged in investigations. Health Education England will review training of doctors and nurses on engaging with bereaved families and carers.

- **Acute Trusts** will receive training to use the Royal College of Physicians’ Structured Judgement Review case note methodology. Health Education England and the Healthcare Safety Investigation Branch (Annex L) will engage with system partners, families and carers and staff to understand broader training needs and to develop approaches so that NHS staff can undertake good quality investigations of deaths.

- **NHS Digital** is assessing how to facilitate the development of provider systems and processes so that providers know when a patient dies and information from reviews and investigations can be collected in standardised way.

- **The Department of Health** is exploring proposals to improve the way complaints involving serious incidents are handled particularly how providers and the wider care system may better capture necessary learning from these incidents³.

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¹ Further information is available from: [http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf](http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf)

² [https://improvement.nhs.uk/resources/serious-incident-framework/](https://improvement.nhs.uk/resources/serious-incident-framework/)

³ This follows the Parliamentary and Health Service Ombudsman’s report *Learning from Mistakes* (July 2016) and the Public Administration and Constitutional Affairs Committee hearings on this report.
Chapter 1 - Mortality Governance

Context
8. In December 2016, the Care Quality Commission (CQC) published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

9. The Secretary of State for Health accepted the report’s recommendations and in a Parliamentary statement[^4] made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

Accountability
10. Mortality governance should be a key priority for Trust boards. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

11. This *National Guidance on Learning from Deaths* should be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks. They should work towards achieving the highest standards in mortality governance. However, different organisations will have different starting points in relation to this agenda and it will take time for all Trusts to meet such standards. Over time this guidance is likely to be updated to include wider providers of NHS care and whole healthcare systems.

Responding to Deaths
12. Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care. The standards expected of Trusts are set out at Annex C.

13. Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of

failure of clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, regular mortality reporting to the Board at the public section of the meeting with data suitably anonymised, and outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff.

Death Certification, Case Record Review and Investigation

14. There are three levels of scrutiny that a provider can apply to the care provided to someone who dies; (i) death certification; (ii) case record review; and (iii) investigation. They do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a case record review has been undertaken (though a case record review will inform the information gathering phase of an investigation together with interviews, observations and evidence from other sources). For example, the apparent suicide of an in-patient would lead to a Serious Incident investigation being immediately instigated in advance of death certification or any case record review. The three processes are summarised below:

(i) Death Certification: In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

(ii) Case Record Review: Some deaths should be subject to further review by the provider, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. At a minimum, providers should require reviews of:

i. all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;

ii. all in-patient, out-patient and community patient deaths of those with learning disabilities (the LeDeR review process outlined at Annex D should be adopted in those regions where the programme is available otherwise Structured Judgement Review or another robust and evidence-based methodology should be used) and
with severe mental illness;

iii. all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);

iv. all deaths in areas where people are not expected to die, for example in relevant elective procedures;

v. deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;

vi. a further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

The above minimum requirements are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the Mental Health Act 1983 (Annex E).

Providers should review a case record review following any linked inquest and issue of a “Regulation 28 Report on Action to Prevent Future Deaths” in order to examine the effectiveness of their own review process.

Providers should apply rigorous judgement to the need for deaths to be subject to a Serious Incident reporting and investigation. For example, there may be instances where deaths clearly meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken). Equally, problems identified in case record review may lead to the need for investigation whether this is an investigation under the Serious Incident Framework or other framework/procedure (see section iii)

(iii) Investigation: Providers may decide that some deaths warrant an investigation and should be guided by the circumstances for investigation in the Serious Incident Framework.
Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication are needed to avoid problems.

Providers should review an investigation they undertake following any linked inquest and issue of a “Regulation 28 Report to Prevent Future Deaths” in order to examine the effectiveness of their own investigation process. If an inquest identifies problems in healthcare, providers may need to undertake additional investigation and improvement action, regardless of the coroner’s verdict.

Consistency and Judgement in Case Record Review

15. All Trusts currently undertake some form of mortality review. However there is considerable variation in terms of methodology, scope, data capture and analysis, and contribution to learning and improvement. To generate learning for improvement in healthcare, clinicians and staff should engage in robust processes of retrospective case record review to help identify if a death was more likely than not to have been contributed to by problems of care.

16. The Structured Judgement Review (SJR) case note methodology is an approach being rolled out by the Royal College of Physicians. Other methodologies exist and Trusts may already be using them. Trusts need to be assured that the methodology they are using is robust and evidence-based, that it will generate the information they are now being required to publish and that their staff are trained and given sufficient time and resources to undertake case record reviews and act on what they learn.

17. Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

18. The judgement of whether a problem may have contributed to a death requires careful review of the care that was provided against the care that would have been expected at the time of death. Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems none of which would be likely to have caused the death in isolation but which in
combination can contribute to the death of a patient. Some of these elements of care are likely to have occurred prior to the admission and providers should support other organisations, for example in primary care, to understand and act on areas where care could be improved.

19. Trusts should acknowledge and cooperate with separate arrangements for the review (and where appropriate investigation) of certain categories of deaths, for example suicides, homicides, and child and maternal deaths.

Objectivity in Case Record Review

20. To ensure objectivity, case record reviews should wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge. Objectivity of reviews should be a component of clinical governance processes. Providers may wish to consider if their review processes should additionally be the responsibility of a designated non-executive director who could do this by chairing the relevant clinical governance committee.

Investigations

21. This National Guidance on Learning from Deaths and the Serious Incident Framework are complementary. This guidance sets out what deaths should be subject to case record review (paragraph 14(ii)), which is inevitably a wider definition than deaths that constitute Serious Incidents. Equally, when a death meets Serious Incident criteria there is no need to delay the onset of investigation until case record review has been undertaken. A review of records will inevitably be undertaken as part of an investigation process. However, immediate action to secure additional information and evidence to support full investigation should not be lost due an inappropriate requirement for all deaths (regardless of nature) to first undergo a case record review.

22. Inquiries by the coroner and investigations by providers are conducted to understand the cause of death and contributing factors. However provider investigations are not conducted to hold any individual or organisation to account. Other processes exist for that purpose including criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, including the General Medical Council and the Care Quality Commission. In circumstances where the actions of other agencies are required then those agencies must be appropriately informed and relevant protocols must be followed.

Medical Examiners
23. The introduction of the Medical Examiner role will provide further clarity about which deaths should be reviewed. Medical Examiners will be able to refer the death of any patient for review by the most appropriate provider organisation(s) and this new mechanism should ensure a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient’s death. NHS Improvement and the Department of Health are commissioning research to explore whether Medical Examiners are best placed to select which deaths need further review and ensure they do not inadvertently miss or over-refer certain types of cases. Prior to the implementation of the Medical Examiner system, Trusts are advised to allow for any doctors undertaking the certification of death to refer cases for case record review to the most relevant organisation.

Learning
24. Providers should have systems for deriving learning from reviews and investigations and acting on this learning. The learning should be shared with other services across the wider health economy where they believe this would benefit future patients, including independent healthcare services and social care services. Recommendations within any “Regulation 28 Report on Action to Prevent Future Deaths” from the coroner should also be integral to a provider’s systems to support learning within and across their organisation and local system partners.

25. Regardless of whether the care provided to a patient who dies is examined using case record review or an investigation, the findings should be part of, and feed into, robust clinical governance processes and structures. The findings should be considered alongside

other information and data including complaints, clinical audit information, mortality data, patient safety incident reports and data and outcomes measures etc. to inform the Trust’s wider strategic plans and safety priorities.

26. Where case record review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported via local risk management systems to the National Reporting and Learning System (NRLS).

27. All patient safety incidents reported as resulting in death or severe harm to a patient are clinically reviewed by the National Patient Safety Team at NHS Improvement to determine if there are implications for national learning and if a response is appropriate. Any deaths that are identified via case record review as due to problems in healthcare would meet the criteria for NRLS reporting. More information on the national process is available at https://improvement.nhs.uk/resources/patient-safety-alerts. All serious incidents that relate to patients should be reported to the NRLS for the same reason.

Cross-system Reviews and Investigations
28. In many circumstances more than one organisation is involved in the care of any patient who dies. Guidance in relation to cross-system reviews and investigations is at Annex H.

Roles and Responsibilities of National Bodies and Commissioners
29. Guidance is provided at Annex I. The lead roles with overall responsibility for the learning from deaths programme at each of the relevant national organisation are provided at Annex K.
Key Principles

30. Providers should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below.

<table>
<thead>
<tr>
<th>Bereaved Families and Carers - Key Principles:</th>
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</thead>
<tbody>
<tr>
<td>• bereaved families and carers should be treated as equal partners following a bereavement;</td>
</tr>
<tr>
<td>• bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;</td>
</tr>
<tr>
<td>• bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;</td>
</tr>
<tr>
<td>• bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one;</td>
</tr>
<tr>
<td>• bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed;</td>
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<tr>
<td>• bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;</td>
</tr>
<tr>
<td>• bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;</td>
</tr>
<tr>
<td>• bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in delivering training for staff in supporting family and carer involvement where they want to.</td>
</tr>
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Context

31. Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients within the NHS is crucially important. The principles of openness, honesty, and transparency as set out in the Duty of Candour should also be applied by
providers in all their dealings with bereaved families and carers. Yet the Care Quality Commission’s report *Learning, candour and accountability* identified that NHS providers are continuing to fail too many bereaved families and carers of those who die whilst in their care.

32. When a patient dies under the management and care of a Trust, bereaved families and carers should be informed immediately after the death. People who are bereaved need others to recognise and acknowledge their loss. Recognition by professionals, appropriately expressed, may be particularly valued. Communication at the time of a death, and afterwards, should be clear, sensitive and honest. Bereaved families and carers should be given as much information as possible in line with the Duty of Candour for providers. Every effort should be made to hold these discussions in a private, sympathetic environment, without interruptions. Providers should ensure that their staff, including family liaison officers where available, have the necessary skills, expertise and knowledge to engage with bereaved families and carers. This includes recognising and dealing with common issues such as family members feeling guilty about their loss.

33. All too often the terms of the conversation people have with the NHS about a concern or complaint are set by the organisation. Organisations can often be too quick to dismiss or explain away concerns, compounding the grief of bereaved families and carers with obfuscation and a lack of openness. Paying close attention to what bereaved families and carers say can offer an invaluable source of insight to improve clinical practice. Listening to them goes hand in hand with the Duty of Candour. In particular, bereaved families and carers should be asked if they had concerns about the quality of care received by the deceased to inform decisions about the need to undertake a case record review or investigation.

34. When reviewing or investigating possible problems with care, involvement of bereaved families and carers begins with a genuine apology. Saying sorry is not an admission of liability and is the right thing to do. The appropriate staff member should be identified for each case, including to explain what went wrong promptly, fully and compassionately. This may include clinicians involved in the case but this may not always be appropriate and should be considered on a case by case basis.

35. Depending on the nature of the death, it may be necessary for several organisations to make contact with those affected. This should be discussed with the bereaved families and carers and a co-ordinated approach should be agreed with them and the
organisations involved. If other patients and service users are involved or affected by the death they should be offered the appropriate level of support and involvement.

36. The provider should ensure that the deceased person’s General Practitioner is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation.

Bereavement Support

37. Bereavement can influence every aspect of well-being. Providers should offer a bereavement service for families and carers of people who die under their management and care (including offering or directing people to suicide bereavement support) that offers a caring and empathetic service at a time of great distress and sadness. This includes offering support, information and guidance. This should include bereavement advisors to help families and carers through the practical aspects following the death of a loved one such as:

- arranging completion of all documentation, including medical certificates;
- the collection of personal belongings;
- post mortem advice and counselling;
- deaths referred to the coroner;
- emotional support, including counselling;
- collection of the doctor’s Medical Certificate of Cause of Death and information about registering a death at the Registrar’s Office;
- details of the doctor’s Medical Certificate of Case of Death (this is needed to register a death at the Registrar’s Office).

38. The following should also be considered:

- timely access to an advocate (independent of the Trust) with necessary skills for working with bereaved and traumatised individuals;
- support with transport, disability, and language needs;
- support during and following an investigation. This may include counselling or signposting to suitable organisations that can provide bereavement or post-traumatic stress counselling, with attention paid to the needs of young family members, especially siblings;
• further meetings with the organisations involved or support in liaising with other agencies such as the police.

Review
39. If the care of a patient who has died is selected for case record review providers should:

• have formed that decision based on the views of the family and carers. Providers should require reviews in cases where family and carers have raised a significant concern about the quality of care provision (paragraph 14 (ii)(i));
• communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed for the future.

Investigations
40. If a provider feels that an investigation into a death is needed, early contact should have been made with bereaved families and carers so that their views helped to inform the decision.

41. Bereaved families and carers will expect to know: what happened; how; to the extent possible at the time, why it happened; and what can be done to stop it happening again to someone else. If a provider proceeds with an investigation, skilled and trained investigators need to be able to explain to bereaved families and carers the purpose of the investigation which is to understand what happened. If problems are identified, the investigation should be clear why and how these happened so that action can be taken to prevent the same mistakes from occurring again.

42. Provided the family or carer is willing to be engaged with regarding the investigation, an early meeting should be held to explain the process, how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation. This should set out realistic timescales and outcomes. There should be a named person as a consistent link for the families and carers throughout the investigation, for example a family liaison officer.

43. Bereaved families and carers should:

• be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held;
be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation;

• have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided;

• have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings. This may disclose confidential personal information for which consent has been obtained, or where patient confidentiality is overridden in the public interest. This should be considered by the organisation’s Caldicott Guardian and confirmed by legal advice in relation to each case;

• have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date;

• be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case;

• have an opportunity to respond on the findings and recommendations outlined in any final report; and,

• be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

Guidance

44. NHS England will develop guidance for bereaved families and carers, identifying good practice for local services on the information that families say they would find helpful. It will cover what families can expect by way of local support in relation to investigations and what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement.

45. Public Health England has published guidance which provides advice to local authorities and the NHS on developing and providing suicide bereavement support⁸.

Annexes
Annex A - Board Leadership

BOARD LEADERSHIP - KEY POINTS

The board should ensure that their organisation:

- has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress;
- pays particular attention to the care of patients with a learning disability or mental health needs;
- has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
- adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised;
- ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts;
- shares relevant learning across the organisation and with other services where the insight gained could be useful;
- ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;
- acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in
some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and,

- **works with commissioners to review and improve their respective local approaches** following the death of people receiving care from their services.

Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.
Annex B - Non-Executive Directors

Context

1. The board of directors of an NHS Trust or Foundation Trust is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, and in the case of a Foundation Trust taking into consideration the views of the board of governors.

2. Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. Commissioners are accountable for quality assuring the robustness of providers’ systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

3. All Trust directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the board and help develop proposals on strategy. Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective to the boardroom and should scrutinise the performance of the provider’s management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

Learning from Deaths

4. Executive and non-executive directors have a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

- the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support;
- quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; and
• the information the provider publishes is a fair and accurate reflection of its achievements and challenges.

5. From April 2017, providers will start to collect and publish new data to monitor trends in deaths. Alongside this, they will need to establish an ongoing learning process. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, non-executive directors should hold their organisation to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable. The roles and responsibilities of non-executive directors include:

i. **Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example:**
   • be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust, are they sufficiently senior/experienced/trained?
   • seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation’s processes, but understand limitations of any direct comparisons;
   • ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer/investigator and quality of the review or investigation;
   • is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
   • how was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
   • are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
   • for coordination of responses to reviews/investigations through the provider’s clinical governance processes, who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation’s Serious Incident processes?
ii. **Champion and support learning and quality improvement such as:**
   - ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this;
   - understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better;
   - understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients - ensuring that learning and improvements are reported to the board and relevant providers;
   - supporting any changes in clinical practice that are needed to improve care resulting from this learning;
   - ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes;
   - paying attention to the provision of best practice and how the learning from this can be more broadly implemented.

iii. **Assure published information; ensure that information published is a fair and accurate reflection of the provider’s achievements and challenges, such as:**
   - ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement;
   - checking that relevant team are working towards a timely quarterly publication, in line with the Quality Accounts regulations and guidance;
   - checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter by quarter basis;
   - ensuring the organisation can demonstrate to stakeholders that “this is what we said we would do, and this is what we did” (learning and action), and explain the impact of the quality improvement actions.
Annex C - Responding to Deaths

Trusts should have a policy in place that sets out how they respond to the deaths of patients who die under their management and care.

### POLICY FOR RESPONDING TO DEATHS - KEY POINTS

The policy should include how providers:

- **determine which patients are considered to be under their care and included for case record review if they die** (it should also state which patients are specifically excluded);

- **report the death within the organisation and to other organisations who may have an interest** (including the deceased person’s GP), including how they determine which other organisations should be informed;

- **respond to the death of an individual with a learning disability** ([Annex D](#)) or mental health needs ([Annex E](#)), an infant or child death ([Annex F](#)) and a stillbirth or maternal death ([Annex G](#)) and the provider’s processes to support such deaths;

- **review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past**;

- **review the care provided to patients whose death may have been expected**, for example those receiving end of life care;

- **record the outcome of their decision whether or not to review or investigate the death**, which should have been informed by the views of bereaved families and carers;

- **engage meaningfully and compassionately with bereaved families and carers** - this should include informing the family/carers if the provider intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved. Initial contact with families/carers are often managed by the clinicians responsible for the care of the patient. Given that providers must offer families/carers the opportunity to express concerns about the care given to patients who have died, then the involvement of clinicians who cared for the patient may be considered a barrier to raising concerns. Providers should therefore offer other routes for doing this;

- **offer guidance, where appropriate, on obtaining legal advice for families**,
| carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by providers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates. |
Annex D - Learning Disabilities

Context

1. Since the 1990s, there have been a number of reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities. The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so. Overall, people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people.

2. A concerning finding from CIPOLD was that assumptions were sometimes made that the death of a person with learning disabilities was ‘expected’ or even inevitable, because that person had learning disabilities. As with the CQC report of 2016, CIPOLD also identified deaths that should have been, but were not, reported to mandatory review processes, including safeguarding reviews and to the coroner.

3. The lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff. If we are to improve service provision for people with learning disabilities and their families, and reduce premature deaths, we need to look wider than NHS-related circumstances leading to a person’s death, in order to identify the wider range of potentially avoidable contributory factors to their death. A cross-sector approach to reviewing deaths of people with learning disabilities is imperative; one that includes families, primary and secondary healthcare, and social and third sector care providers. Such a balanced approach across acute and other settings is needed from the outset of a review process, in order to accurately determine if there are any concerns about the death, or to identify examples of best practice that could lead to service improvement.

4. There is unequivocal evidence that demands additional scrutiny be placed on the deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review (LeDeR) programme, commissioned by Healthcare Quality Improvement Partnership (HQUIP) for NHS England. Once fully rolled out, the programme will receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age. These will be conducted by trained reviewers.

5. The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person’s death and to develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

Scope

7. At present, NHS England is working with NHS Digital to explore the options and potential of ‘flagging’ the records of people with learning disabilities on the NHS Spine¹³. Over time, this could provide an access point for identifying that a person who has died had learning disabilities.

8. The LeDeR programme currently supports local reviews of deaths of people with learning disabilities aged 4 years and over. The lower age limit is set at 4 years of age because before that age, it can be difficult to be sure that a child has learning disabilities as defined above.

Operationalising Mortality Reviews of People with Learning Disabilities
9. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities.

¹³ Spine supports the IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems in 20,500 organisations.
10. All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.

11. The standardised review process involves discussing the circumstances leading up to the person’s death with someone who knew them well (including family members wherever possible), and scrutinising at least one set of relevant case notes. Taking a cross-agency approach, the reviewer develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death, identifies any best practice or potential areas of concern, and makes a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated.

12. A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18-24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas. A full multi-agency review is recommended if there have been any concerns raised about the death, if any ‘red flag alerts’ have been identified in the initial review, or if the reviewer thinks that a full multi-agency review would be appropriate. The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

14 ‘Red flag’ alerts are those identified in the initial review that may suggest potential problems with the provision of care e.g. no evidence that an assessment of mental capacity has been considered when this would have been appropriate; delays in the person’s care or treatment that adversely affected their health.
13. The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes. This enables an integrated approach to initial reviews of deaths of people with learning disabilities to be taken whenever possible, so as to avoid unnecessary duplication but ensure that the specific focus of the different review or investigation processes is maintained.

14. Alignment of LeDeR with SJR for example will enable a balanced approach to be taken to reviewing deaths of people with learning disabilities that draws on contributions from across acute and other settings. Deaths of people with learning disabilities that occur in hospital settings should be subject to the LeDeR review process in order that insights from families, primary and secondary healthcare, and social and third sector care providers are all included in the mortality review.

15. The LeDeR programme provide annual reports on its findings, collating learning and recommendations at the regional and national level on how best to take forward the learnings across the NHS.

16. Because of the different methodology adopted by the LeDeR programme, it would not be appropriate to use the same definition of ‘avoidable death’ as used by the SJR, nor to compare rates of avoidable deaths across and between the two review processes. The LeDeR programme will continue to use the Child Death Review Process terminology of ‘potentially avoidable contributory causes of death’ and the Office for National Statistics definition of avoidable deaths using ICD-10 coding of the underlying cause of death15.

Integration of the LeDeR Process into National Level Mortality Review Structures

17. When a death of a person with learning disabilities occurs, mandatory review processes need to take precedence, working with the LeDeR programme reviewers to ensure that a coordinated approach is taken to the review of the death in order to minimise duplication and bring in the learning disabilities expertise of the LeDeR reviewers, whilst recognising that some investigatory processes will be more focused than that of LeDeR which is cross-agency in nature and may require the provision of additional information.

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18. Learning and recommendations from LeDeR reviews will identify opportunities for improvement at the local, regional and national level. Governance structures that can support the cross-agency implementation of recommendations from mortality reviews are required at all levels, but in particular for the reviews of deaths of people with learning disabilities. Such structures exist in the form of regional steering groups for the LeDeR programme, and these are usually best placed within the safeguarding framework. Not all deaths of people with learning disabilities are safeguarding issues; however the existing multi-agency framework and statutory responsibility mean that this is a natural ‘home’ for governance of mortality reviews.

Guidance for Providers

19. Key points to note are:

- All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology;
- The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017. If there is a death of a person with learning disabilities in an acute setting in an area that is not yet covered by the LeDeR programme, Trusts are recommended to use the SJR process or a methodology of equivalent quality that meets the requirements for the data that must be collected as an interim measure;
- If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: [http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf](http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf) The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed;
- Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred;
- Trusts are encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Reviewers would be expected to conduct reviews independent of the Trust in which they work.
Annex E - Mental Health

1. Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people\textsuperscript{16}. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems.

2. Reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

Inpatients detained under Mental Health Act

3. Regulations\textsuperscript{17} require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45\% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.

4. Under the Coroners and Justice Act 2009, coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

5. In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider’s commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the Serious Incident Framework.

People with Mental Health Disorders in Prisons

6. Evidence shows that there is a high incidence of mental health problems in prisons: 72\% of adult male and 71\% of female prisoners may have 2 or more mental disorders (e.g.\textsuperscript{16} The Five Year Forward View For Mental Health (NHS England, 2016) is available at: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf \textsuperscript{17} Regulation 17, Care Quality Commission (Registration) Regulations 2009)
personality disorder, psychosis, anxiety and depression, substance misuse); 20% have 4 or more mental disorders.

7. There have been large increases in the number of natural and non-natural deaths in prisons over the most recent five-year reporting period. The increase in recent years in non-natural deaths in prisons are due to a number of factors. Prisons contain a high proportion of vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of suicide or self-harm. Issues that increase risk include drug/alcohol abuse, family background, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems. The increase in part reflects an ageing prison population. Prisons are also very challenging environments particularly so for those prisoners who have a learning disability. Average estimates of prevalence of learning disabilities amongst adult offenders in the UK is thought to be between 2-10%. This figure is much higher for children who offend. Prisoners with learning disabilities are also more likely than other prisoners to suffer mental ill health. As such, the mental wellbeing of prisoners with learning disabilities should be a key consideration for healthcare staff of NHS providers along with all other prison staff.

8. The Serious Incident Framework states that in prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so. The PPO has clear expectations in relation to health involvement in PPO investigations into death in custody. Guidance published by the PPO must be followed by those involved in the delivery and commissioning of NHS funded care within settings covered by the PPO.

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19 Guidance is available online: http://www.ppo.gov.uk/updated-guidance-for-clinical-reviews/
Annex F - Children and Young People

Infant and Child Mortality

1. Over the last 20 years, the UK has gone from having one of the lowest mortality rates for 0 to 14 year olds in Europe to one of the highest\(^1\). In 2014, 4,419 children and young people aged 0 to 18 years old died in England and Wales. 24% of deaths in children and young people are thought to be preventable\(^2\). In the year ending March 2016, 68% of all deaths occurred in hospital, 22% in the home, 4% in a public place, and 4% in a hospice. In the year ending March 2016, 32% of all deaths occurred following a perinatal or neonatal event, 26% in children with chromosomal, genetic and congenital anomalies, 8% in children with 'sudden unexpected and unexplained' death, 7% in children with malignancy, 6% in children with acute medical or surgical illnesses, 6% in children with infection, 5% in children suffering trauma, 3% in young people taking their life, and 2% following deliberately inflicted injury, abuse or neglect\(^2\).

2. In child mortality review, professionals have moved away from defining 'avoidability' to instead using the language of 'a preventable death' where the latter is defined as a death in which 'modifiable factors may have contributed to the death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths'\(^3\). In the year ending March 2016, 54% of deaths in hospital and 31% of death in the home were identified as having modifiable factors. Most modifiable factors are found in children dying from perinatal/neonatal events, followed by trauma, followed by those with chromosomal, genetic and congenital anomalies\(^2\).

National Data on Causes of Death and International Comparisons\(^4\)

3. The UK ranks 15 out of 19 Western European countries on infant (under one year of age) mortality and has one of the highest rates for children and young people in Western Europe\(^5\). There is a strong association between deprivation and mortality; for example infant mortality is more than twice as high in the lowest compared with the highest socio-economic groups\(^6\).

Infants (under 1 year)

4. Around 60% of deaths during childhood occur in infancy. Infant mortality can be split into neonatal mortality (deaths 0–27 days) and post-neonatal mortality (28–365 days). Births without signs of life (stillbirths if after 24 weeks of pregnancy) do not contribute to infant mortality but are also an important indicator of maternal and child health. The Infant
Mortality Rate (IMR) is an indicator of both population health and the quality of healthcare service. It is also a key international indicator in the United Nation's Sustainable Development Goals and in UNICEF international comparisons.

5. Neonatal mortality accounts for between 70% and 80% of infant deaths. The great majority of neonatal deaths are due to perinatal causes, particularly preterm birth, and are strongly related to maternal health, as well as congenital malformations. The remainder of infant deaths are post-neonatal and are due to a broad range of causes including sudden infant death syndrome (SIDS). Stillbirths (defined in the UK as a baby born without signs of life after 24 completed weeks of pregnancy) account for half of all deaths during the perinatal period. In 2014, the IMR across the UK was 3.9 deaths per 1,000 live births. Although there has been an overall decline in the IMR across the UK over the past 45 years, in recent years the reduction in infant mortality in the UK has not equalled the gains observed in comparable countries. An international study of mortality in the UK compared with similar wealthy countries in Europe and elsewhere showed the UK to have IMR in 1970 similar to the average of the group, but that the UK had become among the worst performing 10% by 2008.

6. Social inequalities play a role in almost all the leading causes of infant death. The mechanisms underlying this social gradient are related to increased risk of preterm delivery in more deprived groups, as well as to maternal health during pregnancy (for example, smoking, poor nutrition, substance abuse) and uptake of recommended practices such as breastfeeding and safe infant sleeping positions. Maternal age is also associated with infant mortality. Many of the causes of infant mortality are preventable and necessitate actions at both a population and individual level:

- maximising the health and wellbeing of women before conception and during pregnancy (smoking cessation programmes, promotion of breastfeeding and promoting healthy weight in women of childbearing age)
- protecting and supporting health promotion and early intervention services (universal midwifery and health visiting services for new mothers)
- promoting evidence-based research into maternal and infant health, and translating findings into improved practice, standards of care, and ultimately policy
- identifying best practice and reducing variations in outcomes across health care services
Children (1-9 years)

7. The main factors that contribute to death during childhood are different to those that contribute to death during infancy or adolescence. The common causes of death amongst 1 to 9 year-olds are cancer, injuries and poisonings, congenital conditions and neurological and developmental disorders. Injuries and poisonings from external causes are the leading cause of death in boys aged one to four years, whilst cancer is the leading cause of death in girls of the same age. For both girls and boys five to nine years of age, cancer is the leading cause of death. Very early life also still has an impact on mortality in later childhood; children who were born preterm remain more likely to die before age 10 years compared to children born at term.

8. In the period 2012-2014, the mortality rate in children aged 1-9 years in the U.K. was 12.1 per 100,000 population. Although the mortality rate has declined across the UK since the 1970s, the UK’s recent progress has been significantly lower than in other wealthy European countries, and concerning the incidence of death due to diseases such as asthma and diabetes is higher than equivalent high-income countries. The scale of difference between the UK child mortality rate and the average suggests there are around 130 excess deaths of 1- to 9-year-olds each year in the UK.

9. Many childhood deaths are preventable. As with infants there is a strong association between deprivation, social inequality, and mortality. Causes amenable to interventions include environmental and social factors as well as health service factors and key actions include the following:

- creating safe environments, including access to information and safety equipment schemes to promote safety in the home;
- reduce road speed limits in built-up areas to 20mph;
- ensuring that clinical teams looking after children with long-term conditions such as asthma, epilepsy and diabetes deliver care to the highest standards, incorporating good communication, open access for patients and families, use of established tools such as the epilepsy passport and asthma plan, adherence to the components prevalent in the best practice tariff for diabetes, and address early the optimal conditions for safe transition to adult services. Implicit in this is teaching self-management and ownership of the condition;
- increasing the provision of high-quality end-of-life care and access to appropriate palliative care;
• delivering integrated health systems across primary and secondary care; whilst providing the optimal configuration of specialist services for children with complex conditions needing tertiary care, such as cardiac, renal conditions and children's cancer.

Young People (10-19 years)
10. After the first year of life, adolescence is the life stage when children are most likely to die. The factors leading to death in adolescence are different to those in earlier childhood, and differ between males and females. The most common causes of death in this age group are injuries, violence and suicide, followed by cancer, substance misuse disorders and nervous system and developmental disorders.

11. Although the mortality rate in young people has decreased across the UK since the 1970s, progress recently has been slower than that seen in other wealthy countries. The UK's 'average' adolescent overall mortality today is a mixed picture. Whilst our injury mortality rate is amongst the lowest, we have a higher rate of deaths due to 'non communicable diseases' such as asthma than other equivalent wealthy countries. Social inequalities are important since injury and illness are associated with poor environmental conditions and hazards such as smoking, alcohol, and drug use.

12. Many deaths are preventable and key actions include:

• reducing deaths from traffic injuries through the introduction of graduated licensing schemes;
• improving adolescent mental health services;
• improving services for children with long term conditions, and especially those transitioning to adult care;
• increasing the involvement of young people and their families with rare and common long-term conditions in developing guidelines, measuring outcomes, service design and research trials.

13. Underpinning all efforts to reduce child mortality in England lies an urgent need to collect high-quality data to better understand the reasons why children die, to allow accurate international comparisons, and to inform health policy. This requires a national system for the analysis of child mortality data, as well as improved child death review processes.
Historical Background to the Process of Child Mortality Review

14. Since 1\textsuperscript{st} April 2008, Local Safeguarding Children’s Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such responsibility is enshrined in the Children’s Act 2004 and applies to all children under 18 years of age. The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document, Working Together to Safeguard Children\textsuperscript{11}. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths. Working Together describes two interrelated processes:

i. a “Rapid Response” multi-professional investigation of an individual unexpected death; and,

ii. a Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CDOP is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process.

Drivers for Change including new Legislation

15. The review of child deaths has been, to date, far more comprehensive than that for adults. However the following drivers for change exist:

i. \textit{Variation in process}. There is significant variation across the system in how child deaths are reviewed, which deaths are reviewed, and the quality of the review. Specifically:

- ‘unexpected’ deaths in the community are generally reviewed as per the Sudden Unexpected Deaths in Infancy (SUDI) process. However there is variation in when a death is considered “unexpected” and in the timing of triggering investigations.
- hospital deaths are usually reviewed at a Mortality and Morbidity (M&M) meeting. However there is wide variation, across the NHS, in how these meetings are convened, no standardisation on terminology, and a confused array of investigations (root cause analysis, serious incident inquiry, mortality review) that follow certain types of deaths.
there is wide variation in CDOP processes (size, structure and functioning) and many CDOP panels are dislocated from governance processes within their local children’s hospital.

ii. *The Wood Review*\(^2\). In 2016, Alan Wood recommended that national responsibility for child death reviews should move from the Department for Education to the Department of Health, that DH should re-consider how CDOPs should best be supported within the new arrangements of the NHS, and that DH should determine how CDOPs might be better configured on a regional basis with sub-regional structures to promote learning. He also recommended that child deaths be reviewed over a population size that allowed a sufficient number of deaths to be analysed for patterns and themes. He went further to recommend that the NHS consider the role CDOPs should play in the process for achieving a common national standard for high quality serious incident investigations. Finally, he supported the intention to introduce a national child mortality database, and urged DH to expedite its introduction.

iii. *The National Adult Case Review programme*\(^3\). This programme uses a very different structured judgment review (SJR) methodology to that used in child mortality review. It focuses on problems in heath care processes within an organization rather than trying to understand the cause of death. Cases in which care is judged to be poor are scored according to an ‘Avoidability of Death’ scale. It is important to recognise that many 16 and 17 year olds die in adult ITU’s and therefore it is important to understand what processes should take precedence in the review of such patients.

iv. *Medical Examiner process*. The Medical Examiner will be introduced across England. This appointee will link with bereaved families as well as the Coroner and their involvement will affect all mortality review processes.

v. *CQC report: Learning, Candour, and Accountability*\(^4\). This report identified inconsistencies in: the involvement of families and carers; the process of identifying and reporting the death; how decisions to review or investigate a death was made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions.

vi. *Legislative change (Children and Social Work Bill 2017)*. The Wood Review recommendation that national responsibility for child death reviews should move from the Department for Education to the Department of Health is being enacted through
the Children and Social Work Bill 2017. Under the new legislation, local authorities and clinical commissioning groups are named as ‘child death review partners’ and must make arrangements for the review of each death of a child normally resident in the local authority area. They may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. The proposed legislation also states that the ‘child death review partners’ must make arrangements for the analysis of information about deaths reviewed and identify any matters relating to the death or deaths in that area a) relevant to the welfare of children in the area or to public health and safety and b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

National Child Mortality Programme

16. NHS England is undertaking a national review of child mortality review processes both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life. Central to the programme is the creation of a National Child Mortality Database, which is currently being commissioned. The effective functioning of the national database requires high-quality, standardised data arising from simplified and standardised local mortality and CDOP review processes. NHS England have therefore established 3 work streams:

- the simplification and standardisation of mortality review processes in the community and hospital;
- a review of the governance arrangements and standardisation of CDOP processes;
- the creation of the national child mortality database.

17. The goals of the NHS England’s child mortality review programme are to:

- establish, as far as possible, the cause or causes of each child’s death;
- identify any potential contributory or modifiable factors;
- provide on-going support to the family;
- ensure that all statutory obligations are met;
- learn lessons in order to reduce the risk of future child deaths;
- establish a robust evidence base to inform national policy across government to reduce avoidable child mortality across the UK nations.
18. NHS England, the Department of Health and the Department for Education are working together to produce new statutory guidance for child death review. This guidance will cover the processes which should take place following the death of a child, and in particular how the death should be reviewed at local mortality meeting and child death overview panel. This new guidance will be published in late 2017.

**Reporting**

19. The definitions used within the adult Case Review programme for record review and to identify problems in care are not recognised within *Working Together*. NHS England’s work programme intends to identify best practice and standardise processes across deaths in hospital and the community, to improve the experience of families and professionals. The deaths of children who are treated in acute, mental health and community NHS Trusts should be included by Trusts in quarterly reporting from April 2017. The information should come from child death review processes, and should include reporting problems related to service delivery.

**Board Leadership**

20. Hospital Trust, Local Authority, Community Trust, Mental Health Trusts, and CCG boards should ensure that learning is derived from the care provided to children who die, by the appropriate application of the child mortality review process, and that learning is shared and acted on.

21. Many of the points around board leadership relating to adult deaths (set out in the main body of this guidance) also apply for child deaths. For example, providers must ensure that they have a board-level leader designated as patient safety director to take responsibility for the learning from deaths agenda (Annex A) and he or she should also have specific responsibility for the learning from child mortality processes. The director should ensure that the reviews are delivered to a high quality, with sufficient numbers of trained staff to lead the child mortality review process.

22. Particular attention should be paid to the deaths of children and young people with learning disabilities or mental health conditions, as these present with frequent co-morbidities and are often a more vulnerable group.

23. Providers should acknowledge that an independent investigation (one commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may be required where the integrity of the investigation is likely to be challenged.
Best Practice in responding to Death of a Child who dies under a Trust’s Care

24. All Trusts should have a policy in place that sets out how they respond to the deaths of children who die under their care. In doing this they should be mindful of current expectations described within Working Together to Safeguard Children (2015) and of NHS England’s current review of child mortality review processes. New statutory guidance on child death review will be published in late 2017.

25. That policy should also set out how Trusts:

- communicate with bereaved parents and carers. This should include providing an honest and compassionate account of the reasons for death and knowledge of any potential problems in care that may need further review, ensuring initial contacts are managed by clinicians responsible for the care of the patient, and offering support to express concerns about the care given to patients who have died;
- achieve independence (where relevant) and objectivity in the child mortality review process, as well as lay membership within wider clinical governance systems.

Cross-system Reviews and Investigations

26. When the death of a child involves treatment across the health care pathway (primary: secondary: tertiary care) it is expected that child mortality review processes will not be duplicated and that a single overarching meeting will be convened. Child mortality review processes should interface with existing organisational governance systems. The NHS England child death review programme is mindful of expectations arising from the Serious Incident Framework, which sets out the circumstances in which further investigation is warranted in certain situations. It is therefore anticipated that when a review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this is reported via local risk management systems to the National Reporting and Learning System (NRLS). Regardless of the type of review, its findings must form an integral part of and feed into the organisation’s clinical governance processes and structures. Review findings should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust’s wider strategic plans and safety priorities.
Bereaved Families and Carers

27. Working Together places the family at the heart of its processes. However it is recognised that the multitude of investigations that may unfold following a child’s death can cause great confusion and distress to parents. The national bereavement group and bereavement charities are closely involved with developing NHS England’s child death review programme – both in the co-design of systems and public guidance that explains processes.

28. The national Child Death Review programme recognises the following principles:

- bereaved families and carers should be treated as equal partners both in the delivery of care and following a bereavement;
- bereaved families and carers should receive a high standard of bereavement care, including being offered appropriate support;
- bereaved families and carers must always receive an honest, caring and sensitive response;
- bereaved families and carers should receive timely, responsive contact and support in all aspects of any review process, with a single point of contact and liaison.

Learning Disabilities and Mental Illness

29. NHS England’s National Child Mortality Review programme fully recognises the unique challenge in reviewing the deaths of children with learning disabilities and mental health disorders. The Programme is working closely with the Learning and Disabilities Mortality Review (LeDeR) programme, and also aims to align itself with the Children and Young People’s (CYP) Mental Health Programme and Specialised Commissioning particularly with regard to deaths in Tier 4 inpatient CAMHS Units. It will also work closely with the National Programme on Suicide in Young People. Going forward, the programme will ensure that there are appropriate mechanisms in place to allow data flows to occur unencumbered between all these systems and the national Child Mortality Database.

Conclusion

30. This section highlights the very different circumstances that pertain to the death of a child in acute, mental health and community organisations. Although infant and child mortality has declined in the UK, these improvements have not been sustained in comparison to other European countries. While poverty and inequality have a major impact on child mortality, we can nonetheless do much in front line service delivery to improve outcomes
for children, and experiences for both bereaved parents and the professionals who deliver care. Sadly, deaths in childhood are often an inevitable consequence of congenital malformations, birth events, and long-term conditions or chronic illness. Many, however, have preventable factors, and there is therefore an absolute imperative to scrutinise all deaths both locally and nationally to ensure that learning always occurs.

31. NHS England is seeking to address this by establishing a National Child Mortality Database to allow analysis and interpretation of child mortality data. The programme will also seek to improve, standardise and simplify the processes that follow the death of a child. This is predominantly to improve the experience of bereaved parents at such an overwhelming time, but also to enable uniformly robust data collection, to ultimately lead to a reduction in infant and child mortality in this country.

References
8. Roberts J Bell R. Social inequalities in the leading causes of early death a life cause approach. 2015
Annex G - Maternity

1. In England, maternity care is generally safe and for the majority of women and their babies there is a good outcome. However, when things go wrong, the impact is devastating and has a profound effect on the parents, partners, siblings and extended family members.

2. Dr Bill Kirkup was tasked by the Secretary of State for Health to investigate and report on maternity services at Morecambe Bay NHS trust. The Report of the Morecambe Bay Investigation in 2015\textsuperscript{20} highlighted a number of failures over a number of years at the Trust which resulted in poor care and the tragic deaths of mothers and babies. The report makes recommendations for mandatory reporting and investigation of serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. It recommends a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review. In Learning not Blaming\textsuperscript{21} the Government accepted this recommendation.

3. In October 2016, Safer maternity care: next steps towards the national maternity ambition was published setting out an action plan for the Government’s vision for making NHS maternity services some of the safest in the world, by achieving the national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030 with an interim measure of 20% by 2020. The plan details the actions needed at national and local level that build on the progress already made to improve the safety of maternity services.

4. Currently MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK)\textsuperscript{22}, appointed by Health Quality Improvement Partnership and funded by NHS England, run the national Maternal, Newborn and Infant


\textsuperscript{21} The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report ‘Investigating Clinical Incidents in the NHS’, and the Morecambe Bay Investigation (July 2015).

\textsuperscript{22} ‘MBRRACE-UK’ is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The aim of the MBRRACE-UK programme is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.
Clinical Outcomes Review to conduct surveillance of all late fetal losses, stillbirths and neonatal deaths, biennial topic-specific confidential enquiries into aspects of stillbirth and neonatal death or serious neonatal morbidity and surveillance and confidential enquiries of all maternal deaths.

5. Surveillance reports on stillbirths and neonatal deaths are published annually. Reports on maternal deaths are published on a triennial basis, because the number of maternal deaths from individual causes is small, and thus three years’ worth of data is required to identify consistent lessons learned for future care and to maintain anonymity and confidentiality.

6. A maternal death is defined internationally as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy. Deaths are subdivided on the basis of cause into: direct deaths, from pregnancy-specific causes such as preeclampsia; indirect deaths, from other medical conditions made worse by pregnancy such as cardiac disease; or coincidental deaths, where the cause is considered to be unrelated to pregnancy, such as road traffic accidents. Maternal deaths are very rare. The MBRRACE-UK report ‘Saving Lives, Improving Mothers Care highlights that for 2012-14, the maternal death rate was 8.5 per 100,000 women. Overall, 241 women among 2,341,745 maternities in 2012–14 died during or within 42 days of the end of pregnancy in the UK.

7. Better Births (2016)24, the report of the NHS England commissioned National Maternity Review, set out a five year forward view for improving outcomes of maternity services in England. The report highlighted the lack of a standard approach to investigating when things wrong during before, during or after labour: Reviews and investigation are currently undertaken using different protocols and processes by different organisations. The Report recommended there should be a national standardised investigation process for when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence. Work has now begun on the development of a Standardised Perinatal Mortality Review Tool that will enable maternity

23 Of these 41 deaths were classified as coincidental
and neonatal services to systematically review and learn from every stillbirth and neonatal death in a standardised way.

8. Maternal deaths, neonatal deaths and stillbirths occurring in acute, mental health and community Trusts should be included by Trusts in quarterly reporting from April 2017.

9. It should be borne in mind that in addition to hospital obstetric units, maternal deaths can occur in a local midwifery facility (for example, a local midwifery unit or birth centre) or during home births. The definition also covers up to 42 days after the end of pregnancy.
Annex H - Cross-system Reviews & Investigations

1. In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being primary care and acute care, ambulances services and acute care, or mental health services combined with any of these. Case record reviews typically have to rely on the records held by a single organisation, but even these records can provide indications of possible problems in earlier stages of the patient pathway.

2. Where possible problems are identified relating to other organisations, it is important the relevant organisation is informed, so they can undertake any necessary investigation or improvement. Most trusts already have effective systems to notify other organisations when concerns are raised via incident reports, and are likely to be able to adapt these to address potential problems identified in case record review.

3. Trusts should consider whether they can routinely arrange joint case record reviews or investigations for groups of patients where more than one organisation is routinely providing care at the time of death - for example, for older people with dementia and frailty receiving frequent input from their GP and from community mental health nurses. Commissioners have a role in encouraging appropriate routine collaboration on case record review.

4. Where the provision of care by multiple providers, and particularly the coordination of that care, is thought to have potentially contributed to the death of a patient, investing the significant resources required to coordinate major and complex investigations must be considered. For example, the Serious Incident Framework outlines the principles which underpin a serious incident investigation process and the relevant content is set out in paragraphs 5 to 10 below.

5. The organisation that declares the serious incident is responsible for recognising the need to alert other providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.
6. All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate. Commissioners should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process. Commissioners themselves should provide support in complex circumstances. For example, where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this process. If commissioners do not have the capability or capacity to manage this type of activity this should be escalated to ensure appropriate resources are identified. This may be something to consider escalating through the relevant Quality Surveillance Group or through specific review panels and clinical networks. This should ensure the cumulative impact of problems with care can be resolved.

7. In some circumstances the local authority or another external body may be responsible for managing and co-ordinating an investigation process. Where this is the case, providers and commissioners must contribute appropriately and assure themselves that problems identified will be addressed.

8. Often in complex circumstances, separate investigations are completed by the different provider organisations. Where this is the case, organisations (providers and commissioners and external partners as required) must agree to consider cross boundary issues, such as gaps in the services that may lead to problems in care. The contributing factors and root causes of any problems identified must be fully explored in order to develop effective solutions to prevent recurrence. Those responsible for coordinating the investigation must ensure this takes place. This activity should culminate in the development of a single investigation report.

9. To determine oversight of an investigation, the RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model supports the identification of a single ‘lead commissioner’ with responsibility for managing oversight of serious incidents within a particular provider. This means that a provider reports and engages with one single commissioning organisation who can then liaise with other commissioners as required. This approach is particularly useful where the ‘accountable commissioner’ is geographically remote from the provider (and therefore removed from other local systems and intelligence networks) and/or where multiple commissioners’ commission services from the same provider. It facilitates continuity in the management of serious incidents, removes ambiguity and therefore the risk of serious incidents being
overlooked and reduces the likelihood of duplication where there is confusion regarding accountability and/or responsibility and general management of the serious incident process.

Healthcare Safety Investigation Branch

10. The Healthcare Safety Investigation Branch (HSIB) will provide capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out up to 30 investigations itself per year where there is a deeper learning opportunity for the NHS. Through a combination of setting exemplary practice and structured support to others, the HSIB is expected to make a decisive difference to the NHS, promoting a culture of learning and a more supportive relationship with patients, families and staff.

11. Providers will benefit from the HSIB, and their expert advice on safety improvement. It should mean timely investigations, with a genuine commitment to openness, transparency and engagement with staff and patients and their families and carers that adopt an ethic of learning and continuous improvement. The HSIB will contribute strongly to the culture change that is needed in the NHS.
Annex I - Roles and Responsibilities of National Bodies and Commissioners

1. Each national organisation will have a single lead at executive level who has accountability, internally and externally for that organisation’s support of delivering against the national programme on learning from deaths. This will include ensuring progress is reported to the National Quality Board and ensuring that learning from deaths remains a priority area in future developments. A list of the lead roles for each national organisation is at Annex K and will be made available on each organisation’s website.

2. As the independent regulator of health and social care, the Care Quality Commission will use this national guidance on learning from deaths to guide its monitoring, inspections and regulation of services. Inspectors will use new key lines of enquiry in relation to safety and governance, set out in the Care Quality Commission’s assessment framework, to assess learning from deaths, collect evidence and identify good practice. Where specific concerns are identified, the Care Quality Commission can use its powers to take action with individual providers and will report its findings of good and poor progress in individual inspection reports or national publications to help encourage improvement.

3. NHS Improvement will continue to provide national guidance for managing serious incidents. Local processes setting out what deaths should be subject to case record review will inevitably use a wider definition than deaths that constitute Serious Incidents. Equally, when a death clearly meets Serious Incident criteria there is no need for an initial stage of case record review to be completed before work to initiate and support a full investigation is undertaken. Serious Incident guidance provides the framework upon which the Care Quality Commission and commissioners (including CCGs and NHS England) will assess the quality of investigations undertaken across the NHS. NHS Improvement will, alongside the Healthcare Safety Investigation Branch and others, support implementation of best practice in investigations by Trusts.

4. As the revised inspection regime of the Care Quality Commission will assess providers’ ability to learn from deaths as a key component of high quality care, work to address this will be factored into NHS Improvement’s work to support providers in achieving good or outstanding Care Quality Commission care ratings. Regional teams will work with
providers, their commissioners and NHS England to identify areas where improvements can be made and the strategies which can help deliver the change required.

5. Nationally, NHS Improvement commissions (via the Healthcare Quality Improvement Partnership) the work of the Royal College of Physicians to develop and roll-out the Structured Judgement Review methodology, which will be providing a national training programme for acute Trusts to support them to carry out the methodology for adult inpatient deaths.

6. **NHS England** has a direct commissioning role as well as a role in leading and enabling the commissioning system. This national guidance on learning from deaths will guide its practice in both of these areas.

7. The **National Institute for Health and Care Excellence (NICE)** has produced best practice guidelines on the care of the dying, covering adults and children. These guidelines are supported by measurable quality standards that help Trusts demonstrate high quality care, and by information for the public describing the care that should be expected in the last days of life.
Annex J - Structured Judgement Review in Mental Health Trusts

Background
1. Some mental health providers have seen a missed opportunity in not learning more widely from deaths by reviewing the safety and quality of care of a wider group of people. This is despite research showing that people with mental health problems have greater health care needs than the general population and may suffer unnecessarily with untreated or poorly managed long-term conditions.

Where Next - Making a Decision on the Review Method
2. Since 2014 hospitals in Yorkshire and the Humber have been working together with the AHSN Improvement Academy to refine a mortality review method called Structured Mortality Review (SJR), a method proposed for all acute hospitals in England. The acute sector methodology reviews phases of care appropriate to their settings, such as initial assessment and first 24 hours, care during a procedure, discharge/end of life care and assessment of care overall. Written explicit judgements of care and phase of care scores form the basis of the reviews. This now forms the basis of the national acute hospitals mortality review programme.

3. This methodology and review format was seen as potentially valuable by three regional Mental Health trusts and they have individually worked to create phase of care headings more appropriate to mental health care, with the support of the Improvement Academy and Professor Allen Hutchinson. These three trusts are at different stages of implementation. In the early adopter trust the tool was also adapted to include a pen picture to enable the reviewer to understand both the life and death of the person, considering this fundamental to understanding areas for learning that may include review of physical health and lifestyle choices. In the same trust this approach was used within Learning Disability services prior to the introduction of the Learning Disability Review of Deaths (LeDeR) programme. In another trust both the mental health care and community care facilities have been using the methods.

Introducing the Review Process
4. Just as with the acute services, future reviewers require initial training in how to make explicit judgements of the quality and safety of care and how to assess care scores for...
each phase of care. Assessments are made of both poor and good care and it is common to find that good care is far more frequent than poor care.

5. One of the findings from introducing the methods into mental health care is that many of the reviewers naturally have a focus on the mental health care component of the services. But review teams have found that using this review method they also identify common long-term conditions such as diabetes and heart disease that do not appear to have been well managed. For example, in one hospital it became evident that many people had a number of co-existing comorbid/long term conditions, yet it was unclear from the records whether or not the person was receiving support and or review from primary care and or secondary care services for their physical health. There is value, therefore, in also training up review staff who have an understanding of what good care looks like in long-term conditions within the context of mental health facilities.

6. Scoring of the phases of care is a new approach for many clinical staff in mental health care (just as has been the case in acute care) and scoring was initially felt to be very daunting by some reviewers. Nevertheless, as staff become more confident with its use, scoring can often be seen as a natural outcome of their judgements on the level of care provided. Some of the hospital teams have set up a mortality-reviewers support group to provide peer review and guidance. Feedback of the good care may be shared with both the individual staff and the wider teams - this is often well received. Of course, concerns also have to be discussed with services to identify areas for improvement.

Where Next

7. The use of the structured judgement method often receives very positive feedback from staff trained in this methodology and so in one centre SJR is being rolled out for wider use to review the quality of care being received whilst people are currently receiving services. Looking forward, it has been recognised that whilst services can learn from each case, more can be learnt from the aggregation of cases, where patterns of poor care and good care emerge. In one case study that has sought for such patterns it is of note that where patterns exist of poorer care, these have been in the main linked to the management of physical ill health within mental health and learning disability services.

8. For further details please contact Allyson Kent allyson.kent@nhs.net, or Professor Allen Hutchinson allen.hutchinson@sheffield.ac.uk Yorkshire and The Humber AHSN Improvement Academy.
Annex K - National Leads

The list below provides the lead role with overall responsibility for the learning from deaths programme at relevant national organisations:

- NHS Improvement - Executive Medical Director
- Care Quality Commission - Chief Inspector of Hospitals
- Department of Health - Director of Acute Care and Workforce
- NHS England - National Medical Director
Annex L - Background and Links

Learning Disabilities Mortality Review (LeDeR) programme
Background is available at http://www.bristol.ac.uk/sps/leder

Quality Accounts
Background is available at:
http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx

Healthcare Safety Investigation Branch
The new Healthcare Investigation Branch (HSIB) will offer support and guidance to NHS organisations on investigations, and carry out certain investigations itself. It is envisaged that the HSIB will be established to:

i. generate investigation findings and recommendations which drive action on the reduction or prevention of incident recurrence;

ii. conduct investigations and produce reports that patients, families, carers and staff value, trust and respect; and,

iii. champion good quality investigation across the NHS, and lead on approaches to enhance local capability in investigation.

The HSIB will be hosted by NHS Improvement and will undertake a small number of investigations annually. It will focus on incident types that signal systemic or apparently intractable risks in local healthcare systems. The HSIB and the role of Chief Investigator will play a crucial part in developing the culture of safety, learning and improvement in the NHS that will be one of the key elements of national policy and cross-system action in the years ahead.
Implementing Structured Judgement Reviews for Improvement
Acknowledgements

This toolkit is based on the Royal College of Physicians’ National Mortality Case Record Review Programme and the regional work carried out by the Academic Health Science Networks (AHSN) in Yorkshire and Humber and in the West of England.

Mortality Review Steering Group

We would like to thank the members of the mortality review steering groups who have engaged with the regional programmes and enabled us to put this toolkit together.

Yorkshire & Humber AHSN:
Acute Trusts: Airedale NHS Foundation Trust, Barnsley Hospital NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Harrogate and District NHS Foundation Trust (national pilot site), Hull and East Yorkshire Hospitals NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, Mid-Yorkshire Hospitals NHS Trust, North Lincolnshire and Goole NHS Foundation Trust, Rotherham NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust (national pilot site).
Mental Health Trusts: Bradford District Care NHS Foundation Trust, Humber NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust

West of England AHSN:
Acute Trusts: University Hospitals Bristol NHS Foundation Trust, North Bristol NHS Trust, Royal United Hospitals Bath NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, Gloucestershire Hospitals NHS Foundation Trust, Weston Area Health NHS Trust, Taunton & Somerset NHS Foundation Trust, Salisbury NHS Foundation Trust.
Mental Health Trusts: 2Gether NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust (from November 2017).
Aim

This toolkit aims to support the implementation of the Structured Judgement Review (SJR) process to effectively review the care received by patients who have died. This will in turn allow learning and support the development of quality improvement initiatives when problems in care are identified.

This toolkit also provides information and links to resources on change management and quality improvement methodologies.

Who will benefit from this document?

This document is for those wishing to implement the SJR process at a regional or local level, with specific reference to clinicians, managers, commissioners and trainers in secondary and tertiary care. It should also be useful as a reference for community and primary care providers.

Licence

This toolkit was created in collaboration with the Royal College of Physicians, Yorkshire & Humber AHSN Improvement Academy, and the West of England AHSN.

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This document is version 1.3 June 2018
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### Glossary

- **AHSN**: Academic Health Science Network
- **CQC**: Care Quality Commission
- **DNACPR**: Do not attempt resuscitation
- **EOL**: End of Life
- **HSMR**: Hospital Standardised Mortality Ratio
- **LD**: Learning Disability
- **LFD**: Learning from Deaths
- **NHSE**: NHS England
- **NHSI**: NHS Improvement
- **NMCRR**: National Mortality Case Record Review
- **PPI**: Patient and Public Involvement
- **RCP**: Royal College of Physicians
- **SJR**: Structured Judgement Reviews
- **SMHI**: Summary Hospital-level Mortality Indicator
- **TEP**: Treatment Escalation Plan
About Academic Health Science Networks (AHSNs)

What is the role of AHSNs?
As the only bodies that connect NHS and academic organisations, local authorities, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients. This means we are uniquely placed to identify and spread health innovation at pace and scale; driving the adoption and spread of innovative ideas and technologies across large populations. Although small organisations – which ensures we remain flexible and responsive to emerging opportunities and challenges – we lead large regional networks. Hence our impact rests in our ability to bring people, resources and organisations together quickly, delivering benefits that could not be achieved alone.

How are AHSNs different and distinct?
Everything AHSNs do is driven by two imperatives: improving health and generating economic growth in our regions. We are the only partnership body that bring together all partners across a regional health economy to improve the health of local communities. We have a remit from NHS England to occupy a unique space outside of the usual NHS service contract and performance management structures. This enables us to foster collaborative solutions. We use our local knowledge and harness the influence of our partners to drive change on the ground and integrate research into health improvement. We are as interested in seeing healthcare businesses thrive and grow, creating jobs and bringing in investment to the UK, as we are in seeing the healthcare system improve.

Patient Safety Collaboratives
Each AHSN hosts a Patient Safety Collaborative (PSC) which is commissioned by NHS Improvement. PSCs work with organisations nationally and regionally to help support and encourage a culture of safety, continuous learning and improvement.

Yorkshire & Humber AHSN Improvement Academy
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Twitter @improve_academy

West of England AHSN
contactus@weahsn.net
www.weahsn.net
Twitter @WEAHSN
The National Mortality Case Record Review programme

Most Acute Trusts have systems in place to ensure patient safety and quality of care. Many of these include ways of reviewing hospital deaths, often by detailed review of the case notes, to identify areas that could be improved and areas of good practice that could be expanded. However, it has been noted that there is often variability in such review processes and the extent from which learning is gathered and utilised to inform practice.

In order to standardise mortality reviews across the country the National Mortality Case Record Review (NMCRR) programme was commissioned by Healthcare Quality Improvement Partnership (HQIP) and funded by NHS Improvement in 2016. This programme is being delivered across England and Scotland by the Royal College of Physicians in partnership with the Yorkshire and Humber AHSN Improvement Academy and DATIX.

This programme is based on the Yorkshire and Humber mortality review programme set up by the YHAHSN Improvement Academy in 2014.

The NMCRR pilot phase ran from July 2016 to January 2017 and the pilot sites were:

- NHS Highland (Scotland)
- York Teaching Hospital NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust
- St George’s University Hospitals NHS Foundation Trust
- West of England AHSN.

Aim

The NMCRR programme’s aim is to improve understanding and learning about problems and processes in healthcare associated with mortality, and also to share best practice. It helps healthcare professionals to identify themes and address deficiencies in processes and patient care.

The programme is enabling closer work between AHSNs and healthcare colleagues to address deficiencies in patient care that are identified, through continuous quality improvement, and sharing of best practice.
Background

A 2016 Care Quality Commission (CQC) report\(^1\) found that some organisations were not giving learning from deaths sufficient consideration and therefore missed valuable opportunities to identify and make improvements in quality of care.

This review was carried out in response to the identification of the low rates of review or investigations into deaths noted at Southern Health NHS Foundation Trust.\(^2\) Additionally the review was influenced by reports into care quality at Mid-Staffordshire NHS Foundation Trust\(^3\) and University Hospitals of Morecambe Bay NHS Foundation Trust.\(^4\)

Based upon the findings of the review the National Quality Board (NQB) published the first edition of the National Guidance on Learning from Deaths for Trusts.\(^5\)

Learning From Deaths Guidance

The National Quality Board Guidance, published in March 2017, sets out the following key requirements which will ensure organisations effectively respond to and learn from patient deaths.

Each Trust should at a minimum ensure there is:

- Meaningful engagement and support of bereaved families and carers.
- The introduction of structured case record reviews when reviewing patient deaths.

It is noted that Trusts must have mechanisms to review all deaths of people:

1. With a Learning Disability
2. With a Serious Mental Health Illness
3. Those aged under 18 years
4. Perinatal and maternal deaths

Additionally it is advised that Trusts review all inpatient deaths:

1. Where family or staff concerns have been raised.
2. Where the patient was not expected to die, for example an elective procedure.
3. Where an alarm has been raised such as a Dr Foster alert or CQC concerns.
4. Where the learning will inform a provider’s quality improvement work e.g. end of life care.

There is an expectation from the Department of Health that Trusts will publish quarterly data.

Trusts must also develop a learning from deaths policy to identify how they will meet the requirements outlined in the national guidance.

NHS Improvement have released a number of resources to support trusts implement the requirements of the national guidance which can be accessed at: improvement.nhs.uk/resources/learning-deaths-nhs

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\(^2\) Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015. December 2015.


Structured Judgement Reviews: an overview

Background

SJR is a standardised, yet not rigid, case notes review methodology usable across services, teams and specialties. SJR blends traditional, clinical-judgement based, review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.¹

Since 2014, the Yorkshire & Humber AHSN Improvement Academy has supported the uptake of SJR by its acute and mental health trusts.² The Improvement Academy has successfully standardised mortality review methodology across all 13 acute trusts in Yorkshire and Humber. This work has subsequently led to the NMCCRR programme and to SJR being one of the recommended tools for the review of patient deaths, as outlined by the NHS Improvement guidance on implementing the National Quality Board’s learning from deaths framework.³

Strengths of an SJR

The benefits of utilising the SJR methodology is that it provides a structured and replicable process to review deaths, which examines both interventions and holistic care giving reviewers a rich data set of information.⁴

The SJR methodology allows organisations to ask ‘why’ questions about things that happen to enable learning and actions where required.

SJR allows the identification and feedback of good care in the same detail as ‘problematic’ care, which is integral as evidence suggests most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

How the SJR method works

A SJR is usually undertaken by an individual reviewing a patient’s death and mainly comprises of two specific aspects; namely explicit judgement comments being made about the care quality and care quality scores being applied. These aspects are applied to both specific phases of care and to the overall care received.

The phases of care are as follows:

- Admission and initial care – first 24 hours.
- Ongoing care.
- Care during a procedure.
- Perioperative/procedure care.
- End-of-life care (or discharge care).
- Assessment of care overall.

Whilst the principle phase descriptors are noted above, dependant on the type of care or service the patient received not all phase descriptors may be relevant or utilised in a review.


Structured Judgement Reviews: the component parts

**Explicit Judgement Comments**

Here the reviewer makes explicit judgement comments on the phase/overall care reviewed which allows the reviewer to concisely describe and assess the safety and quality of care provided.

Judgement comments can be made on anything the reviewer thinks is pertinent to a particular case, including technical aspects of care such as management plans, whether care meets good practice and the interventions undertaken. More holistic aspects of care such as end-of-life decision making and involvement of families are also reviewed.

It is recommended that explicit statements use judgement words and phrases e.g. ‘good’, ‘unsatisfactory’, ‘failure’ or ‘best practice’.

RCP examples of explicit judgement comments:

- **Very good care** – rapid triage and identification of diabetic ketoacidosis with appropriate treatment.
- **Overall, a fundamental failure to recognise the severity of the patient’s respiratory failure.**

**Phase of care scores**

Once explicit judgement comments are made, the reviewer then applies a phase of care/overall care score.¹

Only one score is given per phase of care and is not required for each judgement statement.

This allows the reviewer to come to a rounded judgement on the phase of care being reviewed, which is particularly useful when there is a mix of good and poor elements of care.

Therefore a phase of care could identify elements of poor care and still be rated a positive score overall if there were also elements of care that were very good.

The following care scores are used:

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Assessment of problems in healthcare

Whilst the explicit judgement comments and care scoring are the main two elements of an SJR, reviewers will subsequently be asked to make an assessment of problems in healthcare. The reviewer is asked to comment on whether one or more specific types of problems were found and, if so, identify if it is deemed this led to harm. Problem types are listed in the box to the right.

Overall care scores and further review

Overall care scores are integral to the review process. A score of 1 or 2 is given when the reviewer judges the care overall is either poor or very poor.

If a first stage review judges that the overall care score is less than three and either poor (2) or very poor (1) then the case should be subject to further scrutiny.

This may take a number of forms depending upon the detail of the governance structure within organisations.

The purpose of the on-going review in these circumstances is to define any further action needed. Typically poor or very poor care will attract an analysis or investigation which aims to understand the reasons for poor care and to provide comment on the possibility of the care having contributed to the death of the patient.

It is important to note that the SJR cannot comment on, nor describe, the “avoidability” of a patient’s death.

Problem types

1. Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls).
2. Problem with medication / IV fluids/ electrolytes/ oxygen (other than anaesthetic).
3. Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE).
4. Problem with infection management.
5. Problem related to operative/ invasive procedure (other than infection control).
6. Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes).
7. Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR)).
8. Problem of any other type not fitting the categories above including communication and organisational issues.
Operational process

This flowchart (Figure 1) provides an example of the operational processes a trust may follow when undertaking an SJR.

It should be noted that this is simply an interpretation of the inclusion and exclusion criteria, governance processes and feedback mechanisms a trust could potentially follow and is not meant to be prescriptive.

Exclusion criteria
- Cases already in the Serious Incident process or in legal process/ coroner’s inquests

Inclusion Criteria
- All deaths in specialties with <10 deaths/month
- Deaths in specialties with > 10 deaths/month identified through case selection process

Case selection process
- Must dos from national guidance – patients with severe mental health illness / learning disabilities, elective admission deaths, concerns from families/ carers etc.
- Local criteria, for example, deaths due to specific diagnosis such as sepsis /stroke, deaths from cardiac arrests, concerns raised by staff
- A sample of cases selected out for quality assurance purposes.

SJRs
- Prolems in care identified / overall care scores <3
- Good practice identified

Themes/ learning points
- Investigation if deemed appropriate by governance team/mortality lead.
- Duty of candour process.

Good practice identified

Figure 1
The following case study provides a fictional account of a patient death which has undergone an SJR. It outlines the processes for case selection, explicit judgement comments and care scores allocated.

Key learning points from this case include the potential need for earlier ceiling of treatment decisions and end of life recognition.

Explicit judgement comments from the reviewer are shown as handwritten notes in blue.

**89 Year old male admitted 28/09/2017 - 23:05 - from Nursing Home.**

**Presenting complaint** – Increasing shortness of breath

**Past Medical History** – Myocardial Infarction x2, Hypertension, Type 2 Diabetes Mellitus, Dementia. Admitted to Nursing Home 10 weeks previously due to functional decline. No community Do Not Attempt CPR (DNACPR) or Treatment Escalation Plan (TEP) in place.

**Background** – GP review 27/09/2017 – diagnosed likely Lower Respiratory Tract Infection (LRTI), started on oral Amoxicillin.

**Initial Assessment** – Observations stable – NEWS 1 – HR -92, purulent sputum – sample sent to micro, oral antibiotics to continue.


**30/09/2017** continued deterioration of condition despite treatment including micro recommended IV antibiotic regime.

**01/10/2017** – Developed Type 2 Respiratory Failure, review by ITU – not for Non Invasive Ventilation – ward level ceiling of treatment.

Re-cannulated for intravenous fluids as cannula tissued. DNACPR subsequently signed – symptom trigger started and active intervention stopped.

Family informed of decision.

Patient died at 21:35 – 01/10/2017.

**02/10/2017** – Discussion with Bereavement Office, family raised concerns regarding involvement in care and end of life decisions.

Case meets automatic inclusion criteria outlined in Figure 1 – as family concerns had been raised. Case therefore subject to an SJR. Due to overall care score and no problems in care identified not for further review.
Phase of care: Admission and initial management (approximately the first 24 hours)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information you think is important or relevant that you wish to comment on then please do so.

- Thorough admission clerking, with clear and concise notes and management plan.
- Good background history obtained from patient and wife.
- Early senior review on Acute Medical Unit with prompt and effective handover of care to Care of the Elderly ward.
- Handover from ambulance documented no community DNACPR or TEP in place, however unfortunately no early discussion with patient and family documented regarding escalation plans despite patient being an elderly gentleman with co-morbidities. This is suboptimal practice.

Please rate the care received by the patient during this phase. Please circle only one score.


Phase of care: Ongoing care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information you think is important or relevant that you wish to comment on then please do so.

- Despite increased confusion, medical team not specifically asked to review patient. Patient only seen by junior staff on ward round which is inadequate.
- Good escalation of concerns when NEWS increased, with senior registrar review who commenced sepsis bundle as per guidelines, resulting in prompt administration of IV antibiotics and IV fluids.
- Patient catheterised which was adequately documented and clinically indicated for accurate fluid output. However accuracy of fluid output recording in nursing notes was poor.
- Relatively timely review requested from ITU.

Please rate the care received by the patient during this phase. Please circle only one score.


Phase of care: Care during a procedure

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information you think is important or relevant that you wish to comment on then please do so.

Not applicable, no procedures performed.

Please rate the care received by the patient during this phase. Please circle only one score.

Phase of care: Perioperative care
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information you think is important or relevant that you wish to comment on then please do so.

Not applicable, no procedures performed.

Please rate the care received by the patient during this phase. Please circle only one score.

Phase of care: End of Life Care
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information you think is important or relevant that you wish to comment on then please do so.

• It was noted that there was a delay in identifying patient was reaching end of life (EOL), resulting in a delay in DNACPR being signed. Due to delay patient was unnecessarily cannulated on day of death.
• Whilst family were informed of decision made by senior medic, they were not involved in discussions which was inappropriate.
• Once patient was identified as EOL a symptom trigger was commenced which was regularly completed resulting in patient receiving appropriate EOL care with symptom control.

Please rate the care received by the patient during this phase. Please circle only one score.

Phase of care: Overall assessment
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information you think is important or relevant that you wish to comment on then please do so.

• Patient received generally good care during inpatient stay, which involved good quality initial clerking and deterioration identification and treatment.
• However opportunities were missed to discuss treatment escalation plans early which resulted in a delay in patient commencing an EOL pathway. Additionally the patient’s family were not appropriately involved in this discussion.

Please rate the care received by the patient during this overall phase. Please circle only one score.

Please rate the quality of the patient record. Please circle only one score.
**Assessment of problems with healthcare**

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

- No (please stop here)
- Yes (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

**Problem types**

1. **Problem in assessment, investigation or diagnosis** (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)
   - Yes  □ No □
   - Did the problem lead to harm?
     - No  □ Uncertain □ Yes

2. **Problem with medication / IV fluids/ electrolytes/ oxygen (other than anaesthetic)**
   - Yes  □ No □
   - Did the problem lead to harm?
     - No  □ Uncertain □ Yes

3. **Problem with infection management**
   - Yes  □ No □
   - Did the problem lead to harm?
     - No  □ Uncertain □ Yes

4. **Problem related to treatment and management plan** (including prevention of pressure ulcers, falls, VTE)
   - Yes  □ No □
   - Did the problem lead to harm?
     - No  □ Uncertain □ Yes

5. **Problem in clinical monitoring** (including failure to plan, to undertake, or to recognise and respond to changes)
   - Yes  □ No □
   - Did the problem lead to harm?
     - No  □ Uncertain □ Yes

6. **Problem in resuscitation following a cardiac or respiratory arrest** (including cardiopulmonary resuscitation (CPR))
   - Yes  □ No □
   - Did the problem lead to harm?
     - No  □ Uncertain □ Yes

7. **Problem of any other type not fitting the categories above**
   - Yes  □ No □
   - Did the problem lead to harm?
     - No  □ Uncertain □ Yes

Where do Structured Judgement Review outcomes fit?

**Reviews, SJR and Case Investigations**

The terms review, structured judgement review or just SJR and case investigation that appear in this document have clear definitions.

A review of the case notes, which is also in some cases referred to as a screening of the case notes is any non-validated, variously structured and usually relatively brief review of the case notes. As such these reviews are variable in quality and cannot create a validated care score. Some simple reviews of this type may be lengthy and complex but still do not generate a validated care score.

The SJR is a validated research methodology which is able to create an overall care score. The methodology used is explained in more depth elsewhere in this toolkit.

Both simple reviews and the SJR are retrospective analyses of case notes and both have the ability to generate comment on the quality of care that is delivered. In addition, the SJR methodology allows the reviewer to comment as to whether harm had occurred. Both methods can be used to “flag up” poor care and trigger further inquiry into that quality of care.

It is important to recognise that neither the review nor the SJR methodology can generate an outcome which describes if the care that was observed was more likely than not to have contributed to the death of the patient.

Investigations into the quality of care received by patients’ is therefore a fundamentally different process from the retrospective case note reviews described. An investigation is a formal process where an opinion is formed, usually by a group of clinicians and clinical governance experts, on the standard of care delivered and crucially, in the context of this document, whether the care received was more likely than not to have contributed to the death of the patient. The investigation will usually draw on evidence from a variety of sources which will in many circumstances include the outcome of the validated SJR.
Serious incident reporting framework and Duty of Candour

As part of the SJR methodology reviewers make an assessment of problems in healthcare which may have resulted in harm. Some deaths may subsequently be identified as being subject to the NHS England (NHSE) Serious Incident Reporting Framework and the CQC Duty of Candour requirements.

It is therefore recommended that Trusts undertake SJRs in a timely manner, ideally within 6 weeks, to ensure Duty of Candour processes can be followed at the most appropriate time.

Issues with care which meet the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) should be reported via local risk management systems to the National Reporting and Learning System (NRLS).


Data collection and reporting

A key part of the NMCRR programme has been to develop and build an on-line platform to enable mortality reviews to be aggregated by Trusts and Health Boards and to conduct analysis to facilitate learning and quality improvement initiatives. Since June 2017, the NMCRR core team has implemented the RCP National Mortality Review platform in 15 Trusts and Health Boards throughout England and Scotland with a further 40 signed up to implement during early 2018. We continue to actively recruit Trusts and Health Boards wishing to implement the on-line platform.

The data entered into the on-line system will allow Trusts to collate cases to enable them to report the numbers and types of reviews undertaken. The data is not intended to contribute to the national reporting framework described in Learning from Deaths neither will allow any comparisons of outcomes to be constructed.

More complex governance processes within Trusts will be required to allow these latter metrics to be created and published.
How to embed SJR into your organisation

The following pages outline how organisations may approach the development of their learning from problems in care.

**Identify project team members & roles and responsibilities**

Depending on your organisation, set up your team. The group could be incorporated as part of an existing mortality or patient safety group, or alternatively it could be established as a distinct group.

In either case, you will need to ensure it is made up of key representatives of groups that will be affected by subsequent changes.

Table 1 offers some suggestions about who might be included. The list is not prescriptive and may be dependent on your organisation.

**Table 1: Key representatives to consider**

- Executive Board sponsorship, including the Trust Medical Director and a Non-Executive Director responsible for overseeing learning from deaths (as outlined in the National Guidance)
- A project leader, who has change and quality improvement experience. (Ideally a senior clinician)
- Senior medical representation from each relevant clinical division
- Managerial representation.
- Non-medical clinical representation including nursing, allied health professionals and pharmacy
- Trust Quality Improvement team member
- Managerial representation
- Community representation including a GP, a clinician with experience in mental health and a clinician with experience with learning disabilities.
- A safeguarding team member and clinical risk team member.
- A patient experience team member, bereavement office / patient advice and liaison service team member and a Chaplain.
- Support function team members including an audit team member, IT professional, administrative support and legal team member.
- Patient and public representatives
It is advisable for your team to include public and family representatives, which may include existing trust public and patient involvement (PPI) representatives, who are able to provide the group with appropriate insights on how the changes could best meet the needs of families and carers who suffer bereavement. This involvement can take a number of formats; however it is best if such team members are involved in co-producing these processes.

Example 1. Within the West of England AHSN area, PPI representatives have been present on the Mortality Review Steering Group and have provided significant insight and influence on how structured judgement reviews could be implemented to best meet families and carers needs.

Example 2. Within the Yorkshire & Humber region, a Carers and Relatives Involvement subgroup has been set up to inform the regional steering group. See page 25.

The PPI team at the West of England AHSN have produced a PPI toolkit which provides useful resources for professionals who are looking to understand how to best involve the public, patients and families, available at www.weahsn.net/wp-content/uploads/PPI_Toolkit.pdf

The Yorkshire & Humber AHSN Improvement Academy has produced three manuals on how to plan for PPI in projects, work with PPI panels and budgeting available at www.improvementacademy.org/about-us/patient-and-public-engagement/


“As a public contributor on the Mortality Review Steering Group we are, in partnership with our colleagues from the acute hospital trusts and the West of England AHSN pleased that the importance of the public voice in informing the valuable work of the group is recognised. Together, we aim to ensure that a system which reviews all deaths of elective patients and a proportion of those admitted as an emergency is established by all acute hospital trusts in the West of England, so that learning from such reviews, results, as appropriate, in improved health services delivery.”

Christine Teller, Public contributor
West of England AHSN

“It is very encouraging that the public is involved in this very important work, so that the mortality review programme is not only driven by clinical and/or budget pressures, but the voices of the family/carer are heard loud and clear.”

Barbara Stephenson, Public contributor
Yorkshire & Humber AHSN
Spreading SJR within your organisation: identifying barriers to change

A large part of the role of the team will be to ensure that the learning from SJRs translate into improvement actions. The team will need to establish where barriers to implementation exist and discuss these at team meetings.

Commitment planning is a useful way of looking at stakeholders’ commitment thus articulating where barriers exist, and prompting where actions may be required to address these (see Figure 2).

Some barriers can be avoided by the way that the steering group is established and because of the skills of the membership. Others are external to the group.

The list in Figure 3 is another approach that can be used to help you think through the various factors that might be the cause of the resistance. The list is not exhaustive and will depend on your context. You may find it helpful to use a forcefield diagram (see Figure 4) to analyse the forces for and resistance to change.

Figure 2. Commitment planning diagram

<table>
<thead>
<tr>
<th>Person or group</th>
<th>Opposed</th>
<th>Not committed</th>
<th>No resistance</th>
<th>Help it happen</th>
<th>Make it happen</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
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<td>D</td>
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</tbody>
</table>

Figure 3: Example barriers to implementation

**Project related**
- Lack of leadership support
- Weak sponsorship
- Lack of accountability
- Lack of consensus
- Lack of control plan / measures

**Resource related**
- Competing priorities
- Time pressure
- Work pressure / overloaded workforce
- Shortage of internal resources
- Financial cost

**Staff related**
- No perceived benefit from implementation
- No perceived relevance from change
- Staff fear of change
- Resistance to change
- Motivation and engagement

**Organisation related**
- Unanticipated events
- Cultural change
- Lack of communication

Figure 4: Forcefield analysis
Spreading SJR within your organisation

Culture

Culture can play a significant influencing role on the speed, effectiveness and lifespan of improvement initiatives within organisations.

Whilst the implementation of the practical processes of SJR may occur relatively quickly, developing an environment in which the learning and actions gathered through the SJR process are effectively utilised to deliver high quality care requires an open, honest and learning focused culture.

A number of publications located in the recommended resources section of this toolkit explore the role of culture on change in more detail and include recommendations on how high performing and learning organisational cultures can be developed.

Leadership

It is apparent that effective trust and divisional leadership is integral to the implementation of SJR, with a specific focus on clinical leadership. Such leadership will not only be the driving force for implementing and spreading the use of SJR but will also be intrinsic in developing the open and learning focused culture discussed above.

Training

Although this toolkit provides an overview of the processes and benefits of SJRs, it should not negate the need to undergo specific SJR methodology training.

Integral to the NMCRR programme is the training of healthcare professionals to conduct mortality reviews. Following the publication of Learning from Deaths by the National Quality Board in March 2017, the approach to training in England changed. In an effort to ensure that capacity and capability exists to train in-hospital mortality reviewers more quickly, it was decided not to visit Trusts and Health Boards to train reviewers but instead to hold a minimum number of training sessions throughout August 2017 – January 2018 aimed at training Tier One Trainers. These trainers sit regionally as a resource for Trusts to access to train in-hospital reviewers.

A list of Tier One Trainers, their locations and contact details is available via the RCP mortality webpage www.rcplondon.ac.uk/mortality

By the end of the training phase we will have trained around 360 Tier One Trainers throughout England. We are currently working with Scottish colleagues to continue their training throughout 2018.

Within the Yorkshire & Humber area over 750 clinical staff from thirteen acute and four mental health trusts have been trained across specialties, departments and roles from consultants and registrars to specialist nurses and patient safety leads.

Within the West of England AHSN all six acute trusts within the region, and two outside the region, have been trained in undertaking SJRs by West of England AHSN regional Tier One trainers. In total over 135 cascade trainers now exist in the region with cascade training delivered to over 400 clinical staff.
Make contact with others

Whilst each Trust is likely to follow a different implementation process with regards to SJRs; making contact with others and having a collaborative platform for shared learning is highly recommended.

West of England experience

Within the West of England, Clinical and mortality leads from across the region meet on a quarterly basis, interspersed with monthly Steering Group calls to share progress and the learning from implementation, as well as the number and outcomes of reviews. The Collaborative is supported by 2 GPs and 2 public contributors who aid the discussions on involving relatives and carers, and how to take the out of hospital learning forward. The 2 Mental Health trusts in the region have recently joined the group.

Non-executive and Executives of our participating organisations were periodically invited to attend the quarterly face to face meetings to apprise them of individual and regional progress. This enabled us to gain buy in at a senior level for this work that supported those making changes at team level.

The inclusion of such members has enabled the steering group to develop the processes for shared learning across the system, which has been recognised as integral for delivering higher quality and safer care as patients are rarely cared for by an individual organisation alone.

The West of England AHSN has supported the development and sharing of resources for member organisations including operational process maps and educational material.

Yorkshire & Humber experience

Within Yorkshire & Humber, Acute and Mental Health Trusts’ mortality leads come together quarterly to share learning, achievements and challenges; shaping the programme bottom-up.

Mortality leads tell us they feel empowered by these meetings and being able to share their local challenges and explore solutions as a group.

Challenges addressed as a group include the development of robust local case selection tools and systematic identification of learning disabilities deaths.

A separate carers and relatives involvement subgroup informs the steering group.
Known challenges

What is the challenge?
During the implementation of SJRs within the Yorkshire and Humber and West of England AHSN regions a number of shared issues and challenges became apparent.
Such challenges and potential solutions will be explored in further detail within this section.

What are the potential ways forward?
When it comes to problem solving through issues, you can use this framework:

• What is the problem?
• Why is it a problem?
• When is it a problem?
• Where is it a problem?
• How is it a problem?
• Who is it a problem for?

If you don’t truly understand the problem, you cannot solve it! The cornerstone of any effective root cause analysis is having an accurately defined problem.

Using robust problem solving techniques will ensure you address the ‘real’ issue – not just the symptoms. It’s not difficult - just have a questioning attitude. Never stop with the first reason given or the obvious.

There may be multiple root causes for any given problem. Make sure you follow all of them through – they may all need fixing!

The five whys is a tool that helps to identify the root cause of a problem by verbally questioning the reasons given. It enables the peeling away of layers through a process of questions repeatedly asking “why” until you reach the root cause.
Known challenge: identifying deaths of people with a learning disability

What is the challenge?

Often, Acute Trusts have difficulties in identifying and tracking people with learning disabilities (LD) through the system to ensure that deaths of people with a LD undergo a mortality review.

Nationally, the Learning Disabilities Mortality Review (LeDeR) Programme, delivered by the University of Bristol, is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision.

Further information can be found at: www.bristol.ac.uk/sps/leder

What are the potential ways forward?

The LeDeR review team have produced a number of briefing papers which include the programme’s definition of a learning disability and guidance on identifying the scale of this disability. These resources can be accessed at:

- www.bristol.ac.uk/media-library/sites/sps/leder/Briefing%20paper%201%20-%20What%20do%20we%20mean%20by%20learning%20disabilities%20V1.2.pdf
- www.bristol.ac.uk/media-library/sites/sps/leder/12.%20Identifying%20the%20degree%20of%20a%20person's%20learning%20disabilities.pdf

Trusts within the West of England AHSN steering group are working with Mental Health Trust partners to identify an agreed definition for the steering group.

Within the Yorkshire and Humber AHSN region, Acute Trusts work closely with their local LD liaison nurses and coding departments ensuring that patients with LD who have died as an inpatient are flagged up for a SJR. For example, in Leeds Teaching Hospitals NHS Trust, all deaths coded as LD are reviewed for appropriateness of coding by the lead LD nurse. The nurse, additionally, performs a holistic assessment of care which is triangulated with the SJR findings. Trust wide learning is reported through the Mortality Improvement Group. All LD reviews are also referred to the regional LeDeR programme.

Nationally, to help with the tracking of people with a learning disability between primary and secondary care, some learning disability liaison teams utilise information contained within the GP QOF learning disability register to flag people with a learning disability who are admitted to hospital.

Some areas are also utilising summary care records (SCR) with additional information to ensure a person’s learning disability is included in their record.

Within West of England AHSN, a steering group member is working within their local partners towards ensuring all who are on the GP QOF learning disability register have a SCR with additional information. It should additionally be noted that NHS Digital is working to develop a process that will flag the records of people with a learning disability on the NHS Spine which is accessible to all providers.
Known challenge: defining severe mental health illnesses

**What is the challenge?**

Under the National Quality Board guidance, organisations must review deaths of all patients with severe mental health illnesses. However, it is noted that there is no nationally agreed definition for severe mental health illness (SMI) or what methodology should be used when undertaking these reviews.

**What are the potential ways forward?**

NHS Improvement currently recognises that while there is no single definition of the conditions which would constitute a SMI, that this is generally restricted to the psychoses such as schizophrenia and bipolar disorder.

However, it recognises that personality disorders, eating disorders, obsessive compulsive disorder and substance misuse can be just as severe and disabling. It therefore currently recommends that whilst the former disorders meet the criteria for a SMI, trusts can also choose to review the deaths of those with other significant mental health needs, as mentioned, if this can be done proportionately and effectively.

Nationally, work is underway by the Royal College of Psychiatrists to better clarify the expectations of mortality reviews of people with mental health illnesses, including definitions, and develop a review methodology for those under the care of mental health and community services. It is currently recommended that Acute Trusts utilise SJR or another suitable methodology to review the acute care of those with severe mental health needs.

A number of Acute Trusts within the Yorkshire and Humber AHSN and West of England AHSN areas have been reviewing deaths of patients under the following categories:

- under section,
- under a deprivation of liberty safeguard (DoLS)
- under the care of a secondary care mental health team such as a mental health liaison team.

Within the Yorkshire and Humber AHSN area, the Improvement Academy has been working with four mental health trusts since 2014, supporting the uptake of SJR for the review of mental health deaths. We have adapted the SJR tool to create phases of care headings more suitable for mental health reviews such as risk assessment and allocation of care. It is also important to understand the life lived by the person, the range of comorbidities and not just what happened at their death. More information on our experience is available in Annex J of the National Quality Board Guidance:


Additionally, the Improvement Academy has recently set up a separate mental health mortality review programme using an adapted SJR tool. For more information visit

www.improvementacademy.org/patient-safety/mortality-review-programme.html
Known challenge: families/ carers involvement in the review process

What is the challenge?

Nationally, Trusts have recognised the challenge of systematically embedding the voices of bereaved families and carers into their local mortality review processes.

What are the potential ways forward?

It is crucial for Trusts to have systems in place to capture concerns and complaints from bereaved families and carers. Within Yorkshire & Humber AHSN region, a number of methods have been adopted by organisations to allow for families’ and carers’ voices to feed into mortality review processes.

The format depends largely on local organisational structures and availability of resources. For example, Hull and East Yorkshire Hospitals NHS Trust issues questionnaires to all bereaved families through its bereavement office aiming to provide a route for families’ concerns to inform its case selection process. Another Trust sends letters to families of patients whose deaths have been identified as requiring SJRs. The letter requests families to feedback to the mortality lead any identified potential issues in the care received by the deceased.

Since November 2017, Yorkshire & Humber AHSN Improvement Academy has also been working with its Carers and Relatives Involvement Subgroup to develop a flexible framework for the systematic embedding of families’/carer’s voices at the various steps of the mortality review process including case selection, review and learning. For more information on when the framework will be available please contact the Improvement Academy.

In the future, changes to the process of death certification, in which deaths will be scrutinised by a medical examiner, will result in bereaved families being systematically given an opportunity to raise concerns regarding their relatives care. However, it is noted that the introduction of the medical examiners role is not expected until April 2019 and therefore Trusts should endeavour to develop effective and appropriate mechanisms for families to raise concerns. Further information regarding the medical examiner role can be found at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/517184/DCR_Consultion_Document.pdf

Where a review identifies problems in care, Duty of Candour processes should be followed. Families should be offered a genuine apology, be informed and involved in the investigation process, be given an appropriate lead point of contact to discuss questions and concerns with and finally be informed of the learning and actions developed from the investigation.

Additional resources regarding family involvement and bereavement support can be found in the recommended resources section. NHS England are due to develop guidance on how best to engage bereaved families and carers.
Known challenge: clinician engagement

What is the challenge?

To enable SJR to be effectively utilised for organisational learning and improvement, it is integral to ensure that there is effective engagement with clinicians. Such engagement relates to both the workload implications of routinely undertaking SJRs and the implications of feeding back review outcomes to the clinicians/teams involved in the care.

What are the potential ways forward?

Workload

It is recognized that undertaking SJRs often requires significant dedicated organisational resources and reviewers time. Within the Yorkshire & Humber AHSN and West of England AHSN regions, Trusts have found it useful to develop case selection processes to identify cases that require structured judgement reviews. This ensures all appropriate deaths are reviewed whilst reducing workload on clinicians. It is suggested that trusts review a sample of those deaths ‘selected out’ for quality assurance purposes. Some trusts in the West of England have spread reviews across specialties to help with workload, whereas others have kept reviews within specialty, but completed by a reviewer independent of care.

Furthermore, within the West of England AHSN steering group, one Trust has utilised a charitable donation to fund a case selection nurse, who will review all deaths against the selection tool to identify cases to be taken forward to an SJR, thus, releasing clinician capacity. Finally, the trust also agreed that reviews would be undertaken at a rate of 2 reviews per clinician per month, with clinicians recording how long they spend conducting mortality reviews to enable this to be included in subsequent year’s job plans.

Feedback

Feedback is an essential component of learning. Departmental and speciality specific themes can be fed back through a number of routes including M&M meetings, speciality level dashboards or via divisional leads. When problems in care are identified feedback should be carried out in a no blame manner. The onus is on the mortality/governance group rather than the reviewers to carry out this task.

It is important to recognise good care provided. Within the Yorkshire & Humber AHSN region, Doncaster and Bassetlaw Teaching Hospitals NHS Trust routinely acknowledges exemplary practice by either individuals or ward teams by way of a letter from the Deputy Medical Director.

Finally, steering group members have recognised the importance of feeding back and reviewing good and excellent care, alongside poor care, to identify, learn from, and spread examples of high quality care.
Known challenge: the community care - hospital interface

What is the challenge?
Hospital teams in both AHSNs have highlighted challenges regarding feeding back review outcomes to external partners including community and primary care providers and also reviewing deaths post discharge (within 30 days). CCGs and General Practitioners have been similarly concerned.

What are the potential ways forward?
With respect to exploring ways to feed back review outcomes, the West of England AHSN steering group has provided a useful forum to discuss such communication issues and identify potential solutions. Such discussions have been enhanced by, for example, the inclusion of representation from local GP’s and a CCG clinician. Similar initiatives have occurred in the YHAHSN.

Some Trusts within the West of England AHSN steering group are now feeding back review outcomes to their local CCG Quality Boards, in addition to mandatory reporting requirements, enabling the dissemination of information across the wider health community.

Additionally, a number of trusts have agreements in place that where a patient dies within a trust, but aspects of their care has been delivered in another trust, there is agreement to share this information and undertake a SJR in the locality where concerns have been raised.

Data exchange can be a challenge across institutional boundaries, despite there being a willingness to collaborate. One trust has approached the challenge of post-discharge review by developing an area wide data sharing agreement, which is currently awaiting national agreement. Once agreed this will grant the Trust access to patient identifiers for post discharge deaths, resulting in such deaths being brought into scope for SJR review. Another trust has undertaken post-discharge reviews by means of joint reviewing with both General Practioners and hospital teams accessing their electronic data separately while working in the same setting.
The West of England Academic Health Science Network (WEAHSN) has a strong patient safety portfolio. As part of our work on needless harm we partnered with the Royal College of Physicians in late 2016 to pilot and be an early adopter of their Structured Judgement Review (SJR) process.

Using our experience in delivering collaborative events and workstreams we approached all acute hospitals in the region to improve learning from deaths with the aim of standardising the mortality review process, share learning and issues, triangulating outcome themes and facilitate local and region-wide quality improvement (QI) initiatives.

Our Mortality Reviews Breakthrough Collaborative (using the IHI model) commenced in September 2016 and saw two trusts from out of the West of England region join our six acute trusts in establishing the Collaborative Steering Group. The group membership also included two GPs, two public contributors and more recently our two mental health trusts.

Whilst all the acute trusts were involved from the outset, we took a step-wise approach using three trusts as early implementers to refine the method and gain confidence before bringing in other Trusts. This reflected our awareness that mortality reviews can be a challenging process to standardise within organisations never mind across them.

This also allowed the other five trusts to accelerate their implementation plans when the National Learning from Deaths guidance was announced in March 2017.

We sought regular senior leadership involvement that enabled local teams to reconfigure their approach to learning from deaths and worked together regionally to review mortality in a standardised way.

The West of England AHSN has delivered the SJR training to eight organisations, which has resulted in over 135 cascade trainers being trained within the region, who directly support the roll-out of the SJR process to their respective Trusts.

The most consistent theme to emerge from the West of England Patient Safety Collaborative Mortality Reviews implementation has been the failure to quickly recognise end-of-life palliative care across settings.

It has also been identified that patients are being sent to hospital inappropriately, with limited conversations happening with the family, patient or carers about their wishes. Once patients enter the hospital, there is initially a focus on pathways for treatments such as sepsis care.

Through the review outcomes we have learnt the importance of timely and compassionate last phase of life conversations and means we have been able to swiftly move to initiate work on the ReSPECT process.¹ This directly supports care at the end of life to ensure that the whole system seeks to meet the wishes of the patient.

¹ Recommended Summary Plan for Emergency Care and Treatment www.respectprocess.org.uk/
Yorkshire & Humber AHSN Improvement Academy Experience

The Improvement Academy consists of a team of improvement scientists, patient safety experts and clinicians who are committed to working with frontline services, patients and the public to deliver real and lasting change. It was established as part of the Yorkshire & Humber AHSN in May 2013.

The Yorkshire & Humber Mortality review programme was set up in 2014 to support the uptake of the Structured Judgement Review methodology by both our acute and mental health trusts. To date all 13 of our acute trusts have adopted SJR as review methodology and 4 of our 6 mental health trusts are using an adapted SJR tool with phases of care to suit mental health mortality reviews.

The Improvement Academy has trained more than 750 reviewers from the multidisciplinary team across departments and specialities. Trained reviewers include specialist nurses, consultant surgeons/physicians, senior registrars, and senior allied health professionals.

Mortality leads come together quarterly as the steering group to share learning, experience and challenges, thus shaping the programme bottom up. A lay subgroup involving carers and relatives informs the programme steering group.

Locally, Trusts have developed case selection processes and since 2014 approximately 7000 SJRs have been carried out in the region. A number of Trusts have aligned their review processes with their local incident reporting systems allowing for concerns from staff to be captured.

Our common themes include:
- recognising and managing the deteriorating patient, including end of life care.
- communication within organisations, including handover and documentation.
- recognition and management of sepsis.

The Improvement Academy has set up learning events bringing together improvement experts and trusts to support the translation of themes into practical improvement steps. Our work is also aligned with our regional Patient Safety Collaborative (PSC) programme so that problems in care identified through the review process can be tackled through PSC priority themes such as patient deterioration.

Systematic analysis of problems in care and emergent themes feed quality improvement initiatives locally, contributing to real and sustainable improvements. These include:

22% increase in appropriate and timely start of end-of-life care pathways in Doncaster and

Bassetlaw Teaching Hospitals NHS Trust since January 2016.

A fall in HSMR associated with septicaemia (except in pregnancy) from 139 to 103 in Mid-Yorkshire Hospitals NHS Trust over a two year period.

19% reduction in cardiac arrest events per 1,000 bed nights in Sheffield Teaching Hospitals NHS Foundation Trust.

Improved care is seen across the community-hospital interface. For example, a trust is collaborating with their ambulance service to improve recognition of ‘red-flag’ sepsis, allowing prompt administration of life-saving antibiotics on the way to hospital.

Our work over the past four years has demonstrated how standardised retrospective mortality case notes review can provide a robust method for organisations to assess their care systems and identify problems in care.

Our support for organisations in Yorkshire & Humber learning together has yielded demonstrable benefits to organisations, leading to less organisational isolation and improved patient experience across the whole healthcare journey.
Learning and Quality Improvement

Utilising learning and developing actions for improvement are the most important benefits of implementing a structured case note review methodology.

Structured case note reviews will provide trusts with a rich data set from which they can derive themes, learn where improvements can be made and ultimately develop improvement plans which will deliver higher quality care.

Whilst this toolkit focuses on SJR, the following section outlines how Trusts may utilise the learning gathered to develop, measure and evaluate improvement projects.

The IHI Model for Improvement

Quality Improvement science is the application of a systematic approach to improvement using specific methods and techniques in order to deliver measurable improvements in quality, care and safety. Our approach uses the methodology developed by the Institute for Healthcare Improvement called the IHI Model for Improvement.

The model asks three questions:

1. What are you trying to accomplish?
2. How will we know if a change is an improvement?
3. What changes can we make that will result in an improvement?

The model then asks you to test out emergent change ideas using Plan, Do, Study, Act (PDSA) cycles.
Question 1: What are you trying to accomplish?

This is made up of three stages:

1. Understanding your problem
2. Diagnosing why the problem is occurring
3. Agreeing the aim of your improvement activities.

The learning and themes identified from thematic analysis of cohort of SJRs allow the identification of problems in care, which is the first step in the ‘improvement journey’.

A number of diagnostic tools can be used to help gain a better understanding of your problem. Some examples:

- Existing data e.g. local /national audits or surveys
- New/bespoke data e.g. brief patient/staff surveys
- Brainstorming
- Process mapping
- Fishbone diagram
- Driver diagrams
- 5 Whys

Once you are confident that you understand your problem, you can move on to agree an aim.

An aim is an explicit description of the team’s desired outcome. It is important to keep this aim as SMART (specific, measurable, achievable, realistic and time-bound) as possible. It should be meaningful to staff, patients and families. For example, for a patient falls reduction project, the aim might be ‘to reduce patient falls on Ward A by 50% within 6 months’.
How will we know if a change is an improvement?

This second question relates to the need to measure whether improvement is happening.

There are different types of measures:

- **Process measures.** These relate to the parts of the system that affect delivery of the required outcome. In essence, they tell us whether the system is behaving the way we would wish, e.g. adherence to agreed timelines for reviews.

- **Outcome measures.** This relates to the aim, so if your aim is to improve sepsis management, your outcome measure might be time from sepsis diagnosis to antibiotic administration.

- **Balancing measures.** This would be included if it was felt that the delivery of one improvement goal could have a negative consequence for another part of the system e.g. completing SJRs impacting negatively on clinic numbers.

**Reasons for measuring:**

When we talk about measurement in healthcare there are two types of measurements that are more familiar to healthcare professionals and can cause confusion when we talk about measurement in an improvement context.

- **Measurement for judgement:** where measures are used to judge us against performance targets, other Trusts, etc. Improvement is not about judgement, however, you can use measures to judge and manage your own progress.

- **Measurement for research:** where large amounts of data are gathered in order to test a hypothesis.

Measurement for improvement gathers just enough data to show that improvement is happening and we present this data using run chart.

**Run charts**

A run chart is a tool that measures your progress over time.

Whilst being visually accessible, they are underpinned by a robust statistical evidence-base that can prove whether or not improvement has occurred. The rules associated with reading run charts can be found here: [http://qualitysafety.bmj.com/content/20/1/46](http://qualitysafety.bmj.com/content/20/1/46)

For more information on measuring visit [MindSetQI on measurement](http://qualitysafety.bmj.com/content/20/1/46).
What change can we make that will result in an improvement?

As you go about answering the first two questions, you are likely to generate a number of change ideas along the way.

If you have not, there are a number of sources such as the evidence-base and other services/colleagues.

The PDSA cycle

Once a change idea has been identified, it should be tested using rapid PDSA cycles.

PDSA is an effective method that helps teams plan the actions, test it on a small scale, and review before deciding how to continue.

Using PDSA cycles is a powerful and rapid way of taking ideas, trying them in practice, learning what works, and what doesn’t to help you achieve success.

You can then broaden the scale of the test, or adjust your ideas through more than one PDSA cycle. It may take a few cycles before the idea starts to work reliably.

For a fun way to introduce a team to quality improvement, check out this blog post www.weahsn.net/2016/01/anyone-for-tennis/

For an introduction to PDSA cycles watch this video https://youtu.be/xzAp6ZV5ml4
It is important for organisations to adopt credible improvement tools and approaches when trying to understand the problems in care identified through the mortality review process, and introduce improvements.

It is essential when developing action plans, to try understand what factors might be at play, including systems factors and behavioural attitudes.

The following tried and tested tools can support you to develop your local approaches to improving care.

**Human Factors**

Human Factors is an established scientific discipline considered in the design of ‘human system interfaces’ in many safety-critical, high-reliability industries. Coupling the concepts from human factors and patient safety is now widely accepted by patient safety experts. Human factors principles can be applied in the analysis of problems in care and development of improvement actions.

Yorkshire & Humber Improvement Academy have developed a free Bronze level e-learning to support front-line staff to improve the safety of their care available at www.improvementacademy.org/training-and-events/bronze-human-factors-training.html

**Achieving Behaviour Change (ABC)**

The problems with implementing best practice are well recognised, and interventions to change practice, such as education, audit and feedback, do not consistently lead to change.

The two main issues are:

- a failure to understand barriers and levers to implementation of best practice
- a failure to use behaviour change theory to design implementation strategies

Yorkshire & Humber Improvement Academy, through the Yorkshire Quality and Safety Group, works with internationally-recognised behaviour change experts to apply psychological insights to implementation problems where behaviour change is required.


**Positive Deviance**

This asset based approach to quality improvement is built on the premise that solutions to problems already exist within communities. Certain individuals, teams, or organisations – positive deviants – identify these solutions and succeed despite facing the same constraints as others in their community. As these solutions are identified from within, the behaviours and strategies that facilitate success are likely to be affordable to implement, sustainable over time, and acceptable to others in the community. More information is available in the resource section.

The Learning from Excellence approach, developed by the Birmingham Children’s Hospital, aims to identify, appreciate, study and learn from episodes of excellence in frontline healthcare. www.learningfromexcellence.com

**Yorkshire Contributory Factors Framework**

In 2012, a systematic review of 83 research studies focusing on the causes of hospital patient safety incidents was conducted. The result of this piece of work is the first evidence based framework of accident causation in hospitals: the Yorkshire Contributory Factors Framework. This is a tool which has an evidence base for optimizing learning and addressing causes of patient safety incidents (PSIs) by helping clinicians, risk managers and patient safety officers identify contributory factors of PSIs. Finding the true causes of patient safety incidents offers an opportunity to address systemic flaws effectively, for the benefit of all our future patients.

Available at: www.improvementacademy.org/tools-and-resources/the-yorkshire-contributory-factors-framework.html
Embed your change

Project Management

Project management tools such as Project Initiation Documents (PIDs), Gantt charts, stakeholder and engagement plans and risks and issues logs may be useful to outline and plan the project dependent on scale. Further information can be accessed at: www.weahsn.net/what-we-do/west-of-england-academy/improvement-resources-and-tools/the-improvement-journey/step-2-develop-a-shared-purpose/project-management

Evaluation

Evaluation allows those undertaking change to assess whether their change was actually an improvement, as not all change will lead to an improvement. Evaluation can take a number of forms and can include different evaluation designs.

The West of England Academic Health Science Network Quality Improvement team have produced a number of resources regarding evaluation which can be accessed from: www.weahsn.net/what-we-do/west-of-england-academy/improvement-resources-and-tools/the-improvement-journey/step-4-test-and-measure-improvement/evaluation-for-a-qimprovement/ Further evaluation resources can be found in the recommended resources section.

Sustainability

The final challenge when you have identified changes that result in improvements is ensuring it becomes sustainable and is embedded into everyday practice.

The West of England AHSN Quality Improvement team have identified a number of resources which can help sustain and spread a change and can be accessed from: www.weahsn.net/what-we-do/west-of-england-academy/improvement-resources-and-tools/the-improvement-journey/step-5-implement-embed-and-sustain/

Training in Quality Improvement

For training in Quality Improvement, the Yorkshire & Humber AHSN’s free Bronze QI e-learning modules can be accessed here: www.improvementacademy.org/training-and-events/bronze-quality-improvement-training.html

You can find out more about the Model for improvement through the MINDSet quality improvement toolkit. Although aimed at people involved in providing and commissioning services for people with mental health projects, it is an excellent resource for practical quality improvement guidance. Available at http://mindsetqi.net/ as a PDF to download.

Celebration

On project completion, even though there may be a recognition that there is still much to do, it is important to remember celebration.

• Celebrate project completion with the team:
• Ensure the sponsor and stakeholders are involved (if possible).
• Acknowledge everybody’s efforts.
• Share and reflect on the positive lessons learned.
• Use corporate recognition systems.
• Avoid “institutionalised recognition” – be sincere.
• Say “thank you” and mean it.
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Acknowledgements:

Special thanks to everyone who has supported this programme to date, with particular thanks to the individuals who helped deliver the cascade trainer sessions across the West of England and Yorkshire & Humber AHSN regions.

Thank you to Nathalie Delaney at the West of England AHSN Patient Safety Collaborative for layout of the toolkit.
Resources

www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has
www.nice.org.uk/Content/GetPublished/O/OutPrac/SupportForServiceImprovementAndAudit/HowToChangePracticeBarriersToChange.pdf
www.kingsfund.org.uk/sites/default/files/field_publication_file/developing-collective-leadership-kingsfund-may14.pdf
www.health.org.uk/publication/quality-improvement-made-simple
www.hqip.org.uk/resources/guide-to-quality-improvement-methods/
www.apcrc.nhs.uk/evaluation/methodology.htm
www.qihub.scot.nhs.uk/media/596811/the%20spread%20and%20sustainability%20of%20quality%20improvement%20in%20healthcare%20pdf%20.pdf
www.rcplondon.ac.uk/file/7633/download?token=manvTuo

LifeQI

LifeQI is a Web-Software platform built to support and maintain Quality Improvement work in Health and Social Care. It makes it easy for teams to run QI projects and organisations to report on QI activities.

Across the Patient Safety Collaboratives, a number of organisations are using LifeQI as the platform for recording and sharing data.

Contact details for LifeQI
lifeqisystem.com
help@lifeqisystem.com
@lifeqisystem

Contact your Academic Health Science Network to find out if you have access to the Life System.
The most recent version of this toolkit and supporting resources are available at

www.weahsn.net
www.improvementacademy.org
www.yhahsn.org.uk
www.rcplondon.ac.uk
## Agenda item

437/18

## Report

CQC Monthly Report

## Executive Lead

Angela Wood, Interim Chief Nurse

## Link with the BAF

BAF: B1  
Corporate Risk Register: 5027, 5268

### Purpose

**Decision**  
**To note** √  
**Approval**  
**For information**

### Executive Summary (including reason for the report, background, key issues and risks)

This report is presented to the Trust Board of Directors to update regarding the findings and the ongoing actions following CQC Inspections between July and October 2018.

The Trust received the core service unannounced inspections on 25-27 September 2018 and 16-18 October 2018. The Trust received the well led inspection on 22-24 October 2018

Published feedback for the July Inspection, and initial verbal feedback has been used to formulate action plans to address areas identified for improvement.

Further action plans are being developed to address the concerns identified as part of the latest feedback.

Paediatric ED and NIV Action plans are being submitted fortnightly to CQC as part of the assurance process in relation to the licence conditions.

### Recommendations

It is recommended that:

The Board receive this report for noting

### Appendices

1. Paediatric ED and NIV Action plans  
2. Core Service Inspection and Unannounced Children’s Inspection Action plans
1. **Introduction**

1.1 The Care Quality Commission is the independent regulator of all health and social care services in England. They monitor, inspect and regulate hospitals and other care providers.

2. **CQC Inspection**

2.1 From the 2016 CQC Inspection there were three regulation breaches and 64 must and should do actions. The progress to implement these has been monitored as follows:

- The three regulation breaches have clear action plans – the evidence to confirm compliance with these action plans has been reviewed on a regular basis.
- The 64 must and should do actions have all been reviewed, and where compliance cannot be confirmed, further actions have been identified. The progress within implementing these has been reviewed on a regular basis.

2.2 The CQC Provider Information Request was submitted on 5 July 2018 and any issues identified from the data were reviewed and investigated.

2.3 The Trust received a focused inspection on 17 July 2018 looking at Non Invasive Ventilation and treatment of paediatric patients in the Urgent and Emergency Care Centre (UECC). Action plans were submitted to the CQC and these are being reviewed and resubmitted on a fortnightly basis. The up to date position against the action plans is detailed in Appendix 1.

2.4 In order to prepare staff for the inspections the following has been undertaken:

- The processes for the CQC inspections have been developed (including for the Factual Accuracy process) and have been circulated to all relevant individuals to ensure that they are aware of their role in an inspection.
- 13 staff awareness sessions have been held (a mixture of in the hospital and community). A leaflet has been developed to support staff with the inspection.
- NHS Improvement supported the Trust on 29 August 2018 with some peer reviews and mock interviews. The feedback has been positive, and each team were welcomed to the area, colleagues were open and honest about the care they provide and patients were complimentary about those caring for them and the service they received. A series of key areas for improvements were identified and include and actions put in place. The Trust then replicated these peer reviews with Executive Directors leading the reviews.
- A bi-weekly CQC Steering Group meeting was held to prepare staff and share the work that is being undertaken.

2.5 The Trust received the core service unannounced inspection on 25-27 October 2018. The CQC inspected the following four core services;

- Acute - Maternity
- Acute – Children and Young People
- Acute – Medicine
- Acute – Urgent and Emergency Services.

High level feedback was given at the end of the 27th October and this was followed up by a letter issued to the Trust the following day. The letter stated the preliminary findings;

2.5.1 Urgent and Emergency Care core service

- The CQC found evidence of ongoing concerns in relation to nurse and medical staffing within the paediatric emergency department and the impact this had on patient safety.
- Healthcare assistants did not all have the correct level of competency to care for children and young people.
- Call bells were not always in reach of patients.

However:

- There was a dedicated and hard-working team within the service and junior doctors told us they felt supported.
- Staff spoke positively about the accessibility of training and appraisals.
• Adult patients requiring care in the Resuscitation area were managed well and staff adhered to guidelines.

2.5.2 Medical Care core service

• The CQC identified some issues in relation to medicines management. This included missed dosages and a complacency amongst some staff in learning from such incidents.
• The CQC identified some concerns around mental capacity and Deprivation of Liberty Safeguards. We found inconsistencies in the application and use of paperwork. Managers were aware and were taking action to manage this.
• The CQC found there were issues in relation to safe staffing numbers on wards. Managers were aware and there was mitigation in place.

However:
• The CQC observed staff delivering compassionate care and observed positive interactions between practitioners and patients.
• Staff spoke positively about working for the trust and felt valued
• The CQC found evidence of collaborative teamwork across medical wards.

2.5.3 Maternity core service

• The CQC found the leaflets and information sheets in all areas were overdue for review and contained some out of date guidance.
• The CQC identified some issues in relation to an insufficient core number of staff on the delivery suite. Midwives were regularly pulled from other areas to support.
• The CQC found there was minimal oversight of the service’s risk register. Actions were not always updated or reviewed.

However:
• The CQC found examples of innovation including the use of non-pharmaceutical methods to improve patient outcomes.
• Staff spoke positively about leadership within the service.
• In relation to safeguarding, the CQC found examples of robust information sharing and comprehensive referrals.

2.5.4 Children and Young People core service

• Staffing levels within the Special Care Baby Unit did not meet the British Association of Perinatal Medicine standard for the number of neonatal nurses who were qualified in specialty (QIS), and the ward manager was not supernumerary.
• The CQC were concerned that some of the training provided to staff, for example, sepsis training, did not meet current guidance.
• The quality of safeguarding children referrals was inconsistent across the service.

However:
• The CQC observed staff delivering compassionate care and observed positive interactions between practitioners and patients.
• Staff spoke positively about working for the trust and felt valued.
• Staff spoke positively about leadership within the service.

Action plans have been generated to address the initial concerns raised and these are included in Appendix 2.

2.6 The use of resources inspection was held on 28 September 2018. The initial feedback was that the Trust staff had an overwhelming positive impact on the discussions. NHS Improvement (NHSI) were very appreciative of staffs input to the day. The letter of feedback was received by the Trust and additional information was requested and provided. NHSI will feed the final report into the CQC as part of the overall assessment.

2.7 The Trust received a community unannounced inspection on 16-18 October 2018. The inspection was of the Community Children and Young People core service only. High level feedback was given at the end of the 18th October and this was followed up by a letter issued to the Trust. The letter stated the preliminary findings;
• Staff were very enthusiastic about their work and promoted a culture focused on the needs of children and families.
• Practitioner caseloads were high and records were not always completed within the required timescale. However, the inspection team understood work was ongoing in relation to developing a new 0-19 service model, which includes reviewing staff competencies and caseload management.
• The inspection team identified concerns with the quality of safeguarding referrals and subsequent reports. Once the referral goes to the local authority there is no audit trail record of the actual referral, although staff are recording that the referral has been made.
• There was inconsistent practice in the use of the alert flag on the system in the sexual health unit to identify vulnerable children and young people.
• The majority of safeguarding level 3 training was comprised of online training, with minimal opportunity to engage in face-to-face training.

Action plans have been generated to address the initial concerns raised and these are included in Appendix 2.

2.8 The CQC well led inspection was held on 22-24 October 2018. High level feedback was given at the end of the 24th October and this was followed up by a letter issued to the Trust. The letter stated the preliminary findings:
• The CQC identified some concerns about the management and oversight of risk throughout the organisation, and of the quality governance arrangements.
• Linked to this are concerns around the pace of delivery in responding to risk, and the pace in delivery of some actions. The CQC found there is a tendency towards reassurance rather than assurance at all levels across the organisation.
• The CQC found there were limitations in the organisation’s approach to patient and staff engagement, including people with protected characteristic, and there were no formal strategies to support this.

However,
• In relation to IM&T, the CQC saw positive examples of good clinical systems and investment in clinical engagement.
• Patient catering was very patient-centred and based around meeting the specific needs of individuals.

Action plans are being generated to address the initial concerns raised and these will be provided at the next meeting.

3. Conclusion
3.1 Work is continuing to address any concerns raised by the CQC.

Anne Rolfe, Quality Governance, Compliance and Risk Manager
November 2018
## Appendix 1 – Action Plans from the 17 July 2018 Inspection

### NIV Action Plan (submitted 7 November 2018)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Actions required</th>
<th>Action by date</th>
<th>Person responsible (Name and job title)</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Undertake an urgent review of the management of non-invasive ventilation patients to address the immediate risks to patients | 1) A multi-disciplinary team to review current arrangements for NIV, make recommendations and implement these to address the immediate risks to patients  
2) Complete a risk assessment to support the clinical review and demonstrate mitigating actions and residual risks | 7th August 2018  
10th August 2018 | Helen Dobson (Deputy Chief Nurse)  
George Briggs (Chief Operating Officer) | Complete – Task and Finish Group established.  
Complete – Risk assessment undertaken.  
To be monitored monthly from 12th September 2018. |
| Explain how the designated lead and task group will address the immediate and on-going risks to non-invasive ventilation patients | 1) Set up regular fortnightly meetings of the NIV task group  
2) Produce Terms of Reference for the meeting including group members and scope and responsibilities | 10th August 2018  
10th August 2018 | Anne Rolfe (Quality Governance, Compliance and Risk Manager) | Complete – Meetings arranged.  
Complete – approved at the group. |
| Business Case for establishing a Respiratory Support Unit (RSU) | 1) Secure Support from project management office (PMO)  
2) Visit to Sheffield Teaching Hospitals (STH)  
3) Business Case | 25th August 2018  
20th August 2018  
23rd August 2018 | George Briggs (Chief Operating Officer)  
Orla Reddington (Clinical Lead for Inpatient Therapies) / Chris Bott (Clinical Lead Practitioner - Hospital at Night)  
Gill Richardson (Programme Manager Acute Care) / Louise Deakin (Associate General Manager) / Mark Hill (Head of Nursing for Medicine) | Complete - Support provided where required.  
Visit held, learning shared as part of the development of the business case.  
Business case approved at Business Investment Committee (BIC) on 3rd October 2018 and at October 2018 Board of Directors. |
| 4) Review of beds to identify location | Will be reviewed after submission of business plan to Executive Team meeting on Monday the 10th of September. Preferred ward is A3. |
| 5) Training Plan | Business case reviewed by executive team changes and updates advised. Clinical review by Medical Director sought and resubmitted for 24th September re final approval. |
| 6) Recruitment Plan | Ward A3 identified as Respiratory ward and dedicated Respiratory Support Unit. Following approval at BIC, plans now being put in place to reconfigure wards to include RSU on A3. |
| 7) Equipment list to be developed | Weekly operational meetings scheduled first meeting held 5.11.18. Attended by Medical Engineering, Procurement, NIV Clinical Lead, Respiratory Nurse Consultant, Associate General Manager, Operational and Performance Manager and Matron. Progress against all areas to be managed through this meeting. |

George Briggs (Chief Operating Officer) / Sally Kilgariff (General Manager) / Louise Deakin (Associate General Manager) / Mark Hill (Head of Nursing for Medicine / Orla Reddington (Clinical Lead for Inpatient Therapies) / Chris Bott (Clinical Lead Practitioner - Hospital at Night) | Recruitment commencing for Therapist additional support week of 24th September 2018. This will support and identify the ward, equipment, training and number of beds required. |

Band 7 Job Description to be reviewed and will be advertised by end November 2018. |
| Explain how non-invasive ventilation patients admitted to the acute medical unit will be managed and how risks around appropriate staffing levels and staff competency will be minimised. | 1) It is recognised that within the short term, the Trust will not be able to provide 1:2 level nursing care for patient’s receiving NIV within the Acute Medical Unit. Therefore, with immediate effect, all patients that are commenced on NIV will be cared for within the High Dependency Unit (HDU).

2) Trust communications to be issued regarding ongoing situation of NIV/BiPAP patients


To minimise risks around staffing, patients requiring non-invasive ventilation will be cared for within HDU with immediate effect | 1) Develop a Standard Operating Procedure to ensure all aspects of caring for NIV patients on HDU have been addressed.

<table>
<thead>
<tr>
<th>Task</th>
<th>Start Date</th>
<th>End Date</th>
<th>Responsible Parties</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>3) Medical NIV rota to be established</td>
<td>10th Aug 2018</td>
<td>Complete – NIV monthly rota established.</td>
<td>(Operational and Performance Manager)</td>
<td></td>
</tr>
<tr>
<td>4. Telephone for access to person nominated on NIV rota</td>
<td>10th Aug 2018</td>
<td>Complete – detailed in SOP.</td>
<td>Chris Bott (Clinical Lead Practitioner - Hospital at Night)/ Louise Deakin (Associate General Manager)</td>
<td></td>
</tr>
<tr>
<td>5. Guidelines for role of on-call Physio and Hospital @ Night team to be established</td>
<td>10th Aug 2018</td>
<td>Complete – detailed in SOP.</td>
<td>Orla Reddington (Clinical Lead for Inpatient Therapies) / Chris Bott (Clinical Lead Practitioner - Hospital at Night)</td>
<td></td>
</tr>
<tr>
<td>To provide assurance that patients receiving NIV are being treated in accordance with national guidance and local policies</td>
<td>Ongoing</td>
<td>Ongoing – initial one completed. Discussed at Therapy services Governance Meeting 1st October 2018, on agenda for next Medicine Divisional Governance Meeting (November October 2018).</td>
<td>Orla Reddington (Clinical Lead for Inpatient Therapies)</td>
<td></td>
</tr>
<tr>
<td>1) Real time audits will be undertaken of all NIV patients to ensure treatment in line with the relevant guidance.</td>
<td>Ongoing reviewed weekly</td>
<td>Ongoing – shifts being filled through additional locum bookings</td>
<td>Sophie Hodkinson (Rota Co-ordinator for integrated Medicine)/ Louise Deakin (Associate General Manager)</td>
<td></td>
</tr>
<tr>
<td>Second Medical Registrar to work weekend days to strengthen the review of patients on NIV.</td>
<td>Ongoing reviewed weekly</td>
<td>Ongoing – shifts being filled through additional locum bookings</td>
<td>Sophie Hodkinson (Rota Co-ordinator for integrated Medicine)/ Louise Deakin (Associate General Manager)</td>
<td></td>
</tr>
<tr>
<td>Undertake a nursing and medical record keeping audit.</td>
<td>31st Oct 2018</td>
<td>The audit has commenced in the Trust and the results are being analysed.</td>
<td>Philippa Collins (Research, Innovation and Clinical Effectiveness Manager)</td>
<td></td>
</tr>
</tbody>
</table>
### Paediatric UECC Action Plan (submitted 7 November 2018)

<table>
<thead>
<tr>
<th><strong>Recommendation</strong></th>
<th><strong>Actions required</strong></th>
<th><strong>Action by date</strong></th>
<th><strong>Person responsible (Name and job title)</strong></th>
<th><strong>Comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>To conduct an urgent review of children’s services in the Urgent and Emergency Care Centre to address the immediate risks to child patients.</td>
<td>Review to be undertaken with recommendations acted upon</td>
<td>17th August 2018</td>
<td>Amanda Edmunds, Deputy Head of Nursing, Family Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Amanda Edmunds, Deputy Head of Nursing, Family Health</td>
<td>Completed - Meeting dates set, first meeting undertaken with actions assigned, Terms of Reference (TOR) drafted and to be approved</td>
</tr>
<tr>
<td></td>
<td>Formulate Paediatric Taskforce to oversee completion of required actions</td>
<td>17th August 2018</td>
<td>Helen Dobson, Deputy Chief Nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To undertake a full analysis of capacity vs demand in consideration of the Intercollegiate Committee Standards for children and young people in emergency care settings</td>
<td>31st August 2018</td>
<td>Mel Simmonds, Associate General Manager - UECC</td>
<td>Completed - Requirement agreed with Consultant Body on 7th September 2018 and has now been translated into the Business Case.</td>
</tr>
<tr>
<td></td>
<td>To develop business case for required workforce</td>
<td>28th September 2018 Revised 5th December 2018</td>
<td>Mel Simmonds, Associate General Manager – UECC</td>
<td>Agreed with Consultant body on 7th September 2018. Business Case being reviewed to incorporate changes identified following the departmental review.</td>
</tr>
<tr>
<td></td>
<td>Risk assessment to be reviewed monthly</td>
<td>Ongoing</td>
<td>Mel Simmonds, Associate General Manager – UECC</td>
<td>Completed – Risk assessment undertaken and reviewed monthly at UECC governance group</td>
</tr>
<tr>
<td></td>
<td>Ratify sub risks and mitigations</td>
<td>30th November 2018</td>
<td>Mel Simmonds, Associate General Manager - UECC</td>
<td>To be agreed at UECC 13 November 2018 Governance meeting</td>
</tr>
<tr>
<td></td>
<td>Undertake a paediatric ED summit to plan service provision and mitigate risks.</td>
<td>31 October 2018</td>
<td>Angela Wood – Interim Chief Nurse</td>
<td>Summit held with representatives from Integrated Medicine and Family Health Divisions along with the full Executive Team.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Actions required</td>
<td>Action by date</td>
<td>Person responsible (Name and job title)</td>
<td>Comments</td>
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<td></td>
<td></td>
<td>Intermediate plan requested and plan enacted on 26 October 2018. Risk Assessment undertaken. SOP developed re decant of paediatrics from 12 midnight to 7am (note principles agreed with CQC and SOP submitted to CQC). Evaluation meeting conducted and plan reviewed on a weekly basis.</td>
</tr>
</tbody>
</table>
| 2.             | To provide appropriate clinical oversight 24 hours a day, seven days a week to safely manage deteriorating child patients and to ensure all staff are able to provide safe care and treatment | 10th August 2018    | Mark Hill, Head of Nursing – Integrated Medicine | Completed - Shifts advertised and being filled by the Bank Office.  
Additional HCA shifts put out to bank to support the monitoring of the waiting room, support completion of required observations and general overview of children in the waiting room 24/7 pending full workforce review  
October 2018 visit – undertake Training Needs Analysis of HCSW in paediatrics and ensure appropriate training programme to ensure competency to provide care  
Posters to be displayed within the paediatric area identifying the designated paediatric lead on shift  
Designated lead doctor for paediatrics to be identified on the rota each shift with dedicated telephone (October 2018) |  
Allocate specific HCSW to paediatrics. Training Needs Analysis completed for dedicated HCSWs. Education lead identifying dates for required competencies/training. |
|                | Additional HCA shifts put out to bank to support the monitoring of the waiting room, support completion of required observations and general overview of children in the waiting room 24/7 pending full workforce review | 31st October 2018 - Training Needs Analysis  
31st March 2019 – Implement programme | Mel Simmonds, Associate General Manager - UECC | Allocated specific HCSW to paediatrics. Training Needs Analysis completed for dedicated HCSWs. Education lead identifying dates for required competencies/training. |
<p>|                | Posters to be displayed within the paediatric area identifying the designated paediatric lead on shift | 10th August 2018    | Angela Knowles, Ops &amp; Performance Manager - UECC | Posters in place and updated daily. |
|                | Designated lead doctor for paediatrics to be identified on the rota each shift with dedicated telephone (October 2018) | 10th August 2018    | Mustafa Kendeel, UECC Consultant Lead for Paediatrics | Completed – detailed on rota and based in paediatric department in UECC. |</p>
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Actions required</th>
<th>Action by date</th>
<th>Person responsible (Name and job title)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional named middle grade shift has been added to the core rota between 14.00 – 00.00 (October 2018)</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; August 2018</td>
<td>Mel Simmonds, Associate General Manager – UECC</td>
<td>Complete – undertaken and weekly reporting to CQC in place.</td>
<td></td>
</tr>
<tr>
<td>To ensure there are 2 qualified paediatric nurses on 24/7 within the UECC with immediate effect (October 2018)</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; August 2018</td>
<td>Mark Hill, Head of Nursing – Integrated Medicine</td>
<td>Weekly plan and report formulated and fed back to CQC. Joint working with Family Health/Bank Office where there are gaps in provision with the support of an escalation protocol that is in development. Complying with Section 31 conditions – undertake daily review. Actions taken to support the provision of 2 paediatric nurses in the paediatric area 24/7: Allocated UECC Team Leader to monitor the rota coverage on a daily basis Development of an escalation process to support finding resolutions where cover is not available Joint working between UECC and Children’s services to identify cover on a daily, weekly basis All shifts not covered out to bank and agency including off framework agencies. Daily huddle with executive support to review previous day’s cover, unblock difficulties and ensure there are plans in place for the following day(s). Recruitment undertaken; appointed 4 RSCN band 5 nurses of which 2 qualify end of Mark 2019. Two with estimated start date of December 2018. Band 7 Paediatric Lead Nurse appointed with estimated start</td>
<td></td>
</tr>
<tr>
<td>Recommendation</td>
<td>Actions required</td>
<td>Action by date</td>
<td>Person responsible (Name and job title)</td>
<td>Comments</td>
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</tr>
<tr>
<td>Ensure observations are conducted hourly for all unwell children</td>
<td></td>
<td>10&lt;sup&gt;th&lt;/sup&gt; August 2018</td>
<td>Kerry Barnard, Matron – UECC</td>
<td>date of January 2019. Agreement with CQC for 1 RSCN plus 1 RGN (with EPLS training). Implemented – evidenced through audit. Explored actions to look at definition of unwell child, building paediatric dashboard and reviewing escalation process. 75% of observations were conducted in line with required timeframe.</td>
</tr>
<tr>
<td>Monthly operational meetings held between the Head of Nursing – UECC &amp; Paediatric UECC team</td>
<td></td>
<td>17&lt;sup&gt;th&lt;/sup&gt; August 2018</td>
<td>Mark Hill, Head of Nursing – Integrated Medicine</td>
<td>Completed - First meeting took place 15&lt;sup&gt;th&lt;/sup&gt; August 2018 and are scheduled to take place monthly thereafter.</td>
</tr>
<tr>
<td>Establish regular meetings between paediatric UECC and paediatric acute services</td>
<td></td>
<td>31st October 2018</td>
<td>Helen Dobson – Deputy Chief Nurse</td>
<td>Completed - Meetings occur at 3pm every day to discuss daily issues. Matrons from both areas are working together to agree a more formal meeting plan. The Task and Finish Group meetings are being held and a Children’s Board is being established.</td>
</tr>
<tr>
<td>NIC daily safety checklist implemented</td>
<td></td>
<td>24th August 2018</td>
<td>Kerry Barnard, Matron – UECC</td>
<td>Completed – checklist used.</td>
</tr>
<tr>
<td>To install CCTV in the paediatric waiting area to allow remote monitoring from the Nurses Station</td>
<td></td>
<td>14&lt;sup&gt;th&lt;/sup&gt; September 2018</td>
<td>Anthony Bennett, Security Manager</td>
<td>Completed - Installed.</td>
</tr>
<tr>
<td>To recruit substantively to HCA positions to support Paediatrics within</td>
<td></td>
<td>31&lt;sup&gt;st&lt;/sup&gt; October 2018</td>
<td>Mark Hill, Head of Nursing – Integrated</td>
<td>Complete - Shortlisting completed. Interviews undertaken</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Actions required</td>
<td>Action by date</td>
<td>Person responsible (Name and job title)</td>
<td>Comments</td>
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</tr>
<tr>
<td>UECC</td>
<td>To recruit substantively to 1.26wte band 5 paediatric UECC nursing posts</td>
<td>9th November 2018</td>
<td>Kerry Barnard, Matron – UECC</td>
<td>Completed - Interviews held on 10 October 2018 and 4 wte appointed.</td>
</tr>
<tr>
<td></td>
<td>To over recruit as part of current recruitment campaign to enable future developments of service</td>
<td>9th November 2018</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>Adverts out for band 5 and band 6 RSCNs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31st January 2019</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>Recruit all suitable candidates</td>
</tr>
<tr>
<td></td>
<td>Re-advertise Band 5 vacancy</td>
<td>9th November 2018</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>Completed - current advert extended</td>
</tr>
<tr>
<td></td>
<td>To recruit 1wte Band 7 Lead Paediatric Nurse</td>
<td>30th November 2018</td>
<td>Kerry Barnard, Matron – UECC</td>
<td>Completed - Candidate appointed 04.10.18 with a start date of 26.11.18</td>
</tr>
<tr>
<td></td>
<td>Management of UECC Paediatric Nurses transferred to Deputy Head of Nursing for Family Health</td>
<td>1st April 2019</td>
<td>Mark Hill, Head of Nursing – Integrated Medicine</td>
<td>Completed - Leadership support arrangements established between UECC Paediatrics and Family Health Paediatrics</td>
</tr>
<tr>
<td>3. Assurance of staff competencies in relation to managing a sick child</td>
<td>To recruit 1wte Band 6 Joint Paediatric Practice Development Post in conjunction with Family Health</td>
<td>30th November 2018</td>
<td>Amanda Edmunds, Deputy Head of Nursing – Family Health</td>
<td>Establishment Control Form approved by going to panel. Advert has closed. Interview scheduled for 9 November 2018</td>
</tr>
<tr>
<td></td>
<td>To increase completion of ‘Assessing, Identifying and Managing the Sick Child’ from 60% to 100% unless on long term leave/within 2 months of start date)</td>
<td>31st August 2018</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>Completed - All RSCNs completed – 100%</td>
</tr>
<tr>
<td>4. Ensure effective triage assessment and early warning</td>
<td>Identify the amendments to Meditech &amp; Sepia that are required to implement POPs</td>
<td>31st August 2018</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>Completed - Amendments identified and agreed</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Actions required</td>
<td>Action by date</td>
<td>Person responsible</td>
<td>Comments</td>
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</tr>
<tr>
<td>score for children is in place in ED.</td>
<td>POPs training completed with paediatric nursing team including use of Meditech</td>
<td>28th September 2018 Revised date 31/12/18</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>POPs training package identified and to be sent out w/c 1.10.18. Meditech training element to be developed. All staff to be informed to prioritise completion of the POPs training to enable prompt introduction whilst recognising the capacity issues. Support provided from Family Health Division. SOP being developed and to be approved at Governance Meeting to be held 13.11.18</td>
</tr>
<tr>
<td></td>
<td>Meditech &amp; Sepia amendments implemented and go live with POPs tool</td>
<td>5th October 2018 Revised date 31/1/19</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>PEWS tool continues to be completed and will be used until POPs embedded. POPs to be introduced once training completed. POP element framework built into meditech</td>
</tr>
<tr>
<td>5. Undertake an urgent review of competency for prescribing and administering medicines to children</td>
<td>To develop and implement a competency assessment framework for paediatric prescribing and administration</td>
<td>30th September 2018 Revised date – 31/12/18</td>
<td>Kerry Barnard, Matron – UECC/ Osman Chohan - Chief Pharmacist</td>
<td>Meeting to be held between Pharmacy, Family Health and UECC to commence development. An overall medication management meeting took place on 26 October 2018, and the competencies for prescribing as per the NMC guidelines were agreed. Assessment tool to be developed in line with NMC standards.</td>
</tr>
<tr>
<td></td>
<td>100% completion (excluding long term leave) of Meds Management competency framework</td>
<td>1st April 2019</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>A competency framework needs to be developed and so forms the second phase of the previous action</td>
</tr>
<tr>
<td></td>
<td>All paediatric nurses in UECC to</td>
<td>20th August 2018</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>Completed - 100% compliance achieved for</td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
<td><strong>Actions required</strong></td>
<td><strong>Action by date</strong></td>
<td><strong>Person responsible</strong></td>
<td><strong>Comments</strong></td>
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<tr>
<td></td>
<td>complete e-learning package on the care of children with sepsis from E-learning for Health, incorporating assessment component</td>
<td></td>
<td>Matron - UECC</td>
<td>RSCNs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10th August 2018 Revised date – 31st October 2018</td>
<td>Mark Hill, Head of Nursing, Integrated Medicine</td>
<td>Outcome of audit being finalised. 75% of observations conducted within required timeframe.</td>
</tr>
<tr>
<td>6.</td>
<td>Timely monitoring of patients records to check for accuracy and completeness.</td>
<td>Weekly medical and nursing records audit to track frequency of observations and records quality using a sample of the most unwell children</td>
<td>30th September 2018 Revised date – 31st October 2018</td>
<td>Kerry Barnard, Matron – UECC</td>
</tr>
<tr>
<td></td>
<td>Monthly medical and nursing records audit to track frequency of observations and records quality</td>
<td></td>
<td></td>
<td>Philippa Collins (Research, Innovation and Clinical Effectiveness Manager)</td>
</tr>
<tr>
<td></td>
<td>Undertake a nursing and medical record keeping audit.</td>
<td>31st October</td>
<td>Kerry Barnard, Matron – UECC</td>
<td>To be finalised.</td>
</tr>
<tr>
<td></td>
<td>Undertake monthly PEWS audits</td>
<td></td>
<td>Kerry Barnard, Matron – UECC</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Timely review of incidents with evidenced learning outcomes</td>
<td>All overdue serious incidents to be completed.</td>
<td>7th September 2018 Mitigation included in comments – all future SIs will follow due process and outlying SIs will follow trust escalation process</td>
<td>Angela Shaw, Head of Patient Safety</td>
</tr>
<tr>
<td></td>
<td>Learning from incidents to be presented to CSU Governance</td>
<td>Ongoing and embedded</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>Completed - Discussed at Governance meeting from September 2018 and onwards.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Actions required</td>
<td>Action by date</td>
<td>Person responsible (Name and job title)</td>
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<tr>
<td></td>
<td>Registers maintained of staff learning events &amp; attendees</td>
<td>Ongoing and embedded</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>Completed - Registers maintained.</td>
</tr>
<tr>
<td></td>
<td>Develop monthly learning from incidents newsletter and commence circulation</td>
<td>30th September 2018</td>
<td>Jane Jackson, Governance Lead – Integrated Medicine</td>
<td>Completed - Published.</td>
</tr>
<tr>
<td>10. Competency assessment tools used to assess staff competency for the care of children with diabetes/diabetic ketoacidosis, sepsis etc</td>
<td>All ALS trained nurses in UECC to complete e-learning package on the care of children with sepsis from E-learning for Health, incorporating assessment component</td>
<td>30th September 2018 Revised date 31/12/18</td>
<td>Kerry Barnard, Matron - UECC</td>
<td>Compliance level was 33% as at 2 October 2018 and 39% at 29 October 2018. Scheduling of training for outstanding staff being identified with a target of prioritising staff who work in paediatrics department in UECC.</td>
</tr>
<tr>
<td></td>
<td>All paediatric nurses in UECC to complete the e-learning package on the care of children with diabetes and diabetic ketoacidosis from 'E-learning for Health', incorporating assessment component</td>
<td>30th September 2018</td>
<td>Kerry Barnard, Matron – UECC</td>
<td>Completed - 100% compliance obtained.</td>
</tr>
<tr>
<td></td>
<td>All registered staff nurses/advanced clinical practitioners who work in majors to complete Trust Safe use of Insulin E-learning package</td>
<td>30th September 2018 Revised date 31st December 2018</td>
<td>Helen Dobson – Deputy Chief Nurse</td>
<td>An assessment of the Trust e-learning package by the workforce identify that it did not meet the needs of the workforce. The Trust will review content and complexity of the package to ensure it is more appropriate to enable improved competency of staff</td>
</tr>
<tr>
<td></td>
<td>Annual competency assessment</td>
<td>1st April 2019</td>
<td>Kerry Barnard,</td>
<td>Teaching plans are being written and</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Actions required</td>
<td>Action by date</td>
<td>Person responsible (Name and job title)</td>
<td>Comments</td>
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<tr>
<td>programme for all required competencies developed</td>
<td></td>
<td>Matron - UECC</td>
<td>linking in with other local hospitals to create a joined up programme.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 2 – Action Plans following the Core Service Inspections

Children and Young people core services: CQC initial feedback and action plan:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Desired Outcome</th>
<th>Actions</th>
<th>How will we know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staffing levels did not meet BAPM standard/QIS.</td>
<td>Increase number of nurses Qualified in Speciality (QIS)</td>
<td>SSPRD funding approved for Two staff for 2018/19 and two staff for 2019/20 One staff commenced course September 2018. Two more staff nominated for September 2019 to maintain recommended level and safety (70% QIS) Monitor e-roster for evidence</td>
<td>Completion of course. Currently at 66% for QIS (September 2018)</td>
</tr>
<tr>
<td>The ward manager is not supernumerary</td>
<td>Ward manager not included in numbers.</td>
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<tr>
<td>2. Some of the training does not meet current guidance eg Sepsis</td>
<td>All staff up-to-date with Sepsis 6.</td>
<td>All staff to complete PILS training of which Sepsis is included within this Standard Operating Procedure for Sepsis has been ratified at governance Sepsis 6 charts with printers Development of paediatric development practitioner role to support with training, education and competence. Education to staff provided by clinical educator for the Critical Care Operational Delivery Network (ODN)</td>
<td>Evidence of MaST completion Signing sheet to demonstrate that staff have seen and read the policy Once charts received from printers these need to be embedded within practice from both a medical and nursing perspective. Recruitment to the role and defined training programme to be developed. To access regional networking group to share good practice Evidence of staff attending one of the 4 training sessions</td>
</tr>
</tbody>
</table>
Simulation sessions

- provided per year by ODN to support with any area of training need. ODN also provide simulation day which incorporates consultants medical staff nursing staff and anaesthetists. Evidence of staff attendance to in house simulation sessions run by simulation department which includes both paediatric ward and Urgent and Emergency Care staff.

<table>
<thead>
<tr>
<th>3. Quality of safeguarding referrals inconsistent across the service</th>
<th>All safeguarding referral are consistent and follow the process ie EMARF and referral to MASH</th>
<th>Work with Safeguarding team to monitor</th>
<th>Staff attendance at bespoke training session regarding referrals, time lines and professional challenge were delivered by the safeguarding team. Redesign of acute children’s safeguarding team will provide additional support to ward based colleagues and a day to day oversight of safeguarding issues. Evidence of safeguarding level 3 training Evidence of safeguarding supervision attendance</th>
</tr>
</thead>
</table>
## CQC Inspection feedback and actions taken for Maternity core service

<table>
<thead>
<tr>
<th>Issue</th>
<th>Desired Outcome</th>
<th>Actions</th>
<th>How will we know</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Maternity core service</strong>&lt;br&gt;The preliminary findings that we fed back to you were:</td>
<td>That all leaflets are reviewed in a timely manner and leaflets which will go out of date in the next quarter are addressed.&lt;br&gt;Updated leaflets will then be put in place before the point of expiry is reached. If a new leaflet cannot be prepared in time, the current leaflet will be removed form use.&lt;br&gt;When practice changes pertinent leaflets will be updated.</td>
<td>Two leaflets for Induction of Labour and Caesarean Section were not current information, these have been removed. The induction of labour leaflet had been updated; but all old stock had not been removed. This was actioned on Wed 26th Sept. and all leaflets were reviewed and out of date or not current practice leaflets were removed immediately.&lt;br&gt;This action was fed back to the CQC inspectors on Thursday 27th in the leadership team interview.</td>
<td>The ward managers and clinic team leader will keep their area’s leaflet titles and stock to a minimum and together in one place in their area.&lt;br&gt;The stock will be reviewed 3 monthly and a signed record maintained of this check.&lt;br&gt;Leaflets due to expire or in the event of new guidance being published, then a leaflet review will be requested by the subject specialist.&lt;br&gt;A model similar to the review of guidelines and policies will be put in place, so that a register of leaflets is maintained with their expiry dates.&lt;br&gt;Leaflet currency will be reviewed at the monthly maternity guideline meeting.</td>
</tr>
<tr>
<td>- We identified some issues in relation to an insufficient core number of staff on the delivery suite. Midwives were regularly pulled from other areas to support.</td>
<td>The maternity service had a 6% vacancy factor over the summer months.&lt;br&gt;Significant recruitment has occurred and all vacancies are filled.&lt;br&gt;Recruitment to the Midwifery bank has also occurred to ensure that even with the vacancies now filled, if there are any service shortfalls these can be escalated with a greater fill rate from temporary staffing.</td>
<td>The issue of labour ward staffing was discussed at the leadership interviews with the CQC inspectors and the current vacancy and recruitment position was given on Thursday 27th Sept.</td>
<td>Labour Ward staffing report for July to Sep&lt;br&gt;&lt;br&gt;An analysis of the midwifery labour ward staffing position for the last quarter is attached.&lt;br&gt;Now new starters are joining the team from end September and in early October (staggered starting dates) this will be largely addressed, once induction is completed.</td>
</tr>
</tbody>
</table>
• We found there was minimal oversight of the service’s risk register. Actions were not always updated or reviewed.

The Risk Register was reviewed at the Maternity Governance meeting on 28 September 18 and risks which were addressed were closed.

That all staff are confident and familiar with the risks on the risk register. That the leads for each risk are updating and where indicated closing the risks when the issue is concluded.
### Medicine

<table>
<thead>
<tr>
<th>Issue</th>
<th>Desired Outcome</th>
<th>Actions</th>
<th>How will we know</th>
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</thead>
<tbody>
<tr>
<td>1. We identified some issues in relation to medicines management. This included missed dosages and a complacency amongst some staff in learning from such incidents.</td>
<td>To reduce the number of omitted medications across the Division of Medicine</td>
<td>1. Pharmacy Governance Lead to meet divisional senior nursing team on 20.11.18 to review current education, training and audit process in place</td>
<td>Audit Results – Benchmark of starting position</td>
</tr>
<tr>
<td></td>
<td>To reduce the number of omissions of critical medicines for patients across the division of Medicine</td>
<td>2. Agree a plan of action in relation to education, training and audit with support from Pharmacy Colleagues</td>
<td>Service Improvement Action Plan compliance</td>
</tr>
<tr>
<td></td>
<td>To improve the education, training and sharing of learning in relation to medication safety across the division of Medicine</td>
<td>3. Review with Chief Pharmacist the support given to ward teams from a Pharmacy and/or Pharmacy Technician perspective</td>
<td>Re-audit cycle to embed and sustain the actions put in place through the service improvement plan</td>
</tr>
<tr>
<td></td>
<td>To pilot the roll out of E prescribing across the Division of Medicine</td>
<td>4. Review the trust wide roll out of Electronic Prescribing across the division</td>
<td></td>
</tr>
<tr>
<td>2. We identified some concerns around mental capacity and Deprivation of Liberty Safeguards. We found inconsistencies in the application and use of paperwork. Managers were aware and were taking action to manage this.</td>
<td>To ensure that colleagues receive the required education, training and support to appropriately apply the principles of the mental capacity act</td>
<td>1. Head of Nursing and Deputy Head of Nursing to meet with Adult Safeguarding Lead to review attendance at Corporate Committees from a Divisional Perspective</td>
<td>1. Operational Safeguarding Divisional Lead – Matron Jane Grainger Strategic Safeguarding Divisional Lead – Mark Hill Head of Nursing and Deputy, Gail Smith, Deputy Head of Nursing</td>
</tr>
<tr>
<td></td>
<td>To ensure that there is a ‘user friendly’ approach to the use of documentation to reflect interventions in line with mental capacity act</td>
<td>2. Monthly meetings to commence with Divisional Senior Nursing Team and Adult Safeguarding Team to identify areas of support, and development and to review current ‘live’ safeguarding cases/concern</td>
<td>2. Meetings commenced in October 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Chief Nurse to undertake a ‘time out session’ with divisional and safeguarding specialist nursing</td>
<td></td>
</tr>
</tbody>
</table>
team to review the approach to education, training and support to frontline colleagues in relation to Mental Capacity Act

4. A trust wide review of medical/nursing documentation to support a ‘user friendly’ approach to the assessment, documentation and application of the principles of the Mental Capacity Act (lead Deputy Chief Nurse)

1. Continue to actively recruit to all substantive vacancies at registered Nurse and Health Care Assistant roles through trust wide campaigns, divisional campaigns and individual speciality recruitment

2. Continue to actively work with bank and agency colleagues to foster working relationships to progress movement from bank/agency contracts to substantive appointments

3. Ensure that our approach to recruitment and retention continues to be in line with service demand and the focus of family friendly / work life balance options eg condensed hours, annualised hours

- 3. We found there were issues in relation to safe staffing numbers on wards. Managers were aware and there was mitigation in place.

| To aim for 100% fill rates for all Registered Nurse and Health Care Assistant shifts across the Division of Medicine |
| To reduce the potential links to patient experience and patient outcomes linked to safe and sustainable staffing |

| Audit Programme |
| MAST Training Compliance |
| Colleague Feedback |

| Substantive Fill rates |
| Bank and Agency Fill rates |
| Recruitment profile |
| Incident Management |
| Staffing review to the Board of Directors |
4. Continue to support and develop the compass programme across the division of medicine identifying further opportunities for rotation and development across the division of medicine

5. Continue to support the internal rotation of colleagues across the division

6. Continue to review the workforce model for in-patient ward areas formally each 6 months and more frequently as required to look at alternative workforce models in line with changing patient acuity and need

7. Continue with the staffing daily arrangements we have in place for the management of safe and sustainable staffing across the division of medicine

8. Continue to pro-actively manage short term and long term sickness
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>438/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Patient Led Assessment of the Care Environment Report (PLACE)</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Angela Wood, Interim Chief Nurse</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B1: This report highlights the findings of the PLACE assessment and where improvements could be made. It also details the national scores and where the Trust sits against those in relation to the patient environment.</td>
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<tr>
<td>Purpose</td>
<td>To note</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>This report is provided to enable the Board Members to receive information relating to the Trust PLACE assessment against the National position. Challenges remain in place with regards to the dementia environment and continuous refurbishment of wards and departments. Mitigating actions being taken include refurbishment to the whole of ward B5 which was found to be in a poor state of repair</td>
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<td>Recommendations</td>
<td>It is recommended that the Board of Directors note the contents of the report.</td>
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<tr>
<td>Appendices</td>
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</table>
1.0 Purpose of the Report:

1.1 This report provides a short briefing on the findings of the final report from the visit / inspection / accreditation of the Trust by the PLACE Assessment team which took place on 2nd and 4th May 2018.

2.0 Situation and Background

2.1 PLACE (Patient Led Inspection of the Care Environment) as set out by the NHS Commissioning Board is in its fifth year of assessment, which commenced in 2013

2.2 Each PLACE assessment will generate a score in the six separate domains of Cleanliness, Food, Privacy and Dignity, General Maintenance/Décor, Disability and Dementia. The results must be published locally, with an accompanying action plan that sets out how the organisation expects to improve their services before the next assessment.

2.3 The Trusts process for the assessment is to arrange the date with all the participants, this date is not shared with any other Trusts members of staff. The patient representatives choose the areas to be visited on the actual day of the assessment it is not done prior to the day, this is to ensure that a true reflection of the organisation is observed and no advanced work in relation to the environment or cleaning can take place. The patient representatives are advised to choose locations that cover the whole age range of the wards and departments and not those that may have been recently refurbished. It is unclear from the reports if this process is used on other Trusts when deciding which areas to assess, this could ultimately impact on the level of scores achieved if locations have either been chosen in advance or are targeted at recently refurbished/ new areas.

2.4 Trusts were this year given the full allocated time to arrange their assessments this ran from 15th February 18 to the 4th June 18. The Trust was complaint in meeting the target dates issued.

2.5 In support of the assessment, the Patient Assessors were required to complete a separate summary sheet that Trusts are expected to respond to the information submitted from the assessment will be shared nationally with other agencies such as the Care Quality Commission to triangulate evidence.

2.6 This is the sixth assessment in the new format, however there are a few questions that have been changed. This will make comparing like for like, year on year difficult.

2.7 The marking and weighting criteria has been issued this year, along with additional reports that are automatically generated once scores have been committed and cannot be changed.

2.8 The assessment team was made up of five Public Governors, one volunteer two member of Health watch and eight Trust employees.

3.0 Assessment of any areas of non-compliance identified in the final report:

3.1 Graph

<table>
<thead>
<tr>
<th>ROTHERHAM DISTRICT GENERAL HOSPITAL- Collection: 2018</th>
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<tbody>
<tr>
<td>Cleanliness</td>
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<tr>
<td>Achieved Score (Actual)</td>
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<tr>
<td>Available Score (Actual)</td>
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<tr>
<td>Site Score</td>
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<tr>
<td>Organisation Average</td>
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<tr>
<td>National Average</td>
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</table>
3.2 The above table is the final TRFT scores that have been aligned against the national average, this year none of the sections have scored above the national average which is disappointing. The cleanliness section is just over 1% below national average and only 1% lower than last year’s score. Nationally 300 Trusts reported a cleanliness score of 100% out of a possible 1198 Trusts that took part. This is in turn has raised the national average score from 2017.

3.3 The Data Quality report published by NHS Digital identified a number of changes in this year’s scoring algorithm, these are:

3.3.1 Minor changes were made to the Privacy, Dignity and Wellbeing domain questions. Although these were not considered to have had a significant effect on comparability, it is advised to treat comparisons with caution because changes were made to the online collection system (the addition of a ‘not applicable’ option) in order to improve the accuracy of responses. This may have led to a slight reduction in scores.

3.3.2 For the Condition, Appearance and Maintenance domain, a new set of questions was introduced around improving accessibility through the installation of handrails and the provision of a variety of seating types and toilets which can accommodate a wheelchair and carer/staff member. The addition of this section is likely to have resulted in a small downward change in the scores and an overall reduction of the national average, so comparisons should again be treated with caution for these reporting years.

3.6 In the Food and Hydration domain, the tasting component was amended to introduce a weighted aspect to the scoring algorithm and also to increase the range of possible responses from a 3 point to a 5-point scale. This is likely to have led to a downward change in the score for Ward Food, although this will have been balanced by a rise in the Organisational Food domain leading to an overall small reduction in the overall food national.

3.7 The scores submitted for the food and hydration section was discussed at the Quarterly Contract Catering meeting. Some of the questions where the Trust did not gain full score included:

3.7.1 The daily choice of breakfast items is six or more (the Trust provides 4) this can be looked at for 2019.

3.7.2 Patients choose their lunch and supper at the point of service (the Trust is no more than one meal ahead) this would create significant waste and may increase costs, the group accepted this would always be a lower score.

3.7.3 All patients not requiring a special diet can choose from four or more options including one vegetarian at lunch time (the Trust provides three hot options including vegetarian) this would increase the base costs of food.

3.7.4 The earliest supper service time is 5.30pm (the Trusts supper service starts at 5pm) the group agreed that 5.30pm is too late and leaves a large gap from the 12.00 lunch time service. Service to remain at 5pm regardless of points scored, this is about patient experience not point scoring.

3.7.5 Patients not requiring a special diet can choose from four or more hot options including one vegetarian at supper time (the Trust provides two hot options including one vegetarian) this would increase the base costs of food.
3.9 The above table is the final Breathing Space scores aligned against the national average scores, there is only one area scoring above national average which is Privacy, Dignity and Wellbeing all the remaining sections scored lower, again the changes to the algorithm above also applies to this location.

4.0 Assessment of implications of areas of non-compliance identified in the final report:

4.1 There is no national requirement to achieve 100% compliance, however the Trust needs to be aiming to be equivalent or better than the national average

4.2 The main areas of concern identified on the inspection day are

4.3 Dementia friendly environments not having the appropriate signage/ clocks and decoration

4.4 Not enough hand rails in wards and departments that can be grabbed if needed

4.5 The food service was slow on ward A5 at the time of assessment, subsequently the food sampled was mostly cold.

4.6 Maxillo-facial department scored the lowest of the cleaning scores at 84% due to a number of qualified pass marks (not a full fail or a full pass)

4.7 B5 scored the lowest score for the condition appearance and maintenance at 55% this was reported in more detail in the interim report submitted in June18.

4.8 Appendix 1 shows the surrounding Trust scores as a comparison against the national averages and TRFT’s position. Appendix 2 is the failures report where the Trust failed to gain full scores.

4.9 Action plans to address the failures are being put in place.

5.0 Summary of any best practice identified in the final report:

5.1 The PLACE final scores do not highlight any best practice, however any scores that have achieved a level above the national average could be considered best practice, the Trust has failed to achieve this in all areas with the exception of Privacy, Dignity and Wellbeing at Breathing space.

5.2 This could be viewed as a negative position, however the Trust receives very few complaints about the food, environment or cleanliness of wards and departments and lots of positive comments via the friends and family test.

6.0 Recommendations to address areas of non-compliance or improvement

6.1 The failures report will be issued to the Estates and Facilities Teams to address the environmental areas identified on the assessment, an update on progress from this group will be requested. This will then be presented to the Patient Experience Group. There are some elements of the assessment that
without redesign of the area will never attract a pass score, such as not having to walk back through a waiting area from a consulting room in any outpatient area. A full list of failures will be sent to each department for them to lead on.

### 7.0 Conclusion

#### 7.1
The action plan will be presented to the Patient Experience Group on a quarterly basis.

#### 7.2
For the reasons stated above some actions will not be possible to implement.

#### 7.3
The date of the next assessment will be between February and May 2019

#### 7.4
The table below identifies the scores from the local hospitals, showing where they are either above (Green) or below (red) the national average score.

<table>
<thead>
<tr>
<th>Organisation Name</th>
<th>Organisation Type</th>
<th>Cleaning Score %</th>
<th>Food Score %</th>
<th>Chief Food Score %</th>
<th>Ward Food Score %</th>
<th>Privacy &amp; Dignity Score %</th>
<th>Wellbeing Score %</th>
<th>Condition Appearance Score %</th>
<th>Quality Assurance Score %</th>
<th>Score</th>
<th>Date</th>
<th>Score</th>
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<tr>
<td>NATIONAL AVERAGE SCORE</td>
<td></td>
<td>98.47</td>
<td>90.17</td>
<td>88.97</td>
<td>90.52</td>
<td>84.16</td>
<td>94.13</td>
<td>78.89</td>
<td>84.19</td>
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<td>THE ROTHERHAM NHS FOUNDATION TRUST</td>
<td>ACUTE -MEDIUM</td>
<td>97.13%</td>
<td>85.36%</td>
<td>88.27%</td>
<td>84.56%</td>
<td>80.13%</td>
<td>92.11%</td>
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<td>BARNSLEY HOSPITAL NHS FOUNDATION TRUST</td>
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<td>99.40%</td>
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<td>85.28%</td>
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<td>89.02%</td>
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<td>85.75%</td>
<td>93.28%</td>
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<td>90.00%</td>
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<td>91.00%</td>
<td>85.16%</td>
<td>93.27%</td>
<td>87.25%</td>
<td>97.21%</td>
<td>80.95%</td>
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<td>Report</td>
<td>The National Staff Flu Campaign Executive Summary Report</td>
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<td>Executive Lead</td>
<td>Angela Wood, Interim Chief Nurse</td>
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<tr>
<td>Purpose</td>
<td>Decision □ To note ✔ Approval □ For information □</td>
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<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>To present Board with the executive summary of the 2018/19 Staff Flu plan and the Trust response to the letter of 7 September 2018 sent to Chief Executives of NHS Trusts and Foundation Trusts on behalf of NHS England. (Appendix A) The report will also include the Trust self-assessment report, against the best practice management checklist for healthcare worker vaccination (Appendix B) Finally, the report will also set out the infection prevention and control statement position with regards to higher risk clinical areas and staffing. The key points arising from the report are:</td>
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<td>• The Trust has a robust approach to staff vaccination in line with national best practice and operated as a divisionally led campaign</td>
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<td>• The Trust meets the requirements set out in the self-assessment standards</td>
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<td>• All colleagues are included in the Trust vaccination programme</td>
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<td>• The Trust is vaccinating staff with quadrivalent flu vaccine as advised by PHE and ordered in accordance, in advance of more recent advice indicating staff 65 and over should receive adjuvant trivalent vaccine</td>
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<td>• Access to adjuvant trivalent has been challenging nationally. The Trust has taken the decision to signposted staff 65 and over to their GP in line with the recommendations set out by PHE (analysis of numbers showed small numbers of frontline staff 65 and over)</td>
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<td>Recommendations</td>
<td>Comply with the recommendations set out the letter to the Trust re publication of performance.</td>
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<tr>
<td>Appendices</td>
<td>A. Health care worker flu vaccination letter (inclusive of its own two sub appendices) B. The Rotherham NHS Foundation Trust - Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2018</td>
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1.0 Introduction

1.1 The national flu campaign commences each season usually in late September. Preparations for the Trust campaign started in the summer with an evaluation of the success and areas of improvement from the previous year.

1.2 At the Business Continuity and winter plan debriefs 2017/18, the flu campaign was hailed a successful and positive campaign. One area that was highlighted for consideration for this year was to widen vaccination to include partner frontline workers based in Trust premises. The Trust identified Flu cases in 2017/18 in many areas of the Trust.

1.3 The Trust ambition is to offer and achieve 100% of all workers (including frontline) albeit this a challenging target.

1.4 Recent National Institute for Health and Care Excellence (NICE) guidance highlight a correlation between lower rate of staff vaccination and increased patient deaths.

50% of confirmed influenza infections have no symptoms therefore can be passed on unknowingly. Evidence suggests 10% increase in vaccination may be associated with 10% fall in sickness absence. Patients feel safer and more likely to get vaccinated when they know NHS staff are vaccinated.

1.5 The Trust has a Flu lead responsible for delivery of the annual flu campaign, and associated CQUIN. Point prevalence, the Trust has a 60% total number of front line staff vaccinated.

1.6 The Trust lead collaborates with NHS Employers and manages the Flu communications on behalf of the organisation. There is an identified FLU HQ and a training programme to maximise divisional peer vaccinators in line with best practice.

1.7 The Trust submits its performance monthly via Immform and has met the deadlines for this.

1.8 All staff are asked to consider vaccination, should they wish to decline, an opt out form is requested and infection prevention advice is reiterated. The Heads of Nursing and Therapies will be advised during the campaign of their divisional uptake.

1.9 The Flu lead has the support of the Board, Trade Union colleagues and the regional PHE team in delivery of the national campaign.

1.10 The Trust will be working with professional organisations and trade unions to maximise uptake of the vaccine; to identify and minimise any barriers; to discuss and agree which clinical environments and staff should be defined as ‘higher-risk’. Appropriate risk assessment will be undertaken in high risk areas and discussions will be held with trade union representatives to determine how to respond to situations where clinical staff in designated high risk areas decline vaccination.

1.11 Should a flu outbreak be seen at the Trust the DIPC and IPC team will work with the divisions to enable steps to be taken to maintain the overall safety of the service. Should measures such as redeployment of staff be appropriate this will be taken under the direction of the DIPC.

1.12 Injecting fun and positive engagement within the Flu campaign, the Heads of Nursing and Therapies nominate leading figures from divisions to become peer vaccinators. The Engagement Officer has developed a fun interactive media campaign including the comeback of Fluenta De Ville and her new flu babies. Hong Kong Fluexy and Rosemary lead our fight in combating flu using all communications collateral. Finally, a social media campaign ‘get your jab ‘has seen colleagues from across the organisation singing and celebrating being safe.

2.0 Conclusion

2.1 The Trust reports its flu vaccination activity on a weekly basis. Monthly CQUIN updates are provided and reported at the Finance and Performance meeting.

2.2 The evaluation of the flu campaign 18/19 will form part of the winter plan debrief undertaken as part of business continuity as occurred in 17/18.

2.3 We remain positive that we will achieve above and beyond the CQUIN target and confirm that all colleagues, in work, have been offered flu vaccination.
Appendix A - Health care worker flu vaccination letter

Wellington House
133-155 Waterloo Road
London SE1 8UG
martin.wilson1@nhs.net

Friday 7 September 2018

To: Chief Executives of NHS Trusts and Foundation Trusts

Dear Colleague

Health care worker flu vaccination

We know you appreciate the importance of all healthcare workers protecting themselves, their patients, their colleagues and their families by being vaccinated against seasonal flu, because the disease can have serious and even fatal consequences, especially for vulnerable patients. Your leadership, supported by the Flu Fighter campaign and the CQUIN has increased take-up of the flu vaccine, with some organisations now vaccinating over 90% of staff. Our ambition is for 100% of healthcare workers with direct patient contact to be vaccinated.

In February, the medical directors of NHS England and NHS Improvement wrote to all Trusts to request that the quadrivalent (QIV) vaccine is made available to all healthcare workers for winter 2018-19 because it offers the broadest protection. This is one of a suite of interventions that can and should be taken to reduce the impact of flu on the NHS.

Today we are writing to ask you to tell us how you plan to ensure that every one of your staff is offered the vaccine and how your organisation will achieve the highest possible level of vaccine coverage this winter.

Healthcare workers with direct patient contact need to be vaccinated because:

a) Recent National Institute for Health and Care Excellence (NICE) guidelines\(^1\) highlight a correlation between lower rates of staff vaccination and increased patient deaths;

b) Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic). Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues;

c) Flu-related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence;

d) Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated.

\(^1\) https://www.nice.org.uk/guidance/ng103
In order to ensure your organisation is doing everything possible as an employer to protect patients and staff from seasonal flu we ask that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of 2018.

Where staff are offered the vaccine and decide on the balance of evidence and personal circumstance against having the vaccine, they should be asked to anonymously mark their reason for doing so by completing a form, and you should collate this information to contribute to the development of future vaccination programmes. We have provided an example form [appendix 2] which you may wish to tailor and use locally, though we suggest you use these opt out reasons to support national comparisons.

We specifically want to ensure greatest protection for those patients with specific immune- suppressed conditions, where the outcome of contracting flu may be most harmful. The evidence suggests that in these ‘higher-risk’ clinical environments more robust steps should be taken to limit the exposure of patients to unvaccinated staff and you should move as quickly as possible to 100% staff vaccination uptake. At a minimum these higher-risk departments include haematology, oncology, bone marrow transplant, neonatal intensive care and special care baby units. Additional areas may be identified locally where there are a high proportion of patients who may be vulnerable, and are receiving close one-to-one to clinical care.

**In these higher-risk areas, staff should confirm to their clinical director / head of nursing / head of therapy whether or not they have been vaccinated. This information should be held locally so that trusts can take appropriate steps to maintain the overall safety of the service, including considering changing the deployment of staffing within clinical environments if that is compatible with maintaining the safe operation of the service.**

We would strongly recommend working with your recognised professional organisations and trade unions to maximise uptake of the vaccine within your workforce; to identify and minimise any barriers; to discuss and agree which clinical environments and staff should be defined as ‘higher-risk’; and to ensure that the anonymous information about reasons for declining the vaccine is managed with full regard for the dignity of the individuals concerned. Medical and nurse director colleagues will need to undertake an appropriate risk assessment and discuss with their staff and trade union representatives how best to respond to situations where clinical staff in designated high risk areas decline vaccination.

It is important that we can track trusts’ overall progress towards the 100% ambition. Each trust shall continue to report uptake monthly during the vaccination season via ‘ImmForm’. However from this year you are also required to report how many healthcare workers with direct patient contact have been offered the vaccine and opted-out. This information will be published monthly by Public Health England on its website.

By February 2019 we expect each trust to use its public board papers to locally report their performance on overall vaccination uptake rates and numbers of staff declining the vaccinations, to include details of rates within each of the areas you designate as ‘higher- risk’. This report should also give details of the actions that you have undertaken to deliver the 100% ambition for coverage this winter. We shall collate this information nationally by asking trusts to give a breakdown of the number of staff opting out against each of the reasons listed in appendix 2.

You can find advice, guidance and campaign materials to support you to run a successful local flu campaign on the NHS Employers Flu Fighter website [www.nhsemployers/flufighter](http://www.nhsemployers/flufighter)

Finally we are pleased to confirm that NHS England is once again offering the vaccine to social care workers free of charge this year. Independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff.

There are two parallel letters to primary care and social care outlining these proposals in more detail.

Yours sincerely

- signed jointly by the following national clinical and staff side professional leaders -
Prof Stephen Powis ..................................................National Medical Director, NHS England and on behalf of National Escalation Pressures Panel

Prof Paul Cosford ......................... Medical Director & Director of Health Protection, Public Health England

Prof Jane Cummings ..................................................Chief Nursing Officer, NHS England

Sara Gorton (Unison).................................Co-chair, National Social Partnership Forum

Prof Dame Sue Hill...............................................Chief Scientific Officer, NHS England

Dame Donna Kinnair. Acting Chief Executive & General Secretary, Royal College of Nursing

Prof Carrie MacEwen ...........................................Chair of the Academy of Medical Royal Colleges

Ruth May.....................................................Executive Director of Nursing, NHS Improvement

Dr Kathy Mclean...........................................Executive Medical Director NHS Improvement

Danny Mortimer (NHS Employers)..................Co-chair, National Social Partnership Forum

Pauline Philip ..................................................National Director of Urgent and Emergency Care

Suzanne Rastrick ..............................................Chief Allied Health Professions Officer, NHS England

Keith Ridge ..................................................Chief Pharmaceutical Officer, NHS England

John Stevens ..................................................Chairman, Academy for Healthcare Science

Gill Walton ..................................................Chief Executive, Royal College of Midwives
Appendix 1 - Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2018

<table>
<thead>
<tr>
<th>A</th>
<th>Committed leadership (number in brackets relates to references listed below the table)</th>
<th>Trust self-assessment</th>
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<tr>
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<tr>
<th>B</th>
<th>Communications plan</th>
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<th>C</th>
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<tr>
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<th>D</th>
<th>Incentives</th>
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<tr>
<td>D2</td>
<td>Success to be celebrated weekly (3,6)</td>
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Reference links
6. [https://www.nice.org.uk/guidance/ng103/chapter/Recommendations](https://www.nice.org.uk/guidance/ng103/chapter/Recommendations)
Dear colleague,

Did you know that 7 out of 10 front line NHS staff had the flu vaccine last year, and in some departments more than 9 out of 10 staff were vaccinated?

The flu jab gives our body the information it needs to fight the flu, which stops us from contracting and spreading the virus. For those of us who work in care settings, getting the flu jab is an essential part of our work. In vaccinating ourselves we are protecting the people we care for, and helping to ensure that we are able to provide the safest environment and effective care for patients.

We want everyone to have the jab. The sooner you get it, the more people you can protect. We hope that you will agree to having the vaccine – this really helps to protect patients, you and your family. But, if you choose not to have the flu vaccine, we want to understand your reasons for that by filling in this anonymous form.

Signed

Chief Executive, Medical Director, Director of Nursing, and Trade Union representative

Please tick to confirm that you have chosen not to have the vaccine this year:

I know that I could get flu and have only mild symptoms or none at all; and that because of this I could give flu to a patient. I know that vaccination is likely to reduce the chances of me getting flu and of me passing it to my patients. But I still don’t want the vaccine.

Please tick each of the boxes below that apply to your decision not to have the jab. I DON’T WANT TO BE FLU VACCINATED BECAUSE:

I don’t like needles
I don’t think I’ll get flu
I don’t believe the evidence that being vaccinated is beneficial
I’m concerned about possible side effects
I don’t know how or where to get vaccinated
It was too inconvenient to get to a place where I could get the vaccination
The times when the vaccination is available are not convenient
Other reason – please tell us here

Thank you for completing this form.
### A Committed leadership

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### B Communications plan

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| C3 | Schedule for 24 hour mobile vaccinations to be agreed (3,6) |                       |

### D Incentives

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| D2 | Success to be celebrated weekly (3,6) |                       |
### Agenda item 440/18

**Report**
Review: Audit Committee Terms of Reference

**Executive Lead**
Anna Milanec, Director of Corporate Affairs/Company Secretary

**Link with the BAF**
B6 and B8:

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<th>Purpose</th>
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#### Executive Summary (including reason for the report, background, key issues and risks)

Each of the Board Committee’s undertake a review of its terms of reference on an annual basis. The November 2018 Audit Committee terms of reference were reviewed and discussed by the Committee at its meeting on 16 November 2018.

Proposals to consider a more active role regarding oversight of clinical governance processes and controls, were discussed. However, the Committee acknowledged the existing role of the Quality Assurance Committee as part of the assurance framework, and agreed that the Audit Committee’s oversight in this regard was sufficient, based on the role of QAC. Such proposals were not therefore accepted.

Remaining amendments after review are provided in red text on the draft document at appendix 1, and are minor. One area that has been given more emphasis is the Committee’s role with regard to cyber security.

#### Recommendations

The Board of Directors is asked to approve the revised Audit Committee Terms of Reference.

#### Appendices

1. Proposed Terms of Reference
# AUDIT COMMITTEE

## DRAFT TERMS OF REFERENCE

| Committee Status | The Audit Committee ("the Committee") is a committee of the Board of Directors and has no executive powers, other than those specifically delegated to it in these terms of reference.  
It is authorised to investigate any matter within its terms of reference and to be provided with the resources to do so. It also has the right of access to all information that it deems relevant to fulfil its duties and is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request from the Committee.  
The Committee has delegated powers to obtain any outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. |
|---|---|
| Reporting to | The Committee is accountable to the Board of Directors and the Committee Chair will report regularly on the Committee's proceedings.  
The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is required.  
The minutes of Committee meetings shall be formally recorded and made available to the Board of Directors.  
On an annual basis, the Committee will report to the Board on its work in support of the annual governance statement, specifically commenting on:  
- The fitness for purpose of the assurance framework;  
- The completeness and extent to which risk management is embedded at the Trust;  
- The integration of governance arrangements;  
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business;  
- The robustness of the processes behind the quality report.  
This annual report will describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. |
| Purpose | The Committee advises the Board of Directors and provides an independent and objective review on the adequacy of Trust’s system of internal control, including audit arrangements (internal and external), financial systems, financial information, assurance arrangements including governance, risk management and compliance with legislation. |
**Membership**

The Committee shall be appointed by the Board of Directors and shall consist of at least three members made, up as follows:

A Non-Executive Director will chair the meeting (but not the Chair of the Finance and Performance Committee).

Two further Non-Executive Directors.

At least one member will have recent and relevant financial experience\(^1\).

The Trust Chairman shall NOT be a member of the Committee.

Members will be expected to attend at least 80% of meetings per annum.

---

**Attendees**

The following are expected to attend each meeting:

Director of Finance;

The Company Secretary, to ensure coordination of Board committees and to provide appropriate support to the Committee Chair and Committee members;

Representatives from internal audit and external audit will be expected to attend each meeting;

Attendance at, at least 2 meetings per annum (to be agreed with the Committee Chair), will be required by the Trust’s counter fraud specialist; and

It is for the Audit Committee Chair to plan the meetings and invite executive directors and other senior members according to the requirements of each agenda. This will vary from meeting to meeting and will depend on whose area of responsibility an agenda item falls within. Directors / managers should be given sufficient warning that their presence is required so that they come fully prepared.

Other Trust Executive Directors and Trust officers will attend as required by the Committee to provide assurances and explanations to the Committee when discussing audit reports or other matters within the area of their responsibility.

Meetings are not open to members of the public.

Once confidentiality agreements have been signed, two Governors from the Council of Governors (ordinarily, this will be the Lead Governor or their Deputy, and one other) may attend Committee meetings as observers.

At the invitation of the Committee Chair, Governors may participate at meetings. However, the Chair reserves the right to hold all, or part of the meeting in private without Governors and / or other attendees (except the minute taker) if deemed appropriate.

Those in attendance do not count towards the quorum.

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\(^1\) Provision C.3.1, Monitors’ NHS Foundation Trust Code of Governance
| Quorum | A quorum shall be made up of two members. One of the Members shall be appointed Chair of the Committee by the Board. No business shall be conducted unless a quorum is present. |
| Frequency of Meetings | Meetings shall be held at least 5 times a year, but may be held more frequently should circumstances require (to be determined by the Committee Chair). At least once a year, the Committee should meet privately with both the external and internal auditors on a separate basis. |
| Access | The Head of Internal Audit, representatives of external audit and counter-fraud specialists have the right of access to the Chair of the Committee. |
| Meeting administration | Notice of meetings will be given at least seven working days in advance unless members agree otherwise. The agenda shall be determined by the Committee Chair in consultation with the Secretary. Items for inclusion on the agenda shall be submitted at least 7 working days prior to the meeting. The agenda and papers will normally be circulated at least five working days prior to the meeting. The Company Secretary, or their nominee, shall record the minutes of meetings. |
| Committee's Duties | The duties of the Committee can be categorised as follows²: **1. Integrated Governance, Risk Management and Internal Control** The Committee shall review the establishment and maintenance of an effective system of integrated risk management and internal control, across the whole of the Trust's activities (including those of any subsidiary, either currently in existence or to be established)³ that support the achievement of the organisation's strategic objectives. The Committee will be supported in this duty by the Quality Assurance Committee, which is responsible for assuring the Board that an effective system of quality governance, risk management and internal control for the three broad areas of patient experience, clinical effectiveness and the safety of patients and service users, is in place. Matters referred to the Quality Assurance Committee will be dealt with by that Committee. However, through the close relationship with the Quality Assurance Committee, the Audit Committee will provide internal assurance that the processes and outcomes of the Quality Assurance Committee can be used to provide assurance on the overall processes of risk management and internal control across the organisation. This will be evidenced through the Committee’s use of the Board Assurance Framework (BAF), to guide its... |

² Provision C.3.2, Monitors’ NHS Foundation Trust Code of Governance  
³ Refer to FRC Guidance on Audit Committees (April 2016) paragraph 7
In particular, the Committee, will review the adequacy and effectiveness of:

- all risk and control related disclosure statements, (in particular, the Annual Governance Statement) together with any accompanying Head of Internal Audit Opinion, prior to endorsement by the board;
- the underlying assurance processes that indicate the degree of achievement of the organisation’s objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the risk management strategy, structures, processes and responsibilities for identifying and managing key risks facing the organisation;
- the policies and procedures for all work related to anti-fraud, bribery and corruption as set out by the NHS Counter Fraud Authority;
- the work of counter-fraud services; to ensure that there is an effective LCFS established by management that meets mandatory requirements and provides appropriate independent assurance to the Committee, Chief Executive and Board
- the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in regulators’ standards and guidance;
- the operational effectiveness of policies and procedures; and
- the financial control systems.

2. Internal Audit

The Committee shall ensure that there is an effective Internal Audit function established by management that meet the Public Sector Internal Audit Accounting Standards 2017, that utilises an independent risk based approach.

In addition, the Committee will:

- consider the appointment of the internal audit service, the internal audit fee and any questions of resignation or dismissal and make appropriate recommendations to the Board;
- following consultation with all executive and Non-Executive Board members, approve the internal audit programme and more detailed programme of work, ensuring that this is consistent with the needs of the organisation as identified in the assurance framework
- consider the major findings of internal audit investigations (and management’s response) and report progress on material matters to the Board;
- ensure co-ordination and co-operation between the Internal and External Auditors to optimise the use of audit resources;
- ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- review annually the effectiveness of Internal Audit; and
- meet in private with the internal auditor to discuss issues or matters arising.

3. External Audit

The Committee shall review and monitor the external auditors’ independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management’s responses to
their work. This will be achieved by:

- The Committee should make a report to the Council of Governors in relation to the performance of the External Auditors, including details such as the quality and value of the work, and the timeliness of report and fees, to enable the Council of Governors to consider whether or not to re-appoint them. The Committee should also make recommendation to the Council of Governors about the appointment, re-appointment and removal of the External Auditor and approve the remuneration and terms of engagement of the External Auditor.
- discussion and agreement with the External Auditor, before the annual audit commences, of the nature and scope of the audit, as set out in the annual plan;
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee;
- review of External Audit reports, including the report to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;
- review and monitor the External Auditor’s independence, objectivity and effectiveness, particularly with regard to non-audit services that may be provided to the Trust;
- develop and recommend to the Board as required, the Trust’s formal policy on the provision of non-audit services by the External Auditor, including approval of non-audit services by the Committee and specifying the types of non-audit service to be pre-approved, and assessment of whether non-audit services have a direct material effect on the audited financial statements; and
- meet as required in private with the external auditor to discuss issues or matters arising; and

4. Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These could include any reviews undertaken by regulators (such as NHSI and the Care Quality Commission), the NHS Litigation Authority (to become NHS Resolution in early 2018) and professional bodies with responsibility for the performance of staff or functions (such as Royal Colleges and accreditation bodies).

In addition, the Committee will review the work of other committees within the organisation whose work can provide relevant assurance to the Committee’s own scope of work and in relation to matters of quality, clinical governance and risk management, affecting the board assurance framework.

The Committee will provide assurance to the Board that the organisation is properly managing its cyber risk, including appropriate risk mitigation strategies.

The Committee will review the BAF document on a quarterly basis prior to its submission to the Board.

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4 Provision C.3.4, Monitors’ NHS Foundation Trust Code of Governance
5 Refer to FRC Guidance on Audit Committees (April 2016) paragraphs 71, 73 and 74
5. Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust’s financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies, practices and estimation techniques;
- unadjusted mis-statements in the financial statements;
- significant judgments in the preparation of the financial statements;
- significant or proposed adjustments resulting from the audit;
- letters of representation;
- explanations for significant variances;
- qualitative aspects of financial reporting; and
- the rigour with which the Auditor has undertaken the audit.

6. Counter Fraud

The Committee shall satisfy itself as to having adequate arrangements in place for counter fraud that meets the NHS Counter Fraud Authority’s standards; fraud, bribery and corruption, and shall review the outcomes of work in this area.

In accordance with 3.2 of the NHSCFA’ Fraud Commissioners Standards, the Committee has:

‘stated its commitment to ensuring commissioners achieve these standards and therefore requires assurance that they are being met via NHSFCA’s quality assurance programme’.

The Committee will refer any suspicions of fraud, bribery, and corruption to the NHSCFA.

7. Annual report

The annual report shall include a separate section to cover the work of the Committee in discharging the responsibilities outlined above.

The annual report should⁶:

- Explain the significant issues that the Committee considered in relation to the financial statements, operations and compliance, and how these issues were addressed;
- explain, if the auditor (internal / external) provides non-audit services and how auditor objectivity and independence is safeguarded;
- the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and
- Include details of the full auditor (internal / external) appointment process where relevant.

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⁶ Provision C.3.9, Monitors’ NHS Foundation Trust Code of Governance
8. Whistleblowing Policies

The Committee shall review the Trust’s arrangements for its employees to raise concerns, in confidence, about possible wrongdoing in financial reporting and control, clinical quality, patient safety or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action, and reassure individuals raising concerns that they will be protected from potential negative repercussions.

9. Other matters

The Committee shall:

- Review the appropriateness of single tender actions which have been approved by the Executive;
- give due consideration to laws and regulations, and the provisions of The NHS Foundation Trust Code of Governance;
- Committee members shall receive the development and training that they need to fulfil their role on the Committee.

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<tr>
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7 Provision C.3.8, Monitors’ NHS Foundation Trust Code of Governance

*Seen by Audit Committee 16th November 2018*