CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF FINANCE

BOARD OF DIRECTORS

SEPTEMBER 2017

FINANCIAL POSITION AS AT 31ST AUGUST 2017

1 INTRODUCTION

The enclosed financial statements reflect the Trust and its subsidiary companies Income & Expenditure position as at 31st August 2017, details of which can be found in Appendices 1-6.

1.1 SUMMARY POSITION

Performance against the control total is as follows:

	Position at month 5		
	NHSI Plan	Actual	Variance
	£000s	£000s	£000s
Deficit for the year before impairments and transfers	(3,720)	(7,982)	(4,262)
Add: depreciation on donated assets	0	0	0
Less: gain on asset disposal	0	0	0
Less: income from donated assets	2	(18)	(20)
Less: 2016/17 STF post accounts allocation	0	(419)	(419)
Control Total Surplus/(Deficit) including STF	**(3,718)**	**(8,419)**	**(4,701)**
Less: STF 2017/18	(2,617)	0	2,617
Less: STF Incentice schemes	0	0	0
Control Total Surplus/(Deficit) excluding STF	**(6,335)**	**(8,419)**	**(2,084)**

The overall operational financial position is a net deficit of £7,982k against a planned deficit of £3,720k, and therefore £4,262k behind plan. The Trust has therefore failed it's Control Total to date and is not liable for STF funding for £2,617k.

The net deficit of £7,982k included income for £419k as part of 2016/17 STF funding post accounts reconciliation. This net gain in STF of £419k is not included in the control total calculation and therefore the financial position reported to NHSI is a net deficit of £8,419k, or £2,084k behind the planned NHSI control total to month 5.

The Trust reported an under performance of £495k in month 5 relating to NHS clinical activity which is due to lower than expected PbR activity.

At the end of August the Cost Improvement Plan (CIP) delivery is £316k behind projected plans submitted to NHSI.

Performance against the EBITDA margin is behind plan to the end of August.

The deficit position means that the Trust Use of Resources Metrics (UOR) rating score is 3, which is in line with plan.

The Trust Financial Position to Month 5 is behind plan due to three key factors, activity under performance against expectations, CIP slippage due to a shortfall in plans, and in turn non achievement of STF funding for the period April to August 2017.

2 INCOME AND EXPENDITURE POSITION

2.1 *Patient Related Income:*

Clinical Income to month 5 was £130,917k against a plan of £131,412k, and hence behind plan by £495k.

Trust has block contract arrangements in place with both Sunderland CCG and South Tyneside CCG which ensures certainty in funding flows for the year; however PbR contracts with both Durham CCGs and NHS England commissioners and performing lower than expectations at this stage of the year.

Activity figures for Quarter 1, July and August are yet to be fully validated so these may change in the upcoming month.

Appendix 3 provides further details around patient related income to date.

Private Patient Income is over recovered against plan by £19k.

2.2 *Non Patient Related Income:*

Training and Education income is break even to plan to month 5. Research and Development income is ahead of plan by £32k to month 5.

Other Income was ahead of plan by £82k, most of which is due to the cross charge to South Tyneside Foundation Trust funding several posts across the trust.

As mentioned earlier, the Trust has failed the year to date Control Total and is not liable for STF funding for £2,617k.

3 EXPENDITURE

3.1 *Pay Expenditure:*

Pay is currently showing an underspend of £77k against plan, reflecting:

- Agency costs to month 5 are £2,432k, compared to an overall Trust agency staffing budget to month 5 of £1,787k. Much of this spend is to cover vacant posts. The same period in 2016-17 had agency spend at £2,005k which is £427k less than the current period, in addition a challenging CIP target was set for agency reduction in 2017-18. The position on agency spend has the Trust below its maximum agency/ceiling level set by NHS Improvement to the end of August 2017, detailed in Appendix 4.
- To date the net underspend from vacant nursing posts across the Trust is £523k which is inclusive of the costs paid to NHS Professionals and overtime working.
- Cost Improvement Plans for pay are £369k ahead of plan to date mainly due to vacancies across the Trust.
- Key variances by staff group are detailed as:

Key Pay variances by staff group to current month	**£000s**
Consultants Staff (net of vacancies, additional sessions and agency costs)	489
Other Medical Staff (net of vacancies, additional sessions and agency costs)	454
Nursing (net of NHSP Costs)	-523
Other Staff groups, porters, admin & clerical	-497
Total Variance	**-77**

Appendix 4 shows details of pay spend on agency, flexi-bank and overtime for the last 12 months from month 5.

Overall pay costs in August were £17,932k against a budget of £17,978k for the month.

3.2 *Non Pay Expenditure:*

Non-Pay is overspent by £1,780k. Major areas are highlighted as:

- Drugs overspend this month is £656k against plan which is £488k worse than the previous month's position. The large step up in costs this month is due to the previous month's costs being unusually low and not representative of the normal monthly level of spend. To understand why this has happened, Finance and Pharmacy are analysisng all data flows for July's drug costs and will provide an explanation later this month.
- Clinical Supplies is overspent by £431k due largely to CIP under delivery of £495k against plan to date.
- Other Non Pay is overspent by £973k, of which £368k is due to offsite CT and MRI scans sent to third party providers due to shortage of Radiographers and capacity at the Trust. A further £78k of the overspend is due to CIP under delivery against plan to date.
- PDC costs are £324k underspent against plan to date.
- Depreciation costs are in line with plan to date.
- Interest paid is £43k overspent against plan to date.

Appendix 5 shows details of non pay spend for Clinical Supplies, Drugs and Other Non-Pay for the month.

4 CIP POSITION

At the end of Month 5, CIP delivery was £4,018k against a planned delivery of £4,334k and hence an under delivery of £316k. This shortfall is reflective of the unidentified CIP targets set for the Trust for 2017/18, plus slippage against some high level CIP assumptions for agency cost reductions.

Current Trust CIP plans have identified £12.2m of the £13.0m target this year, much of this delivery especially for procurement will be in the later stages of the financial year. At this stage the Trust anticipates total CIP delivery for 2017/18 to be in line with plan of £13m.

Details are provided in Appendix 6.

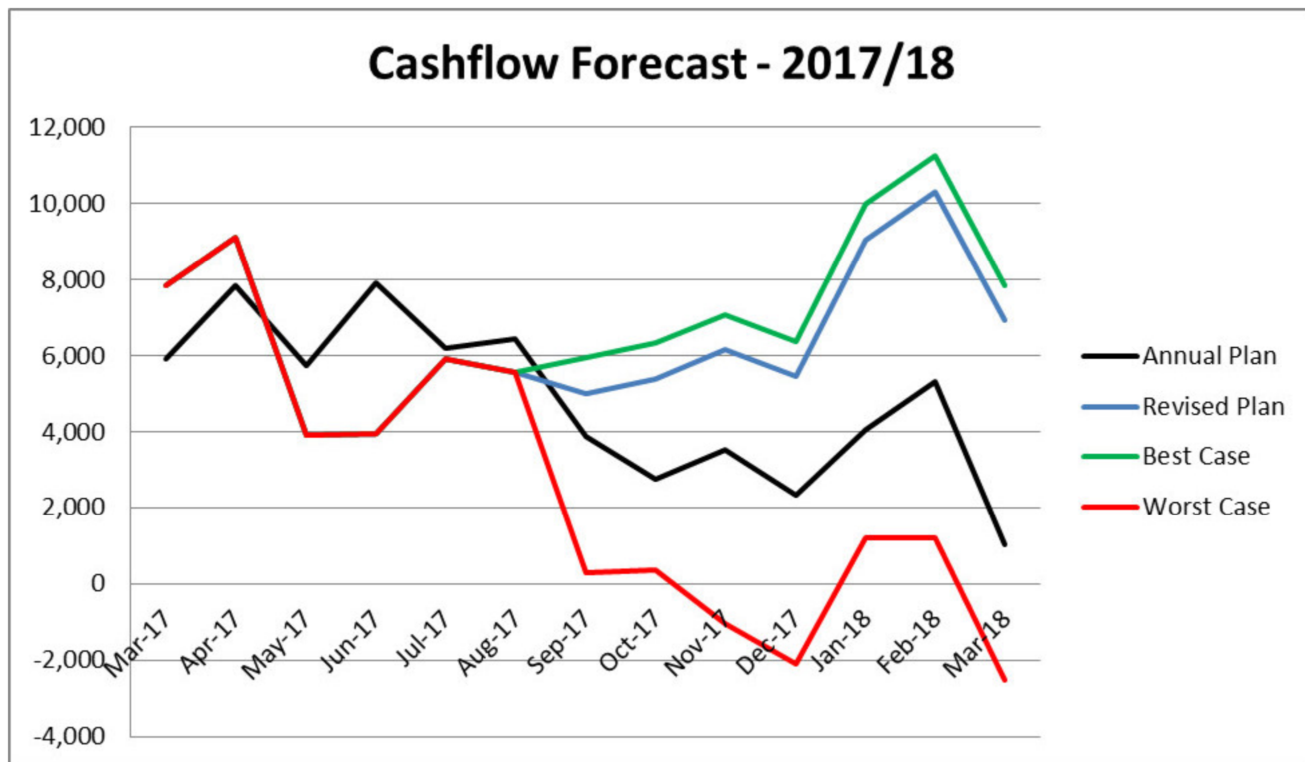
5 CASHFLOW AND WORKING CAPITAL

The cash balance at the end of August 2017 was £5,548k against planned £6,442m. The adverse variance of £894k is predominantly attributable to timing difference in income accruals relating to clinical activity to be reimbursed clinical commissioners.

The adverse NHS debtor variance of £2.93m consists of outstanding clinical activity income invoices £997k, pathology service invoices £393k and miscellaneous charges etc £1.54m.

All debtors continue to be vigorously pursued.

Principal and interest repayments, £316k and £98k respectively, were paid against the Trust's capital borrowing facility, effectively reducing the total value of outstanding loans to £55.35m.



The graph above shows the Trust's forecast cash position to March 2018. The graph shows the monthly cash balances submitted as part of the Annual Plan, the revised plan based on current information and the best and worst case scenarios.

The best case scenario assumes achievement of the control total and CIP targets plus contingency built into the capital programme not being fully required and a VAT refund from HMRC (£926k) relating to a number capital schemes transferred from CHS to CHoICE that became eligible for Capital Goods Scheme relief. The worst case scenario includes an underachievement of the CIP target of £2.28m and nil STF funding (of which the target was £4.15m). The revised plan assumes achievement of the control total for the year and that all STF funding will be received.

The Statement of Financial Position detail is provided in Appendix 2.

6 CAPITAL

Capital expenditure to date is £776k and relates mainly to A&E Development (£456k), Sewing Room Conversion (£124k) and IMT Costed Profile (£78k). Capital spend is behind plan to date, this is mainly due to delays in the Trust receiving NHSE funding for the Global Digital Exemplar project, hence expenditure has also been delayed.

7 RISKS

The current financial position poses a significant risk in the Trust not achieving 2017-18 control total. In turn this will impact the cash receipt of STF funding and give the organisation a genuine risk of running out of cash this financial year.

The two prime risks are firstly, the gap in CIP plans, secondly under performance against PbR contracts with commissioners and the challenge in pulling like for like costs from the system.

8 FORECAST

Despite the current financial position the Trust still believes that it can achieve the required control total for 2017/18.

The Trust is working closely with all commissioners to understand their QIPP plans and the knock on impact to us as a provider, it is essential that costs are removed to mitigate these income reductions.

9 NEXT STEPS

The Trust needs focus on identifying £800k of CIPs to achieve its full £13m CIP target for 2017/18.

In addition to closing the CIP gap the Trust needs to ensure flexibility to remove costs if income volumes continue to show a downward trend.

Next steps on 'closing the gap options' are to be discussed at this months Finance and Performance Committee.

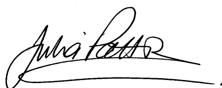
10 SUMMARY

The overall position at the end of August including STF, is a deficit of £7,982k compared to a planned deficit of £3,720k or £4,262k behind plan. The position excluding STF is £2,084k behind plan.

11 RECOMMENDATIONS

The Board is requested to:

- Note the financial position to date.



Julia Pattison
Executive Director of Finance
September 2017

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF PLANNING AND BUSINESS DEVELOPMENT

BOARD OF DIRECTORS

SEPTEMBER 2017

PERFORMANCE REPORT

INTRODUCTION

Please find enclosed the Performance Report for August 2017 which updates Directors on performance against key national targets.

EXECUTIVE SUMMARY

Performance – NHS Improvement (NHSI) Operational Performance Indicators

The Trust's position in relation to NHSI's operational performance indicators is as follows:

A&E 4 hour target

Performance for August was above the 95% target at 95.67% and above the STF trajectory of 93.7%.

The national performance for August was 90.3%. The Trust moved into the top 25% nationally.

Referral to Treatment Time (RTT)

Performance remains above target at 94.5% with all specialties above target apart from T&O, Thoracic and OMFS.

National performance for July remains has deteriorated further and remains below the standard at 89.9%.

Cancer targets (2 week, 31 and 62 day waits)

Due to cancer reporting timescales being 1 month behind, the performance report includes July's confirmed position. The Trust met all cancer waiting time standards with the exception of cancer 31 day waits for subsequent surgery due to breaches in urology.

National performance against the 62 day standard remains below target at 81.4%.

There has been an increase in 2ww referrals in lung which has been flagged to the clinical team and an increase in upper GI patients waiting over 62 days due to complex pathways. We are therefore likely to see an increase in 62 day breaches in these tumour groups in the coming months.

Diagnostics

Performance for August remains above the 1% standard and the recovery trajectory agreed with NHSI (1.31%) at 2.4%. This increase was predicated and highlighted in last month's performance report due to breaches in neurophysiology and respiratory physiology. Predicted performance for September however shows an improvement and is currently close to the 1% standard based on an un-validated position.

National performance for July was 1.8%.

FINANCIAL IMPLICATIONS

For August the STF funding relating to A&E performance will not be achieved due to the financial control total not being met (£185K).

RECOMMENDATIONS

Directors are asked to accept this report and note the risks going forwards.

Alison King
Head of Performance and Information Management

City Hospitals Sunderland chs

Performance Report August 2017

City Hospitals Sunderland Performance Report Overview

This page explains the general layout of the indicator pages that form the bulk of the report

Key:
- Actual performance
- Target, operational standard, threshold or trajectory
- Sustainability & transformation fund (STF) trajectory
- Benchmark (National, Regional or Peer Group)
- Comparative performance for the previous year
- Performance achieving the relevant target
- Performance not achieving the relevant target

Page title representing a key performance indicator or a

Indicator group

Indicator information, including a brief description, the name of the Director lead and consequence of failure

Narrative highlighting recent performance and corrective actions, where applicable

Chart or table relevant to the indicator(s), often displaying Directorate level performance or other supporting information

Table showing current performance compared to target (where relevant)

Trend chart displaying the performance over the past 12 months or year to date

Cancer 2 Week Waits

National Operational Standards

1. Number of urgent GP referrals for suspected cancer
2. Number of patients seen after more than two weeks following an urgent GP referral for suspected cancer
3. % patients seen within two weeks of an urgent GP referral for suspected cancer

Director Lead: Sean Fenwick

Consequence of failure: Timely access to treatment, patient experience, clinical outcomes & financial sanction

Potential financial sanction if standard not achieved = £200 per breach

2WW performance has remained stable in March at 95.5%, which continues to perform above target. At tumour site level, all areas achieved the target this month.

March's performance demonstrated that all tumour groups are performing about the same or better than the equivalent national benchmarking position.

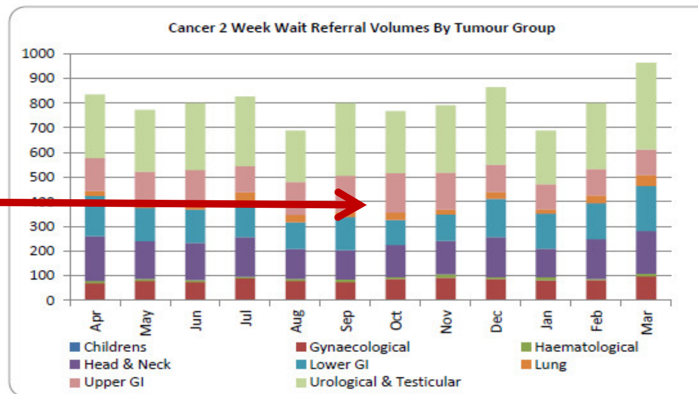
The finalised position for quarter 4 was above target at 95.4%.

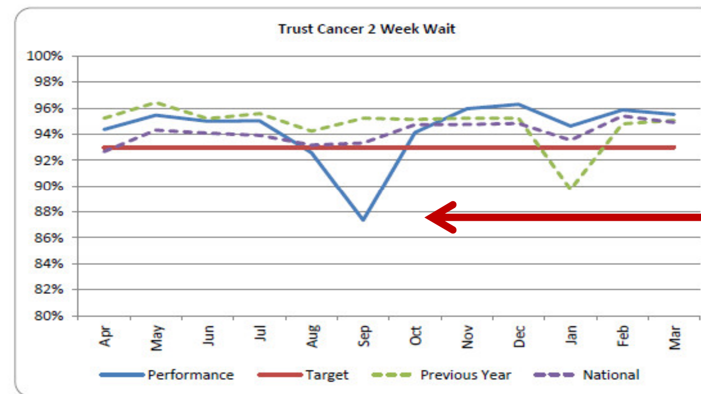
Referral volumes were higher than usual in March, with significantly more referrals compared to average within Lung, Lower GI and Urological tumour groups.

Indicative 2WW performance for April is slightly below target.

Referrals for Suspected Cancer - March 2016*	Volume	Total Breached	Performance	National Benchmark	YTD
Target			93%	93%	93%
Acute Leukaemia	0	0	-	-	100.00%
Children's Cancer	1	0	100.00%	95.7%	100.00%
Gynaecological	97	1	98.97%	95.1%	97.78%
Haematological (Excluding Acute Leukaemia)	10	0	100.00%	96.6%	99.06%
Head & Neck	173	10	94.22%	95.0%	96.25%
Lower Gastrointestinal	185	11	94.05%	94.3%	93.46%
Lung	44	2	95.45%	95.9%	95.56%
Testicular	15	0	100.00%	96.3%	97.90%
Upper Gastrointestinal	103	7	93.20%	92.4%	86.79%
Urological (Excluding Testicular)	334	12	96.41%	95.0%	96.07%
Total	962	43	95.53%	94.9%	94.40%

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales





City Hospitals Sunderland Performance Scorecard

The Performance Report / Corporate Dashboard utilises a visual management approach to the Trust's monthly Performance, covering NHS Improvement Single Oversight Framework metrics as well as national performance measures from the NHS Standard Contract 2017/18 and 'NHS Operational Planning and Contracting Guidance 2017 to 2019'.

Indicator	Director Lead	Target	2016/17	2017/18						12-month trend	Page
			Actual	Month[1]	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD		
Operational Performance Measures - NHSI SOF: These metrics are used by NHS Improvement and form one of the five themes from the Single Oversight Framework, which is used to assess our operational performance. This will influence our segmentation and level of support. They also form part of the 2017/18 NHS Standard Contract.											
A&E - % seen in 4hrs	Sean Fenwick	≥95%	92.97%	95.67%	94.47%	95.46%			94.86%		4
RTT - % incompletes waiting <18 wks	Sean Fenwick	≥92%	94.00%	94.50%	94.55%	94.52%			94.54%		5
Cancer waits - % 62 days	Sean Fenwick	≥85%	84.00%	90.76%	77.04%	90.76%			79.90%		6
% Diagnostic tests ≥6 wks	Sean Fenwick	<1%	2.14%	2.38%	2.75%	1.87%			2.42%		7
National Operational Standards: These are national targets that the NHS must achieve, mostly falling under the domain of quality, which are linked to delivery of the NHS Constitution. They also form part of the 2017/18 NHS Standard Contract.											
Cancelled operations 28 day breaches	Sean Fenwick	0	34	5	11	9			20		N/A
Cancer waits - % 2ww	Sean Fenwick	≥93%	95.91%	96.69%	96.87%	96.69%			96.82%		8
Cancer waits - % 31 days	Sean Fenwick	≥96%	98.67%	98.56%	97.43%	98.56%			97.69%		9
Cancer waits - % 31 days for subsequent treatment - surgery	Sean Fenwick	≥94%	98.40%	92.31%	96.43%	92.31%			95.45%		9
Cancer waits - % 31 days for subsequent treatment - drugs	Sean Fenwick	≥98%	99.90%	100.00%	100.00%	100.00%			100.00%		9
Cancer waits - % 62 days from screening programme	Sean Fenwick	≥90%	100.00%	100.00%	100.00%	100.00%			100.00%		6
Cancer waits - % 62 days from consultant upgrade	Sean Fenwick	NA	88.20%	100.00%	75.44%	100.00%			81.33%		6
National Quality Requirements: These also form part of the 2017/18 NHS Standard Contract. In addition there are a number of zero tolerance indicators that are reported by exception, including Mixed Sex Accommodation breaches, A&E 12-hour trolley waits and urgent operations cancelled for the second time											
RTT - No. incompletes waiting 52+ weeks	Sean Fenwick	0	0	0	0	0			0		N/A
A&E / ambulance handovers - no. 30-60 minutes	Sean Fenwick	0	1349	16	239	26			265		4
A&E / ambulance handovers - no. >60 minutes	Sean Fenwick	0	381	0	41	0			41		4
% VTE risk assessments	Ian Martin	≥95%	98.49%	98.84%	98.64%	98.86%			98.73%		N/A

1. Performance is one month behind normal reporting for all Cancer indicators (July 2017)

Accident & Emergency

NHSI SOF Operational Performance, National Operational Standard & National Quality Requirements

1. % patients who spent 4 hours or less from arrival to admission, transfer or discharge
2. Ambulance handover delays between 15-30 minutes, 30-60 minutes & over 60 minutes

Director Lead: Sean Fenwick

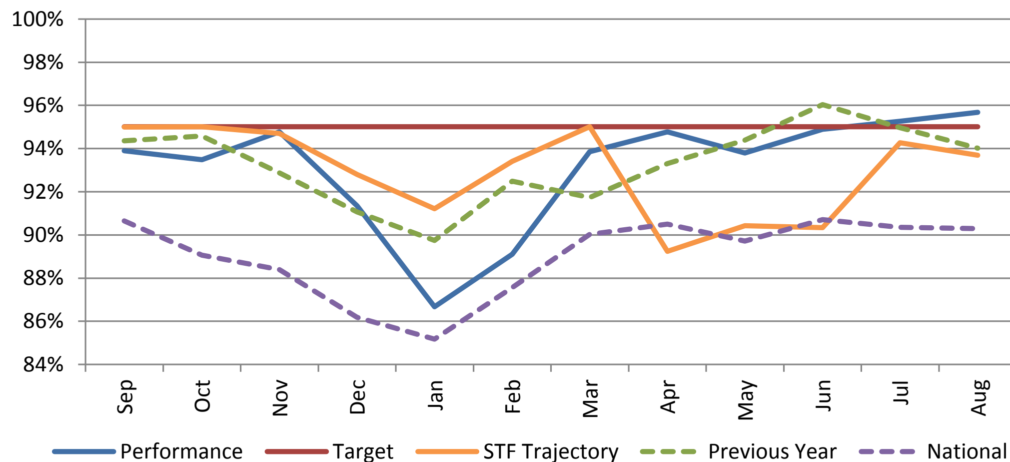
Consequence of failure: Patient experience, quality, access, reputation & financial impact if the STF trajectory is not achieved, which equates to £139k per month during quarter 1

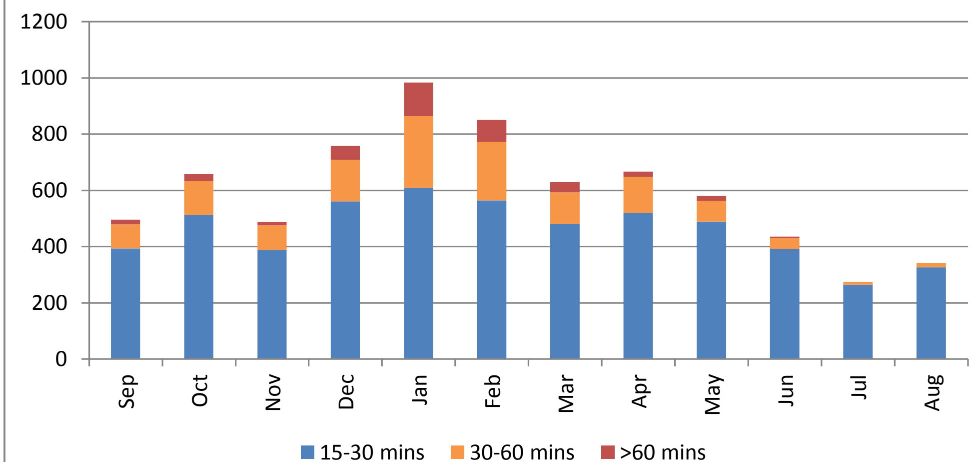
A&E Indicators - August 2017	Target	Month	YTD
A&E % seen in 4hrs - Trust Total	≥95%	95.67%	94.86%
A&E < 4 hrs - Type 1	≥95%	92.98%	91.62%
A&E < 4 hrs - Type 1 - High Acuity	≥95%	86.78%	82.87%
A&E < 4 hrs - Type 1 - Low Acuity	≥95%	93.38%	91.57%
A&E < 4 hrs - Type 1 - Paediatrics	≥95%	98.10%	98.43%
A&E < 4 hrs - Type 2 - SEI	≥95%	99.47%	99.34%
A&E < 4 hrs - Type 3 - Pallion walk in centre	≥95%	99.58%	99.79%
A&E Attendances - Trust Total		12,487	64,716
A&E Attendances - Type 1		7,361	38,371
A&E / ambulance handovers - no. 15-30 minutes	0	326	1,991
A&E / ambulance handovers - no. 30-60 minutes	0	16	265
A&E / ambulance handovers - no. >60 minutes	0	0	41

The total proportion of patients seen in A&E within 4 hours increased during August to 95.67%. This is the first time since 2012 the trust has been above national standard in August. Operational pressures remained constant maintaining the lowest OPAL status throughout the month. Our performance for July moved in to the upper 25% of trusts nationally, the first time since November 2016.

There were 12,487 attendances this month, which is 9% higher than August 2016 (type 1 was up by 11%, type 2 was down by 3% and type 3 was up by 15%). Discounting the counting change, there was a 2% increase in attendance numbers year on year.

There were 2,536 ambulance arrivals this month, which is about the same as August 2016. This continues to represent the third highest volume of ambulance arrivals for any hospital across the North East. The number of handover delays were more than July. However, there were no over 60 minute delays.





Referral to Treatment (RTT)

NHSI SOF Operational Performance & National Operational Standard

1. Number of patients waiting on an incomplete RTT pathway at month end
2. Number of patients on an incomplete RTT pathway waiting 18 weeks or more
3. Percentage of patients waiting less than 18 weeks on incomplete pathways
4. National RTT Stress Test - % risk of failing the incomplete standard in next 6 months

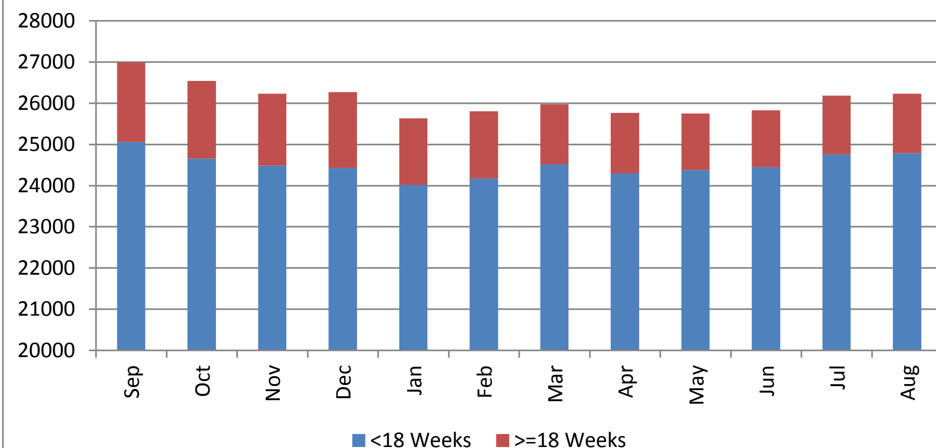
Director Lead: Sean Fenwick
Consequence of failure: Patient experience, quality, access & reputation.

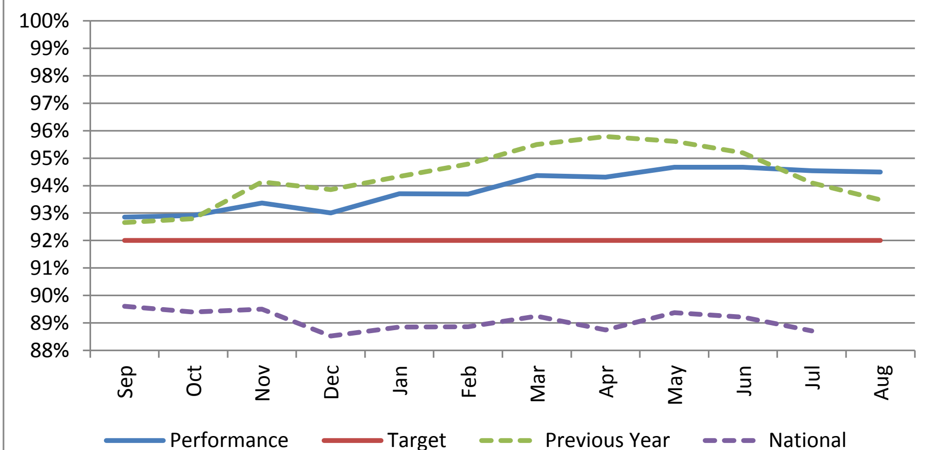
The finalised aggregate level performance for incomplete pathways at the end of July was above target at 94.5%. The Trust remains above the national target of 92.0%.
At specialty level Trauma & Orthopaedics (T&O), Thoracic Medicine and Oral & Maxillo Facial Surgery (OMFS) failed to achieve the 92% target.
T&O performance reduced in August to 84.9% and remains in formal escalation. A revised recovery plan is being produced. Spinal remains a pressure. Thoracic Medicine performance improved by over 2% in August to 88.7%. The specialty's performance continues to be monitored.
OMFS also remains in formal internal escalation. Their performance improved in August to 89.1%. Work continues to improve their position and a revised recovery plan is being developed.
The Trust's RTT stress test risk rating reduced in July and is assessed as having a 12% chance of failing the RTT operational standard in the next 6 months. We are ranked 19th (best) nationally, maintaining the previous month's position.

RTT Incompletes - August 2017	Volume	No. ≥18 Weeks	% <18 Weeks*
Target			≥92%
Cardiology	593	2	99.66%
Ear, Nose & Throat	2,651	151	94.30%
Gastroenterology	300	1	99.67%
General Surgery	1,892	109	94.24%
Geriatric Medicine	442	9	97.96%
Gynaecology	1,111	35	96.85%
Neurology	820	8	99.02%
Ophthalmology	4,278	65	98.48%
Oral & Maxillo Facial Surgery	1,878	204	89.14%
Rheumatology	682	17	97.51%
Thoracic Medicine	843	95	88.73%
Trauma & Orthopaedics	3,010	455	84.88%
Urology	2,682	171	93.62%
Other	5,045	121	97.60%
Trust Total	**26,227**	**1,443**	**94.50%**

***De minimis* level >= 20 pathways in total

RTT Stress Test	May-17	Jun-17	Jul-17
% Risk of failure in next 6 months	9.61%	9.97%	12.06%
National rank (1st is best)	20/153	19/153	19/153





Cancer 62 Day Waits

NHSI SOF Operational Performance & National Operational Standard

1. Number of patients receiving first definitive treatment for cancer following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade
2. Number of patients receiving first definitive treatment for cancer 62 days or more following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade
3. % patients receiving first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade
4. Number of patients receiving first definitive treatment for cancer 104 days or more following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade

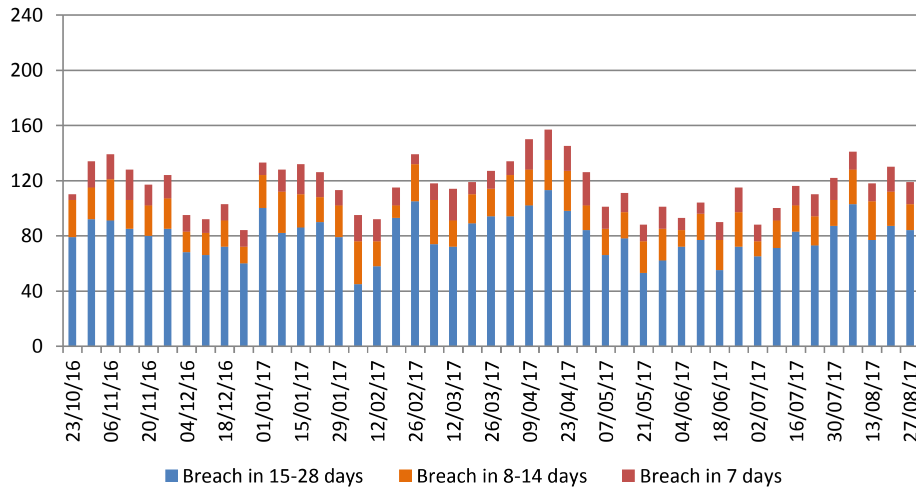
Director Lead: Sean Fenwick
Consequence of failure: Timely access to treatment, patient experience & clinical outcomes.

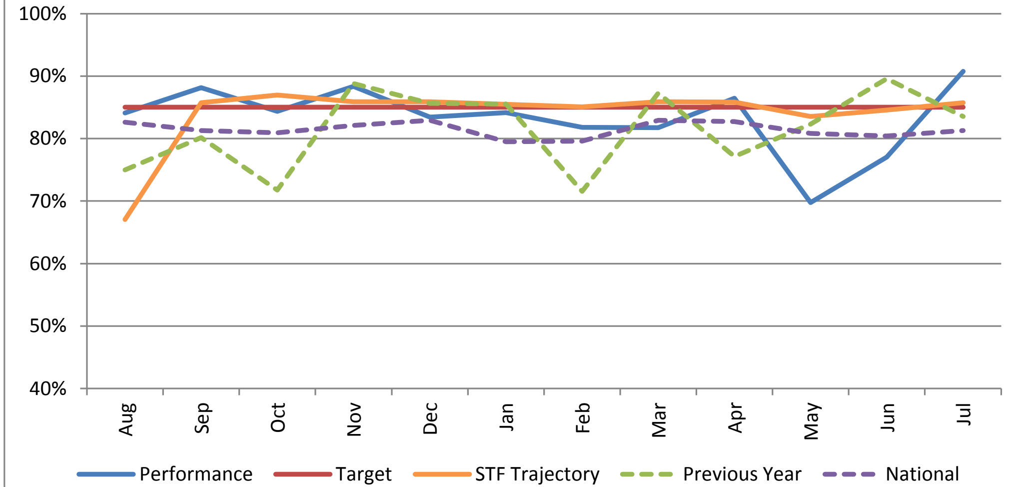
First Definitive Treatment - July 2017*	Volume	Total Breached	Performance	National Performance	YTD	Number ≥104 days
Target			85%	85%	85%	0
Breast	1.0	0.0	100.00%	93.7%	85.71%	0
Gynaecological	2.0	0.0	100.00%	73.8%	81.25%	0
Haematological (Excluding Acute Leukaemia)	2.0	1.0	50.00%	80.6%	87.50%	0
Head & Neck	3.5	0.0	100.00%	64.3%	73.33%	0
Lower Gastrointestinal	7.0	0.0	100.00%	70.8%	84.62%	0
Lung	2.0	0.0	100.00%	70.0%	64.71%	0
Other	0.0	0.0	-	72.1%	100.00%	0
Sarcoma	0.0	0.0	-	70.3%	33.33%	0
Skin	3.0	0.0	100.00%	96.1%	86.21%	0
Upper Gastrointestinal	3.5	0.0	100.00%	74.0%	80.77%	0
Urological (Excluding Testicular)	35.5	4.5	87.32%	76.2%	80.52%	1
Total	**59.5**	**5.5**	**90.76%**	**81.3%**	**79.90%**	**1**

Non GP Referrals						
Screening (Target: 90%)	3.0	0.0	100.00%	90.5%	100.00%	0
Consultant Upgrade	9.0	0.0	100.00%	88.5%	81.33%	0

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales

62 day performance improved in July and exceeded target, STF trajectory and the national average at 90.8%. All tumour groups achieved the target with the exception of the Haematological tumour group. There were 5.5 breaches in total. The final performance for Screening and Consultant Upgrade were both 100%.
Patients who are approaching their breach date are reducing slightly after a recent peak. The main reduction was in patients due to breach in 8 - 14 days.
Indicative performance for August is currently below the national target. Achievement of the STF trajectory and operational standard remains a risk going forwards. Actions are ongoing for Urology in particular.





Diagnostics

NHSI SOF Operational Performance & National Operational Standard

1. Number of patients on the diagnostic waiting list at month end
2. Number of patients on the diagnostic waiting list at month end waiting 6 weeks or more
3. % patients waiting 6 weeks or more for a diagnostic test at month end
4. Number of diagnostic tests/procedures carried out in month

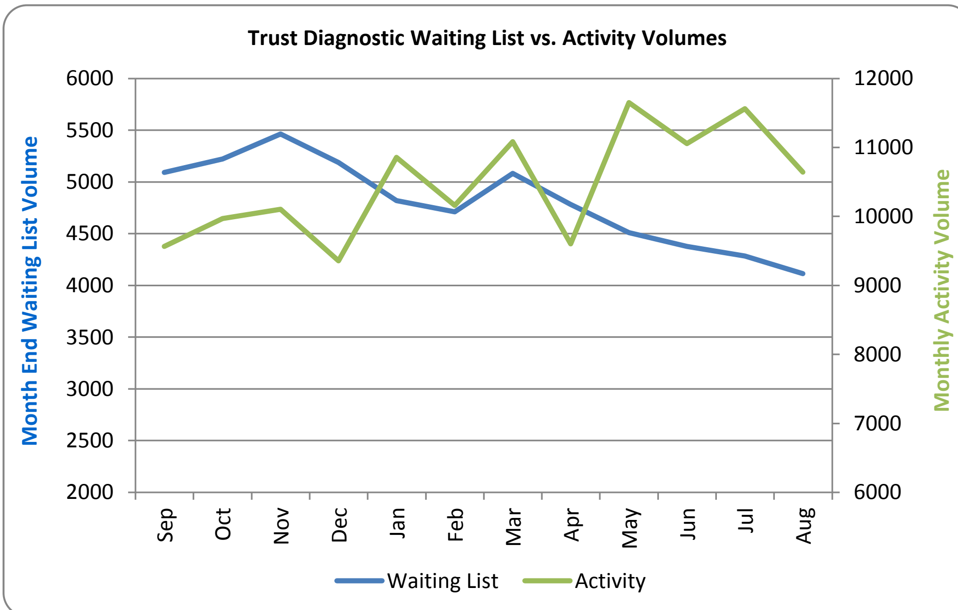
Director Lead: Sean Fenwick

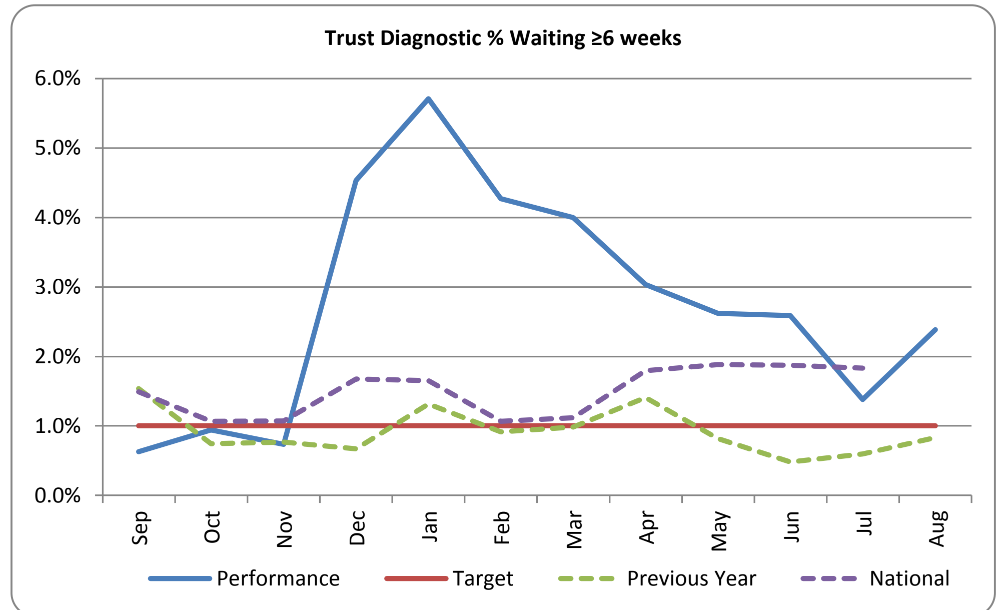
Consequence of failure: Patient experience, quality, access & reputation

The proportion of patients waiting 6 weeks or more at the end of August increased to 2.4% as highlighted last month. This is above the national operating standard of <1% and the revised NHSI recovery trajectory of 1.3%. This is as a result of short term capacity issues in Neurophysiology and admin delays in Respiratory Physiology. Cardiology continue to improve and met the national standard for the first time since October 2016. The standard is predicted to be achieved in September.

The number of patients waiting at the end of the month decreased in August mainly due to reductions in Magnetic Resonance Imaging, Non-obstetric ultrasound and Audiology. Activity reduced in August. The main decreases were seen in Computed Tomography, Non-obstetric ultrasound and Audiology.

	Diagnostics - August 2017	WL Volume	No. ≥6 weeks	%≥6 weeks	Activity
Target				≤1%	
Imaging	Magnetic Resonance Imaging	421	6	1.43%	1,331
	Computed Tomography	324	2	0.62%	2,972
	Non-obstetric ultrasound	1,007	0	0.00%	2,676
	Barium Enema	25	0	0.00%	4
	DEXA Scan	147	0	0.00%	226
Physiological Measurement	Audiology - assessments	150	11	7.33%	969
	Cardiology - echocardiography	772	5	0.65%	994
	Neurophysiology - peripheral	127	23	18.11%	72
	Respiratory physiology - sleep studies	211	28	13.27%	74
	Urodynamics - pressures & flows	240	18	7.50%	113
Endoscopy	Colonoscopy	130	1	0.77%	271
	Flexi sigmoidoscopy	62	0	0.00%	95
	Cystoscopy	347	3	0.86%	479
	Gastroscopy	150	1	0.67%	364
Trust Total		**4,113**	**98**	2.38%	**10,640**





Cancer 2 Week Waits

National Operational Standard

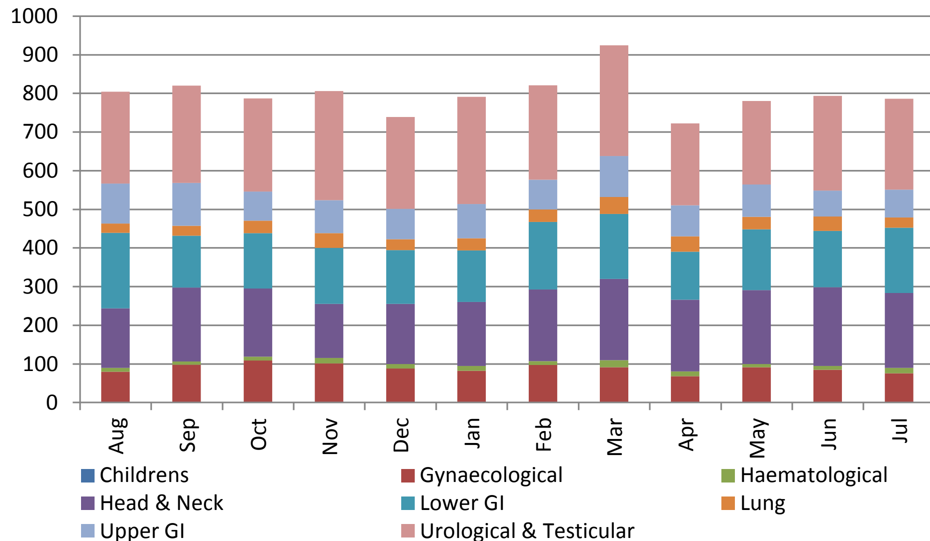
1. Number of urgent GP referrals for suspected cancer
2. Number of patients seen after more than two weeks following an urgent GP referral for suspected cancer
3. % patients seen within two weeks of an urgent GP referral for suspected cancer

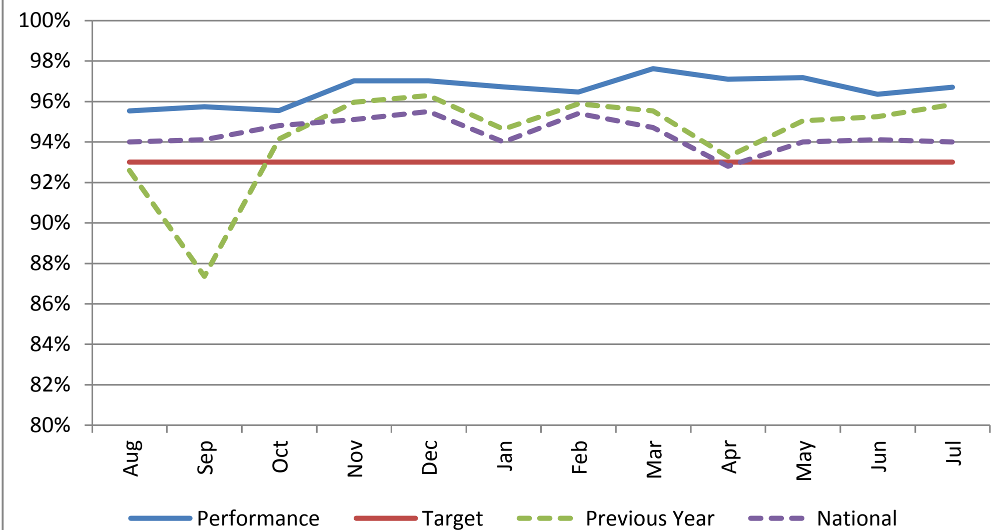
Director Lead: Sean Fenwick
Consequence of failure: Timely access to treatment, patient experience & clinical outcomes

2WW performance was 96.7% in July, which is higher than the previous month and better than July last year and the national average. At tumour site level, all areas achieved the target.
July's performance demonstrated that all tumour groups with the exception of Head & Neck, performed about the same or better than the equivalent national performance position.
Overall referral volumes reduced marginally during July. However Testicular, Haematological, Lower Gastrointestinal and Head & Neck have increased compared to the average over the last 12 months.
Indicative 2WW performance for August is above target.

Referrals for Suspected Cancer - July 2017*	Volume	Total Breached	Performance	National Performance	YTD
Target			93%	93%	93%
Acute Leukaemia	0	0	-	-	-
Breast	0	0	-	95.8%	-
Children's Cancer	0	0	-	94.3%	100.00%
Gynaecological	75	0	100.00%	95.6%	97.48%
Haematological (Excluding Acute Leukaemia)	14	0	100.00%	96.7%	97.73%
Head & Neck	194	10	94.85%	96.0%	95.75%
Lower Gastrointestinal	169	7	95.86%	91.4%	96.64%
Lung	27	0	100.00%	95.4%	98.53%
Other	0	0	-	93.2%	100.00%
Testicular	13	0	100.00%	97.6%	100.00%
Upper Gastrointestinal	72	2	97.22%	93.5%	96.04%
Urological (Excluding Testicular)	222	7	96.85%	96.0%	97.43%
Total	**786**	**26**	**96.69%**	**94.0%**	**96.82%**

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales





Cancer 31 Day Waits

National Operational Standard

1. Number of patients receiving first definitive treatment following a cancer diagnosis
2. Number of receiving first definitive treatment more than one month of a decision to treat following a cancer diagnosis
3. % patients receiving first definitive treatment within one month of a decision to treat following a cancer diagnosis
4. % patients receiving subsequent surgery or drug treatments for cancer within 31 days

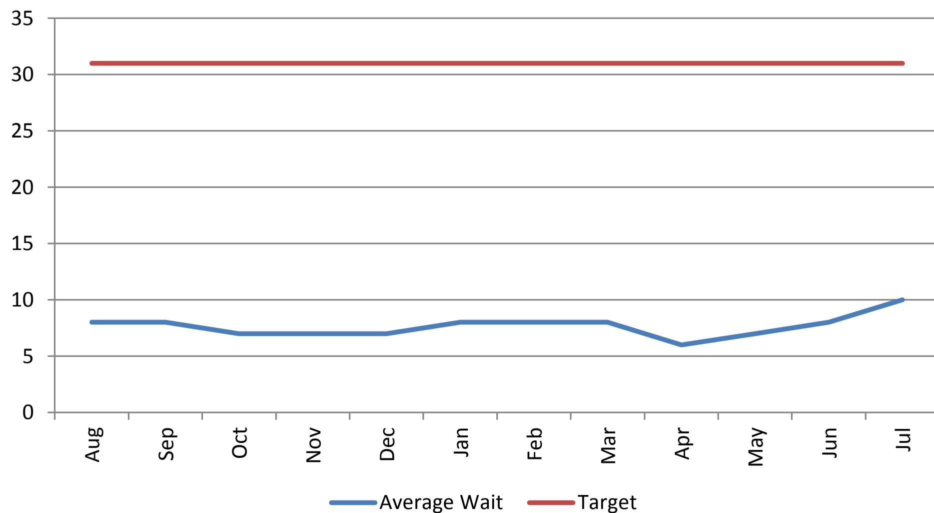
Director Lead: Sean Fenwick

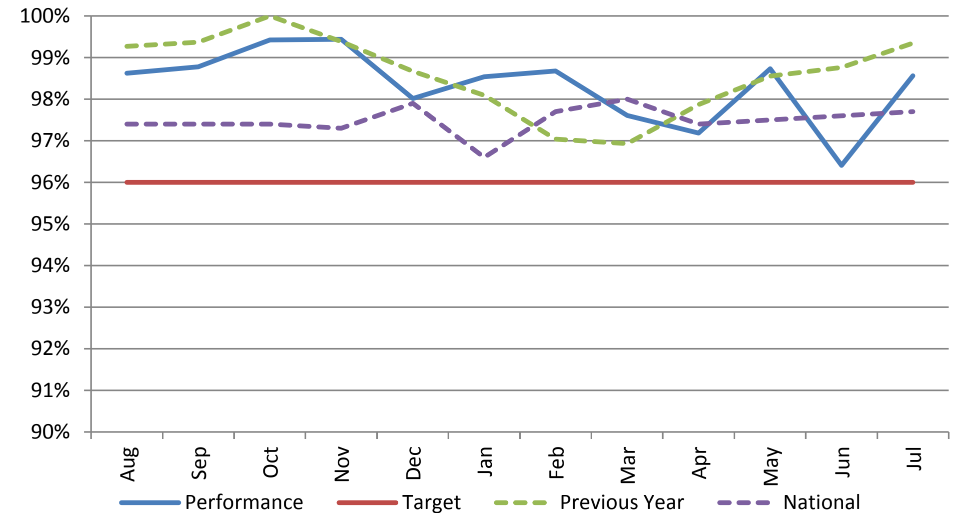
Consequence of failure: Timely access to treatment, patient experience & clinical outcomes.

There were two 31 day breaches overall during July. Aggregate level performance was above target at 98.6%. All tumour groups achieved the target with the exception of the Head & Neck tumour group which was flagged as a risk in May. Performance across all tumour groups, with the exception of Head & Neck, was better than the equivalent national average.
Indicative performance for August is currently above target.
The final performance for July for subsequent drug treatments was above target at 100%.
Subsequent surgical treatment was below target at 92.3% with two breaches relating to the Urological tumour group due to medical reasons.

First Definitive Treatment - July 2017*	Volume	Total Breached	Performance	National Performance	YTD
Target			96%	96%	96%
Breast	3	0	100.00%	98.4%	100.00%
Gynaecological	3	0	100.00%	96.7%	100.00%
Haematological	12	0	100.00%	99.5%	100.00%
Head & Neck	9	1	88.89%	95.4%	88.89%
Lower Gastrointestinal	14	0	100.00%	98.2%	100.00%
Lung	23	0	100.00%	98.9%	100.00%
Other	4	0	100.00%	99.1%	100.00%
Sarcoma	0	0	-	97.7%	100.00%
Skin	5	0	100.00%	97.6%	92.86%
Upper Gastrointestinal	4	0	100.00%	98.6%	100.00%
Urological	62	1	98.39%	95.6%	97.27%
Total	**139**	**2**	**98.56%**	**97.7%**	**97.69%**
Subsequent Treatments					
Surgery (Target: 94%)	26	2	92.31%	96.0%	95.45%
Drug (Target: 98%)	76	0	100.00%	99.6%	100.00%

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales





CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP GUARDIAN ANNUAL REPORT

SEPTEMBER 2017

Introduction

The purpose of this annual report is to outline progress to date with the development of the role of Freedom to Speak Up Guardian (FTSUG) and the support role of Freedom To Speak Up Ambassadors at CHS as well as highlighting the number and nature of concerns raised.

Background

The Francis Report into Mid Staffs and the subsequent Freedom to Speak Up Review recommended that all Trusts have a Freedom to Speak Up Guardian because of the way 'Whistleblowers' at that Trust had been treated. Francis wanted ensure that there is an 'independent' dedicated person in every Trust to whom concerns can be easily reported, a "Freedom to Speak Up Guardian" out with the normal 'line management' structure. This was reinforced in 2015 by the Department of Health who at that point made the appointment of a Freedom to Speak up Guardian mandatory for every Trust.

After a short delay (after the initial National Guardian resigned soon into the post) Dr Henrietta Hughes was appointed as the National Freedom to Speak Up Guardian in October 2016 and since then has been driving the agenda forward.

The ethos of whistleblowing is to prevent harm, protect employees who raise concerns and manage risk.

Progress by the Trust

CHS has had a Whistleblowing (Raising Concerns) Policy in place reflecting the Francis recommendations since 2014. This Policy has been revised and updated in line with developments in the Freedom to Speak Up Agenda and guidance from the Office of the National Guardian. Since 2016 the Director of Human Resources and OD has taken on the role of FTSUG and in May 2017 this role was strengthened with the appointment of 9 Freedom to Speak Up Ambassadors. In addition the Trust has a Non-Executive Director with lead responsibility for FTSU.

The Ambassadors come from a variety of disciplines and locations within the organisation allowing staff to make contact with whomever they are comfortable to report. An important part of this role will be to ensure that, via

the Guardian, lessons learnt are shared across the organisation and that the person raising the concern receives meaningful feedback, is supported throughout the process and thanked for coming forward.

On 11th May, before the Ambassadors were presented to the Trust, a training session was delivered to them by the whistleblowing charity, Public Concern at Work. This included background information on Speaking Up and Whistleblowing, a case study and an interactive session on handling concerns and supporting workers who raise concerns.

This was followed by a briefing open to all staff to reinforce the support available in the organisation, it is fair to say despite promoting this attendance was limited.

Information has been placed on a dedicated Freedom to Speak Up section on the Intranet. In this one area all of the contact details for the Guardian and Ambassadors are located along with a series of FAQs, general information and a link to the full policy document.

On 7th June a poster was issued **(see Appendix 1)** with contact details of the Guardian and Ambassadors, this was also included in the monthly Team Brief.

Standard 'recording concerns' templates and guidance have been issued to all Ambassadors and a central register of concerns and actions taken is maintained for reporting purposes.

The FTSUG meets with the Ambassadors on a quarterly basis to discuss the role, information from the National Guardian's office, any contact with staff raising concerns and then sharing concerns raised to date and how they are being addressed.

In addition to the above, the role has been discussed/ shared at the Staff Engagement Briefing events taking place through June and July.

Since the launch and promotion of the roles in May and June four concerns have been raised, two with ambassadors and two with the FTSUG, two are being dealt with via an internal investigation and another by the Counter Fraud team. The fourth concern is being passed back to the Directorate (with the reporter's approval) for the Senior Manager to address **(see Appendix 2).**

National Position

The National Guardians Office (NGO) will officially commence its case review process to look into cases referred to it where it appears that there is evidence that an NHS trust has not appropriately responded to a concern raised by its staff. Referrals will be accepted from current individual members of NHS staff, FTSUG or regulators (plus staff whose employment ended up to two years ago).The process will run for a twelve-month trial period, after which it will be reviewed and any necessary changes and improvements made. This

will include considering all feedback received from those parties involved in a case review.

The principal purposes of a case review are to look into how a speaking up case was handled and to make recommendations where this did not meet with good practice. Standards of good practice against which a review will assess the handling of concerns and involvement of other agencies is set out in the Francis Freedom To Speak Up report. A central focus will be learning, not blaming. Case review recommendations can include asking a Trust to take action to remedy problems identified with speaking up culture, policies or procedures. The NGO will work collaboratively with the Care Quality Commission (CQC) and NHS Improvement to ensure that where a case review identifies the need for improvement to support speaking up the necessary steps to achieve this will be taken.
As part of their new inspection process CQC inspectors will assess the processes trusts have in place to support Freedom To Speak Up Guardians, as well as speaking up policies, procedures and culture.

Trust Culture/Staff Survey Results

Being free to speak up requires a significant culture change in the NHS, the FTSUG role cannot achieve this single-handedly in the organisation, culture change comes from leadership at all levels and living the Trust values makes a huge contribution to this culture. Ensuring staff are aware of how to raise and handle concerns is everybody's responsibility.

Over the past year (exclusive of concerns raised with the FTSUG) staff reported c13,500 incidents via the Ulysees system, raised 6 Grievance and 4 claims of Harassment all of these were managed through the usual Trust policies and processes. In addition, there will be many other concerns that are raised and resolved at line manager level on a day to day basis that will not be 'visible' at a corporate level.

The 2016 staff survey indicated that across all 32 of the 'key findings' **(see Appendix 3)** there was 'no change' in any of the rankings (compared to all acute trusts) from the previous year as follows:

- 13 Best 20%
- 8 Better than Average
- 10 Average
- 1 Below Average

With regard to reporting, the percentage of staff:

- Reporting errors, near misses or incidents
- Believing that the procedures for reporting errors, near misses and incidents are fair and effective
- Feeling confident and secure in reporting unsafe clinical practice
- Reporting most recent experience of harassment, bullying or abuse

Are all ranked within the 'Highest (best) 20%'.

That said we must be mindful of the low response rate to the survey (35%) which is in the lowest 20% for all acute trusts and the need to improve this and make further progress with those areas that remain in the average / below average categories. An OD plan and a Communication Plan are being developed to help address these concerns.

NEXT STEPS

Progress has been made since the beginning of 2017 in strengthening the culture of openness within the organisation through the Freedom to Speak Up agenda.

To develop this further more publicity is planned including a screensaver for all Trust PCs and information about FTSU at Induction.

In addition the trust OD and Communications plans will be progressed to help support our overall staff engagement and culture development including increasing the response rate to our staff survey.

A series of planned 'walkabouts' for Ambassadors and the FTSUG will be discussed at the next quarterly meeting in November.

The National Freedom to Speak Up Guardian will be visiting the Trust on 13 October to meet with the FTSU team, the CEO and the Board to discuss our commitment to the FTSU agenda and the progress made to date.

Recommendations

Directors are asked to note the content of this report.

Kath Griffin
Freedom to Speak Up Guardian

Appendix 1

Raising Concerns
Freedom to Speak Up

MEET OUR FREEDOM TO SPEAK UP GUARDIAN AND AMBASSADORS

We want our staff here at City Hospitals Sunderland to feel comfortable raising any concerns they may have so, if you are worried or have a concern about something that is happening at work, please do not keep it to yourself. Unless you tell us about your concern – whether it is about patient care, health and safety, a breach of a professional code or other wrongdoing - then we may not find out about it until it is too late. The Freedom to Speak Up Guardian and team of Ambassadors are here to listen to your concerns, openly, or confidentially and will take these forward.

Appendix 2

WHISTLEBLOWING/ RAISING CONCERNS

The table below gives a summary of concerns that have been raised directly with the Freedom to Speak Up Guardian or Freedom to Speak Up Ambassador between October 2016 and September 2017.

No new concerns were raised during Q4.

Date concern raised	Directorate	Nature of Concern	Status as at 18/9/17	Date case closed where applicable
8/6/17	Surgery	Patient safety/ staff safety	Ongoing investigation delayed due to sickness absence	
20/6/17	Medicine	Falsifying rotas/ holidays	Ongoing with Counter-Fraud	
24/7/17	Theatres	Management practice/ bullying & harassment	Concerns transferred back to General Manager with agreement of reporter	15/8/17
7/9/17	Medicine	How a grievance was handled	Reporter on leave, meeting planned for his return w/c 25/9/17	

Appendix 3

3.3. Summary of all Key Findings for City Hospitals Sunderland NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2015.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2015.

'Change since 2015 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2015 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2015 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	• Average
KF12. Quality of appraisals	• No change	✓ Above (better than) average
KF13. Quality of non-mandatory training, learning or development	• No change	✓ Above (better than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	✓ Lowest (best) 20%
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	• Average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	• Average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	✓ Highest (best) 20%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	✓ Highest (best) 20%
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	✓ Highest (best) 20%
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	✓ Below (better than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	✓ Lowest (best) 20%
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	✓ Above (better than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	✓ Above (better than) average
* *KF16. % working extra hours*	• No change	✓ Lowest (best) 20%

3.3. Summary of all Key Findings for City Hospitals Sunderland NHS Foundation Trust (cont)

	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	• Average
KF4. Staff motivation at work	• No change	! Below (worse than) average
KF7. % able to contribute towards improvements at work	• No change	✓ Above (better than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	✓ Highest (best) 20%
KF9. Effective team working	• No change	• Average
KF14. Staff satisfaction with resourcing and support	• No change	✓ Above (better than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	• Average
KF6. % reporting good communication between senior management and staff	• No change	✓ Highest (best) 20%
KF10. Support from immediate managers	• No change	✓ Above (better than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	✓ Highest (best) 20%
KF3. % agreeing that their role makes a difference to patients / service users	• No change	• Average
KF32. Effective use of patient / service user feedback	• No change	• Average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Lowest (best) 20%
KF24. % reporting most recent experience of violence	• No change	✓ Highest (best) 20%
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	✓ Lowest (best) 20%
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Highest (best) 20%

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

SEPTEMBER 2017

ASSURANCE FRAMEWORK 2017/18

Background

The attached document (Appendix 1) details the final Assurance Framework document for 2017/18. This paper will give an overview of the process to develop the 2017/18 Assurance Framework.

Developing the 2017/18 Framework

In order to develop the 2017/18 Assurance Framework (AF), the following issues have been considered:

2016/17 Review:

- Feedback from the 2016/17 AF review, as discussed with the Board of Directors in April 2017
- In year risks and issues including external evidence, incident reporting and complaints and evidence from the Assurance Programme work

2017/18 Issues:

- Objectives as per the previously agreed OGSM documents
- New issues and/or developments from various sources including themes and trends as reported to Corporate and/or Clinical Governance Steering Groups, and Governance Committee

It is crucial that evidence is sought in support of the inclusion or removal of a risk. The AF should be the culmination of work undertaken in the preceding year, plus a prospective look at expected future risks based on the external environment and evidence of internal issues.

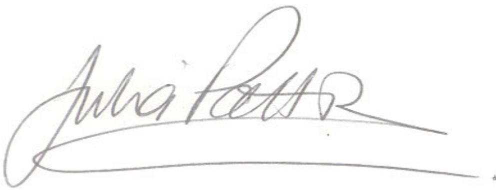
Outcome for 2017/18

The Assurance Framework has been developed having taken account of feedback from the members of Governance Committee and the wider Executive Team. Appendix 1 details the final AF for 2017/18 as approved by the Governance Committee in September 2017. Key amendments from the 2016/17 final document (Appendix 2) include:

- Amendments to Committees to reflect the change to Finance & Performance Committee (no longer Operations Committee)
- Removal of a number of risks from 2016/17:
    - 2: 'To know that clinical staff are clinically competent….'
    - 5: 'Reputation with GPs…'
    - 9: 'Obstetrics & Gynaecology'

- Inclusion of new risks including cash management (new 12.6) and the impact on Executives as a result of ‘Group’ working (new 7.8)
- Amendments to some of the statements included in the ‘control’ and ‘assurance’ columns to reflect updated information such as around safeguarding

Conclusion
The Board of Directors is asked to approve the Assurance Framework document for 2017/18.



Julia Pattison
<u>Exceutive Director of Finance</u>

September 2017

Assurance Framework 2017/18 (Draft)

Highest Safety

No.	Objective/Aim	Principle Risks	Area of Org/ designated Lead	Key Controls/Systems to manage risk	Evidence of Effective Management/ Assurance that controls are working	Gaps in Controls - where are we failing to put systems / controls in place. Where are we failing to make them effective	Gaps in Assurance - where are we failing to gain evidence that our controls / systems are effective	Responsible Group/Committee(s) for the management of the Risk	Overall Responsibility to gain Assurance on behalf of BoD
		1) operational pressures due to activity pressures of Demand > Capacity e.g. staffing, facilities, patient safety & LOS	Director of Operations	Operational Management Group; Corporate Management team; Executive Committee; escalation processes; standard Ops; workforce plans, activity forecasts; estates plan	• Significant improvement in A&E performance • De-escalation of directorates due to performance improvements • Early warning reports have correctly identified areas of risk • Improvements in choose and book slot issues – reduction • Annual planning process identifies significant areas of concern/risk in terms capacity, quality, timeliness and safety • Corporate dashboard reviewed monthly at Operations Committee and BOD. Minutes from quarterly review meetings. • Escalation process and performance framework approved by Operations Committee • Reduced volatility in cancer 2ww performance around peak holiday times • City wide escalation/surge capacity	• More effective forward planning still required • City wide escalation/surge capacity • Community based services aimed at reducing demand •Progress towards all services to be on V6 e.g. audiology and ECHO	• Performance against some Monitor SOF indicators is not consistent e.g. cancer 62 days • Nursing recruitment – lack of availability. Further overseas nurse recruitment planned * Implementation of e-rostering will help the Trust to deploy its nursing workforce more effectively and better control supply and demand for bank workers.	Finance & Performance Committee	Board of Directors
		2) ED pressures relating to increase in attendances. Risk relating to ability of Department to manage the volume increase (and risk to A&E target achievement), and impact on patient flow into 'back of house' facilities such as beds	Director of Operations	Operational Management Group; Corporate Management Team; Executive Committee; Safe and Sustainable Emergency Care programme, escalation processes, local A&E Delivery Board	• Performance remains challenging however we remain in the upper middle 25% of trusts nationally • SSEC dashboard developed to track progress of programme and associated projects. • A&E weekly dashboard • Daily reporting and forecasting	• Continue to develop ambulatory care pathways e.g. T&O. Medical model for ambulatory care still in development • Ability to control demand – e.g. NEAS, Primary and Community services • Ability to recruit appropriate staff. • Ability to divert ambulances	• Target not being met consistently	Finance & Performance Committee	Board of Directors
		3) Ability to recruit senior medical staff to key specialties resulting in a risk to the quality of clinical services provided, ability to retain existing staff and financial pressures. Key specialties include gastro, thoracic and emergency care	Medical Director/Director of Operations		• Successful consultant recruitment in previously identified pressure areas such as Radiology	• National planning and no. of doctors in training • Competitor initiatives to improve recruitment	• Gaps remain in certain specialties	Finance & Performance Committee	Board of Directors

APPENDIX 1

No.	Objective/Aim	Principle Risks	Area of Org/ designated Lead	Key Controls/Systems to manage risk	Evidence of Effective Management/ Assurance that controls are working	Gaps in Controls - where are we failing to put systems / controls in place. Where are we failing to make them effective	Gaps in Assurance - where are we failing to gain evidence that our controls / systems are effective	Responsible Group/Committee(s) for the management of the Risk	Overall Responsibility to gain Assurance on behalf of BoD
1	To ensure the Trust manages activity demand as required including staffing & facilities requirements	4) Inability to recruit sufficient Registered Nurses to fill required staffing levels.	Director of Nursing	1) Operational nurse staffing reviews are held monthly. the Strategic Nurse Staffing Review is carried out annually with a monthly refresh. 2) Monthly monitoring 3) Matrons staffing escalation processes. 4) Revised recruitment processes to streamline recruitment. 5) Plan for international recruitment 2016/17. 6) Partnership with University of Sunderland to deliver Pre-registration training. 7)Adverts on RCN job bulletin 8) Work started to develop programme for nurses living in UK to achieve NMC registration	•Since April 2016- 110 registered nurses appointed. •Identified matron as lead for shortlisting to ensure continuity and standardisation.	•E-rostering will be in place in 2016/17. Nine wards are live to date and roll out will take 18 months to complete. •National shortage of Registered Nurses	• Staff movement to fill gaps. Monthly usage reports and quarterly review meetings are in place to make sure that demand and supply are being properly controlled . •New rostering policy in development. New Roster Policy to JCG 9/03/17. •Vacancies increased to 90 WTE	Executive Committee	Governance Committee
		5) The ability to recruit and manage junior doctors is variable across the Trust. This has an impact on GMC junior doctors survey results (and therefore the ability to recruit), and risks around financial consequences of non compliant rota's. Specific specialties include general surgery, urology and ED	Medical Director	1) Introduction of the Allocate system for rota/leave and job planning management 2) Regular review of rotas by DME 3) Greater involvement of trainees in groups such as mortality & deteriorating patient group 4 Establishment of junior doctors forum 5) Appointment of Guardian of Safe Working 6) Establishment of Exception reporting system 7) Explore feasibility of "Doctor's Assistant Programme"	1) Compliant rota's for all specialties 2) Positive feedback from HENE/GMC for all specialties 3) Improving recruitment in at risk specialties 4) Development of nurse practitioner roles to compensate for junior doctors shortfalls. 5)Review of Consultant job plans and coordination with capacity demand modelling 6) Guardian of Safe Working quarterly Board report	•Allocate software being acquired for deployment August 2017. •Managing Hospital at Night	•Non-compliant rotas in some specialties resulting in significant financial consequences •Feedback from junior doctors questionnaire highlights action required in some specialties	Executive Committee	Governance Committee
		6) The ability to replace equipment in a timely manner impacting on operational, business continuity or patients - risk due to financial constraints	Director of Finance	A 'Medical Equipment Replacement Programme' has been included in the capital programme for the 2017/18 financial year. A time limited sub-group of Capital Development Steering Group will be established to review key equipment needs and options to mitigate risk	All requests for urgent equipment have been approved (from capital contingency funds or leasing) in year	The financial fund available is unlikely to be sufficient to be able to replace all necessary equipment requirements		Capital Development Steering Group / Executive Committee	Governance Committee

APPENDIX 1

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		1) Non-recognition/action on deteriorating patient (including robust handovers & acting on low Early Warning Scores (NEWS)	Medical Director & Director of Nursing	1) CCOT Team procedures 2)Audit and monitoring of NEWS. 3) Education & Training in place and incident reports. 4) Risk Management processes monitored at directorate/department level. 5) Annual Hospital Wide Level of Care and Point Prevalence Survey shows improvements 6) Escalation measures implemented for wards that repeatedly under perform in monthly NEWS audit and NEWS audit. 7)Trust Mortality Review Panel: incorporates review of patient observations/NEWS prior to death. Chair has produced a Clinical Deterioration Summary for CGSG 8) Audit programme for recording of observations/NEWS- reported monthly via Ward Dashboards	1) Reducing no. incidents relating to NEWS 2) Evidence of action taken. 3) Checks on actions & lessons learnt following RCAs 4)Assurance Programme Reports on SI action plans and staff interviews include questions about NEWS process. 5) Electronic obs system introduced in 2015/16 6) Draft revised pain chart devised. To be piloted and rolled out following discussion at CGSG 7) Feedback from end of post surveys and the National Training Surveys to incorporate intelligence from junior doctors into the work of the DPG	1) Inquest reports. 2) Escalation processes failure due to lack of knowledge/capacity issues. 3) Some improvements needed in staff understanding and documentation 4) Audits and incidents demonstrate sub standard performance in some areas	•Limited checks that lessons learnt have been implemented have begun • No checks of content and identified responsibilities of handovers •Follow up of lessons learnt after RCAs involving NEWS and clinical escalation		
2	Deliver the Quality priorities as set out in the Quality Report	2) Number of Incidents relating to numbers of Falls - with serious harm	Director of Nursing	1) Falls group reports 2) Falls assessment and trigger tool 3)Policies and procedures in place 4)Quality Improvement Score Card 5) Dementia environmental standards 6) Wards targeted for Fall Safe programme 7) Falls Policy to be updated and ratified	1) Reducing incidents relating to falls - information provided to the Hospital Falls Group 2) Introduction of patient slippers to assist in the prevention of falls 3) standard operating process to reduce falls in the hospital car park (gritting) 4) Assurance Programme Reports including review of falls risk assessments. 5) Falls Specialist Nurse for REM conducting audits 6) Care Fall training and Fall Safe e-learning package available on ESR	•Fall Safe Programme rolled out Trust wide. Focus on lying/standing BP. Medication high risk. •Availability and take up of online training •Falls risk assessments and care planning not documented correctly on v6.	•Checks of staff knowledge and compliance with Falls Policy have taken place during Assurance Visits •Possible correlation between falls rates and staffing levels •Some checks that lessons learnt have been implemented have begun	Clinical Governance Steering Group	Governance Committee

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		3) Number of hospital acquired pressure ulcers.	Nursing Director	1) Tissue Viability Specialist service 2) Equipment/beds 3) Incident reports & RCAs 4) Intentional rounding into this section as a key control	1) Reduction in pressure ulcers acquired in hospital. 2) Reduction in numbers which deteriorate on admission 3) Improvement in NHS Safety Thermometer data and ward dashboard data 4) Pressure ulcer improvement plan 5) Increased incident reporting and decreased severity of pressure ulcers 6) SSKIN bundle implemented and audited	Poor compliance with policy including appropriate assessment + care/treatment - patient risk assessment not always completed on admission. * Pressure Ulcer Policy requires updating development	•Checks that action has been taken and lessons learnt as a result of pressure ulcer incidents; •Checks on SSKIN bundle and Patient Care Charts show patchy implementation •Assurance Programme checks show further improvements required		
3	Mortality - Identify and remediate factors leading to preventable death	Failure to recognise remediable factors which could prevent deaths	Medical Director	1) Weekly mortality review panel. 2) Review of national mortality measures 3) Utilisation of CHKS mortality profiler module and engagement with clinical teams 4)Local departmental review feedback has significantly improved 5) Fully participates in the regional Mortality Group and its activities 6) Review of coding and death certification practice carried out 7)Participates in regional serious infection project around pneumonia (highest cause of excess deaths) 8) Engage with national programme of Mortality reviews 9) Engagement with LeDeR programme	1) Monthly report to Clinical Governance Steering Group & Quarterly review to Governance Committee and Board of Directors 2) Mortality measures as or better than expected / no outlier positions or alert notices. 3) improvement in all national mortality indicators 4) SHMI- now under 1.0 and remains in Band 2 (as expected) 5) HSMR recently increased and associated with reduction in palliative care coding 6) RAMI better than peers 7) Improvements in the recording of co-morbidities which affects mortality risk profile	•Awaiting definition of new national reporting standards for avoidable deaths •Local mechanism for ensuring that remedial factors have been addressed by specialty teams. • Further work required to ensure accurate and consistent application of palliative care coding	•Require evidence of effectiveness of process, in light of awaited new standard for mortality review. •Checks that action has been taken and lessons learnt as a result of mortality review process. • Board workshop and appointed Executive Director and NED Leads for mortality	Clinical Governance Steering Group	Governance Committee
4	Ensure the Trust is able to maintain and expand services in a competitive environment	2) Ability to deliver the objective of the '3rd centre' ambitions within key specialties e.g. vascular, PPCI	Director of Planning & Business Development	Robust plans in place covering workforce, infrastructure, critical mass requirements, activity for each area; awareness of national service requirements; commissioner support	Independent reviews recommends CHS as third centre. Infrastructure in place, e.g. endovascular theatre, 2nd cath lab. Workforce in place. All national requirements (specification) delivered. Local commissioner support in place. Quarterly review process in place. Local support from neighbouring FTs. CHS strategy aligned to national strategy - 'Major Emergency Centre'	NHS England (not CCG) commissioner led process. Potential lack of support from clinical networks. National drive to reduce the number of specialist centres	PPCI not a formally commissioned service	Executive Committee	Board of Directors

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5	Ensure the patient information system is fit for purpose and does not create any patient safety risks, is used effectively by all staff with accurate data quality, and that the data it stores is secure.	1) Functionality is not fit for purpose. 2) Systems are not implemented correctly, and are not safety assessed. 3) Staff are not competent in the system and do not use it to its greatest advantage/effectively. 4) Staff are competent in the system, but data quality is still poor. 5) Staff do not engage in change management, and are resistant to new ways of working through MEDITECH (Resulting in benefits not being realised). 6) Digital Roadmaps combined with the CHS + ST Alliance - Focus on IT is now beyond confines of CHS. Strategy + systems - Which strategy/systems are required, along with cost/funding and implementation process/timescales is a concern and risks slowing down CHS 7) Risk of cyber crime impacting on the clinical, operational and business functions of the Trust	Director of IT&IG	1) Robust communication process with Meditech to log and escalate issues to address functionality gaps. 2) Implementations & sign off of changes will be through appropriate governance (including CGSG & IM&TSG). 3) End user training via core groups - with signed off competence sheets & review 4) Data Quality processes for identification and resolution of issues - KPIs - Continuous improvement. 5) Ongoing modification and development of the system, including implementation of new modules. 6) Effective governance via Sunderland Informatics Board and CHS IM&T Strategy Group. 7) Robust cyber security monitoring and control processes in place; enhancement to Policy to ensure completely up to date 8) NHS Digital conducting cyber audit against national framework in Oct 17. 9) AuditOne cyber expert undertaking audits in Jan 2018.	1) Issues logged with MEDITECH have significantly reduced, and those which are closely monitored through the MEDITECH 'task system', with regular conference calls, including weekly escalation calls. 2) Post Implementation Reviews. 3) Training attendance sheets and competency assessments/'Happy Sheets' are reviewed by core trainers. Access is granted based on satisfactory results. 4) Data Quality report is also a standard agenda item at monthly Information Governance Group. This also includes a regular review of incidents. 5) Regular updates to IM&TSG and EC. 6) Reports/outputs from Sunderland Informatics Board and CHS IM&TSG. 7) No major incidents as a result of cyber security issues 8) Results of Cyber audits will be presented to IM&TSG	1) Ongoing need for further modifications to the software when identified. 2) Operational and resource pressures are resulting in difficulty in releasing staff to act as core trainers. 3) Operational and resource pressures are resulting in difficulty in releasing staff to be trained/retrained to ensure they are using the system effectively and consistently. 4) As above, but linking with staff to ensure that data quality improves. 5) MEDITECH modular sponsorship/leadership and governance (+ resources) to continue to take forward the Trust's MEDITECH strategy (+ benefits) further - And implementation of new ways of working. 6) Some gaps in core v6 teams due to operational/financial pressures. 7) V6 governance structure continues should there be further issues detected. 8) Data quality KPIs are being developed.9) Ensuring nationally that systems are protected in light of cyber that have an impact locally.	1) Appropriate data specification, collection and information provision - Data management processes have been reviewed, and action plans agreed by IM&TSG - Implementation during 2016/17. 2) It is clear that some of the originally anticipated benefits have not yet been fully realised due to the manner in which it has been adopted. A range of further projects are either underway or are shortly to ne initiated to realise further benefits.	Executive Committee	Governance Committee

Best Quality

APPENDIX 1

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6	Improve the reputation of the Trust - by using feedback from patients and staff	1. Poor communication with Patients & Relatives, discharge communications, attitude and approach around face to face communications impacting on patient understanding and incidents/claims, and the requirement of the Duty of Candour	Medical Director, Director of Nursing	1) Local patient real time patient surveys; and action plans from directorates. 2) PROMs 3) Communications Strategy & Marketing. 4) Patient Experience Improvement Plan. 5) Documented Trust wide approach & training around Duty of Candour including an 'easy use' guide 6) Communications Strategy implemented 7) Real time Feedback provided to PCPEC and in monthly Board reports. 8) Electronic Discharge Policy 9) Clinic on the Day	•Positive patient survey results e.g. patients survey; complaints; press; NHS Choices website. •Discharge summary reports and reports on OPD- GP letters delay	•Communications Strategy not implemented. • Duty of Candour guidance/Trust Policy in draft following consultation. •Lack of compliance with Trust Policy on providing information on discharge. •Poor or modest performance within patient surveys and other feedback collections not acted upon. •Problems identified with electronic sending of discharge communications Post Internal Audit review there has been a development of clear ward procedures to reduce variability, promote an organised and disciplined approach to ensure discharge arrangement are done and communicated to patients in a timely manner.	•Incomplete discharge communications; •Real Time Feedback variable in scores. •Continuing numbers of complaints and incidents flagging communication as an issue. •Checks that action has been taken and lessons learnt from participation in all formats of patient feedback.	Patient, Carer and Public Experience Committee	Governance Committee
		2. Slow turnaround times for incidents, complaints and Root Cause Analysis, resulting in delay and frustration for patients, potential risk around escalation of any problems to legal action and not learning from the incident resulting in further incidents of the same nature (and delays in external reporting)	Director of Nursing	1) Tracking of turnaround times; 2) Appointment of risk facilitators to improve the position 3) Assurance Programme - evidence of lessons learnt & changed processes 4) Improvements to Ulysses system in progress to include direct notification of incidents to Directorate teams 5) Changes to RCA processes and clearance of backlog. 6) Review of HAAS staffing	1) Feedback to relevant groups and Committees around improved timelines and 95% compliance with required timescales 2) Assurance Programme feedback to Governance Committee	Impact of quality risk facilitators to be evaluated	Delayed investigations. Assessment of the effectiveness of upgraded system and revised process.	Clinical Governance Steering Group/Patient Carer and Public experience committee	

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		1) NHSI - compliance with Licence conditions & financial risks	Director of Finance /Director of Corporate Affairs and Legal Services	1. BoD Finance Report; Finance & Performance Committee - revised governance process in place to ensure feed from Programmes to Programme Management Group & to Finance Committee to manage delivery of CIPs 2. Capability & Capacity Review (under "Well Led" framework) - self assessment process on-going; commissioning of work will be in 2017/18 3. Annual Governance statement 4. Annual Report and Accounts submission 5. Annual Self-Certification.	1. Financial Reporting - F&P Committee, EC & BoD reports; alignment with NHSI Risk Assessment Framework; PMG report fed to Finance & Performance Committee; Delivery against £13m CIP target in 2016/17 & improved financial position in year;		External "Well Led review" will not commence until Autumn 2017/18 following 6 month implementation of the new Board Sub-Committee structure; financial performance at risk as at end quarter 1 with risk of loss of STF	Executive Committee	Board of Directors
		2) Risk of non- compliance with NHSI Quality Governance Framework. Monitor compliance - quality governance risks	Medical Director & Director of Nursing	Self assessment via CGSG and Governance Committee. Annual independent assessment via Assurance Programme/external assessment.	Achievement of all NHSI requirements linked to Quality Governance Framework/new framework.	Strengthening of the internal arrangements for monitoring key elements of the Framework; routine reporting of progress & actions via action plan report.	Board not aware of Trust status in relation to compliance with NHSI Quality Governance Framework. Ongoing assessment of compliance.	Governance Committee	Board of Directors

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7	Ensuring compliance with all regulatory body requirements including Monitor, CQC, HSE & NHSLA	3) NHSI compliance - performance governance risks A&E (Annual Plan). For c.difficile see section 4.	Director of Planning & Business Development; MD for C-Diff	•EC Performance Report Subgroups inc. RCA for every C-Diff case •RRG to review all RCAs RCAs for all red incidents •Performance monitored as part of quarterly reviews •Early warning reports developed •Gastroenterology and T.Med escalated as per performance improvement framework •Monitored monthly at BOD, EB, CMT, OC and OMG using Corporate dashboard •Reviewed as part of annual plan submission to Monitor •Performance risks highlighted in discussions with operational areas as well as at formal committees •Performance Improvement Framework agreed at Operations Committee STF trajectories agreed with Directorates •Action plan developed around sustainable delivery of cancer 62 day standard	• Improvements across a number of areas • Early warning reports have correctly identified areas of concern • Recovery plans are in place for all areas of under performance	• More effective forward capacity and demand planning re still required • Early action is taken by specialties to rectify performance issues • Administrative processes and systems require improvement in some areas to improve accuracy of early warning reports to effectively highlight risks • No control over demand, which can lead to operational pressures and non-delivery of target • Achievement of the 62 day cancer performance target is a hightened pressure in 17/18 and not being achieved	Small number of metrics and some Directorates are below national targets	Executive Committee	Board of Directors
		4) Ensuring CQC compliance - fundamental standards	Director of Nursing/Medical Director	Assurance Programme - Quarterly reviews.	Reports and reviews by CGSG & Corp. GSG inc. regular reporting to GC indicate compliance. CQC report	Fundamental Standards published August 2014.	Audits from Assurance/Audit Programme routinely reported to Governance Committee report failings on Fundamental Standards.	Corporate Governance Steering Group & Clinical Governance Steering Group	Governance Committee
		5) HSE - ensuring compliance with all relevant health & safety requirements; learning from mistakes	Director of Corporate Affairs	H&S Group; Corporate Governance Steering Group	Formal Health & Safety Audit carried out by Internal Audit. Monthly H&S Group meeting - minutes and end of year H&S report. Health and Safety team remain with the Trust following the establishment of CHoICE Action taken following Grenfell disaster and no identified areas	Monthly update provided to Corp GSG	No proactive or reactive interventions by HSE in 2016/17. Internal Audit compliance report and action ongoing	Corporate Governance Steering Group	
		6) Lack of achievement of the relevant clinical standards to maintain accreditation from the required clinical bodies. E.g. Endoscopy (Joint Advisory Group on GI Endoscopy -JAG)	Medical Director	Monitoring through local speciality clinical governance arrangements & CGSG	Peer reviews; external assessment & validation processes according to set timetable. National clinical audits (implementation of NICE guidance and Royal College standards).	Process to be established for monitoring participation in accreditation schemes and appropriate escalation to CGSG. Lack of awareness on impact to contracts, and on operational performance.	Process for monitoring participation is not yet in place and responsibilities for monitoring of accreditation schemes are unclear. Lack of clarity of the relevant accreditation bodies and risk with non maintenance of accreditation.	Clinical Governance Steering Group	

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		7) Claims activity increasing will increase NHSLA premiums under new arrangements.	Director of Nursing	Progress reports to Corp GSG, Clin GSG & Governance Committee on compliance with Risk Management Standards and claims activity.	Minutes of department/directorate corporate meetings. Risk Management Strategy, Clinical Governance reviews, action plans, Annual reports.	System for monitoring compliance with policies not robust.	New NHSLA arrangements unclear	Corporate Governance Steering Group & Clinical Governance Steering Group	Governance Committee
		8) Risk that as part of the 'Group' working across the two Trusts, the Executive Team are spread too thinly missing opportunities to prevent non-achievement of core requirements	Chief Executive					All Committee Chairs	Board of Directors
8	Ensure the quality of the service provided by the GIM Directorate is of the highest quality	1) Failure of a number of key performance metrics impacting on patient care (e.g. RTT) 2) Capacity and demand risks service delivery	Director of Operations	1) Weekly escalation meetings with the Director of Operations and the Director of Performance with the GIM senior team & action plans in place 2) close performance tracking led by the Performance Team. 3)Specific meetings and assurance provide to CCG colleagues on the quality and safety of service 4)Directorate have fully rolled out "clinic on the day" as part of the scheduling programme 5)Capacity and demand exercise (stage 1) has been completed 6)Directorate are going through a process of manage de-escalation due to improvements in RTT and Cancer	Performance position showing improvement in Gastroenterology and is now above target	RTT performance - action planning for delivery	Commissioning and Recruitment	Finance & Performance Committee	Board of Directors
9	Ensure the performance of the service provided by Trauma & Orthopaedic Directorate contibutes to the performance delivery at Trust level	1) Failure of a number of key performance metrics impacting on patient care (e.g. RTT) 2) Capacity and demand risks affected service delivery 3) Discharge Communications	Director of Operations	1) Regular escalation meetings with the Director of Operations and the Director of Performance with the T&O senior team & action plans in place 2) close performance tracking led by the Performance Team,	Performance position showing improvement and delivery against action plan in some areas,	RTT performance - action planning for delivery of the RTT target has been reviewed & revised	Not all areas achieving relevant performance or quality target	Finance & Performance Committee	Board of Directors

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10	To Safeguard Children and Vulnerable Adults from deliberate harm/abuse whilst in the care of CHS and work in partnership with key agencies	1) Harm to patients, staff and to CHS reputation because of the increasingly incidence and complexity of Safeguarding generally and at individual case level. 2) Impact on CHS as a result of the Ofsted Inspections	Director of Nursing	· CHS and interagency Policies and Procedures in place. · Comprehensive Mandatory training in place. · Key posts in place – Named Nurse Safeguarding Children, Named Doctors for Safeguarding Children and Looked After Children (LAC), and Safeguarding Lead Adults – all professionally reporting to the ND as Executive Lead. · Safeguarding Children and Adults Groups in place in CHS · CHS participation in interagency arrangements across Sunderland * Processes in place with in CHS and on an interagency to investigate and learn from significant incidents	Policies in place Mandatory training compliance Minutes of meetings Reports to CGSG and Governance Committee Sunderland Council Improvement Plan	Safeguarding Team now working across Healthcare Group with additional resources to enable this but cross Trust work still in development	Audit Results Evidence of learning and changes in practice from significant incidents Evidence of sustained improvement in SCC Children's Services Completion of plan to deliver Lampard Recommendations	Safeguarding Adults Group; Safeguarding Children's Group and Clinical Governance Steering Group	Governance Committee

Shortest Lead Time

APPENDIX 1

No.	Objective/Aim	Principle Risks	Area of Org/ designated Lead	Key Controls/Systems to manage risk	Evidence of Effective Management/ Assurance that controls are working	Gaps in Controls - where are we failing to put systems / controls in place. Where are we failing to make them effective	Gaps in Assurance - where are we failing to gain evidence that our controls / systems are effective	Responsible Group/Committee(s) for the management of the Risk	Overall Responsibility to gain Assurance on behalf of BoD
11	To improve the quality and efficiency of key patient pathways	Not achieving transformation change. Not meeting demands of service users. Not delivering the financial benefits	Director of Planning & Business Development	1.Annual Plan sign off process including EC, BoG & BoD sign off; 2.Lean strategy continues to be taken forward 3.Perfect week and SMART week initiatives 4.Cancer improvement project 5.Streamlined governance arrangements from Sept 15 6.Introduced standard documentation and tracking of projects 7.Number of local service improvement programmes have taken place 8.Approved DTC 9. CSRG reviewing services to improve quality and efficiency of pathways	• New governance arrangements in place which have been independently checked as being robust •Improvements in a number of metric from embedding perfect week initiatives •SMART week in theatres led to lowest ever number of cancellations and highest ever utilisation •Review of Paeds,)&G and Stroke highlight the potential to improve quality and make pathways more efficient •Improvements in cancer pathways (one stop shops)	• Some programmes will require commitment from partner organisations • Project management capacity * Nursing/midwifery involvement not in place - improved efficiency around nurse consultants & specialist nurses •Service provision at off site location (CDDFT) is not controlled in totality by CHS	All benefits identified are yet to be achieved/delivered	Operations Committee/Executive Committee/Finance & Performance Committee	Board of Directors

Cost Leadership

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		1) Failure to secure income and failure to deliver services within income constraints: (a) Delivering under/over performance against contract at a loss (b) Over-performing against the Sunderland Block contract resulting in costs without income	Director of Finance	Monthly meetings between Dir of Ops & DGMs; monthly meetings between DoF & DGMs on high risk areas; Contracting discussions between Head of Contracting & DMs to manage to contract	Analysis fed back to BoD through monthly Finance report including detailed contractual performance such as performance at Point of Delivery and tracking against Annual Plan baseline and contracts (which may differ); minutes of Finance Committee;	SLR/PLICs system not in place to identify cost v income	Profitability can only be measured at high level (speciality) due to absence of PLICs information; decisions on growth/retraction may be wrong due to unavailable information.	Executive Committee	Finance & Performance Committee
		(d) Ensuring receipt of income to cover activity	Director of Finance	CCG contract meetings; internal contract meetings; escalation process DoF - regular meetings with CFO at Sunderland CCG and AO at DDES/N.Durham CCGs; Block contracts in place for Sunderland & ST CCGs to mitigate risk	Finance report feedback re: impacts of under/over performance inc. risk of non payment. Development of Launchpad reports for DM's to proactively manage activity. Contract report developed and included within the Board report.		Quarterly cashing up delays	Executive Committee	Finance & Performance Committee

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12	Financial sustainability in changing environment including the impact of tariff changes & the impact of the operating framework	2) Failure to deliver 2017/18 CIP programme & stretched financial targets in the Annual Plan - impacting on delivery of the financial control total	Director of Planning & Business Development (PMO Director) / Director of Finance	Annual Plan sign off process including EC, BoG & BoD sign off - full awareness of scale of challenge; monthly tracking of performance against CIP target through Finance Committee, EC and BoD;	CIP target = £13m; Control Total = £5.5m deficit. Evidence through monthly financial position at BoD and tracking of action plans through Finance & Performance Committee.		Currently there is a financial gap resulting in non achievement of the financial position, including slippage on CIP delivery (as at end Qtr 1).	Executive Committee	Finance & Performance Committee
		3) Failure to deliver all of the criteria associated with the 'Sustainability Fund' in 16/17, impacting on loss of the fund, cashflow impacts and Use of Resources risk rating	Director of Planning & Business Development (PMO Director) / Director of Operations / Director of Performance and Director of Finance	Annual Plan sign off process including EC, BoG & BoD sign off; enhanced STP performance tracking and management (Dir of Perf/Dir of Ops targeted meetings with areas of slippage); Directorate level 2 OGSMs include actions to ensure delivery of key 'must do's' Weekly monitoring in place against STF trajectories and report sent to DOps, DGMs, CDs, DMs Performance discussed at regular divisional/contracting meetings and intervention as required Weekly trajectory set for A&E in addition to monthly/quarterly Early warning reports in place for all STF indicators		The STF conditions associated with A&E have been achieved but are unfunded due to non achievement of the financial position		Executive Committee	Finance & Performance Committee
		4) Joint working with STFT as part of the 'Group' does not deliver the financial benefits envisaged	Director of Planning & Business Development/ Director of Finance	All clinical service reviews incorporate the need to consider financial impacts as part of their recommendations. Challenges through the Clinical Services Review Group around scale of ambition	Stroke, O&G and Paediatric reviews highlight potential financial benefits		Options for changes will be subject to public consultation and ultimate decision will be made by CCGs	Finance & Performance Committee	Board of Directors
		5) Proposed service changes impacts detrimentally on one organisation more than the other, impacting on the UoR	Director of Finance	Development of financial risk share agreements / contracts to share risks and benefits	Risk share in place across CHS, STFT, STCCG & S'land CCG - signed off at respective Executive Committees		Risk share to be enacted; system wide funding likely to be less than required by the 2 FTs; CCG pressure due to lack of NHSE agreement around use of 0.5% national risk reserve	Finance & Performance Committee	Board of Directors
		6) Failure to maintain cashflow during the year - linked to a control total deficit plan and in year and forecast position (with STF impacts)	Director of Finance	Monthly Tracking processes reported bo F&PC, Exec Comm and BoD	Close work with CCG colleagues on CQUIN, settlement of liabilities and early payment processes; active management eg deferral of BACs payment runs		Deterioration of financial position resulting in loss (to date) of STF - cash impact	Finance & Performance Committee	Board of Directors

APPENDIX 1

Assurance Framework 2016/17

Highest Safety

No.	Objective/Aim	Principle Risks	Area of Org/ designated Lead	Key Controls/Systems to manage risk	Evidence of Effective Management/ Assurance that controls are working	Gaps in Controls - where are we failing to put systems / controls in place. Where are we failing to make them effective	Gaps in Assurance - where are we failing to gain evidence that our controls / systems are effective	Responsible Group/Committee(s) for the management of the Risk	Overall Responsibility to gain Assurance on behalf of BoD
		1) operational pressures due to activity pressures of Demand > Capacity e.g. staffing, facilities, patient safety & LOS	Director of Operations	Operational Management Group; Corporate Management team; Executive Committee; escalation processes; standard Ops; workforce plans, activity forecasts; estates plan	• Significant improvement in A&E performance • De-escalation of directorates due to performance improvements • Early warning reports have correctly identified areas of risk • Improvements in choose and book slot issues – reduction • Annual planning process identifies significant areas of concern/risk in terms capacity, quality, timeliness and safety • Corporate dashboard reviewed monthly at Operations Committee and BOD. Minutes from quarterly review meetings. • Escalation process and performance framework approved by Operations Committee • Reduced volatility in cancer 2ww performance around peak holiday times	• More effective forward planning still required • Implementation of e-rostering starts w/c 27/6/16, which will start to introduce more consistent / transparent and robust ways of working. • City wide escalation/surge capacity • Community based services aimed at reducing demand •Progress towards all services to be on V6 e.g. audiology and ECHO	• Performance against some Monitor SOF indicators is not consistent e.g. cancer 62 days • Nursing recruitment – lack of availability. Further overseas nurse recruitment planned * Implementation of e-rostering will help the Trust to deploy its nursing workforce more effectively and better control supply and demand for bank workers.	Operations Committee	Governance Committee
		2) ED pressures relating to increase in attendances. Risk relating to ability of Department to manage the volume increase (and risk to A&E target achievement), and impact on patient flow into 'back of house' facilities such as beds	Director of Operations	Operational Management Group; Corporate Management Team; Executive Committee; Safe and Sustainable Emergency Care programme, ED rebuild programme; escalation processes	• Performance remains challenging however we remain in the upper middle 25% of trusts nationally • SSEC dashboard developed to track progress of programme and associated projects. • A&E weekly dashboard • Daily reporting and forecasting	• Continue to develop ambulatory care pathways e.g. T&O. Medical model for ambulatory care still in development • Ability to control demand – e.g. NEAS, Primary and Community services • Ability to recruit appropriate staff. • Ability to divert ambulances	• Target not being met consistently	Operations Committee	Governance Committee
		3) Ability to recruit senior medical staff to key specialties resulting in a risk to the quality of clinical services provided, ability to retain existing staff and financial pressures. Key specialties include gastro, thoracic and emergency care	Director of Operations		• Successful consultant recruitment in previously identified pressure areas such as Radiology	• National planning and no. of doctors in training • Competitor initiatives to improve recruitment	• Gaps remain in certain specialties	Operations Committee	Governance Committee

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1	To ensure the Trust manages activity demand as required including staffing & facilities requirements	4) Inability to recruit sufficient Registered Nurses to fill required staffing levels.	Director of Nursing	1) Operational nurse staffing reviews are held monthly. the Strategic Nurse Staffing Review is carried out annually with a monthly refresh. 2) Monthly monitoring 3) Matrons staffing escalation processes. 4) Revised recruitment processes to streamline recruitment. 5) Plan for international recruitment 2016/17. 6) Partnership with University of Sunderland to deliver Pre-registration training. 7)Adverts on RCN job bulletin 8) Work started to develop programme for nurses living in UK to achieve NMC registration	•Since April 2016- 110 registered nurses appointed. •Identified matron as lead for shortlisting to ensure continuity and standardisation.	•E-rostering will be in place in 2016/17. Nine wards are live to date and roll out will take 18 months to complete. •National shortage of Registered Nurses	• Staff movement to fill gaps. Monthly usage reports and quarterly review meetings are in place to make sure that demand and supply are being properly controlled . •New rostering policy in development. New Roster Policy to JCG 9/03/17. •Vacancies increased to 90 WTE	Executive Committee	Governance Committee
		5) The ability to recruit and manage junior doctors is variable across the Trust. This has an impact on GMC junior doctors survey results (and therefore the ability to recruit), and risks around financial consequences of non compliant rota's. Specific specialties include general surgery, urology and ED	Medical Director	1) Introduction of the Allocate system for rota/leave and job planning management 2) Regular review of rotas by DME 3) Greater involvement of trainees in groups such as mortality & deteriorating patient group 4 Establishment of junior doctors forum 5) Appointment of Guardian of Safe Working 6) Establishment of Exception reporting system 7) Explore feasibility of "Doctor's Assistant Programme"	1) Compliant rota's for all specialties 2) Positive feedback from HENE/GMC for all specialties 3) Improving recruitment in at risk specialties 4) Development of nurse practitioner roles to compensate for junior doctors shortfalls. 5)Review of Consultant job plans and coordination with capacity demand modelling 6) Guardian of Safe Working quarterly Board report	•Allocate software being acquired for deployment August 2017. •Managing Hospital at Night	•Non-compliant rotas in some specialties resulting in significant financial consequences •Feedback from junior doctors questionnaire highlights action required in some specialties	Executive Committee	Governance Committee
		6) The ability to replace equipment in a timely manner impacting on operational, business continuity or patients - risk due to financial constraints	Director of Finance	A 'Medical Equipment Replacement Programme' has been included in the capital programme for the 2016/17 financial year. A time limited sub-group of Capital Development Steering Group will be established to review key equipment needs and options to mitigate risk	All requests for urgent equipment have been approved (from capital contingency funds or leasing) during 15/16 and 16/17?	The financial fund available is unlikely to be sufficient to be able to replace all necessary equipment requirements		Capital Development Steering Group / Executive Committee	Governance Committee

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2	To 'know' that clinical staff are clinically competent and engage with patients appropriately	1) Not knowing how clinically competent clinical staff are 2) Not knowing how patient focussed clinical staff are	Medical Director & Director of Nursing	1) Peer review process; 2) Medical staff - appraisal & revalidation process 3) Nursing staff - appraisal process/revalidation - patient/colleague feedback required for revalidation 4) Patient feedback - complaints/incident reporting; feedback from PALS, Friends & Family Test. 5) Junior Doctor incident reporting process 6) All RN's have competencies to achieve with preceptorship. 7) All HCA's who start with the Trust must complete Care certificate programme and achieve specific competencies within a 12 week period .	* Incident/reporting information fed to Clin GSG reducing in relation to clinical competence. * Assurance Programme reports improving and include staff interviews about key clinical risks. * Portfolio's must be submitted, all HCA's and RN's have mid point review and given reminders about submission dates. •Incidents/complaints/capacity/ capability issues will result in an investigation process, with the relevant professional body informed as appropriate. •Evidence fed into the quarterly HR report to Board •Training now recorded on ESR Nurse revalidation process embedded	Action plans not specific enough to address deficiencies and lack of ownership of action Lack of aggregate data available about staff competency. Assurance Programme. Checks that portfolios have been submitted to required timescales Checks that competencies are being reviewed at appraisal League table now in place recording how many HCAs in each area completed Care Certificate	•Lack of knowledge of how clinically competent clinicians are; evidence from Radiology RCA/external validation process. •Continued incidents/complaints - review of lessons learnt. •Assurance programme capacity to test competence; •Assurance programme has shown variable levels of staff knowledge around patient assessments •Systems to support revalidation need strengthening •Are competencies completed fully and to timescales	Corporate Governance Steering Group & Clinical Governance Steering Group	Governance Committee

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3	Deliver the Quality priorities as set out in the Quality Report	1) Non-recognition/action on deteriorating patient (including robust handovers & acting on low Early Warning Scores (NEWS)	Medical Director & Director of Nursing	1) CCOT Team procedures 2)Audit and monitoring of NEWS. 3) Education & Training in place and incident reports. 4) Risk Management processes monitored at directorate/department level. 5) Annual Hospital Wide Level of Care and Point Prevalence Survey shows improvements 6) Escalation measures implemented for wards that repeatedly under perform in monthly NEWS audit and NEWS audit. 7)Trust Mortality Review Panel: incorporates review of patient observations/NEWS prior to death. Chair has produced a Clinical Deterioration Summary for CGSG 8) Audit programme for recording of observations/NEWS- reported monthly via Ward Dashboards	1) Reducing no. incidents relating to NEWS 2) Evidence of action taken. 3) Checks on actions & lessons learnt following RCAs 4)Assurance Programme Reports on SI action plans and staff interviews include questions about NEWS process. 5) Electronic obs system introduced in 2015/16 6) Draft revised pain chart devised. To be piloted and rolled out following discussion at CGSG 7) Feedback from end of post surveys and the National Training Surveys to incorporate intelligence from junior doctors into the work of the DPG	1) Inquest reports. 2) Escalation processes failure due to lack of knowledge/capacity issues. 3) Some improvements needed in staff understanding and documentation 4) Audits and incidents demonstrate sub standard performance in some areas	•Limited checks that lessons learnt have been implemented have begun • No checks of content and identified responsibilities of handovers •Follow up of lessons learnt after RCAs involving NEWS and clinical escalation	Clinical Governance Steering Group	Governance Committee
		2) Number of Incidents relating to numbers of Falls - with serious harm	Director of Nursing	1) Falls group reports 2) Falls assessment and trigger tool 3)Policies and procedures in place 4)Quality Improvement Score Card 5) Dementia environmental standards 6) Wards targeted for Fall Safe programme 7) Falls Policy to be updated and ratified	1) Reducing incidents relating to falls - information provided to the Hospital Falls Group 2) Introduction of patient slippers to assist in the prevention of falls 3) standard operating process to reduce falls in the hospital car park (gritting) 4) Assurance Programme Reports including review of falls risk assessments. 5) Falls Specialist Nurse for REM conducting audits 6) Care Fall training and Fall Safe e-learning package available on ESR	•Fall Safe Programme rolled out Trust wide. Focus on lying/standing BP. Medication high risk. •Availability and take up of online training •Falls risk assessments and care planning not documented correctly on v6.	•Checks of staff knowledge and compliance with Falls Policy have taken place during Assurance Visits •Possible correlation between falls rates and staffing levels •Some checks that lessons learnt have been implemented have begun		

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		3) Number of hospital acquired pressure ulcers.	Nursing Director	1) Tissue Viability Specialist service 2) Equipment/beds 3) Incident reports & RCAs 4) Intentional rounding into this section as a key control	1) Reduction in pressure ulcers acquired in hospital. 2) Reduction in numbers which deteriorate on admission 3) Improvement in NHS Safety Thermometer data and ward dashboard data 4) Pressure ulcer improvement plan 5) Increased incident reporting and decreased severity of pressure ulcers 6) SSKIN bundle implemented and audited	Poor compliance with policy including appropriate assessment + care/treatment - patient risk assessment not always completed on admission. * Pressure Ulcer Policy requires updating development	•Checks that action has been taken and lessons learnt as a result of pressure ulcer incidents; •Checks on SSKIN bundle and Patient Care Charts show patchy implementation •Assurance Programme checks show further improvements required		
4	Mortality - Identify and remediate factors leading to preventable death	Failure to recognise remediable factors which could prevent deaths	Medical Director	1) Weekly mortality review panel. 2) Review of national mortality measures 3) Utilisation of CHKS mortality profiler module and engagement with clinical teams 4)Local departmental review feedback has significantly improved 5) Fully participates in the regional Mortality Group and its activities 6) Review of coding and death certification practice carried out 7)Participates in regional serious infection project around pneumonia (highest cause of excess deaths) 8) Engage with national programme of Mortality reviews 9) Engagement with LeDeR programme	1) Monthly report to Clinical Governance Steering Group & Quarterly review to Governance Committee and Board of Directors 2) Mortality measures as or better than expected / no outlier positions or alert notices. 3) improvement in all national mortality indicators 4) SHMI- now under 1.0 and remains in Band 2 (as expected) 5) HSMR recently increased and associated with reduction in palliative care coding 6) RAMI better than peers 7) Improvements in the recording of co-morbidities which affects mortality risk profile	•Awaiting definition of new national reporting standards for avoidable deaths •Local mechanism for ensuring that remedial factors have been addressed by specialty teams. • Further work required to ensure accurate and consistent application of palliative care coding	•Require evidence of effectiveness of process, in light of awaited new standard for mortality review. •Checks that action has been taken and lessons learnt as a result of mortality review process. • Board workshop and appointed Executive Director and NED Leads for mortality	Clinical Governance Steering Group	Governance Committee
		1) Reputation with GPs other key stakeholders & potential loss of business from GPs	Director of Planning & Business Development	GP newsletter; GP forums; GP surveys; attending LMC meetings in Sunderland; strengthening relationships with the developing Federation	• Discharge communications performance scrutinised monthly - no adverse feedback from either LMC or CCGs. •Current issues flagged from a small number of GPs around DNAs • An access policy has been revised in line with national RTT guidance	No control over demand, which leads to operational pressures	Specific service pressures damage reputation – Breast, Gastroenterology, Thoracic Medicine	Operations Committee/ Executive Committee	Governance Committee

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5	Ensure the Trust is able to maintain and expand services in a competitive environment	2) Ability to deliver the objective of the '3rd centre' ambitions within key specialties e.g. vascular, PPCI	Director of Planning & Business Development	Robust plans in place covering workforce, infrastructure, critical mass requirements, activity for each area; awareness of national service requirements; commissioner support	Independent reviews recommends CHS as third centre. Infrastructure in place, e.g. endovascular theatre, 2nd cath lab. Workforce in place. All national requirements (specification) delivered. Local commissioner support in place. Quarterly review process in place. Local support from neighbouring FTs. CHS strategy aligned to national strategy - 'Major Emergency Centre'	NHS England (not CCG) commissioner led process. Potential lack of support from clinical networks. National drive to reduce the number of specialist centres	PPCI not a formally commissioned service	Executive Committee	Board of Directors
6	Ensure the patient information system is fit for purpose and does not create any patient safety risks, is used effectively by all staff with accurate data quality, and that the data it stores is secure.	1) Functionality is not fit for purpose. 2) Systems are not implemented correctly, and are not safety assessed. 3) Staff are not competent in the system and do not use it to its greatest advantage/effectively. 4) Staff are competent in the system, but data quality is still poor. 5) Staff do not engage in change management, and are resistant to new ways of working through MEDITECH (Resulting in benefits not being realised). 6) Digital Roadmaps combined with the CHS + ST Alliance - Focus on IT is now beyond confines of CHS. Strategy + systems - Which strategy/systems are required, along with cost/funding and implementation process/timescales is a concern and risks slowing down CHS 7) Risk of cyber crime impacting on the clinical, operational and business functions of the Trust	Director of IT&IG	1) Robust communication process with Meditech to log and escalate issues to address functionality gaps. 2) Implementations & sign off of changes will be through appropriate governance (including CGSG & IM&TSG). 3) End user training via core groups - with signed off competence sheets & review 4) Data Quality processes for identification and resolution of issues - KPIs - Continuous improvement. 5) Ongoing modification and development of the system, including implementation of new modules. 6) Effective governance via Sunderland Informatics Board and CHS IM&T Strategy Group. 7) Robust cyber security monitoring and control processes in place; enhancement to Policy to ensure completely up to date	1) Issues logged with MEDITECH have significantly reduced, and those which are closely monitored through the MEDITECH 'task system', with regular conference calls, including weekly escalation calls. 2) Post Implementation Reviews. 3) Training attendance sheets and competency assessments/'Happy Sheets' are reviewed by core trainers. Access is granted based on satisfactory results. 4) Data Quality report is also a standard agenda item at monthly Information Governance Group. This also includes a regular review of incidents. 5) Regular updates to IM&TSG and EC. 6) Reports/outputs from Sunderland Informatics Board and CHS IM&TSG. 7) No major incidents as a result of cyber security issues	1) Ongoing need for further modifications to the software when identified. 2) Operational and resource pressures are resulting in difficulty in releasing staff to act as core trainers. 3) Operational and resource pressures are resulting in difficulty in releasing staff to be trained/retrained to ensure they are using the system effectively and consistently. 4) As above, but linking with staff to ensure that data quality improves. 5) MEDITECH modular sponsorship/leadership and governance (+ resources) to continue to take forward the Trust's MEDITECH strategy (+ benefits) further - And implementation of new ways of working. 6) Some gaps in core v6 teams due to operational/financial pressures. 7) V6 governance structure continues should there be further issues detected. 8) Data quality KPIs are being developed.	1) Appropriate data specification, collection and information provision - Data management processes have been reviewed, and action plans agreed by IM&TSG - Implementation during 2016/17. 2) It is clear that some of the originally anticipated benefits have not yet been fully realised due to the manner in which it has been adopted. A range of further projects are either underway or are shortly to ne initiated to realise further benefits.	Executive Committee	Governance Committee

Best Quality

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7	Improve the reputation of the Trust - by using feedback from patients and staff	1. Poor communication with Patients & Relatives, discharge communications, attitude and approach around face to face communications impacting on patient understanding and incidents/claims, and the requirement of the Duty of Candour	Medical Director, Director of Nursing	1) Local patient real time patient surveys; and action plans from directorates. 2) PROMs 3) Communications Strategy & Marketing. 4) Patient Experience Improvement Plan. 5) Documented Trust wide approach & training around Duty of Candour including an 'easy use' guide 6) Communications Strategy implemented 7) Real time Feedback provided to PCPEC and in monthly Board reports. 8) Electronic Discharge Policy 9) Clinic on the Day	•Positive patient survey results e.g. patients survey; complaints; press; NHS Choices website. •Discharge summary reports and reports on OPD- GP letters delay	•Communications Strategy not implemented. • Duty of Candour guidance/Trust Policy in draft following consultation. •Lack of compliance with Trust Policy on providing information on discharge. •Poor or modest performance within patient surveys and other feedback collections not acted upon. •Problems identified with electronic sending of discharge communications Post Internal Audit review there has been a development of clear ward procedures to reduce variability, promote an organised and disciplined approach to ensure discharge arrangement are done and communicated to patients in a timely manner.	•Incomplete discharge communications; •Real Time Feedback variable in scores. •Continuing numbers of complaints and incidents flagging communication as an issue. •Checks that action has been taken and lessons learnt from participation in all formats of patient feedback.	Patient, Carer and Public Experience Committee	Governance Committee
		2. Slow turnaround times for incidents, complaints and Root Cause Analysis, resulting in delay and frustration for patients, potential risk around escalation of any problems to legal action and not learning from the incident resulting in further incidents of the same nature (and delays in external reporting)	Director of Nursing	1) Tracking of turnaround times; 2) Appointment of risk facilitators to improve the position 3) Assurance Programme - evidence of lessons learnt & changed processes 4) Improvements to Ulysses system in progress to include direct notification of incidents to Directorate teams 5) Changes to RCA processes and clearance of backlog. 6) Review of HAAS staffing	1) Feedback to relevant groups and Committees around improved timelines and 95% compliance with required timescales 2) Assurance Programme feedback to Governance Committee	Impact of quality risk facilitators to be evaluated	Delayed investigations. Assessment of the effectiveness of upgraded system and revised process.	Clinical Governance Steering Group/Patient Carer and Public experience committee	
		1) NHSI - compliance with Licence conditions & financial risks	Director of Finance /Director of Corporate Affairs and Legal Services	1. BoD Finance Report; Finance Committee - revised governance process in place to ensure feed from Programmes to Programme Management Group & to Finance Committee to manage delivery of CIPs 2. Capability & Capacity Review (under "Well Led" framework) - self assessment process on-going; commissioning of work will be in 2016/17	1. Financial Reporting - FC, EC & BoD reports - improvement to overall financial position; alignment with Monitor Risk Assessment Framework; PMG report fed to Finance Committee; Delivery against £13m CIP target in 2015/16; Independent review by Deloitte of governance process & robustness of plans 2. Governance Committee review of Capability & Capacity requirements/process (Jan 16)		External "Well Led review" will not commence until Autumn 2017/18 following 6 month implementation of the new Board Sub-Committee structure	Executive Committee	Board of Directors

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8	Ensuring compliance with all regulatory body requirements including Monitor, CQC, HSE & NHSLA	2) Risk of non- compliance with NHSI Quality Governance Framework. Monitor compliance - quality governance risks	Medical Director & Director of Nursing	Self assessment via CGSG and Governance Committee. Annual independent assessment via Assurance Programme/external assessment.	Achievement of all NHSI requirements linked to Quality Governance Framework/new framework.	Strengthening of the internal arrangements for monitoring key elements of the Framework; routine reporting of progress & actions via action plan report.	Board not aware of Trust status in relation to compliance with NHSI Quality Governance Framework. Ongoing assessment of compliance.	Governance Committee	Board of Directors
		3) Monitor compliance - performance governance risks A&E (Annual Plan). For c.difficile see section 4.	Director of Planning & Business Development; MD for C-Diff	•EC Performance Report Subgroups inc. RCA for every C-Diff case •RRG to review all RCAs RCAs for all red incidents •Performance monitored as part of quarterly reviews •Early warning reports developed •Gastroenterology and T.Med escalated as per performance improvement framework •Monitored monthly at BOD, EB, CMT, OC and OMG using Corporate dashboard •Reviewed as part of annual plan submission to Monitor •Performance risks highlighted in discussions with operational areas as well as at formal committees •Performance Improvement Framework agreed at Operations Committee STF trajectories agreed with Directorates •Action plan developed around sustainable delivery of cancer 62 day standard	• Improvements across a number of areas • Early warning reports have correctly identified areas of concern • Recovery plans are in place for all areas of under performance	• More effective forward capacity and demand planning re still required • Early action is taken by specialties to rectify performance issues • Administrative processes and systems require improvement in some areas to improve accuracy of early warning reports to effectively highlight risks • No control over demand, which can lead to operational pressures and non-delivery of target	Small number of metrics and some Directorates are below national targets	Executive Committee	Board of Directors
		4) Ensuring CQC compliance - fundamental standards	Director of Nursing/Medical Director	Assurance Programme - Quarterly reviews.	Reports and reviews by CGSG & Corp. GSG inc. regular reporting to GC indicate compliance. CQC report	Fundamental Standards published August 2014.	Audits from Assurance/Audit Programme routinely reported to Governance Committee report failings on Fundamental Standards.	Corporate Governance Steering Group & Clinical Governance Steering Group	Governance Committee
		5) HSE - ensuring compliance with all relevant health & safety requirements; learning from mistakes	Head of Estates	H&S Group; Corporate Governance Steering Group	Formal Health & Safety Audit carried out by Internal Audit. Monthly H&S Group meeting - minutes and end of year H&S report. Health and Safety team remain with the Trust following the establishment of CHoICE	Monthly update provided to Corp GSG	No proactive or reactive interventions by HSE in 2016/17. Internal Audit compliance report and action ongoing	Corporate Governance Steering Group	

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		6) Lack of achievement of the relevant clinical standards to maintain accreditation from the required clinical bodies. E.g. Endoscopy (Joint Advisory Group on GI Endoscopy -JAG)	Medical Director	Monitoring through local speciality clinical governance arrangements & CGSG	Peer reviews; external assessment & validation processes according to set timetable. National clinical audits (implementation of NICE guidance and Royal College standards).	Process to be established for monitoring participation in accreditation schemes and appropriate escalation to CGSG. Lack of awareness on impact to contracts, and on operational performance.	Process for monitoring participation is not yet in place and responsibilities for monitoring of accreditation schemes are unclear. Lack of clarity of the relevant accreditation bodies and risk with non maintenance of accreditation.	Clinical Governance Steering Group	
		7) Claims activity increasing will increase NHSLA premiums under new arrangements.	Director of Nursing	Progress reports to Corp GSG, Clin GSG & Governance Committee on compliance with Risk Management Standards and claims activity.	Minutes of department/directorate corporate meetings. Risk Management Strategy, Clinical Governance reviews, action plans, Annual reports.	System for monitoring compliance with policies not robust.	New NHSLA arrangements unclear	Corporate Governance Steering Group & Clinical Governance Steering Group	Governance Committee
9	Ensure the quality of the service provided by Obstetrics & Gynaecology is of the highest quality	1) Loss of CNST Level 3 - indicative of lower quality standards, financial risk & Monitor compliance risk 2) ABP - service review across SOTW management 3) Failures to comply with policies. 4) Serious Case Reviews in Sunderland with risks identified for "vulnerable" babies.	Medical Director, Director of Nursing, CEO (re ABP)	Directorate attendance & reports to Clin GSG; Governance Committee & BoD reports on Clinical quality inc. mortality, CNST etc. Risk Management Strategy. Claims analysis.	1) Risks flagged to Governance Committee & BoD via quarterly update report - escalation process agreed 2) Reduced incidents 3) Reduced number and quantity of claims. 4) Reduced number of safeguarding concerns. 5) Review of governance completed in 15/16 with a follow up report on action plan to CGSG 01/16. 6) Information shared with CCG. 7) Self assessment re Kirkup recommendations.	Clinical dashboard information system not yet implemented	Lack of engagement with corporate reporting. Actions implemented following RCA investigations.	Clinical Governance Steering Group (O&G service overall) + Clin & Corp GSG for CNST	Governance Committee

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10	Ensure the quality of the service provided by the GIM Directorate is of the highest quality	1) Failure of a number of key performance metrics impacting on patient care (e.g. RTT) 2) Capacity and demand risks service delivery	Director of Operations	1) Weekly escalation meetings with the Director of Operations and the Director of Performance with the GIM senior team & action plans in place 2) close performance tracking led by the Performance Team. 3)Specific meetings and assurance provide to CCG colleagues on the quality and safety of service 4)Directorate have fully rolled out "clinic on the day" as part of the scheduling programme 5)Capacity and demand exercise (stage 1) has been completed 6)Directorate are going through a process of manage de-escalation due to improvements in RTT and Cancer	Performance position showing improvement in Gastroenterology and is now above target	RTT performance - action planning for delivery	Commissioning and Recruitment	Operations Committee	Governance Committee
11	Ensure the quality of the service provided by Trauma & Orthopaedic Directorate is of the highest quality	1) Failure of a number of key performance metrics impacting on patient care (e.g. RTT) 2) Capacity and demand risks affected service delivery 3) Discharge Communications	Director of Operations	1) Weekly escalation meetings with the Director of Operations and the Director of Performance with the T&O senior team & action plans in place 2) close performance tracking led by the Performance Team,	Performance position showing improvement and delivery against action plan in some areas,	RTT performance - action planning for delivery of the RTT target has been reviewed & revised	Not all areas achieving relevant performance or quality target	Operations Committee	Governance Committee
12	To Safeguard Children and Vulnerable Adults from deliberate harm/abuse whilst in the care of CHS and work in partnership with key agencies	1) Harm to patients, staff and to CHS reputation because of the increasingly incidence and complexity of Safeguarding generally and at individual case level. 2) Impact on CHS as a result of the Ofsted Inspections	Director of Nursing	· CHS and interagency Policies and Procedures in place. · Comprehensive Mandatory training in place. · Key posts in place – Named Nurse Safeguarding Children, Named Doctors for Safeguarding Children and Looked After Children (LAC), and Safeguarding Lead Adults – all professionally reporting to the ND as Executive Lead. · Safeguarding Children and Adults Groups in place in CHS	Policies in place Mandatory training compliance Minutes of meetings Reports to CGSG and Governance Committee	Audit Cycle to test effectiveness of controls not in place Safeguarding Lead Adults is temporary with only 1 year funding No CHS participation in interagency arrangements across Durham Consequences of Ofsted Inspection in Sunderland unclear	Audit Results Evidence of learning and changes in practice from significant incidents Evidence of sustained improvement in SCC Children's Services Completion of Savile action plan	Safeguarding Adults Group; Safeguarding Children's Group and Clinical Governance Steering Group	Governance Committee

APPENDIX 2

No.	Objective/Aim	Principle Risks	Area of Org/ designated Lead	Key Controls/Systems to manage risk	Evidence of Effective Management/ Assurance that controls are working	Gaps in Controls - where are we failing to put systems / controls in place. Where are we failing to make them effective	Gaps in Assurance - where are we failing to gain evidence that our controls / systems are effective	Responsible Group/Committee(s) for the management of the Risk	Overall Responsibility to gain Assurance on behalf of BoD
				· CHS participation in interagency arrangements across Sunderland * Processes in place with in CHS and on an interagency to investigate and learn from significant incidents	Sunderland Improvement Plan	Continued issues in SCC Children's Services			

Shortest Lead Time

No.	Objective/Aim	Principle Risks	Area of Org/ designated Lead	Key Controls/Systems to manage risk	Evidence of Effective Management/ Assurance that controls are working	Gaps in Controls	Gaps in Assurance	Responsible Group/Committee(s)	Overall Responsibility
13	To improve the quality and efficiency of key patient pathways	Not achieving transformation change. Not meeting demands of service users. Not delivering the financial benefits	Director of Planning & Business Development	1.Annual Plan sign off process including EC, BoG & BoD sign off; 2.Lean strategy continues to be taken forward 3.Perfect week and SMART week initiatives 4.Cancer improvement project 5.Streamlined governance arrangements from Sept 15 6.Introduced standard documentation and tracking of projects 7.Number of local service improvement programmes have taken place 8.Approved DTC 9. CSRG reviewing services to improve quality and efficiency of pathways	• New governance arrangements in place which have been independently checked as being robust •Improvements in a number of metric from embedding perfect week initiatives •SMART week in theatres led to lowest ever number of cancellations and highest ever utilisation •Review of Paeds,)&G and Stroke highlight the potential to improve quality and make pathways more efficient •Improvements in cancer pathways (one stop shops)	• Some programmes will require commitment from partner organisations • Project management capacity * Nursing/midwifery involvement not in place - improved efficiency around nurse consultants & specialist nurses •Service provision at off site location (CDDFT) is not controlled in totality by CHS	All benefits identified are yet to be achieved/delivered	Operations Committee/Executive Committee/Finance Committee	Board of Directors

Cost Leadership

No.	Objective/Aim	Principle Risks	Area of Org/ designated Lead	Key Controls/Systems to manage risk	Evidence of Effective Management/ Assurance that controls are working	Gaps in Controls	Gaps in Assurance	Responsible Group/Committee(s)	Overall Responsibility
		1) Failure to secure income and failure to deliver services within income constraints: (a) Delivering under/over performance against contract at a loss (b) Over-performing against the Sunderland Block contract resulting in costs without income	Director of Finance	Monthly meetings between Dir of Ops & DGMs; monthly meetings between DoF & DGMs on high risk areas; Contracting discussions between Head of Contracting & DMs to manage to contract	Analysis fed back to BoD through monthly Finance report - new report included for 2015/16 including performance at Point of Delivery and tracking against Annual Plan baseline and contracts (which may differ); minutes of Finance Committee;	SLR system not in place to identify cost v income	Profitability can only be measured at high level (speciality); decisions on growth/retraction may be wrong due to unavailable information.	Executive Committee	Finance Committee

No.	Objective/Aim	Principle Risks	Area of Org/ designated Lead	Key Controls/Systems to manage risk	Evidence of Effective Management/ Assurance that controls are working	Gaps in Controls - where are we failing to put systems / controls in place. Where are we failing to make them effective	Gaps in Assurance - where are we failing to gain evidence that our controls / systems are effective	Responsible Group/Committee(s) for the management of the Risk	Overall Responsibility to gain Assurance on behalf of BoD
14	Financial sustainability in changing environment including the impact of tariff changes & the impact of the operating framework	(d) Ensuring receipt of income to cover activity	Director of Finance	CCG contract meetings; internal contract meetings; escalation process DoF - regular meetings with CFO at Sunderland CCG and AO at DDES/N.Durham CCGs	Finance report feedback re: impacts of under/over performance inc. risk of non payment. Development of Launchpad reports for DM's to proactively manage activity. Contract report developed and included within the Board report. End of year income better than in year forecasts. Positive year end agreements have been reached with all Commissioners		Quarterly cashing up delays	Executive Committee	Finance Committee
		2) Failure to deliver 2016/17 CIP programme & stretched financial targets in the Annual Plan - impacting on delivery of the financial control total	Director of Planning & Business Development (PMO Director) / Director of Finance	Annual Plan sign off process including EC, BoG & BoD sign off - full awareness of scale of challenge; monthly tracking of performance against CIP target through Finance Committee, EC and BoD;	CIP target = £15m; Control Total = £2.1m deficit. Evidence through monthly financial position at BoD and Finance Committee. The forecast year end position is £13.9m CIP, therefore over 90% delivery against target, representing a positive position.		Currently there is a gap between the CIP plans and the target required, plus no plans to deliver the stretched target of £2.4m	Executive Committee	Finance Committee
		3) Failure to deliver all of the criteria associated with the 'Sustainability Fund' in 16/17, impacting on loss of the fund, cashflow impacts and FSRR	Director of Planning & Business Development (PMO Director) / Director of Operations / Director of Performance and Director of Finance	Annual Plan sign off process including EC, BoG & BoD sign off; enhanced STP performance tracking and management (Dir of Perf/Dir of Ops targeted meetings with areas of slippage); Directorate level 2 OGSMs include actions to ensure delivery of key 'must do's' Weekly monitoring in place against STF trajectories and report sent to DOps, DGMs, CDs, DMs Performance discussed at regular divisional/contracting meetings and intervention as required Weekly trajectory set for A&E in addition to monthly/quarterly Early warning reports in place for all STF indicators apart from diagnostics (currently being developed)	The STF conditions have been achieved in 2016/17 including the appeal around A&E performance. In addition, the year end position shows over delivery of the control total and therefore the Trust will receive STF 'incentive' funds	System wide action plan needs to assist with delivery of A&E 4 hour standard	A&E performance currently behind trajectory	Executive Committee & Operations Committee	Finance Committee

APPENDIX 2

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		4) Joint working with STFT as part of the 'Group' does not deliver the financial benefits envisaged	Director of Planning & Business Development/ Director of Finance	All clinical service reviews incorporate the need to consider financial impacts as part of their recommendations. Challenges through the Clinical Services Review Group around scale of ambition	Stroke,)&G and Paediatric reviews highlight potential financial benefits		Options for changes will be subject to public consultation and ultimate decision will be made by CCGs	Finance Committee / Operations Committee	Board of Directors
		5) Proposed service changes impacts detrimentally on one organisation more than the other, impacting on the FSRR	Director of Finance	Development of financial risk share agreements / contracts to share risks and benefits				Finance Committee	Board of Directors

APPENDIX 2

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST (CHSFT)
SOUTH TYNESIDE NHS FOUNDATION TRUST (STFT)

BOARD OF DIRECTORS

SAFEGUARDING CHILDREN AND LOOKED AFTER CHILDREN ANNUAL REPORT

SEPTEMBER 2017

INTRODUCTION

The purpose of this report is to provide assurance that both South Tyneside and City Hospitals NHS Foundation Trusts are fulfilling their statutory responsibilities to safeguard children and young people. South Tyneside Foundation Trust and City Hospitals Sunderland Foundation Trust are required under Section 11 of the Children Act 2004 to ensure that children are safeguarded and that their welfare is promoted. Health providers have a key role in safeguarding children and young people, as set out in the statutory guidance "Working Together to Safeguard Children" (2015).

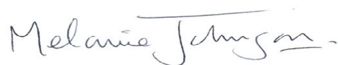
This annual report is to also ensure that each Trust is informed of the progress and developments both locally and nationally on issues related to the safeguarding children and looked after children agenda.

THE OBJECTIVES OF THE REPORT ARE:

- To highlight the work and progress in safeguarding children and young people in South Tyneside Foundation Trust and City Hospitals Sunderland Foundation Trust during 2016-2017.
- To provide assurance that looked after children and young person's needs are met. (Statutory Guidance on Promoting the Health and Well-Being of Looked After Children 2015).
- To provide assurance that South Tyneside Foundation Trust and City Hospitals Sunderland Foundation Trust continue to fulfil their statutory responsibilities in relation to safeguarding children as stated in Section 11 of the Children's Act 2004.
- To provide assurance that the Trust is meeting Care Quality Commission (CQC) Key Lines of Enquiry relating to safeguarding.
- To identify key areas of risk in relation to South Tyneside Foundation Trust and City Hospitals Sunderland Foundation Trust meet their statutory responsibilities during the reporting period.

RECOMMENDATION

Directors are asked to receive the report.



Melanie Johnson
Executive Director of Nursing & Patient Experience

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1. BACKGROUND

Safeguarding and promoting the welfare of children is defined as protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes.

There is a requirement in the Children's Act 2004 for each Trust Board South to receive an annual report on the safeguarding arrangements for STFT and CHSFT, in line with CQC Key Lines of Enquiry. The annual report ensures that there is a clear line of accountability from front line practitioners to the Board.

Under section 11 of the Act, agencies are required to cooperate with local authorities to promote the well-being of children in each local authority area. This cooperation should exist and be effective at all levels of the organisation, from strategic level through to operational delivery.

South Tyneside NHS Foundation Trust (STFT) and City Hospitals Sunderland NHS Foundation Trust (CHSFT) are committed to ensuring service users and visitors are cared for in a safe, secure and caring environment. This endorses the philosophy that safeguarding is everyone's business and everyone working within both health and social care environments has a responsibility to prevent abuse, and where abuse is suspected, to act rapidly and appropriately to protect children, young people (YP) and adults.

Both Trusts' acknowledge the importance of working alongside partner agencies ensuring that everyone, young and old are safe and receives appropriate intervention. Multi-factorial and complex safeguarding activity can be achieved through robust and responsive partnership arrangements, joint working on both local and regional strategic direction, and by incorporating national guidance and policy into Trust policies and procedures.

STFT and CHSFT Safeguarding Children policy is supported by a series of multi-agency policies and procedures within Sunderland, Durham, South Tyneside and Gateshead Safeguarding Children Board's. These are easily accessible on each of the Trusts intranet site.

This report provides a summary for 2016-17 of the arrangements in place at STFT and CHSFT with regard to statutory responsibilities for safeguarding children and young people, including meeting the health needs of Looked after Children.

2. ROLES AND RESPONSIBILITIES

Our statutory duty is to safeguard children and young people and there are professionals in place who have key responsibilities for supporting all activities necessary to ensure that STFT and CHSFT meet their statutory requirements.

In October 2016 the commissioning arrangements for the Named Nurse for Looked after Children (LAC) in Sunderland children Service's, was transferred from STFT to CHSFT to work as part of CHSFT LAC health team, as part of the provision of statutory responsibilities in meeting the health needs of Looked after Children. The LAC services for South Tyneside Children Services remain within STFT.

In January 2017 the NN for Children (CHSFT) then became the NN for Children acute services across STFT and CHSFT. The changes came about after a CQC safeguarding inspection at STFT, requiring safeguarding children arrangements to be strengthened.

2.1 Safeguarding and Looked after Children team

Chief Executive Accountable Officer Safeguarding Children and Adults STFT and CHSFT	Ken Bremner, Chief Executive CHSFT
Executive Lead for Safeguarding Adults and Children STFT and CHSFT	Melanie Johnson, Executive Director of Nursing and Patient Experience
Named Doctor (ND) CHSFT	Dr Darren Bresnen, Consultant Paediatrician, Paediatrics and Child Health
Named Doctor (ND) STFT	Dr Nilda Etorma, Paediatrics Acute Service's (ended July 2016) Interim arrangements in place
Named Nurse Safeguarding Children Community (NN) STFT	Lesley Schuster, Community Services.
Named Nurse Safeguarding Children Acute (NN) STFT and CHSFT	Tracy Dean, Nursing and Patient Experience.
Named Midwife (NMW) CHSFT	Sheila Ford, Head of Midwifery, Obstetrics and Gynaecology Obstetrics and Gynaecology.
Safeguarding Midwife (SMW) CHSFT	Janice Blakey, Obstetrics and Gynaecology Obstetrics and Gynaecology
Named Midwife (NMW) STFT	Angela Smith, Named Midwife, Obstetrics and Gynaecology Obstetrics and Gynaecology Acute Services.
Named Nurse Looked after Children (LAC) CHSFT	Susan Gardner, Nursing and Patient Experience. (October 2016)
Named Nurse Looked after Children (LAC) STFT	Janet Hutchinson, Community Services.
Safeguarding Nurse Advisor Community STFT	Gateshead (2), Community Services South Tyneside (2), Community Services Sunderland (3), Community Services
Paediatric Liaison Nurse CHSFT	Michelle Milburn, Paediatrics and Child Health

The **Chief Executive** (CE) the Chief Executive delegates his safeguarding responsibilities to the Director of Nursing and Patient Experience, who delivers the services with the support of the Named Professionals.

The **Executive Director for Nursing and Patient Experience** (formally Nursing and Quality) is the executive lead for safeguarding children and adults and represented STFT and CHSFT on Sunderland, South Tyneside, Gateshead and Durham Safeguarding Children Boards.

The **Named Doctor (ND)** is a statutory role and works closely with the other team members and with the Designated Doctor (DD) and Designated Nurse (DN) on supporting all activities necessary to ensure that the Trust meets its responsibilities to safeguard and promote the welfare of children. The ND provides a leadership and advisory role with peer review and training, particularly in relation to medical staff and specialist areas. The ND receives supervision from the DD.

The **Named Nurse** (NN) and **Named Midwife** (NMW) are statutory roles alongside the ND to support all activities necessary to ensure that the Trusts meet their statutory responsibilities to safeguard and protect children and young people.
The NN and NMW lead on providing safeguarding children supervision to nursing, and midwifery staff in accordance with the child protection supervision policies and procedures.

The NN and NMW are a point of contact for advice and support to all STFT and CHSFT staff where there are safeguarding concerns, including unborn babies. The NN and NMW receive supervision from the DN.

The **Named Nurse** (NN) for **Looked after Children** (LAC) is a statutory role and is responsible for assessing and promoting wellbeing in the looked after child population.

The **Safeguarding Midwife (SMW)** within CHSFT is a temporary post funded through the Directorate establishment to support supervision, advice and support within maternity services. The level of support in the past year has been 1WTE in response to 2015/16 plans to increase resources. There are plans for 2017/18 to have 1WTE Named Midwife post which will eradicate the need for a Safeguarding Midwife.

The **Paediatric Liaison Nurse (PLN)** supports the NN for CHSFT and is responsible for ensuring paediatric liaison information on all children and young people up to the age of 18 years is appropriately shared with Community Services staff, Health Visitors and School Nurses or the CHSFT Midwife where appropriate. The PLN receives supervision from the NN.

There was **additional non- reoccurring funding** provided by Sunderland CCG to support STFT and CHSFT safeguarding activity to ensure serious case review (SCR's) recommendations were implemented. For CHSFT this consisted of 1 WTE safeguarding advisor who commenced in September 2016 for 1 year. There was a period of 6 months whereby SCR recommendations were not implemented due to resources; however all SCR recommendations are now in place. Due to the changes in the existing safeguarding team and to further strengthen the safeguarding agenda. A Safeguarding Children Advisor post was agreed in February 2017 and the post holder commences in July 2017.

In STFT this funding was utilised to support the CQC findings on improvements and further audit work.

2.2 Designated and lead professionals

Within Sunderland and South Tyneside CCG's there are Designated Doctor's (DD) and Designated Nurse's (DN) who support the Named Professionals and also provide strategic responsibilities in safeguarding children, they are:

Designated Nurse for Safeguarding children	Deanna Lagun. Sunderland CCG
Designated Nurse for Safeguarding children	Carol Drummond. South Tyneside CCG
Designated Dr for Safeguarding Children and Looked after Children	Dr Kim Barrett Sunderland CCG and Consultant Paediatrician at CHSFT
Designated Dr for Safeguarding, Children and Looked after Children and Child Death	Dr Sunil Gupta. South Tyneside CCG and Consultant Paediatrician STFT
Designated Dr for Child Death Reviews	Dr Carl Harvey, Consultant Paediatrician at CHSFT
Safeguarding children lead Nurse and Designated Nurse for Looked after Children	Anne Brock Sunderland CCG and South Tyneside CCG

The **Designated Professionals** provide leadership and strategic health guidance across the local health economy.

The **Designated Doctor (DD)** is a statutory role and the line management for this role is directly by the CCG. The DD, as well as providing leadership and strategic health guidance to the Local Safeguarding Children Boards and serious case review panel sub-group. The DD also provides support and advice to other health professionals on individual cases.

The **Designated Doctor for the Child Death Review Process** provides advice and leadership about reviewing each child death by attending local and South of Tyne overview Child Death panels.

The **Designated Doctor for Looked After Children (DDLAC) and Designated Nurse for Looked After Children (DNLAC)** are statutory roles to provide advice about managing the health of children "in the care of the Local Authority", prospective adopted children, adoptive parents and other permanency care situations. This is in recognition of the fact that the health outcomes for such children are known to be poor in comparison to the majority of children cared for by their own families. The DDLAC and DNLAC also attend the local multi-agency looked after partnership (MALAP) and the MALAP health group.

3.0 MEMBERSHIP OF THE SUNDERLAND, SOUTH TYNESIDE, GATESHEAD AND DURHAM SAFEGUARDING CHILDREN BOARD AND MULTI-AGENCY WORKING

3.1 Local Safeguarding Children Boards

The Executive Lead for Safeguarding Children and Adults is a members of the Local Safeguarding Children Boards. All Safeguarding Children Board's ensure that local child protection arrangements are developed and maintained in accordance with national and local guidance. STFT and CHSFT are active partners in implementing such arrangements.

The Executive Lead, Designated and Named professionals attend a range of sub-committees and working groups for each Local Safeguarding Children Boards. All sub groups have an appointed STFT and/or CHSFT representative with monitoring of attendance in place. Poor attendance is escalated to the Chief Executive, with no escalations for STFT or CHSFT in 2016/17.

3.2 Sunderland Integrated Contact and Referral Team (ICRT)

The Sunderland Initial Contact and Referral Team (ICRT) is a joint initiative between Sunderland City Council, Northumbria Police and the NHS to co-locate key members of staff in order to ensure a timely, response to safeguarding children concerns.

Commissioned by Public Health, STFT Community Services provide one whole time safeguarding advisor and one whole time administration support. They access health agency/services information about a child and family in order to support shared decision making to improve outcomes for children where statutory intervention is required, or, where early intervention may be required.

During 2016-2017 the ICRT advisor attended 568 meetings; this is a reduction from 2015/2016 which had 754 meetings held. This reduction reflects the changing working patterns within the ICRT, following the Improvement plan.

3.3 South Tyneside Integrated Safeguarding Innovations Team (ISIT)

During March 2017, STFT have been working with South Tyneside Children's Services and other partners to make significant changes to how children's safeguarding referrals are being organised and coordinated to help children and their families. ISIT is a new initiative similar to ICRT in Sunderland, whereby a multi-disciplinary team of professionals from partner agencies work together to deal with all safeguarding concerns, where someone is concerned about the safety or wellbeing of a child.

To support South Tyneside Children Services, STFT have committed to providing a full time safeguarding nurse advisor and an administrator support. Health activity data from the ISIT will be available in future annual reports.

3.4 OFSTED inspections

In May 2015 Sunderland City Council's services for children and young people had an OFTED inspection, with the findings published in July 2015.

The overall inspection was 'inadequate' in all areas:

- Children who need help and protection
- Looked After Children
- Achieving permanence (including adoption and the experience of care leavers)
- Leadership, Management and Governance.

In the past year OFSTED have been back as part of the monitoring visits and to date have revisited 3 of the 4 areas identified as inadequate. Leadership and Management are due for a monitor visit June 2017.

The first visit in August 2016 OFSTED reported to have found 'significant progresses for care leavers and in November 2016 reported 'steady progresses and February 2017 'making steady progress from an extremely low baseline.

The improvement board continues to monitor the action plan alongside Together for Children the new company set up to deliver Children's Services in Sunderland. CHSFT will continue to work in partnership with the new company.

In April 2017/18 Sunderland Safeguarding Children Board will implement its new structure, reducing its sub groups significantly.
There are no impending changes to Durham, Gateshead or South Tyneside Boards.

Information from these meetings is cascaded through the Safeguarding Assurance Group (SAG) in STFT and Safeguarding Children and Adults Group (SCAG) in CHSF. See appendix 1 Safeguarding Governance Arrangements.

3.5 Joint targeted area inspections (JTAI)

Between 6 February 2017 to 10 February 2017, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Gateshead to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014. Findings from the inspection were overall positive for the partnership, with a number of areas of strength identified. Areas for further development will be incorporated into an action plan and progressed across the partnership.

3.6 Missing Sexually Exploited and Trafficked (MSET) and Child sexual exploitation (CSE)

Child sexual exploitation (CSE) is when children and young people receive something (such as food, accommodation, drugs, alcohol, cigarettes, affection, gifts, or money) as a result of performing, and/or others performing on them, sexual activities. Those exploiting the child or young person have power over them because of their age, gender, intellect, physical strength and/or resources. For victims, the pain of their ordeal and fear that they will not be believed means they are too often scared to come forward.

MSET is a multi-agency meeting responsible for coordinating and ensuring the effectiveness of multi-agency arrangements for safeguarding and promoting the welfare of children and young people who go missing and/or are at risk of Child Sexual Exploitation (CSE), and/or trafficking. CHSFT and STFT have representation at both Sunderland and South Tyneside meetings.

In order to identify and assess CSE risk in young people presenting into emergency care departments across both Trusts, HEADSSS was introduced. This is a psychosocial interview for adolescent's consisting of focused questions which enable staff to ask young people the difficult questions associated to CSE. If a positive result, this would then lead onto staff completing a Safeguarding Children risk assessment as part of their policies and procedures.

CWILTED, a recognised safeguarding paediatric assessment tool, which enhances the Manchester Triage System by enabling childhood accidents to be investigated more accurately, was implemented in 2016/17 across both Trusts. The implementation of the assessment tool is audited and to date there is 100% compliance on the completion.

CWILTED:

- C- Condition
- W-Witness
- I –Incident
- L-Location
- T-Time
- E-Explanation
- D- Description

HEADSSS

H- Home/Relationships
E- Education/Employment
A-Alcohol/Activities
D- Drugs/
S- Sexuality
S-Suicide/Depression
S-Safety

3.7 Multi-Agency Risk Assessment Conference (MARAC)

MARAC is a monthly risk management meeting where professionals share their own agencies information on high risk cases of domestic violence and abuse and put in place a risk management plan. There is representation from STFT Safeguarding Children Team for the Sunderland and South Tyneside meetings and CHSFT adult team attend in Sunderland.

In 2016/17 there were a total of 1433 MARAC reports completed by the Safeguarding Children Community team across the 3 localities. There was a noted reduction with regard to MARAC cases being discussed of 15% and this is reflected in the changes initiated by Northumbria Police to reduce the period of time spent at MARAC by all agencies. The MARAC chairperson screens all MARAC referrals submitted across the partnership, to ensure only cases go through as per MARAC criteria. Due to the change, discussions with Sunderland CCG re commissioning arrangements are underway as part of the contract agreements for 2017/18.

The work undertaken by STFT and CHSFT safeguarding teams will be reviewed in 2017/18 to ensure no duplication of work or representation is at each MARAC.

4.0 GOVERNANCE ARRANGMENTS

As part of the South Tyneside and Sunderland Healthcare Alliance Group and as part of the single executive team, the Executive Lead for Safeguarding is working towards an integrated approach for STFT and CHSFT adults and children safeguarding teams to share good practice, and better utilise expertise and resources.

The following arrangements are in place across Sunderland, South Tyneside and Gateshead local authorities.

a) Safeguarding Children Board sub groups and task and finish groups are predominantly supported by the Named Nurses for Safeguarding Children, community advisors and Looked after Children Named Nurse.

b) Safeguarding Children Boards across the 4 localities are attended by the Executive Director of Nursing and Patient Experience.

c) STFT and CHSFT have operational meetings on a bi-monthly basis which provides the opportunity to monitor safeguarding activity, action plans and case discussions.

d) Safeguarding Assurance Group (SAG) / Safeguarding Adults and Children Group (SCAG) within each Trust has senior representation from each division to provide leadership and risk management of safeguarding issues. These groups provide assurance via the Choose Safer Care to Trust Board level within STFT and Trust Governance Comittee within CHSFT.

5.0 MONITORING/AUDIT AND EVALUATION/QUALITY ASSURANCE

There is a programme of audit in relation to safeguarding children carried out by the safeguarding children teams. There are a number of audits which have been initiated as a result of actions from Serious Case Reviews (SCR) and learning reviews which have proven to be a challenge over the past year, due to the gap in the Nurse Advisor post at CHSFT and the CQC inspection improvements required within STFT. However all SCR audits are now completed, alongside the annual audit plan with those requiring re auditing in the 2017/18 audit plan.

5.1 Care Quality Commission (CQC)

Following a Joint Targeted Area Inspection (JTAI) in July 2015, consisting of Ofsted, CQC, HMI Constabulary (HMIC) and HMI Probation (HMIP) on the multi-agency response to abuse and neglect in South Tyneside Metropolitan Borough, recommendations were made for STFT, within Accident & Emergency, Maternity Services and Paediatric Services regarding improvements to safeguarding practice.

CQC returned in July 2016 to complete an unannounced safeguarding focused inspection at South Tyneside District Hospital to review processes, procedures and practices for safeguarding children and young people. This inspection highlighted a lack of progress in areas which had been previously identified as requiring improvement from the JTAI, July 2016.

Following the inspection further recommendations were made which required immediate improvement and work was commenced immediately by the adults and

children safeguarding teams, reviewing of the systems and processes, and training, safeguarding supervision and developed an improvement action plan.

An external review of safeguarding children's arrangements was commissioned by STFT in September 2016, to examine the arrangements in the Trust for safeguarding children and young people. The recommendations from this review were incorporated into the STFT CQC action plan alongside the actions form JTAI. A working group was established to meet monthly to progress the improvement action plan and achieve the safeguarding improvements required by the CQC. This group was disbanded in January 2017 and the improvement action plan became part of the Safeguarding Assurance Group remit, providing assurance via the Governance framework.

On the 17th January 2017, CQC revisited STFT to review the progress made against the safeguarding improvement plan. Feedback from this review was positive, with assurance given to the CQC on progress was in place and that safeguarding had been strengthened with increased support/ resources providing support to frontline staff.

The work required to progress the safeguarding improvement plan continues, supported by the increased capacity for both acute and community safeguarding teams. CQC intend to return again to review progress during 2017/2018.

The last CQC inspection for CHSFT was September 2014, in line with the programme of CQC inspections on a Trust wide perspective, monitoring safety, effectiveness, caring, and responsiveness of services and if well led. The overall rating was 'good', there were no specific elements pertaining to safeguarding children. The safeguarding team continue to have regular CQC preparation readiness meetings with support from CHSFT Assurance Manager.

5.2 Sponsored Audits

In 2016 the Executive Lead for Safeguarding sponsored two independent audits. The CHSFT audit one was in relation to testing the levels of compliance with the requirements of both the Intercollegiate Guidance March 2014 and the Trusts own Safeguarding Children Policy, last updated in July 2014. The audit demonstrated 'reasonable assurance' with 2 areas requiring action:

- Quarterly meetings of the Strategic Group have not taken place in accordance with the appropriate Terms of Reference. In accordance with approved terms of reference, the group is responsible for monitoring effectiveness of child protection/safeguarding arrangements across the Trust.

- Monitoring and compliance reporting does not take place in accordance with the provisions in Section 9 of the safeguarding policy.

In March 2017 all actions were completed and a further audit into the impact of the policy on staff compliance will be sponsored in 2018.

The STFT audit assessed the effectiveness of the provision of training in relation to safeguarding processes following recent inspection by CQC. It was to evaluate the training process with regards to safeguarding children. The audit demonstrated 'reasonable assurance' with 5 areas requiring action:

- STFT document their Safeguarding Children Training related procedures to guide staff in the effective and consistent discharge of their related responsibilities, including statistical analysis and quality assurance.
- The Learning and Development Training Unit ensures that staff who require Safeguarding Children Training at all 5 levels are identified on their management reports to the Board.

- The ESR system is developed to give managers the ability to monitor staff Safeguarding Children Training independent of the Learning and Development Training Unit.

- Operational managers develop their understanding of the barriers to meeting the STFT Safeguarding Children Training target and take actions that ensure the target is met as soon as possible.

- STFT consider the use of sanctions or incentives for those members of staff who fail to meet or abide by their Safeguarding Children Training obligations.

All above actions are ongoing as part of the CQC joint action plan, with steady progress being made.

5.3 Children Act section 11 audit

Section 11 of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. Sunderland Safeguarding Children Board section 11 audit was completed, with initial findings for CHSFT demonstrating lack of compliance in missing children policy and training. An action plan was produced which gave assurance that compliance had been met via the Trusts security policies and mandatory safeguarding children training.

A Section 11 audit was completed by STFT for South Tyneside Safeguarding Children Board with no risks identified. Gateshead Safeguarding Children Board has agreed to complete Section 11 audit report during 2017/2018.

5.4 Safeguarding dashboard

Monthly contracting data and quarterly safeguarding dashboards are submitted to Gateshead, Sunderland and South Tyneside Clinical Commissioning Groups (CCGs) to report safeguarding activity.

The dashboards are discussed at the Designated and Named Professionals Assurance Groups.The format of the Sunderland and South Tyneside dashboard was updated this year and forms part of the Clinical Coimmissiong Group contractual agreements within CHSFT and STFT for safeguarding assurance.

The dashboard is submitted to the Clinical Commisionsing Group (CCG) on a quarterly basis and is reviewed and monitored by the Named and Designated Assurance Group. The Named and Designated professionals for CHSFT and STFT are representatives on this group.

The dashboard is reported to the Provider Quality Review Groups and the CCG Quality Safety and Risk Committee. Reports also provide assurance to all 4 Local Safeguarding Adult and Children Boards and NHS England via their agreed governance processes as well as supporting the Provider Named/Lead Professionals in compiling their Safeguarding Annual Reports.

5.5 Saville action plan (Lampard Review)

In February 2015 the Lampard Review was published outlining themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile. The report included 14 recommendations, 9 of which applied to NHS Trusts.

The action plan for CHSFT was signed off via the Corporate Governance Steering Group in May 2016 with a request for a review via the Assurance Programme in March 2017. The Assurance Programme review found "a number of actions identified have been completed but significant gaps remain in compliance with the action plan despite reports that all actions had been completed.

The action plan for STFT had been signed off as complete but a review in 2017 again found a number of gaps.

It is proposed that the completion of this work is overseen by the Director of Nursing via the Safeguarding Assurance Group (SAG, STFT) and the Safeguarding Children and Adults Group (SCAG, CHSFT).

An update will be presented to the Executive Committee in November 2017.

5.6 Female Genital Mutilation (FGM)

FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act making it a criminal offence.

In March 2014 the Department of Health requested voluntary information on the numbers of FGM cases identified within health sectors; however from the 1st September 2014 statutory requirement for FGM patient data was enforced, based on specific categories.

In September 2015 the required recording (and submission) of FGM information across the NHS, FGM Enhanced Dataset was published. The requirements now require all staff, where they have identified FGM, to inform the woman/parent or guardian of the need to report and then record in the health records this information, this particularly impacts on maternity services.

The incidences of FGM reporting across STFT and CHSFT stand at 8 in 2016-17. However the Regional Paediatric Forensic Network, based in the RVI, have seen a small number of cases directly involving children, all of which had been completed outside of the UK. All FGM cases have been reported to children services as well as DOH; however none of the cases resulted in a criminal prosecution.

6.0 SAFEGUARDING ACTIVITY

6.1 Young Persons Nurse

The Young Person's Nurse is commissioned by Public Health within STFT, works as part of the Sunderland safeguarding children team. The role includes working in partnership with the youth offending service to ensure that health needs of those clients are met. The Young Person Nurse currently undertakes health assessments on all children who access Sunderland Youth Offending Service and on receipt of referrals from Sunderland Youth Drug and Alcohol Project (YDAP) within 5 working days. Since 1st April 2016 240, health assessments have been completed, which is an 11% increase from 2015/16. Sexual health screening by the Young Person Nurse has increased by 52%, alongside a 68% increase in screening for Blood Borne Disease. The reduction with regard to onward referrals and referrals to YDAP are noted to have fallen. During 2016/2017 the youth offending service and YDAP have been subject to reorganisation and the current provision is yet to be determined.

6.2 Vulnerable babies interface group CHSFT

This group was established in 2015/16 as part of a service development to improve the outcomes for babies at birth where safeguarding concerns had been identified during ante natal period. This group is chaired by the Safeguarding midwife on a monthly basis and is very well attended. Together the group review complex cases and ensure the best outcome is achieved for the unborn baby. This is an excellent example of multi-agency working.

6.3 Child protection plans/alerts CHSFT and STFT

CHSFT and STFT safeguarding teams receive information from their local Children Services on children and unborn babies who are subject to a child protection plan and/or Looked after. This information is placed on each Trust electronic records system of the child. This is to ensure that staff working with the child are aware of the safeguarding concerns which will support their clinical decision making and ensure appropriate action taken. Where there are no safeguarding alerts in place and the staff have concerns regarding the child's safety and welfare, they would contact children services to find out if they had an allocated social worker or classified as being "a Child in Need."

In the case of an unborn baby, the alert is placed on the mother's electronic record and once the baby is born the alert is transferred to the baby record.

CHSFT record Sunderland, South Tyneside, Durham and Gateshead and as of the 31st March 2017 there were 1239 of alerts in place due to a CP plan, demonstrating a 3% decrease from the previous year and 537 Sunderland LAC alerts, which is 2 cases less than in 2015/16. There has been a steady increase in the number of children who are now subject to child protection plan in Gateshead, with work underway by Gateshead Children Services, to scrutinize the reason for this.

Figure 1 CP Plan alerts in place as of 31.03.17

	Sunderland	Durham	South Tyneside	Gateshead

CP Plan	428	259	213	335
LAC	537	NA	NA	NA

As well as the alerts for above there are Missing Sexually Exploited and Trafficked (MSET) alerts which are in place for 3 months, each time young person's (YP) case is discussed. Many of the YP are discussed more than once and deemed high risk; therefore the alert stays in place until risk reduced.

Recently there has been a MSET transition group setup within CHSFT between the LAC Named Nurse and Adult Safeguarding Lead, as many of the MSET cases discussed are over the age of 18 years. This meeting is to ensure safe hand over to ensure the adult lead has oversight of and can inform the LAC Named Nurse of attendance or concern. The same process will be implemented within STFT in 2017/18.

6.4 Safeguarding referrals

The number of referrals to children services made by CHSFT as of the 31/03/17 was 930 which is a decrease of 12% by compared to 2015/16. The "toxic trio" (Mental health, substance misuse and domestic violence) continue to be the significant underlying causes for child protection referrals to children services. The drop does not present as an issue, as this is in line with children services improvements of agencies adhering to agreed referral thresholds.

In STFT as of the 31st March 2017 a total of 413 referrals were made, an increase in the safeguarding activity has resulted from including the acute and maternity services data. There has been a 22% reduction in submission of Safeguarding Children Referrals from South Tyneside community services noted during this reporting year. This reduction should be viewed with caution as maternity safeguarding referrals have previously been reported within the safeguarding community data until October 2016.

In 2017/18 there will be a standardised reporting for all safeguarding activity across adults and children.

Figure 2 CHSFT Trust wide numbers of referrals made to children services

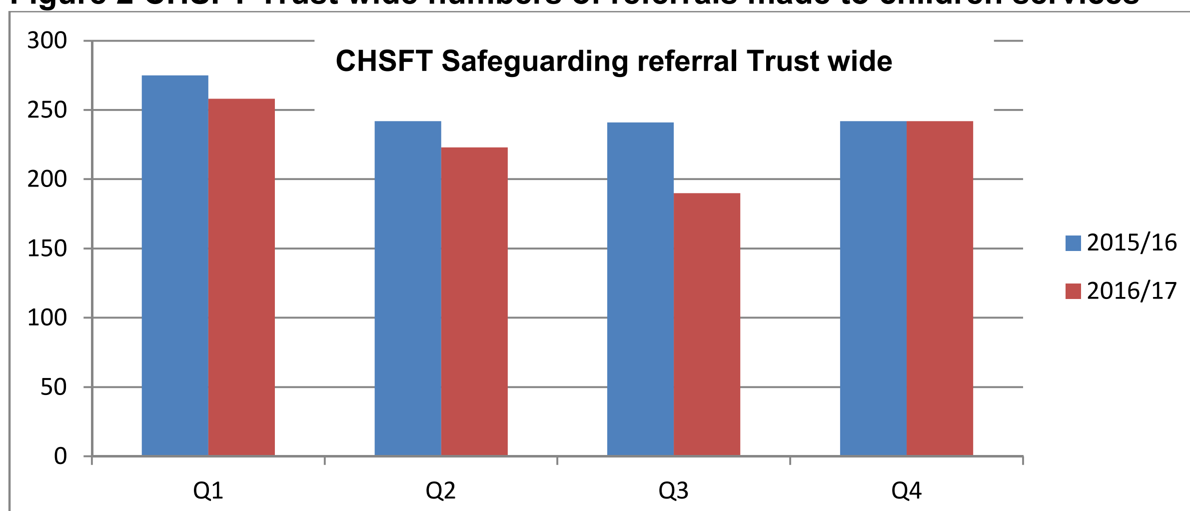


Figure 3 STFT Trust wide numbers of referral made to children services

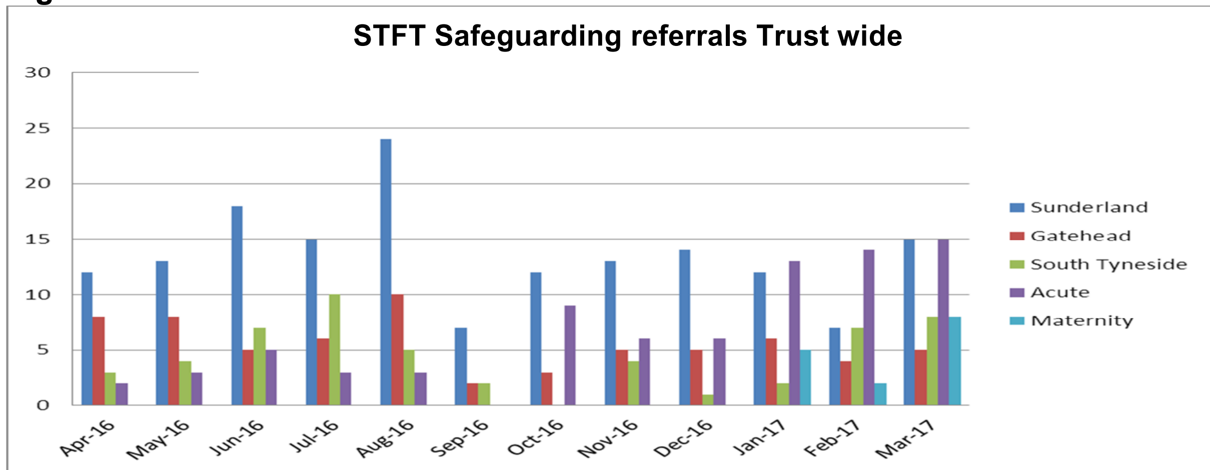


Figure 3 demonstrates an increase in acute and maternity referrals in line with the CQC improvement work, in the later part of the year.

6.5 Safeguarding telephone advice and support

Providing safeguarding advice and support to practitioners is the core function of the safeguarding advisors, across both Trusts. Telephone support and advice has fallen by 31% during 2016/2017 within the STFT safeguarding children community team, across the three localities. An explanation for the drop is directly related to the safeguarding team being based within the same premises as the South Tyneside and Sunderland localities professionals (such a Health Visitors), who can access face to face support. The contact made with staff face to face, has not been captured in the current data and will be addressed for 2017/18.

Themes relating to seeking advice are associated to current or chronic safeguarding concerns, requiring guidance through the referral process or assistance to challenge Children's services decision making. Advice and support activity within the acute services across both sites will be collated for 2017/18.

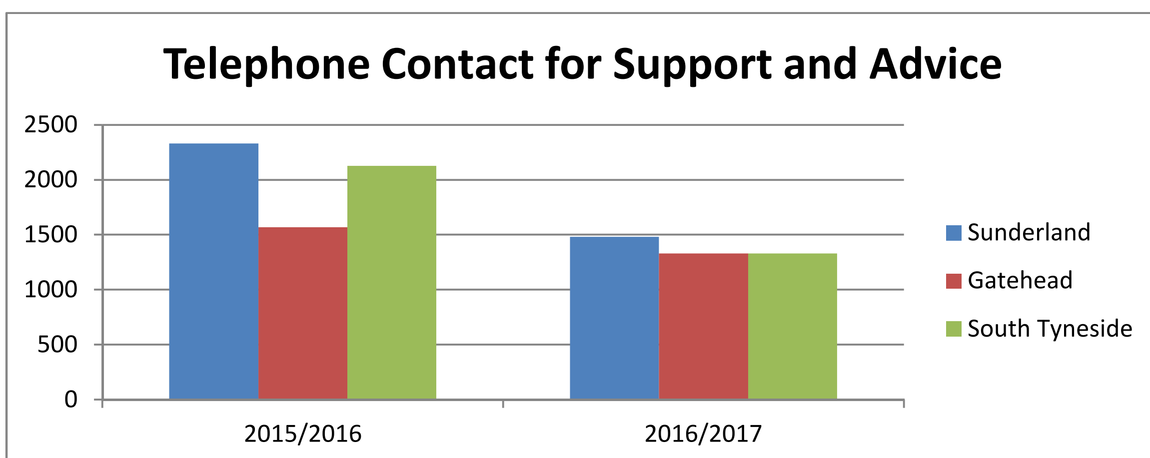


Figure 4 STFT numbers for telephone advice and support

6.6 Peer review

Peer review is an essential part of providing support and guidance to medical staff who are involved in the completion of child protection medicals. At the meetings child protection cases are reviewed with photographs and x-rays, current evidence, literature is reviewed and reports are discussed in this group. The meetings are minuted and actions agreed. Attendance at these meetings are monitored and evidenced as part of the individual's annual appraisal, supporting clinical practice and safeguarding training requirements.

In CHSFT the group membership has been extended to include ED physicians due to the 16-18 year old age group they are involved with through ED.

For STFT the child protection medicals are completed by Consultant Paediatricians therefore the peer review membership will remain as per STFT peer review Terms of Reference.

6.7 Child protection supervision

It is recognised that staff who work with children in need of protection may be subject to particular stresses and anxieties. Safeguarding children supervision is integral to providing an effective "think family" philosophy. Supervision has a number of functions, not least to ensure service delivery is of a high quality and is supporting good evidence based practice.

Nursing supervision is completed by the safeguarding children teams, NN LAC and NMW as per STFT and CHSFT child protection supervision policies and procedures.

The delivery of supervision is 3 monthly for all case holders and 6 monthly for none case holders, delivered by group supervision as required. Future plans 2017/18 will be to align all the children and adults supervision policies and procedures across STFT and CHSFT.

Figure 5 CHSFT Nursing staff child protection supervision compliance

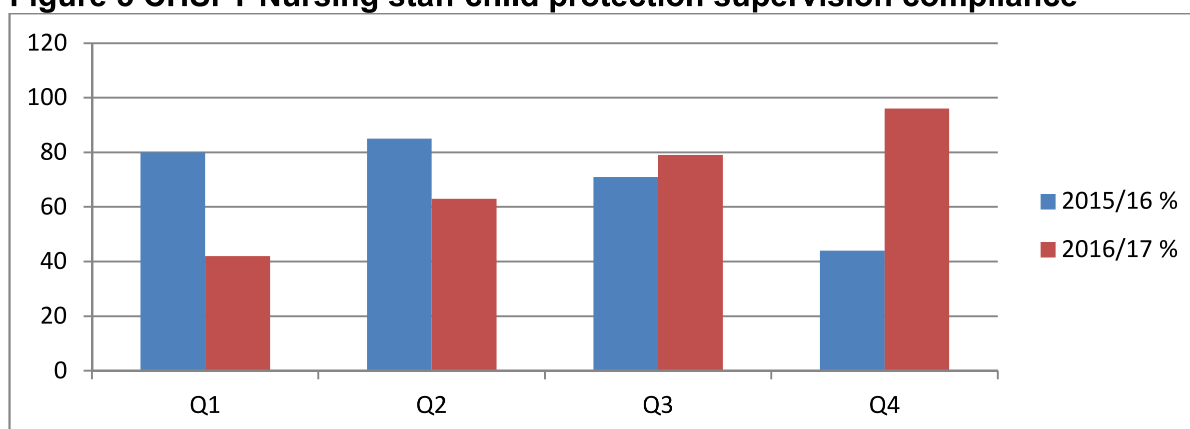


Figure 5 depicts the percentage of nursing staff who have received child protection supervision over the last year, compared to 2015/16 numbers. This is seen as a total of all supervision activity across a range of areas. Capacity issues due to sickness, workload and a lack of trained supervisors had impacted upon the earlier figures and following additional supervisors the figures increased. The additonal non-recuring funding supported the level of supervison completed in Q2 and Q3 with Q4.

Significant improvements have been demonstrated within the maternity data, directly resulting from the full time Safeguarding Midwife post alongside the supervision training undertook by senior midwives who were then able to support the delivery of supervision for all midwives. Compliance form Q1 to Q4 increasing by 54% every 6 months with more recently the development of quarterly supervision to all community based midwives

Figure 6 STFT Safeguarding community child protection supervision compliance 2015/16

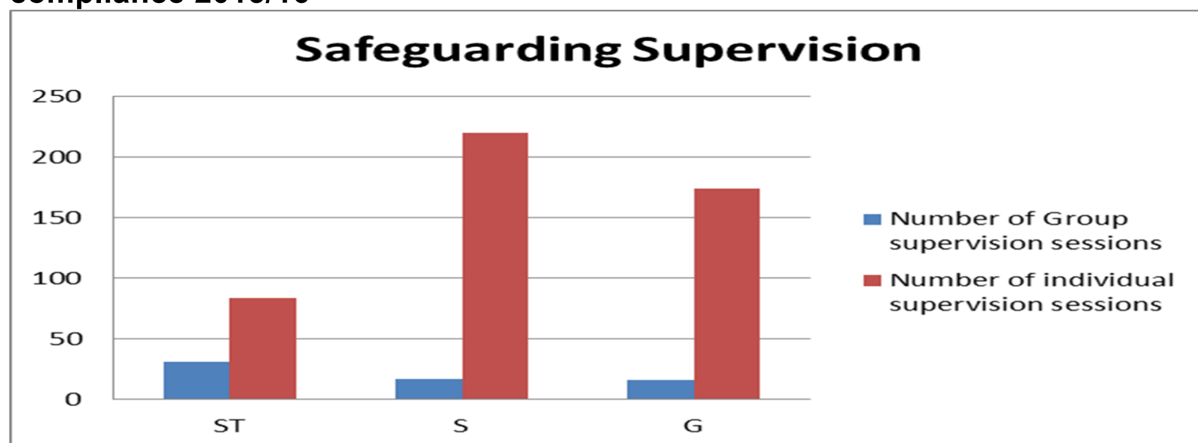


Figure 6 depicts the numbers of supervision provided by the STFT safeguarding community team on a 3-6 monthly basis.

7.0 TRAINING

The required levels of training for health staff are set out in the "Safeguarding Children and Young People – roles and competencies for health care staff" Intercollegiate Document RCPCH (March 2014). The Named professionals review training needs analyses (TNA) on a 6 monthly basis, to ensure staff attend the correct level of training. All training is delivered by the safeguarding children team as per trust mandatory training policy and attendance is reported into the safeguarding dashboard.

As part of the CQC improvement plan a review of STFT safeguarding children training was completed and Executive agreement was obtained to update and align safeguarding children training with CHSFT model. The frequency of training changed from yearly to every 3 years and changes to duration from two to six hours.

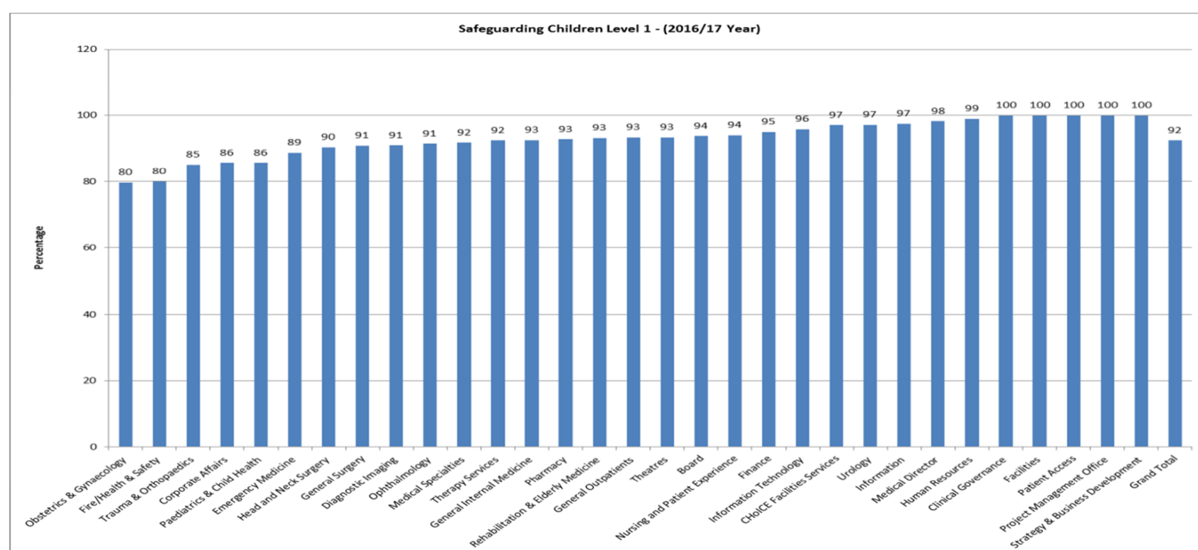
CHSFT E-learning training was supplied by E-learning for healthcare (e-LfH) in partnership with Royal College of Paediatrics and Child Health (RCPCH), up until January 2017 when a bespoke e-learning package was developed by CHSFT safeguarding children team. The reason for the change in e-learning was due to lack of local guidance for staff. The bespoke eLearning will be updated by the safeguarding children team when any changes to safeguarding practice or process internally and nationally, providing assurance that the training was up to date and relevant to the needs of the organisation, as well as complying with National Guidance. (Intercollegiate Document March 2014).

All staff can, and are, encouraged to attend multiagency training provided by the Local Safeguarding Children Boards. There is a requirement that when staff attend external training that they ensure this is recorded in their electronic staff record and this is reinforced with staff at their appraisals. All training sessions have evaluation and impact statement questionnaires completed for monitoring and improvements.

Trust Induction: Identified staff receive e-learning safeguarding children level 1 and depending on their role, e-learning level 2 safeguarding children training as part of their Trust induction programme.

Level 1: All staff including non – clinical managers and staff working in health care, such as administrative, caterers, domestics, transport, porters, community pharmacist counter staff. This is provided through e-learning and to accommodate staff learning needs there is a face to face sessions at level 1 and 2 which they can attend. Requirements are 2 hours every 3 years via e-learning and all data is captured on electronic Staff Record (ESR).

Figure 7 CHSFT Safeguarding children level 1training compliance



Figures 7 demonstrates the year end position is 92% compliance which is a 4% decrease in last year, however is still above target set at 90%.

Level 2: Minimum level required for non-clinical staff who have any contact with children, young people and/or parents/carers, such as administrators for looked after children and safeguarding teams, nurses working in adult acute/community services (including practice nurses), allied health care practitioners and all other adult orientated secondary care health care professionals, including technicians. It is provided through e-learning and to accommodate staff learning needs there are also

3 hour face to face sessions available. Requirements are 3 - 4 hours every 3 years via e-learning and all data is captured on ESR

Figure 8 CHSFT Safeguarding children level 2 training compliance

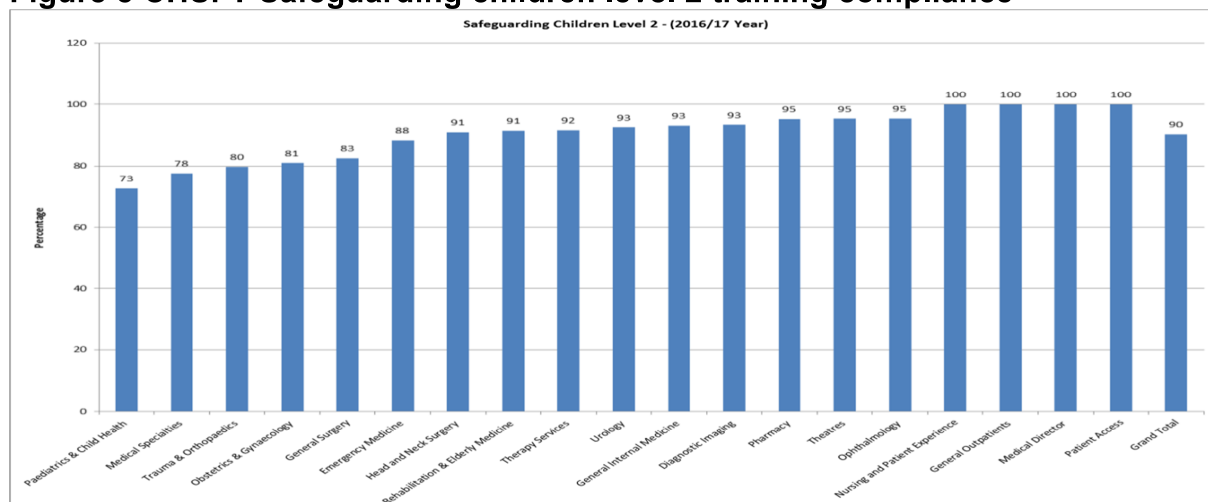


Figure 8 shows level 2 training as end of year 90% which is a 9% increase in last years, as forcasted in last years report.

Level 3: all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns. This includes urgent and unscheduled care staff, adult learning disability staff, learning disability nurses, specialist nurses for safeguarding, health professionals working in substance misuse services, paediatric allied health professionals, sexual health staff, children's nurses, midwives, obstetricians, paediatricians, paediatric radiologists, paediatric surgeons and lead anaesthetists for safeguarding. Requirements are 6 hours every 3 years via face to face and all data is captured on ESR.

Figure 9 CHSFT Safeguarding children level 3 training compliance

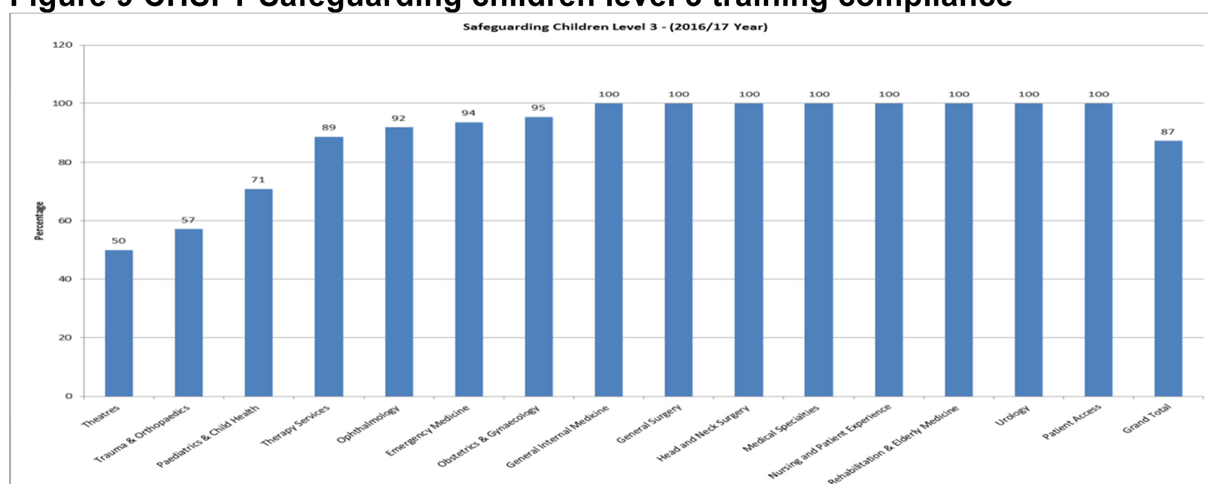


Figure 10 CHSFT Safeguarding children training level 3 directorate compliance

Directorate	Staff No	Staff Completed	% 2016/17 Compliance	% 2015/16 Compliance
Emergency Medicine	141	132	94	81
General Internal Medicine	5	5	100	100

General Surgery	2	2	100	0
Head and Neck Surgery	3	3	100	100
Medical Specialties	8	8	100	100
Nursing and Patient Experience	2	2	100	100
Obstetrics & Gynaecology	152	145	95	95
Ophthalmology	37	34	92	85
Paediatrics & Child Health	154	109	71	81
Rehabilitation & Elderly Medicine	4	4	100	100
Trauma & Orthopaedics	7	4	57	80
Urology	1	1	100	100
Patient Access	12	12	100	100
Theatres	2	1	50	100
Therapy Services	53	47	89	90
Grand Total	**583**	**509**	**87**	**87**

Figure 9 and 10 demonstrates level 3 compliance at 87%, the same as last years. The areas in which compliance is poor are moinitored via the Safeguarding Children and Adults Group and the training manager escalates this information to the department business manager.

STFT had some issues as identified during the CQC inspection in respect of accurate training figures and a vast amount of work has been undertaken to address this. Therefore this report will not include the 2016/17 data but can give assurance that as of the 31st March 2017 level 1 compliance stands at 94%, level 2 at 88%, and level 3 at 86% which indicate substantial improvement.

In additon there is level 4 and 5 which is for Named and Designated professionals with compliance standing at 100% for both across both Trusts.

7.1 SCR briefing and safeguarding awareness sessions

CHSFT safeguarding children team developed a programme of 'Think Family' awareness sessions planned once a month over the year. These sessions were based in the lecture theatre over a lunch time and suggestions came from staff on some of the topics to cover. Children Law, Mental Capacity and DoLs and drugs/alcohol were but a few, with several external agencies facilitating. Feedback from staff was good; however due to the challenges in releasing staff from high flow patient areas the attendance to these had diminished and an alternative mode of awareness will be developed in 2017/18 whereby staff can access information suitable to them, whilst not required to leave the department.

'Safetember' is the month in which patient safety features across both Trusts with the Children and Adults leads delivering a session based on SCR's which had a child and adult element of learning. This date will continue in 2017/18 and will form part of the twice yearly safeguarding awareness days for staff.

7.2 National Child Sexual Exploitation Awareness Raising Day

On the 18th March 2017 both Trusts delievered sessions to raise the profile of child sexual abuse. Poster displays, leaflets and awareness raising with the use of STFT carousel/ intranet site being utilised.

7.3 Domestic Abuse Awareness Week STFT

November 2016 was Domestic Abuse Awarenes Week and a safeguarding forum was held in STFT for Trust staff, raising awareness of the NICE Domestic Violence and Abuse: Quality Standards. Displays with information pertaining to domestic violence across all sites were in place with a safeguarding children and/or adult advisor an Occupational Health practitoner were present to enforce the campaign and answer staff questions. The information was repeated in March 2017 at part of CSE awareness week.

7.4 Safeguarding Annual Symposium CHSFT

This took place on the 27th March 2017 with 100 staff attending. There was an excellent speaker, Mr John Clough. He spoke about his and his families experience of domestic abuse when, his daughter a nurse, was murdered due to dometic abuse. Sunderland Children and Adult services contributed to the day and demonstrated strong multi-agency working. Future plans are to hold a joint STFT and CHSFT symposium for 1 day in 2018.

8.0 LOOKED AFTER CHILDREN HEALTH SERVICE

'Looked after Children' (LAC) is a generic term introduced in the Children Act 1989 to describe children and young people in the care of local authority. The Looked After Children's health team is governed by statutory guidance from the Department of Health 2009 and by NICE guidance published in September 2010, The Children (Leaving Care) Act 2000 and Looked after children knowledge, skills and competences of health care staff Intercollegiate role framework March 2015.

LAC initial health assessments (IHA) need to be completed by a Doctor, within 28 days of a child coming into care, and subsequent review health assessments (RHA) every 6 months for children aged less than 5 years and every 12 months for children/young people aged 5-17) by a LAC nurse in CHSFT and within STFT a HV/ School Nurse age dependant and/or Named Nurse LAC. Their physical needs are addressed in these assessments. Northumberland Tyne and Wear (NTW) provide tier 3 services and there remains ongoing issue with timely appointments from NTW services for referral made by LAC health team and social workers. This has been escalated to the CCG commissioners.

National guidance (Looked after children: knowledge, skills and competence of health care staff March 2015) now advises roles of Name Nurse for LAC and Named Doctor for LAC in line with safeguarding structures. Following a review of LAC services within CHSFT the commissioning arrangements for the Named Nurse LAC was transferred from STFT to CHSFT.

This move allowed changes in the model of delivering on IHA's and RHA's in a less medically defined framework with more nurse led focus. The service now provides a flexible service to meet the needs of the LAC population now such as home visits for those young people who are 'hard to reach'. The new service has also engaged directly with LAC services users to gain feedback on the new approach.

The services for South Tyneside LAC remain within STFT and the IHA are completed by a Dr with the RHA completed by a HV or school nurse alongside the Named

Nurse for LAC. Gateshead Looked After Children Team transferred from STFT to Gateshead Queen Elizabeth Hospital.

The current number of Sunderland children Looked After is 528, of which 78 reside out of area. 2 are currently in secure placements; with 17 accommodated in specialist out of area placements. The reason for the out of area placements are due to the lack of local specialist services i.e. disability care or therapeutic support with education.

The current number of South Tyneside children Looked After is 275, of which 84 reside out of area. There are none who are accommodated in a specialist unit or secure accommodation.

Figure 11 STFT percentages of statutory health assessments in timescale

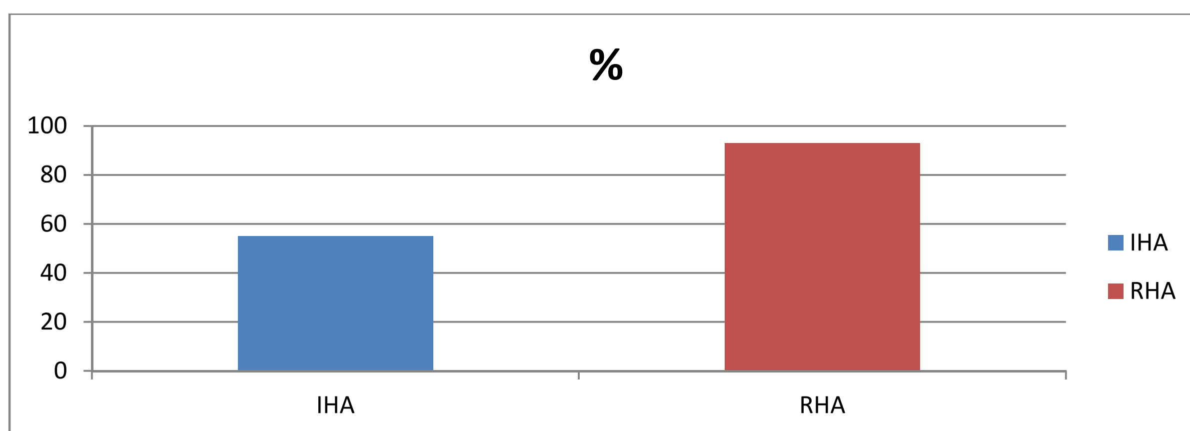


Figure 11 demonstrates the IHA are low and this is a combination of failure to have parental consent ready by time frame from Children Services and appointments being cancelled by carers.

Figure 12 CHSFT Percentage of statutory health assessments in timescale

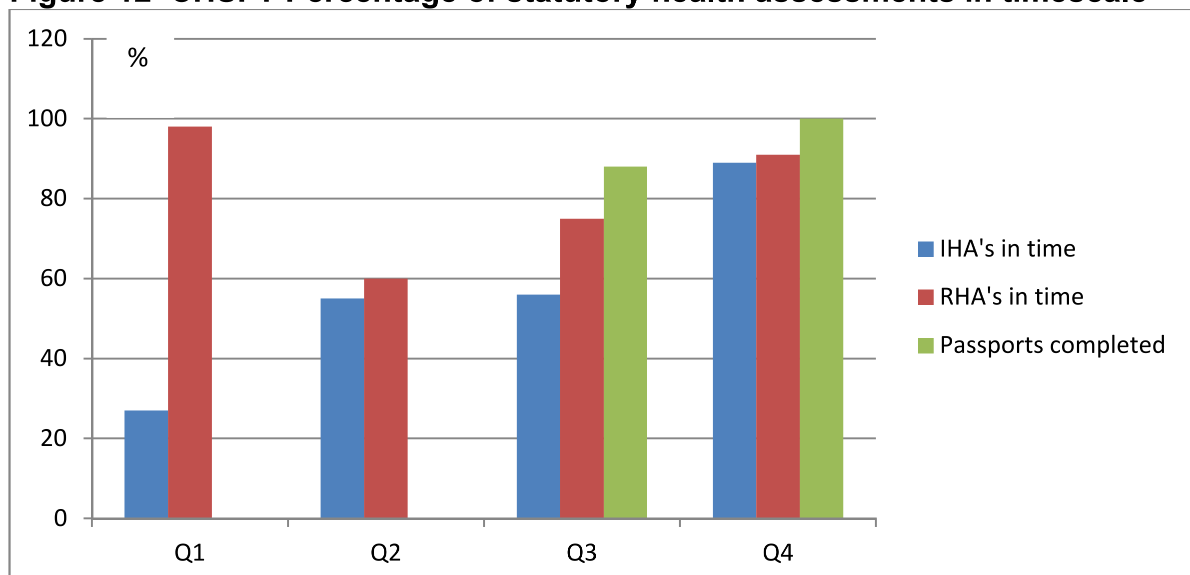


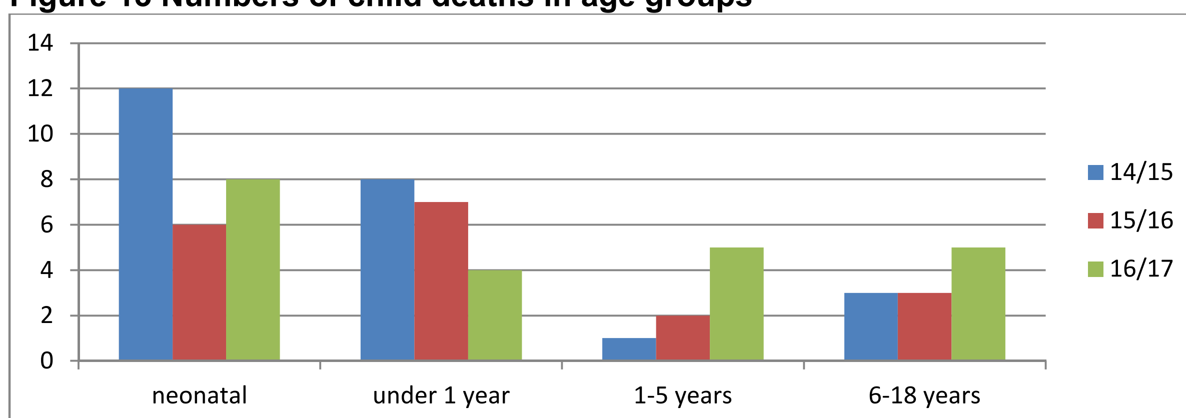
Figure 12 demonstrates a significant improvement in KPI compliance, which has been achieved due to changes in the LAC model and robust partnership working with a LAC service manager. The partnership working consisted of weekly communication to the LAC team informing them of children becoming looked after, supporting his social workers in completing the necessary documents in time frame. The data for health passports, as part of the improved data capture work, commenced in Q3.

Following service user feedback and the Change Council made up of children and young people (Sunderland LA) involvement, the team were able to secure charitable funds from Paediatrics to furnish a dedicated waiting room for young people 13 years and over. The user feedback also indicated the young people's wish not only for a separate waiting area but improvements made to their health passports. Health passports are a health profile, for when they leave the LAC service. Their health information is not something they can often go back to parents and request, therefore this is their information that can support them later in adult life if health issues were to arise.

9. CHILD DEATH REVIEW PROCESS (CDR)

The Designated Doctors for Child Death Review Process (DCDR) for each Trust attend the CDR meetings and South of Tyne child death overview panel (CDOP) meetings. At each meeting every child death is scrutinised to extract learning (local, regional and national) from the death, including where immediate action needs to be taken.

Figure 13 Numbers of child deaths in age groups



The causes of neonatal deaths remain similar to previous years: extreme prematurity, sepsis & congenital abnormality. In the under 1 year category, cot death and congenital abnormality inconsistent with life were the most common causes of death. In the 1–5 years category, the deaths were due to neuro- disability (congenital and post septic) and congenital cardiac abnormalities. This year showed a significant increase due to cardiac abnormalities in comparison to previous years. In the 6–18 years category, all of the deaths were 16 years of age or older. They were due to drugs overdose (2), accidental drowning (1) and congenital abnormalities (2).

Both the two older age categories showed significant increase in cases of death. This year, many of the cases were expected deaths; these were young people who

survived due to increasingly sophisticated medical care for longer periods of time. These children were well known to the Paediatric Department.

During 2016/2017 across the 3 localities STFT safeguarding children team were notified of 36 child deaths. The largest proportions of deaths in the 0-5 age cohort are associated with premature births and deaths of children with known life limiting conditions. Deaths related to 16-18 year old children, relate to unexpected death through accidental harm. Overall the findings show that the pattern of child deaths seen locally reflects those identified in regional and national findings.

Lessons learnt from any deaths are fed back by the DDCDR. Any learning outcomes are monitored by the DDCDR and reported into Strategic Safeguarding Children Group and into STFT and CHSFT training and supervision.

10. LEARNING FROM SERIOUS CASE REVIEWS (SCR) AND INDEPENDENT MANAGEMENT REVIEWS (IMR)

Working Together (2015), requires reviews to be conducted, for cases which meet statutory requirements as well as cases which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. In addition to the statutory SCR processes, the safeguarding teams are also required to contribute to Individual Management Reviews.

Other types of reviews include Child death, review of a child protection incident which falls below the threshold for a SCR and reviews of practice through audit across one or more agencies.

Following the Wood Report May 2016 (DOH) the Government will replace the current SCR system with a system of national and local reviews. This will ensure that reviews are proportionate to the case they are investigating, and improve consistency, speed and quality (this will include accrediting authors).

- Under the new system, lessons from reviews will be captured and shared more effectively so that they can inform good practice.
- A National Panel will be established. This will be responsible for commissioning and publishing national reviews and investigating cases which will lead to national learning.
- Local partners will be required to carry out reviews into cases which are considered to need (at least) to local learning. These should be published.
- The planned What Works Centre for children's social care will analyses and share lessons from local and national reviews.
- Up to £20m has been announced by the Government to fund the centralisation of case reviews and the What Works Centre.

To date there have been no local changes to the process and within any of the 3 localities covered by STFT and CHSFT.

During 2016/2017, seven Serious Case reviews were published across the three local safeguarding children boards, with all action plans up to date. There were 10 requests to conduct new scoping exercises where concerns have been raised under the remit of a potential SCR, with one meeting the criteria.

The Safeguarding Children and Adults Group (SCAG) and Safeguarding Assurance Group (SDAG) oversee the progress and escalate any risks/lack of progress to the Governance Committee as part of the Quality Risk and Assurance Report.

Following the publication of any SCR's briefing sessions will be completed to share the learning across each Trust.

11. CHSFT ACTIVITY 2016-17 ACHIEVEMENTS

This section of the report provides a progress update on the priorities identified in 2015- 2016 Annual report.

11.1 Business case to be made for additional ongoing resources within the safeguarding team to ensure robust supervision is in place for Maternity and acute services.
Update: As part of the maternity review the funding has been agreed and the post will go out to advert in early summer.

11.2 Maintain above 80% safeguarding training figures and improve figures where below.
Update: Achieved all above and new target set at 90%

11.3 Produce a safeguarding audit strategy. This would have 2 strands to it; SCR audits and annual assurance audits. Review Section 11 audit compliance in respect of new data requirements.
Update: Achieved and monitored by SCAG

11.4 Embed the use of Ulysses to complete safeguarding referrals to children services.
Update: Ulysses is now embedded into every day practice.

11.5 Review the LAC health assessment process and ensure data collection is robust to give assurance health performance indicators is met.
Update: Achieved see section 7

11.6 The LAC health team will review to determine how statutory assessments can be done more effectively, more flexibly and still remain LAC focused, including delivering services to the hard to reach teenagers and increasing the co-working with mental health services.
Update: Achieved see section 7

11.7 Within the CSE task and finish group, the CSE screening will be embedded within AED/ PED documentation with the aim of safety netting those vulnerable young people within CHSFT.
Update: Ongoing work to improve compliance within adult ED

11.8 The opinions of the LAC will be sought which has led to the creation of an adolescent sitting room at the children's centre.
Update: Achieved see section 7

11.9 To develop a multi-agency LAC strategy.

Update: Transferred to Multi Agency Looked After Partnership.

11.10 Child protection supervision training to key staff.
Update: 2 supervisor training sessions delivered to 24 staff.

11.11 Child protection supervision documentation to be within Clarity for NMC revalidation.
Update: All staff receive supervision notes which they can upload into Clarity.

12. STFT ACTIVITY 2016-17 ACHIEVEMENTS

12.1 The past year has focused on the delivery of the CQC joint inspection action plan alongside the Serious Case Reviews action plans.

13. CHSFT and STFT FUTURE ACTIVITY 2016-17

13.1 LAC newsletter in partnership with Change Council

13.2 Improve CYPS service for CHSFT LAC

13.3 Monthly bespoke training sessions to increase midwives knowledge and skills of domestic violence and the impact this has on the pregnant woman and her unborn baby STFT and CHSFT.

13.4 Ensure dog safety message is embedded into midwifery practice and is incorporated into the maternity postnatal baby records STFT and CHSFT.

13.5 Collaborative working between STFT and CHSFT safeguarding adults and children teams.

13.6 Electronic CHSFT maternity pregnancy records to have safeguarding documentation incorporated.

13.7 Child Protection –Information Sharing to be live within CHSFT and STFT patient records systems by March 2018.

13.8 Safeguarding children nurse advisor acute services for CHSFT and STFT.

13.9 LAC nurse appointment for CHSFT.

13.10 Safeguarding Advisor Acute services appointment for STFT.

13.11 New process to replace monthly 'Think family' awareness in place for staff i.e. safeguarding newsletter.

13.12 Voice of child across STFT and CHSFT with a service user group.

13.13 Child and young person annual report.

13.14 Improve IHA compliance within STFT.

13.15 Target hard to reach young people to ensure health assessments in place by means of creative working.

13.16 A single IT solution to support the Safeguarding Team across the 3 locality areas.

13.17 Safeguarding Supervision will be further developed to include a review of the Supervision arrangements to the community services in light of recommendations from the National Health Visiting Core Service Specification (NHS England).

13.18 The Safeguarding Children Policy should be updated during 2017/2018 to include the improvement work undertaken following the CQC review and to ensure it is updated in line with local and national guidelines.

13.19 STFT and CHSFT Adoption Procedure will be reviewed to ensure all health information is within child's adoption records.

13.10 Continue to develop integrated safeguarding team across STFT and CHS.

Report produced by the Named Nurses for STFT and CHSFT with contributions from safeguarding children teams.

CITY HOSPITALS SUNDERLAND SAFEGUARDING CHILDREN AND ADULTS **APPENDIX 1**

CHILDREN OPERATIONAL MEETING (fortnightly)

CHILDREN AND ADULTS OPERATIONAL MEETING (monthly)

↔ SAFEGUARDING BUSINESS MEETING (bi-monthly)

↕

SAFEGUARDING CHILDREN AND ADULTS GROUP (SCAG) (bi-monthly)

↓

SUNDERLAND CHILDREN & YOUNG PEOPLES PARTNERSHIP

TOGETHER FOR CHILDREN (SSC)

LOCAL SAFEGUARDING BOARDS

- Sunderland
- Durham

CLINICAL GOVERNANCE STEERING GROUP (monthly via minutes of SCAG)

↓

EXECUTIVE COMMITTEE (monthly via QRA Report)

↓

GOVERNANCE COMMITTEE (monthly via QRA Report)

↓

TRUST BOARD (monthly via QRA Report)

APPENDIX 2

2017-07-06 CHS Governance Arranger

APPENDIX 3

2017-07-06 STFT Governance Arranger

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

AUDIT COMMITTEE

SEPTEMBER 2017

ANNUAL REPORT 2016/17

The Audit Committee, as part of its terms of reference, provides an Annual Report of its work to the Board. This report covers meetings relevant to the 2016/17 year. The principal purpose of the report is to give the Board assurance as to the work carried out to support the Accountable Officer's review of the internal control arrangements. The Committee's cycle of business enables the Audit Committee to carry out its key objectives necessary to support its assurances regarding the effectiveness of the organisation's internal controls. (A copy of the 2016/17 cycle of business is attached).

In the view of the Audit Committee the Annual Governance Statement is consistent with the view of the Committee on the organisation's system of internal control and the Committee supports the Board's approval of the Statement.

The Committee met seven times formally during the financial year and once in relation to the review of the annual accounts. Officers and staff of the trust and Internal and External auditors have attended each meeting to report, provide information and facilitate the meetings.

During the year the Committee has reviewed the establishment and maintenance of an effective system of financial governance, risk management and internal control, across the whole of the trust's activities that supports the achievement of the organisational objectives. In particular it has reviewed disclosure statements from the internal and external auditors and other independent assurances, prior to Board endorsement. We can confirm that we are satisfied that risk management is embedded within the organisation, from assurances gained by review of the work of the Governance committee, in particular we have reviewed their work on the Assurance Framework and risk register.

There has been discussion between the Chairs of the Audit Committee and the Governance Committee and the responsible officers, as well as review of Minutes to ensure that there are no significant matters, which have not been covered in the work programme of one of these Committees.

As part of its work throughout the year the Audit Committee has also:

Reviewed the Annual Report and Financial Statements before submission to the Board, focussing in particular on:

- The Annual Governance Statement;
- Changes in and compliance with accounting policies and practices.
- Unadjusted misstatements in the financial statements;
- Significant judgements in the preparation of the financial statements;
- Significant adjustments resulting from the audit (there were none);
- The letter of representation and
- The qualitative aspects of the financial reporting.

Based on this review the Audit Committee recommends to the Board that it approve the Annual Report and Financial Statements for signature by the Accountable Officer.

Internal Audit:
The formal meetings always include at least one member of the Internal Audit team. The Audit Committee considers their reports, review and agrees strategy plans and programmes, and reviews their effectiveness during the year. We also consider any major findings, and the management response in detail. We ensure that we are satisfied as to, co-ordination with external audit. There is also an annual review of their effectiveness.

External Audit:
There is always at least one representative of the External Audit team at the Audit Committee formal meetings. We review their work and findings, follow up their management requests and agree their fee proposals. Their annual report to Governors is reviewed as to adequacy before being submitted to them. In reviewing their reports (including their annual letter), we monitor management responses.

Meeting in private of the Committee with the Internal & External Auditors:
The members of the committee did not meet with the above bodies this year without the presence of the officers, as both were new appointees. There will be a meeting in 2017/18.

Local Counter Fraud Services:
We ensure that there is an effective function established by:

- Considering the provision and cost of the service.
- Reviewing and approving the strategic and annual plan.
- Considering the findings of their work and investigations, including management response.
- Conducting an annual review of their effectiveness.

Clinical Risk:
Whilst it is not the remit of the Audit Committee to manage a programme of clinical risk assessment, it is within their remit to overview the work of the Governance Committee in this respect. We confirm that a close liaison between the Committee's is maintained, including the benefit of having their Chair as a member of the Audit Committee, and that we are satisfied that their programme manages the key risks.

Self-Assessment:
The Committee last carried out a self-assessment on the 13th October 2016.

Conclusion:
The Board of Directors is requested to note this report.

David Barnes
Chair of the Committee

June 2017

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS IN PUBLIC

MORTALITY REVIEW AND LEARNING FROM DEATHS POLICY

SEPTEMBER 2017

INTRODUCTION

1. The CQC report *Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England* was published on 13th Dec 2016.
2. In a statement to Parliament on the same day, the Secretary of State accepted all of the CQC's recommendations and made a series of commitments. A key recommendation was a request to the National Quality Board (NQB) to draw up a **national framework on learning from deaths**.
3. In March 2017, the NQB published the first edition of the '*National Guidance on Learning from Deaths'*. One of the key requirements for Trusts was to publish a policy on how it responds to, and learns from, deaths of patients who die under its care.

OVERVIEW

4. The NQB guidance states that all Trusts must have a policy in place setting out how they respond to the deaths of patients who die under their care. These must be published on Trust websites by **September 2017** following a public Board meeting.
5. The guidance states that all policies must include:

    - the Trust's mortality review process, including the method used, how the scope of deaths for potential review is determined and how deaths are selected for review,
    - how the Trust responds to the death of someone with a learning disability or severe mental health needs, of an infant or child, or a stillbirth or maternal death,
    - how the Trust decides which deaths – whether reviewed or not – require an investigation under the Serious Incident framework, and
    - how the Trust engages with bereaved families and carers, including how they are supported by the Trust and involved in investigations where relevant.

6. In this 'fast moving' agenda, some of the sections within the document will require further amendment following publication of additional national guidance, i.e. advice on how best to involve families in mortality reviews and investigations.

RECOMMENDATION

7. Directors are asked to accept the policy and to be assured that the document meets all National Quality Board requirements.

Ian Martin
Medical Director

David Laws
Trust Mortality Lead

Gary Schuster
Clinical Governance Manager

City Hospitals Sunderland NHS
NHS Foundation Trust

Mortality Review & Learning From Deaths Policy

Document Reference	To be determined by Corporate Affairs
Document status	Draft (during development)
Target Audience	All clinical staff involved in mortality case record reviews and investigations and who have a role to play in learning from death
Date Ratified	To be added following approval
Ratified by	Policy Committee
Release Date	To be added following approval
Review Date	To be added following approval
Sponsor	Ian Martin, Medical Director

Version Control

Version	Dates of amendment	Author	Update comments
1.0	Sept 2017	David Laws, Consultant & Chair Trust Mortality Lead and Gary Schuster, Clinical Governance Manager	New policy in response to national requirement under the National Quality Board 'Learning From Deaths' Programme

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1 INTRODUCTION

1.1 The Care Quality Commission (CQC) published a report, 'Learning, candour and accountability; a review of the way NHS trusts review and investigate the deaths of patients in England' on 13 December 2016.

1.2 The report describes a review of the process of investigating deaths in a sample of NHS acute, mental health and community Trusts in England. This was undertaken in response to a review of mental health and learning disability deaths at Southern Health NHS Foundation Trust between April 2011 and March 2015. The report identified that:

- families and carers are not treated consistently well when someone they care about dies,
- there is variation and inconsistency in the way that Trusts become aware of deaths in their care,
- there was an inconsistent approach across Trusts to determine when to investigate deaths,
- the quality of investigations is variable and generally poor, and
- there are no consistent frameworks that require Boards to keep deaths in their care under review and share learning from these.

1.3 In their review, the CQC made a number of recommendations about how the approach to learning from deaths could be standardised across the NHS. These recommendations were accepted by the Secretary of State for Health, who asked the National Quality Board to produce a framework for the NHS on identifying, reporting, investigating and learning from deaths in care.

1.4 In March 2017, the National Quality Board published the first edition of the 'National Guidance on Learning from Deaths'. One of the key requirements for Trusts was to publish a policy on how it responds to, and learns from, deaths of patients who die under its management and care.

2 PURPOSE AND SCOPE

2.1 The purpose of the Mortality Review & Learning from Death Policy is to describe the process by which patients who die in our care are identified, reported and investigated. It aims to strengthen current arrangements, where appropriate, and to ensure that learning is shared and acted upon.

2.2 It seeks to ensure the Trust engages meaningfully and compassionately with bereaved families and carers and supports staff to find all opportunities to improve the care the NHS offers by learning from death.

3 DUTIES / RESPONSIBILITIES

3.1 Board of Directors

The Board of Directors is collectively responsible for ensuring the quality and safety of the healthcare it provides. The Board must ensure that robust systems are in place for recognising, reporting, and reviewing or investigating deaths where appropriate.

3.2 Chief Executive

The Chief Executive is responsible for the statutory duty of quality in the organisation and takes responsibility for the implementation of this policy.

3.3 Medical Director

The Executive / Board lead for Learning from Death is the Medical Director. Their responsibilities in respect of the Learning from Death programme, include:

- ensuring that all doctors and nurses (working with the Executive Director of Nursing & Patient Experience) are supported to fulfil their duty to engage in learning from death, participate fully in case record reviews and investigations, where appropriate and fulfil the Trust Duty of Candour requirements,
- ensuring that the Trust is learning from problems in healthcare identified by the review or investigation of deaths,
- ensuring that any serious concerns following a patient death are brought to the attention of the Board,
- publishing quarterly mortality reports to the public Board meetings, and
- ensuring that the annual Quality Account summarises the outcomes and learning from the Trust mortality review process.

3.4 **Designated Non-Executive Director for Learning from Death**

A specific Non–Executive Director (NED) has been identified to oversee the Trust's approach to Learning from Death. Their responsibilities in relation to the guidance, include:

- ensuring the processes in place for reviewing and learning from death are robust and can withstand external scrutiny,
- championing and supporting effective actions that improve patient safety, and
- ensuring that mortality review outcomes information shared with the public is presented in a meaningful and understandable way.

3.5 **Mortality Review Panel**

The Mortality Review Panel will be responsible for providing assurance to the Board on patient mortality based on clinical review of care received by those who die in hospital.

3.6 **Speciality Mortality Meetings**

Participation in mortality meetings should be considered a core activity for all clinicians. Whilst it is recognised that different specialties and directorates will have different requirements, the main principles are that they should be a forum for discussion of patient deaths and the associated clinical events and act as a driver for improvement.

3.7 **Rapid Review Group**

The Rapid Review Group (RRG) reviews Directorate Initial Incident Review forms relating to adverse events reported to have had a moderate or more severe impact, and establishes which require investigation to identify their root cause. RRG then commissions the appropriate level of investigation, setting appropriate Terms of Reference. RRG monitors progress of commissioned investigations, considers completed root cause analyses received from directorates, and either approves them or requires their amendment as appropriate.

Once the relevant investigation processes involving a death have concluded, RRG are responsible for determining the appropriate level of avoidability and NCEPOD quality scoring before closure. They also ensure appropriate actions and notification processes are engaged.

3.8 **Clinical Directors**

To ensure that all doctors in their Clinical Directorate are supported to fulfil their duty to engage in responding to deaths; to identify specific doctors to be involved in case record reviews and investigations and to meet the Duty of Candour requirements.

3.9 **Divisional General Managers / Directorate Managers / Heads of Department**

Senior Managers / Heads of Department are responsible for the proactive implementation of this policy within their business areas.

3.10 **Nurses, Allied Health Professionals and other clinical staff**

All healthcare professionals should be involved in mortality review meetings, as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews insofar as they affect their area of practice, to full involvement in the production of data and implementation of recommendations.

4. DEFINITIONS

4.1 Learning from Death offers a standardised framework for identifying, reporting, investigation and learning from deaths in care. The following definitions clarify the terms used in the national programme:

Avoidable / Preventable death

These terms are used interchangeably in the NHS and for the purpose of this policy 'preventable' or 'unpreventable' will be used with reference to whether anything could have been done during the admission associated with an in-hospital patient death to change the outcome.

Case Record Review

A structured critical review of the case records to determine whether there were any problems in the care provided to the patient in order to learn from what happened. The review should use a recognised and credible approach, for example the Structured Judgement Review (Royal College of Physicians) or the PRISM (Hogan) methodology.

This policy identifies a concise **first stage 1a screening review** conducted by the clinical team responsible for the patient's care at the time of death which is designed to be used in all deaths. This screening review will identify any deaths that warrant subsequent structured in-depth reviews: a **departmental stage 1b review** conducted by an appropriate specialist not primarily responsible for the patient's care at the time of death and a **Mortality Review Panel stage 2 review** that will identify whether the death is due to problems in care. The stage 2 review will determine judgements on the quality of care and the avoidability of the death.

Death certification

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. The process includes identifying cases for referral to the Coroner and links to the Medical Examiner role.

Death due to problems in care

A death that has been clinically assessed using a recognised methodology of case record review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

To identify avoidable deaths it is important to initially establish whether there were problems in the way healthcare was delivered to the patient (the processes of care). If a patient is harmed by healthcare but the care was delivered to an acceptable standard, this harm is known as a complication. A death following a complication, such as intracerebral bleeding after appropriate administration of thrombolysis would not be regarded as avoidable.

PRISM 2 defines a problem in healthcare as **'any point where the patient's healthcare fell below an acceptable standard and led to harm'.** Problems include:

- An omission or inaction such as failure to diagnose and treat
- An act of commission or affirmative actions related to the delivery of care such as incorrect treatment or management

The term “problem in healthcare” is preferred to the traditional term “adverse event” as this latter term tends to be associated with discrete incidents and is more likely to identify acts of commission than omission. The term “problem/s in healthcare” allows a reviewer to broaden their perspective and assess the impact of multiple small events (usually omissions) across the patient journey.

It may be difficult to identify one clear cut problem or even identify the point at which things went wrong. Avoidable deaths are more likely to result from a combination of problems in healthcare.

Death verification
The process of formal confirmation of a patient death and documentation of the time, date and location of death.

Duty of Candour
The Duty of Candour is a legal duty on healthcare organisations to apologise and fully patients/carers if there have been mistakes in their care that have led to moderate or more sever harm (definition given by NHS England). Duty of Candour aims to ensure patients receive accurate and truthful information about what happened and why and what action and lessons have resulted from the investigation.

Investigation
A systematic analysis of what happened, how it happened and why. 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. The Trust Incident Policy details the process of investigation, including the different levels of investigations required in specific circumstances.

Mortality Governance
Refers to a network of processes designed to monitor and challenge mortality performance and sets out the arrangements for investigating and learning from death.

Mortality Meetings
Involve reviewing patient deaths and complications in a structured manner. These meetings have the potential to identify improvements required for raising clinical standards and improving patient safety.

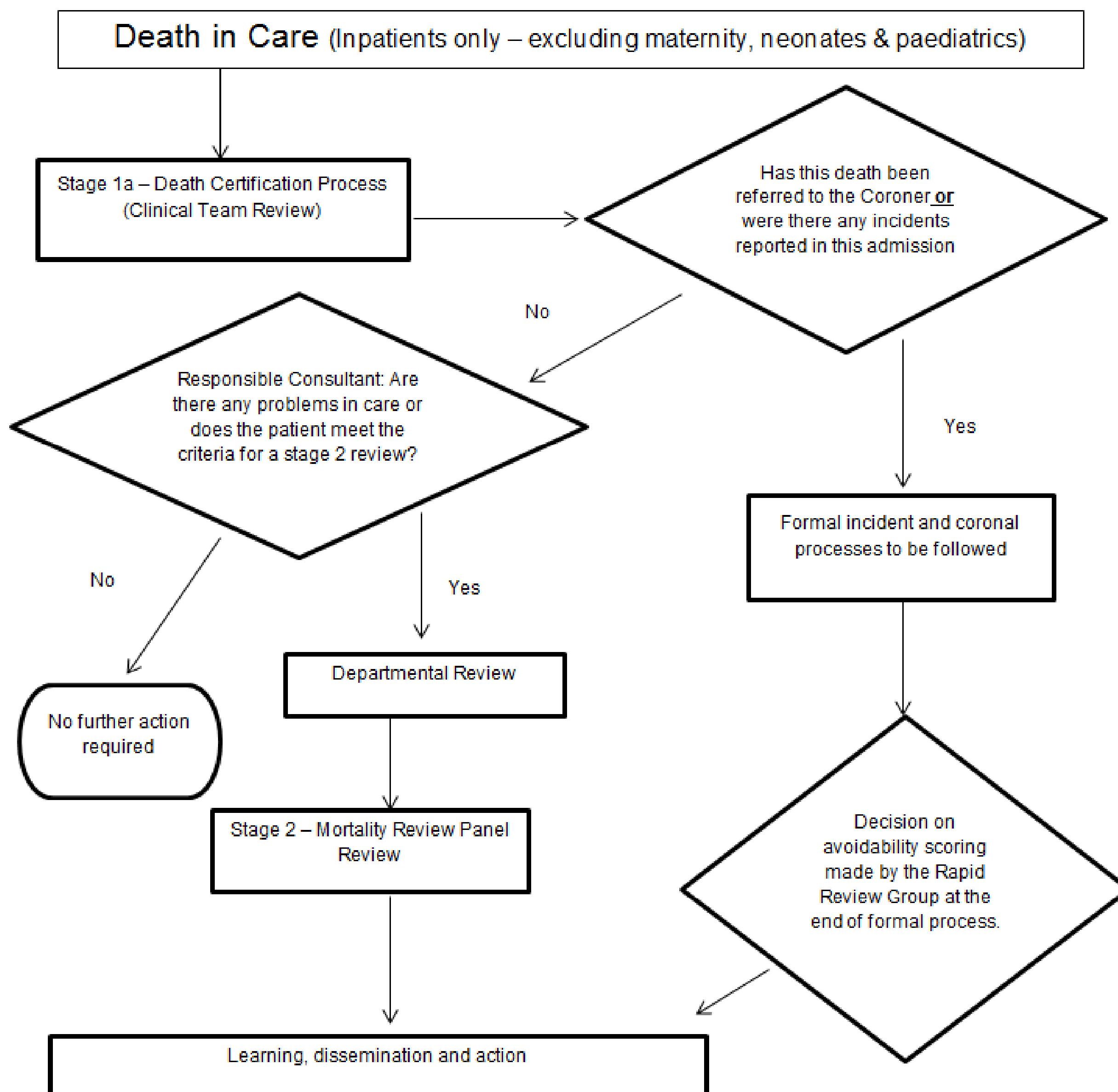
5. MORTALITY REVIEW & LEARNING FROM DEATHS – DEATH CERTIFICATION, CASE RECORD REVIEW AND INVESTIGATION

5.1 Levels of review

Level of review	Which deaths to include	Method
Stage 1 – Death Certification Process (clinical team screening review and, if indicated, structured Departmental Review)	All adult in-patient deaths	• Responsible Consultant at the time of death performs **stage 1a mortality screening review** • Completion of review document on Meditech V6 • Confirms accuracy of death certificate • Confirms completion of discharge letter • Records any involvement with the coroner • Identifies if there are any potential

		problems in care • Identifies if any other departments should perform a review of care provided • Identifies if the patient was in receipt of End Of Life Care prior to death – If **YES** – Patient death may be selected for End of Life audit to determine quality of end of life provision • Does the patient meet any of the criteria for structured mortality case record review – If **YES stage 1b departmental review** (ideally) conducted by specialist consultant not directly involved in the provision of the patient's care. Any learning points will be recorded at completion of this departmental review
Stage 2 – Mortality Review Panel (independent peer review)	Nationally set criteria	• Structured Case Record review by independent reviewer within the Trust Mortality Review Panel • Review death certificate for accuracy and completeness • Check reportable deaths have been referred to Coroner • If findings reveal the death should have been reported, report immediately • Identify learning opportunities • Liaise with departments to produce recommendations for improving the safety and quality of care
Stage 3 – Corroboration & collation (independent triangulation)	Patient deaths subject to: • Coroner's Inquest • Serious Incident Framework analysis	• Collating judgements from other sources through RRG – i.e. adjusting avoidability scores following departmental review post MRP, determining avoidability score based on coroner's reports, determining avoidabilty scores based on RCA findings, address Duty of Candour issues where avoidability of death is identified as more likely than not to have occurred

The flowchart below summarises the levels of review



5.2 Certification and registration of a death – opportunities to raise concerns

5.2.1 When a death occurs the consultant responsible for care has a duty to decide whether the coroner needs to be informed and to oversee the process of completing the death certificate, including the recording of the cause of death. In normal circumstances, there will be an opportunity to discuss with the bereaved family the cause of death and at this stage the family should be asked whether they have any concerns about the care of the deceased patient. To assist the doctors in making this decision the Coroner has issued a Guide to Reportable Deaths which details which cases must be referred to the Coroner. Currently these guides can vary between Coroners however there is work underway, led by the Chief Coroner to introduce standardised guides.

5.2.2 If any concerns are identified at any stage of the certification or registration process, the death will receive a 'second stage case record review' (see below).

5.2.3 Appendix 1 sets out the Standard Operation Procedure (SOP) for completion of Medical Death Certification and Cremation Forms.

5.3 Stage 1 case record mortality review – Appendix 2

5.3.1 A concise **Stage 1a screening mortality review** conducted by the clinical team responsible for the patient's care at the time of death is designed to be used in all deaths. This screening review will identify any deaths that warrant subsequent structured in-depth reviews: namely, a **departmental stage 1b mortality review** conducted by a specialist not primarily responsible for the patient's care at the time of death and a **Stage 2 Mortality Review** conducted by an independent reviewer within the Trust's Mortality Review Panel team.

5.3.2 Wherever possible the ***Stage 1a mortality screening review*** should be completed by the ***responsible consultant at the time of the patient's death***. This stage will also ensure determinations and documentation after death is completed in a timely fashion and is satisfactory. The document should be completed after determination of the death certification process has been made. The document should be completed and saved on Meditech V6 within 5 days of the death. Foundation doctors should not conduct this review under any circumstances as high-level judgements and understanding is needed. The responsible consultant may delegate this task to a cross-covering consultant in their absence. A senior specialist trainee may be delegated this task under direct supervision as part of their training, but this should not form part of their service commitment on a routine basis.

5.3.3 If the Stage 1a screening mortality review identifies criteria are met for a Stage 2 review, a departmental **Stage 1b case record mortality review (Appendix 3)** must be completed within **4 weeks** by a consultant. This should be conducted by a consultant within the same department who has (ideally) not been directly involved in the patient's care.

5.4 Stage 2 case record mortality review – Appendix 4

5.4.1 An independent review of the notes will be carried out by the Mortality Review Panel when:

- One or more criteria for a Stage 2 Mortality Review are met (**Appendix 5**) as determined at Stage 1a Mortality Screening review
- Stage 1b Departmental case record review suggests an independent Trust-level review may be helpful or where the death is judged to have greater than 50:50 chance of being preventable

Judgements on the quality of care and the avoidability of the death will be determined at this stage. The Mortality Review Panel will report to the Mortality Review Group on a quarterly basis.

5.4.2 For certain groups of patients, there are already well-established processes in place to guide local mortality reviews and investigations. For reviewing the deaths of patients who had a **learning disability,** the Learning Disabilities Mortality Review Programme (LeDeR) is used (**Appendix 6**). **Maternal and neonatal deaths** are reviewed within an existing process which is described in **Appendix 7.** Similarly a robust process for the **review of deaths in children and young people** is outlined in **Appendix 8.**

5.4.3 For the **death of an individual with mental health needs,** the Team Manager of the Sunderland Psychiatric Liaison Team (NTWMHT) and the Head of Patient Experience and Practice Development (CHSFT) undertake reviews of patients who have passed away whilst detained or have an existing mental health problem. However, additional formal links with mental health services are currently under discussion and will be incorporated into the policy in due course.

5.5 Investigations

5.5.1 All deaths are cross referenced to the Trust's incident reporting system to identify any death in which an incident was reported during the patient's hospital stay. Where an incident has

been recorded, second stage case record review will be carried out in order to judge whether the incident was part of a problem in care that contributed to the patient's demise.

5.5.2 Case record review is not a replacement for investigation, which includes root cause analysis (RCA). RCA involves reviews of case records reviews but goes beyond this by utilising other evidence including discussions with staff. Second stage case record reviews may identify the need for incident reporting and subsequent investigation.

5.6 Cross-system Reviews and Investigations (flowchart Appendix 9)

5.6.1 In many circumstances organisations other than the Trust are involved in the care of a patient who dies whilst in the care of the Trust, with the most common ones being primary care, ambulance services, other acute Trusts and mental health services.

5.6.2 In the past, case record review has largely been restricted to review of records held by the Trust, however it is sometimes possible to identify problems in care at earlier stages of the patient's contact with health services. Where this is the case, it has been possible to ask for reviews to be carried out by other organisations, however this has largely been restricted to other acute Trusts and the National Quality Board's regulations make it clear that the NHS needs to substantially strengthen arrangements. As these arrangements come into place, it is expected that Trust staff will engage with cross-system reviews and investigations as required.

5.7 Serious Incidents

5.7.1 The Trust should apply rigorous judgement on deaths subject to Serious Incident Reporting and investigation where the death clearly meets the Serious Incident Framework. The RRG will determine which reported incident meets the NHS England criteria of a Serious Incident. The Trust Incident Reporting Policy gives the definition of a Serious Incident and shows the guidance which RRG applies when considering whether an adverse event meets the national definition of a Serious Incident.

5.8 Meaningful engagement with bereaved families and carers

5.8.1 This should include informing the family/carers if the Trust intends to review or investigate the care provided to the deceased patient. When a death is being investigated as part of either a Serious Incident RCA investigation or an Inquest this should include details of how families/carers will be involved to the extent that they wish to be involved.

5.8.2 Processes are already in place in the Trust that reflects the requirements of Being Open and Duty of Candour. These ensure families and carers are involved and informed with regard to their involvement with any investigation process.

5.8.3 Nationally, there is ongoing work to determine what support bereaved relatives and carers can expect from Trusts. The policy will be flexible to accommodate the outcomes from this important area of work.

5.9 Learning from deaths

5.9.1 The purpose of reviews and investigations of death is to identify any learning in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

5.9.2 It is beyond the scope of this policy to outline all the organisational and educational mechanisms that can be employed to do this. However, it is clear that case record reviews and investigations must include summaries of the lessons that need to be learnt and disseminated. The Trust will collate themes and report on action taken as a result.

5.9.3 Lessons to be learned are shared on an individual, group and organisational level dependent upon the issue and relevance. Reports detailing lessons learned from deaths are provided to the Trust Bereavement group on a monthly basis to inform their work and necessary action planning. Key learning is also identified within the quarterly report which the Mortality Review Group provides to Clinical Governance Steering Group and shared with the clinical governance leads to disseminate across their respective areas of responsibility.

5.9.4 A detailed narrative account of the learning from reviews / investigations and any actions taken and their impact will be included in the annual Quality Account (Quality Report).

5.10 Deaths referred to the Coroner

5.10.1 The coroner is an independent judicial office holder, appointed by the Crown. Coroners investigate all deaths where the cause is unknown, where there is reason to think the death may not be due to natural causes, or deaths which need an inquiry for some other reason e.g. a death in police custody.

5.10.2 The role of the coroner is to determine who the deceased person was, when, where and how (i.e. in what circumstances) they came by their death. When the death is suspected to have been either sudden, of unknown cause, violent, or unnatural, the coroner decides whether a post-mortem examination is necessary and if warranted opens an inquest.

5.10.3 A post-mortem examination of the body will usually establish the cause of death, if the cause of death is found to be one of natural causes then the Coroner will close his investigation and a death certificate will be issued. However if the cause of death is found to be unnatural or cannot be ascertained then an inquest will be opened. An inquest is held in open court (this means members of the general public may attend should they wish) and seeks to establish who, when, where and how the person came about their death.

5.10.4 Inquests involving patient's receiving care at City Hospitals Sunderland
The place where death occurs will dictate which Coroner's jurisdiction will be involved and investigate the death, therefore the patient may have received care at CHS but then discharged home to South Tyneside, in which case the death will be investigated by the South Tyneside Coroner.

5.11 The City Hospitals Sunderland Inquest Process

5.11.1 The Inquest Team at CHS will be notified by the Coroner that an investigation into a death has been opened and information is required from the Trust to facilitate this. Case notes will immediately be secured and the originals maintained within the Inquest Offices ensuring chain of evidence, should it be required. Copies of both paper medical records and electronic records are provided to the Coroner to facilitate the investigation.

5.11.2 The Risk and Inquest Manager (R&I) determines in conjunction with the Coroner which staff will be required to provide statements to assist with the investigation and ensures that these are provided in accordance with the required standards. The R&I Manager also ensures that appropriate support is provided to staff involved in the process and if necessary external support services are accessed. If the case is complex (involving multiple specialties or has the potential for significant litigation) then the R&I will ensure that appropriate legal advice and support is obtained and will ensure that National Health Service Resolution (NHSR) are informed.

5.11.3 Once initial statements and records have been reviewed and the post mortem (if necessary) has been completed the Coroner will advise the R&I Manager if an inquest is required. If so then additional statements may be required and the R&I Manager will facilitate this and ensure that staff are appropriately supported and prepared to attend court.

5.12 Police Investigations

5.12.1 The police will be involved in investigating a death if there is a suspicion that a crime has occurred. Generally, deaths should be reported to the police if it is suspected that assault, violence or other criminal act has caused or contributed to the death e.g. intentional poisoning

During working hours when the Coroner is notified of a death then if warranted a decision will be taken as to whether the case requires escalation to the police in which case the Coroner will ensure that this takes place. If a death takes place out of hours and it is suspected that the death is due to a criminal act then the police should be contacted immediately and hospital staff should not wait for the Coroner's usual office hours. There is a 24/7 on call service in operation to deal with such matters.

5.12.2 Criminal investigation by the police takes priority over other enquiries or investigations and therefore may be put on hold, as it may potentially prejudice a criminal investigation and subsequent proceedings (if any).

5.12.3 The Trust is part of a multi-agency agreement between the Coroner, Northumbria Police, and the Health and Safety Executive which is known as a Memorandum of Understanding (MOU). This sets out the investigation processes that will take place and how they will be coordinated and managed. The CHS designated point of contact for the MOU is the R&I Manager.

6. MONITORING COMPLIANCE / EFFECTIVENESS OF THE POLICY

Area for monitoring	Method	Frequency	Responsibility	Monitoring Assurance Group	Lead for developin g action plan	Group responsible for monitoring action plan
Duties and responsibilities of staff involved in Mortality Review & Learning from Death Policy	Review of policy	Three yearly (*or earlier given the dynamics of the national agenda*)	Policy author(s)	Mortality Review Group	Policy author(s)	Clinical Governance Steering Group (CGSG)
Case selection and review method	Review of case review method used	Annual	Trust mortality lead / Clinical Governance Depart	Mortality Review Group	Trust mortality lead / Clinical Governan ce Depart	CGSG
How the Trust responds to the death of specific types of patients	Review of case selection	Annual	Trust mortality lead / Clinical Governance Depart	Mortality Review Group	Trust mortality lead / Clinical Governan ce Depart	CGSG
Engagement with families / carers – support and involvement in	Review of current process	Annual	Trust mortality lead / Clinical Governance Depart	Mortality Review Group	Trust mortality lead / Clinical Governan	CGSG

Area for monitoring	Method	Frequency	Responsibility	Monitoring Assurance Group	Lead for developing action plan	Group responsible for monitoring action plan
the investigation process					ce Depart	
Learning from death	Trust Mortality Report	Quarterly	Trust mortality lead / Clinical Governance Depart	Mortality Review Group	Trust mortality lead / Clinical Governance Depart	CGSG
	Quality Report	Annual	Clinical Governance Manager	Mortality Review Group	Clinical Governance Manager	CGSG

7 DISSEMINATION, IMPLEMENTATION AND TRAINING

7.1 This policy will be implemented following approval of the document by the appropriate committees. Dissemination of the policy requirements will be achieved through the following mechanisms:

- available on the Trust's intranet and brought to the attention of all clinical and healthcare staff by means of an intranet link,
- reference to it will be made across the network of local clinical governance groups and meetings, including the Clinical Governance Leads meeting,
- included as part of local Trust induction for new starters, and
- inclusion in the City Hospitals Team Brief.

Training needs will be identified and assessed during the implementation of this policy and will be coordinated jointly by the Mortality Review Group, Clinical Governance Department and Risk & Inquest Team.

8 CONSULTATION, REVIEW AND APPROVAL/RATIFICATION

8.1 Consultation of the policy has included the following stakeholders:

- Trust Mortality Review Group and Panel
- Clinical Governance Steering Group,
- Risk Management Team, Litigation and Inquest Services
- Bereavement and Chaplaincy Services
- Clinical Directors,
- Clinical Governance Leads,
- Matrons,
- Operational Management Group,
- Child Death Leads,
- Learning Disability Leads,
- Maternal Death Leads, and
- Clinical Governance Department.

8.2 The policy will be reviewed after 3 years following approval or earlier if any significant changes are announced by the National Quality Board / Care Quality Commission / NHS Improvement. The review and any revisions will be jointly coordinated by the Medical Directors Office and Clinical Governance. Approval of the policy will be through Executive Committee and ratification through Policy Committee.

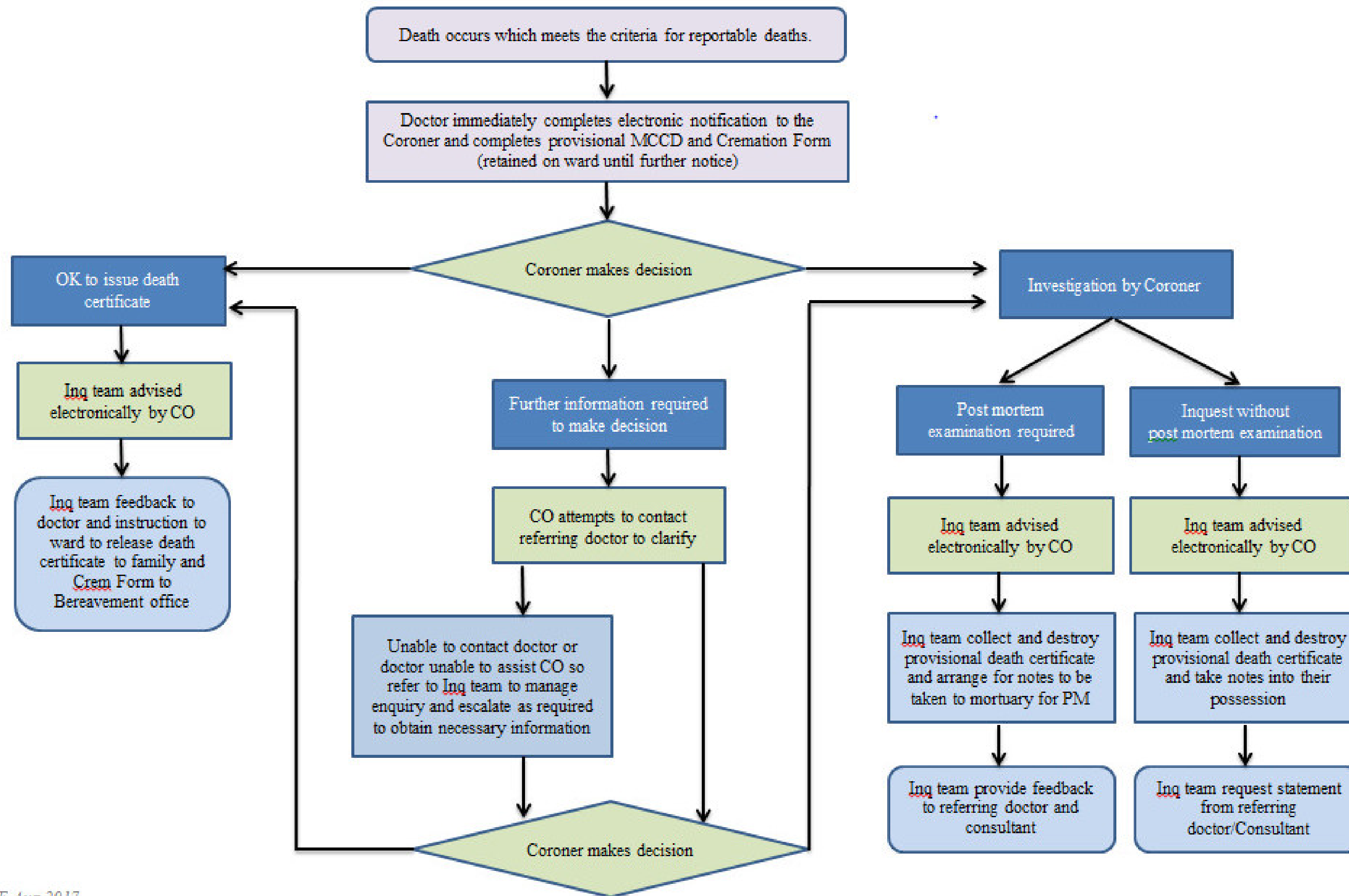
9 REFERENCES

- Care Quality Commission (2016) Learning, Candour and Accountability: http://www.cqc.org.uk/content/learning-candour-and-accountability
- National Quality Board (2016) National Guidance on Learning from Deaths: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
- National Quality Board (2016) National reporting dashboard: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-learning-from-deaths-dashboard.xlsx
- Morbidity & Mortality Meetings: A guide to good practice, Royal College of Surgeons (2015)

10 ASSOCIATED DOCUMENTS

- Post Mortem Policy
- Do Not Attempt Cardiopulmonary Resuscitation Policy (DNACPR)
- Organ & Tissue Donation Policy
- Incident Reporting Policy
- Investigating and Learning from Incidents Policy
- Trust Risk Management Strategy
- Maternity Risk Management Strategy
- Clinical Outcome Reviews Programme (Procedural document)

Standard Operating Procedure for completion of Medical Death Certificate and Cremation Forms



Appendix 2

Stage 1a Screening Mortality Review (To be completed on V6)

Death certification to be reviewed by senior clinician (**Not** Foundation doctor & ideally responsible consultant at time of death)

Stage 1a screening mortality review document (to be completed after death certification process has been determined):

To be completed by senior clinician, preferably consultant for all adult (non-Maternity patients) who die in hospital in patient care record.

Purpose is for 1) post death quality assurance, and
2) identification of patients for Stage 2 mortality review.

Q1. Were there any problems in care during the admission prior to death that may have had an impact upon this patient's death (e.g. acts of omission, commission, misdiagnosis, delays in diagnosis and/or treatment, recognition of deterioration or failings in response to deterioration, any poor quality care)?

Y/N If Yes, one sentence describing issue.

Q2. Death certificate options:

Select 1 option:
Death certificate issued independently by hospital
Death certificate issued after discussion with coroner's office
Death certificate not issued: For coroner's inquest
Death certificate issuance not determined at this stage

Q3. Please affirm that a saved Discharge Summary (deceased) has been completed and is accurate

Y/N If No, state why…

Q4. Was the patient in receipt of end of life care prior to death?

Y/N If yes, was the palliative care team involved in provision of end of life care Y/N/ N/A

Q5. Does this patient meet any of the criteria for mandatory stage 2 review (see list of inclusion criteria)?

Y/N – select option(s)

Criteria for Stage 2 (Trust MRP) Mortality review;

- Deaths referred to the coroner where the death was unexpected
- Deaths referred to the coroner where the death is unexplained
- Deaths referred to the coroner which are associated with an invasive procedure
- Patients with a known Learning Disability who die in hospital (As part of the LeDeR process)
- Patients with a severe mental illness who die in hospital – Those patients formally receiving Mental Health Care provision during admission prior to death – i.e. Under care of liaison psychiatry services at time of death
- Deaths associated with a cardiac arrest call in hospital (death within 24 hours of cardiac arrest call)

- Deaths associated with a reported significant clinical incident relating to the quality of care
- Deaths associated with a concern about problems in care (acts of omission or commission leading to death)
- Deaths where bereaved families and carers have raised a significant concern about the quality of care provision
- Deaths associated with an active formal area of concern within the Trust (i.e. identified by external bodies – CQC alerts, SHMI data, audit data)
- Deaths within a designated clinical area of improvement e.g. sepsis
- Death associated with any other issue which in the opinion of the responsible consultant is worthy of further review

If any criteria for Stage 2 review are met please ensure a structured departmental mortality review is completed within 2 weeks

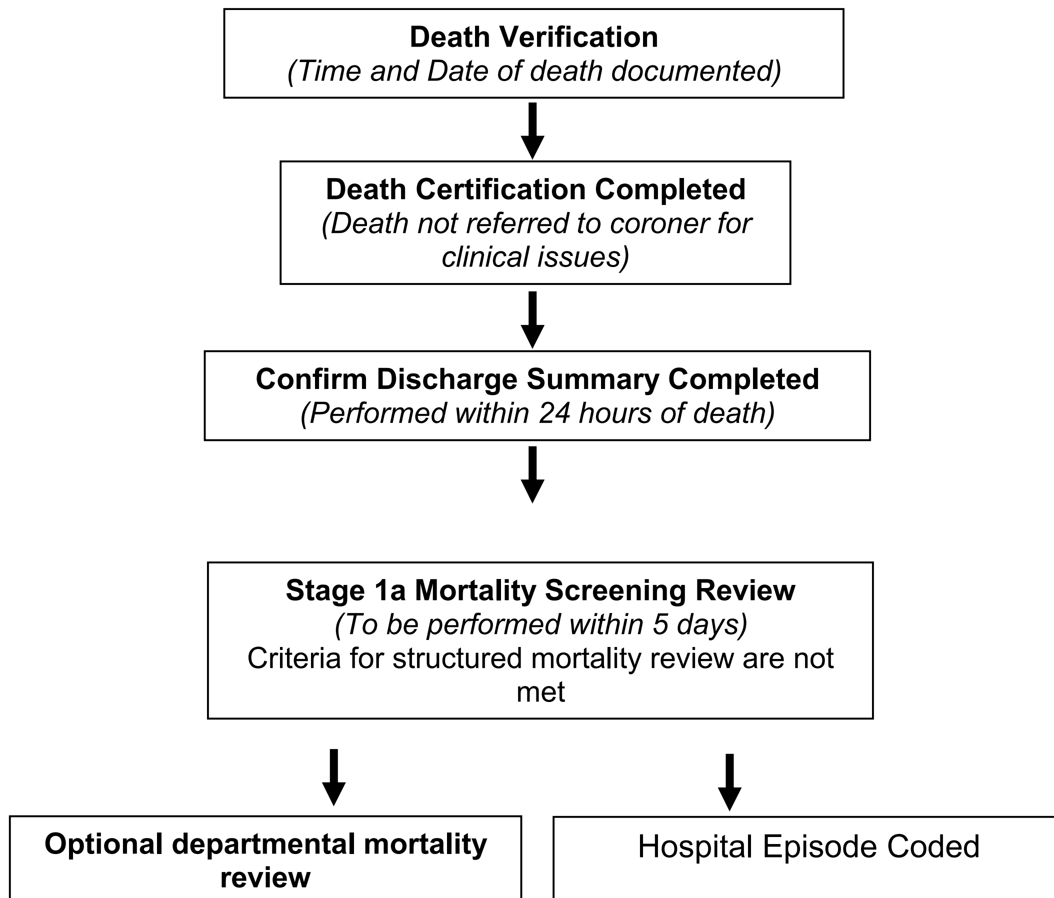
Q6. Is your department going to complete a departmental mortality review for this patient independent of the above criteria?

Y/N

Q7. Please select other departments that may wish to perform their own mortality review for this patient (during this admission)

List of departments – provides notification to nominated individual within each department (Departmental CG lead/mortality lead)

Flowchart of Process for mortality review for deaths NOT meeting Stage 2 review criteria



Appendix 3

Stage 1b (Generic) Departmental Structured Mortality Review (To be completed on V6)

All reviewed patients should be discussed at the next available Mortality meeting

Date of review [insert]

Pull through **Demographics** (as per MRP document)
(Patient details, age at death, sex, day of admission & death, Length of stay, specialty at time of death, type of admission)

Pull through **Recorded death certificate details**

1) Admission and initial management (first 24 hours)

Comments: *Note any problems in care in addition to excellence in care*

Rating: Excellent, Good, Adequate, Poor, Very Poor or Not applicable to department

2) Ongoing Care within department (Overview of reviews, investigations, treatments etc)

Comments: *Note any problems in care in addition to excellence in care*

Rating: Excellent, Good, Adequate, Poor, Very Poor

3) Review of relevant invasive procedure(s) (not iv cannulation)

Details:

Rating: Excellent, Good, Adequate, Poor, Very Poor, N/A

4) Any problems with monitoring or managing clinical deterioration (Recognition, Initial Response, Escalation)

Yes / No / N/A
Comments:

5) Any clinical event during last admission which has prompted a serious incident framework review (via RRG)

Yes / No / Unknown
Comments:

6) Overall assessment of care within department - mandatory

Rating: Excellent, Good, Adequate, Poor, Very Poor
Explanatory comment

7) **Brief Summary of care**

8) Note any learning points to be highlighted at Departmental Mortality meeting
Comments box:

9) Stage 2 review requested (in light of departmental review) Y/N

Appendix 4

Stage 2 Structured Trust Mortality Review (To be completed on V6)

Date of review [insert]

Pull through **Demographics** (as per MRP document)
(Patient details, age at death, sex, day of admission & death, Length of stay, specialty at time of death, type of admission)

Pull through **Recorded death certificate details**

1) Admission and initial management (first 24 hours)

Comments: *Note any problems in care in addition to excellence in care*

Rating: Excellent, Good, Adequate, Poor, Very Poor or Not applicable to department

2) Ongoing Care within department (Overview of reviews, investigations, treatments etc)

Comments: *Note any problems in care in addition to excellence in care*

Rating: Excellent, Good, Adequate, Poor, Very Poor

3) Review of relevant invasive procedure(s) (not iv cannulation)

Details:

Rating: Excellent, Good, Adequate, Poor, Very Poor, N/A

4) Any problems with monitoring or managing clinical deterioration (Recognition, Initial Response, Escalation)

Yes / No / N/A

Comments:

5) Any clinical event during last admission which has prompted a serious incident framework review (via RRG)

Yes / No / Unknown

Comments:

6) Overall assessment of care within department - mandatory

Rating: Excellent, Good, Adequate, Poor, Very Poor

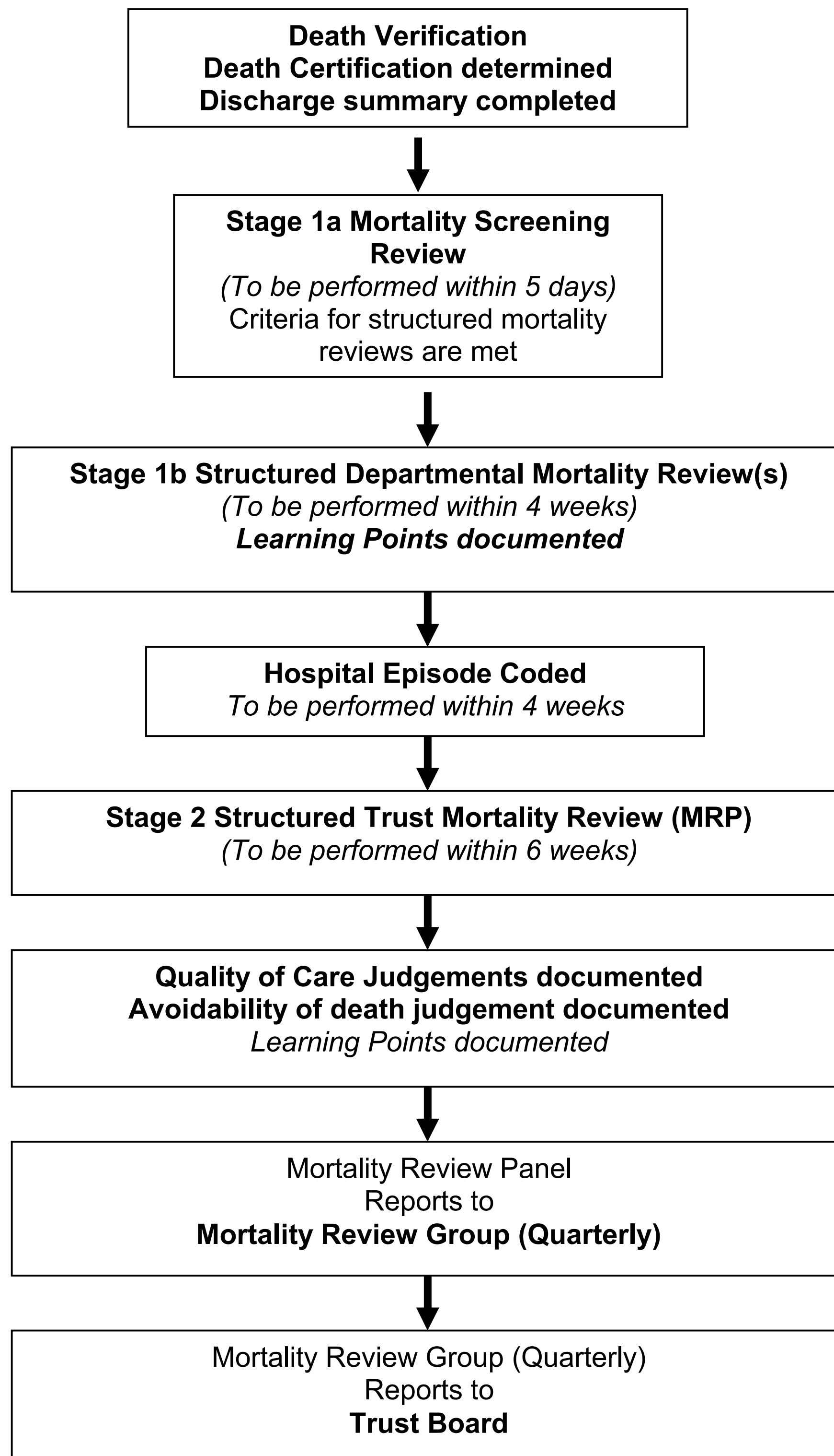
Explanatory comment

7) Note any learning points:

Comments box:

8) Judgements in Quality of Care and Preventability of Death (Hogan and NCEPOD)

Flowchart of Process for mortality review for deaths meeting Stage 2 review criteria



Appendix 5

Criteria for Stage 2 Mortality Review

- Deaths referred to the coroner where the death was unexpected
- Deaths referred to the coroner where the death is unexplained
- Deaths referred to the coroner which are associated with an invasive procedure
- Patients with a known Learning Disability who die in hospital (As part of the LeDeR process)
- Patients with a severe mental illness who die in hospital – Those patients formally receiving Mental Health Care provision during admission prior to death – i.e. Under care of liaison psychiatry services at time of death
- Deaths associated with a cardiac arrest call in hospital (death within 24 hours of cardiac arrest call)
- Deaths associated with a reported significant clinical incident relating to the quality of care
- Deaths associated with a concern about problems in care (acts of omission or commission leading to death)
- Deaths where bereaved families and carers have raised a significant concern about the quality of care provision
- Deaths associated with an active formal area of concern within the Trust (i.e. identified by external bodies – CQC alerts, SHMI data, audit data)
- Deaths within a designated clinical area of improvement e.g. sepsis
- Death associated with any other issue which in the opinion of the responsible consultant is worthy of further review

Patients in receipt of End of Life Care prior to death will be selected for a Trust End of Life Audit review to determine the quality of end of life provision.

Appendix 6

Responding to the death of an individual with a Learning Disability using the LeDeR process

INTRODUCTION

1. The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities and to take forward the lessons learned in the reviews in order to make improvements.

2. The purpose of the LeDeR reviews is not to hold any individual or organisation to account. Other processes exist for that, such as criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation. It is vital, if individuals and organisations are to be able to learn lessons, that reviews are undertaken in a trusted and safe environment that encourage honesty, transparency and sharing of information.

3. At CHSFT four clinical staff have been trained to review the deaths of patients who had a learning disability. The process involves;

   a. The notification of a death to the LeDeR team. This notification can be from anyone from a person involved in their care, their family or a member of the public.

   b. The national team assign the case to a local area contact (LAC). For CHSFT this is the Director of Nursing of Sunderland CCG. The LAC then assigns the case to a local reviewer and informs the LeDeR team.

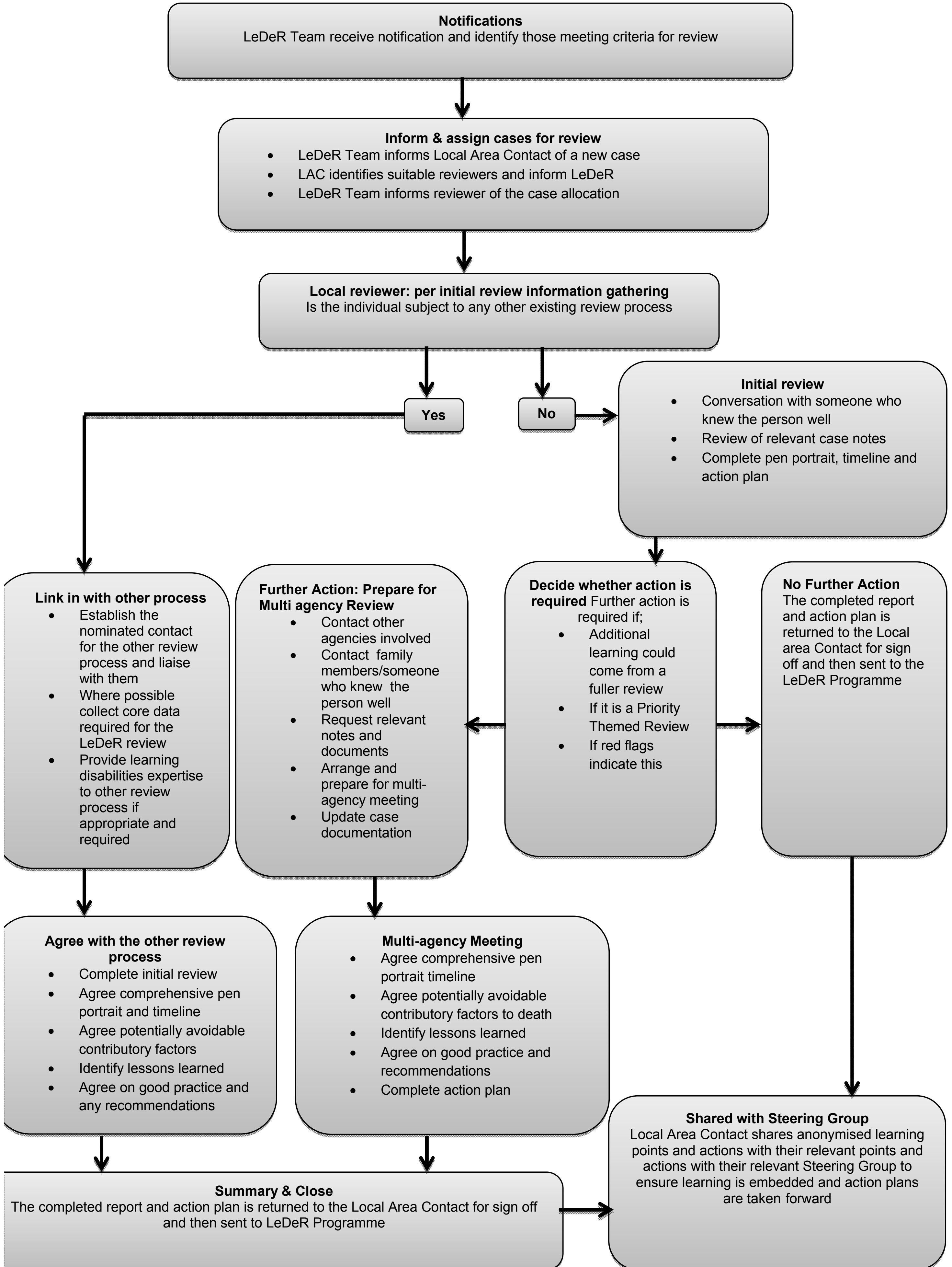
   c. The local reviewer gathers the initial information including whether any other review processes are underway. If there are other reviews in place the local reviewer will liaise with the contact for that review to agree the way forward, if not an initial review will be undertaken. If the person who died meets the criteria for a priority themed review ,or it is felt that there is further learning could be obtained from a more in depth analysis of the circumstances leading to the death, then a multi-agency review meeting must be held.

   d. In CHSFT there is an agreement that if the death raises concerns with regard to safeguarding the case will be sent to the Learning and Improvement in Practice (LIIP) subgroup of the Adult Safeguarding Board for scoping.

   e. Lessons learned to improve care are shared at ward/team level and the LAC shares learning points more widely with the relevant steering group.

   f. The following flow chart outlines the detail of the review process.

LeDeR Process Flowchart



Appendix 7

Responding to a stillbirth, neonatal death or maternal death

The Directorate 'trigger list' for incidents which must be reported through Ulysses includes maternal death, fetal loss from 16 weeks gestation, intrapartum stillbirth and neonatal death.

Maternal Mortality

All maternal deaths (regardless of the standard of clinical care provided) are reported through Ulysses and escalated to the Executive Director of Nursing and Patient Experience (or deputy) as documented in the maternity risk management strategy. The level of investigation is determined by the Trust Rapid Review Group (RRG) and will be completed either by the Directorate Risk Management Team, overseen by the Directorate Manager, or it may be subject to external review at the instruction of RRG. The Head of Midwifery is responsible for reporting all maternal deaths to **MBRRACE – UK** and sharing clinical records for inclusion in the national 'Confidential Enquiry into Maternal Deaths'.

Perinatal Mortality

All fetal losses over 16 weeks are reviewed and the severity rating upgraded or downgraded according to the review findings.

The following are escalated to the Executive Director of Nursing and Patient Experience (or deputy) as detailed in the Maternity Risk Management Strategy –

- The unexpected death of, or severe brain injury to, a baby born under the care of the Trust if it is felt that the clinical care provided may not have been of a reasonable standard

All Perinatal Mortality cases are discussed in the monthly Directorate Perinatal Mortality meeting held jointly with the Neonatologists and neonatal team.

All of the following are reported to MBRRACE-

- late fetal losses from 22+0 weeks gestation to 23+6 weeks gestation
- termination of pregnancy from 22+0 weeks gestation
- stillbirth from 24+0 weeks gestation
- neonatal death up to 28 days of age of all infants born at 20+0 weeks gestation or above and with birth weight >400g

MBRRACE reporting is mandated. MBRRACE publish a Perinatal Mortality report annually and the Directorate produce a joint response with the Neonatologists where indicated which is forwarded to the Trust Clinical Governance Steering Group for noting. The Neonatal team hold internal mortality reviews on a quarterly basis for all cases of neonatal death with an external reviewer present and report all mortalities and learning points to the Neonatal Network.

Additionally the Obstetrics and Gynaecology Directorate report the following to the Royal College of Obstetricians and Gynaecologists 'Each Baby Counts' (EBC) project,

- all term deliveries (≥37+0 completed weeks of gestation) following labour that resulted in one of the following outcomes: Intrapartum stillbirth, early neonatal death within the first week of life and severe neonatal encephalopathy

Reporting to EBC is voluntary rather than mandated but the Trust has signed up to the project along with all other Trusts in the UK. Root Cause Analysis investigations are completed for all cases meeting the EBC criteria and anonymised versions of RRG approved reports shared with EBC.

Appendix 8

Responding to the death of an infant or child (Child Death Review)

OVERVIEW

All deaths of children aged 0-18 years of age are currently reviewed at a local and regional level through the Child Death Overview Process. This process is outlined in Chapter 5 of *Working Together to Safeguard Children (2015)* guidance; (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2).

For children under 12 months of age additional guidance is provided within the report of the working group within the Royal College of Paediatrics and Child Health entitled *Sudden Unexpected Death in Infancy and Childhood;* (https://www.rcpath.org/discover-pathology/news/new-guidelines-for-the-investigation-of-sudden-unexpected-death-in-infancy-launched.html).

The South of Tyne Child Death Overview Panel (CDOP) is responsible for reviewing all child deaths in Sunderland, Gateshead and South Tyneside. Information from all professionals involved would be collected and collated by the local designated doctor and discussed at Local Child Death Review panel (LCDR) in Sunderland prior to discussion at CDOP. This would include information from health, social services, education and police to ensure that as much information is available to be able to evaluate whether the death is deemed preventable and to identify any modifiable factors. These might result in actions at a local, regional or national level to prevent further deaths.

The designated doctor for child death will ensure that families receive information on the Child Death Process and meet with them where possible to discuss any concerns or questions that they might have about their child's death. The purpose of the Child Death Overview Panel (CDOP) is:

- To establish, where possible, a cause or causes of death (in conjunction with the coroner)
- To identify any potential contributory factors
- To provide ongoing support to the family
- To learn lessons in order to reduce the risks of future child deaths

The Trust has detailed information and documentation to use in the event of a child death which is available to paediatric staff via the Q drive (Paediatrics – Child Death).

The designated doctor for child death has produced a guide to the child death review process, entitled 'Responding to the death of an infant or child.

Responding to the death of an infant or

Appendix 9

Flowchart of Process for mortality review for deaths meeting Stage 3 review criteria